NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2024 NCOIL ANNUAL MEETING – SAN ANTONIO, TEXAS
NOVEMBER 22, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Westin Riverwalk Hotel in San Antonio, Texas on Friday, November 22, 2024 at 10:00 a.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Deborah Ferguson, DDS (AR)
Rep. Stephen Meskers (CT)
Rep. Matthew Gambill (GA)
Sen. Larry Walker (GA)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Rep. Deanna Frazier (KY)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Sen. Mark Huizenga (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Michael McLendon (MS)
Sen. Charles Younger (MS)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Sen. Pam Helming (NY)
Asw. Pam Hunter (NY)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Rep. Dennis Paul (TX)
Del. David Green (WV)
Sen. Eric Nelson (WV)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Josh Carnley (AL)
Sen. Clint Penzo (AR)
Rep. Mark Hashem (HI)
Rep. Brian Lohse (IA)
Rep. Peggy Mayfield (IN)
Sen. Jason Howell (KY)
Del. Mike Rogers (MD)
Sen. Jeff Howe (MN)
Rep. Bob Titus (MO)
Sen. Dennis DeBar (MS)
Sen. Hillman Frazier (MS)
Sen. Walter Michel (MS)
Sen. Joseph Thomas (MS)
Rep. Greg Oblander (MT)
Sen. Bill Gannon (NH)
Rep. Forrest Bennett (OK)
Rep. Mark Tedford (OK)
Sen. Roger Picard (RI)
Rep. Joe Solomon (RI)
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. Lana Theis (MI) and seconded by Sen. Jerry Klein (ND) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. David LeBeouf (MA) and seconded by Rep. Dennis Paul (TX), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 18, 2024 meeting.

PRESENTATION ON THE PRIOR AUTHORIZATION LANDSCAPE

Sen. Walter Michel (MS) stated that Mississippi passed a prior authorization reform law a couple of years ago and we thought it was very significant legislation. I'm thankful to see that the Committee is addressing this and I think that maybe the Mississippi law would be a starting point for the Committee to develop a prior authorization reform model law next year.

Emily Carroll, Senior Legislative Attorney at the American Medical Association (AMA), thanked the Committee for the opportunity to speak and stated that prior authorization is certainly a priority topic for us. We've been working to address this issue for many years, largely in the states up until recently. Every year we put together an annual survey of physicians to sort of assess the impact of prior authorization on them and their patients and as in previous years, the survey results continue to show both patient harm and physician harm as well as impact on the healthcare system and employers and employees. We always kind of initially focus first and foremost on the patient harm because we believe it's significant and this year, we continue to see that – 94% of physicians report care delays because of prior authorization and 78% report that prior authorization has led to treatment abandonment by patients. Maybe most concerning is that nearly one in four physicians report that prior authorization has led to a serious adverse event for their patients and this can include hospitalization, long term or permanent impairment or even death. We also look at the impact of prior authorization on physicians. It's draining and exhausting our physicians and their practices. Physicians spend nearly two business days each week completing prior authorizations and they're reporting that the number of prior authorizations continues to increase. And nearly all physicians report prior authorization is leading to burnout. And I really want to stress that this is all happening against the backdrop of a severe physician shortage in the States and nationally and the growing corporatization of healthcare and prior authorization is certainly impacting and leading to this environment that we're seeing these issues with. Also, prior authorization is impacting employers and employees. Almost half of physicians report that their patient's job performance has been impacted by prior authorization. So that's a result of absenteeism or decrease in function due to care delays and prior authorization impact. And then finally, we find that prior authorization is increasing costs for the whole healthcare system, and the impact of it is really causing greater utilization of services, repeat office visits, ineffective initial treatments, and more hospitalization and emergency room (ER) visits.

So, what are we proposing to do about it? The AMA is offering a number of solutions. We have model legislation that we've seen introduced in some of the states but really I've kind of bucketed our solutions into a couple categories. First, faster response times. We really need to

address these care delays. The AMA would say 24 hours as a turnaround time for urgent care and 48 hours for non-urgent. And we really focused on those hours rather than business days and we're really strong proponents of the use of application programming interfaces (APIs) and other standard transactions to help automate the process but we really stress that automation has to be done in the context of other reform efforts, because we're not just trying to get more prior authorization done faster. We also are really looking at reducing the volume of prior authorization. So, as I mentioned, physicians feel that prior authorization just keeps growing and we're really looking at solutions that would reduce that volume and sort of bring prior authorization back to kind of its targeted or initial goal and kind of targeted utilization management. So, some of our options here are those that have been passed in Texas and other states which is gold carding and that's the idea that if you have high approval rates on certain services or episodes of care maybe you wouldn't have to do prior authorization for those services. And we see a lot of states and others looking at sort of eliminating prior authorization generally for some services that may just not make sense like preventive care or other types of services. We would also look to ensure the clinical integrity of prior authorization. So, on the plan side, the reviewer being a physician who has experience treating that type of patient or doing that type of care. We'd also like them to specifically be a licensed physician because really when you're making a medical necessity determination you're really participating in the practice of medicine. And then also we want to make sure that the clinical standards that are being used to do these prior authorizations are not proprietary and really based on national medically recognized standards of care which most national medical specialty societies have developed.

And then we really like the concept that a lot of states are pursuing around data collection, kind of seeing what's behind the black box of prior authorization. What are the rates of approvals? What are the rates of denials? What are the response times? How often are things approved on appeals? We think first of all, that makes it easier for patients to make informed decisions about their plans but also for policymakers to make more targeted reforms in the future. Continuity of care is a big issue. We've seen many proposals that look at ensuring when patients switch plans, they're able to continue on the medication or continue on the service as they switch for a period. And then we want to prevent repeat prior authorization. So, sometimes you'll see kind of stoppage in care while a patient has to go back and get a prior authorization on something they've been stable on for a long time. And then just general transparency. What are the criteria ensuring that once you have a prior authorization, the plan's not going to go back and not cover that service? Real clarity and the reasons for an adverse determination when it comes to the patient and physician. And then just more clarity around the appeals process which we hear is often a difficult journey for many patients. So, we've talked about this before many years ago - the AMA, Blue Cross Blue Shield, America's Health Insurance Plans (AHIP), the Medical Group Management Association (MGMA), and the pharmacists came together and created a consensus document which kind of looked at maybe some of the low hanging fruit around prior authorization and what we thought we could accomplish together voluntarily. Unfortunately, we haven't seen a lot of progress in that space and we're still helping to ensure that the promises of that consensus statement are realized. But really, I think the states have led the way on prior authorization reform. This is just a map of some of the states that passed legislation this year. Some of these states like Wyoming, Illinois, Colorado, New Jersey, and Maine - they enacted some pretty comprehensive reforms this year that look at a lot of those solutions I talked about just a few minutes ago.

And then we're seeing some progress on new ideas. Minnesota took some steps this year after having really strong legislation on the books. They went a step further this year and decided to start looking at how to pull certain services and just prevent prior authorization on them. So,

some cancer care, mental health services, those sorts of things. Vermont did something similar where they will prevent prior authorization on primary care services going forward. So, we're seeing some innovation there. And I'll mention California also passed a bill that's really looking at the use of artificial intelligence (AI) in prior authorization and they will ensure that if a prior authorization is denied a physician is making that determination rather than the algorithm. I also mentioned that there has been some progress at the federal level which we are excited to see and I think it really builds on the work that a lot of the states have done over the last several years. There is a new Medicare Advantage rule that is in effect as of January 1st this year that makes some significant progress around clinical validity and continuity of care in the prior authorization space. And then there's one more rule that some aspects of it will be adopted in 2026 and 2027 but this one is much broader, and it applies to Medicare Advantage, Medicaid, Medicaid managed care organizations, and qualified health plans on federally facilitated exchanges. And these reduce the response times that plans are allowed to respond on prior authorization and it really takes automation for medical services a step forward which I think some states are really looking at adopting. And then there's a lot of transparency requirements too. So, I think states have a real opportunity with these new federal rules to kind of bring their requirements at a minimum up to these federal standards and then of course, there is legislation that is pending at the federal level as well that looks at a lot of the state efforts and attempts to apply some of those to the Medicare Advantage space.

Miranda Motter, Senior Vice President of State Affairs and Policy at AHIP, thanked the Committee for the opportunity to speak and stated that it's probably not going to surprise you that on all thing's prior authorization, AMA and AHIP don't necessarily see eye to eye as it relates to the value of prior authorization. Which is why we're both here to sort of share those perspectives. I will say though that I do think that there is probably a bright spot. I do think that there is probably some agreement as it relates to what quite honestly both of our organizations view as a major barrier to making sure that the administrative burden for providers is reduced as it relates to prior authorization. So, I'll spend some time talking about that but I really wanted to speak about five quick areas this morning. First and foremost, the value of prior authorization. Secondly, and Ms. Carroll spoke to it a little bit, but I do think it's incredibly important to spend a few minutes on that consensus statement that she talked about. Third is where I want to spend some time about where I think there may be some alignment and some real opportunity to again reduce administrative burden for providers but at the same time doing so in a way that doesn't jeopardize patient safety, patient care, patient affordability. And then I'll share really some places where states are leading the way as it relates to reducing this barrier. And then I'll close with just a couple of insights as you all may be looking at proposals moving forward, just a couple of recommendations and suggestions as it relates to that. So, with that, why do health plans use prior authorizations? Health plans advocate for the people that they serve by ensuring that the right care is delivered at the right time, in the right setting and covered at a cost that patients can afford. That's essentially why prior authorization exists. And at the outset I think it's really important for me today to say that doctors provide important care and life saving treatment. But we're all impacted by low value care. Low value care is care that has little or no clinical benefit or where the risk of harm for the care outweighs the benefit. Low value care has a significant impact on our country's healthcare system. But more importantly, it impacts patients. And we can't lose sight of that.

So, we've all seen the studies on the financial impacts of low value care. Here is one, a Journal of the American Medical Association (JAMA) study that estimated 25% of all healthcare expenditures is due to waste in the U.S. system and of that total it's estimated that $75 billion to a $101 billion is related to overtreatment or low value care. Other studies show that 30% of healthcare spent in the U.S. may be unnecessary and it may be harmful to patients. So, low

value care doesn't just have this financial impact. It impacts patients. It may expose them to harm. It may expose them to additional out of pocket costs. It may expose them to lower quality of life. And really important here is low value care impacts help other doctors have to provide as 87% of doctors have reported negative impacts of low value care. They have also reported that at least 15% to 30% of medical care is unnecessary. So in other words, doctors have to fix care of other doctors and that impacts patients. Medical knowledge doubles every 73 days. Primary care doctors would have to practice 27 hours to keep up on all of those changes and so that's really why it's important that health plans, doctors, hospitals all work together to make sure to reduce that low value care and protect patients from unnecessary harmful care and cost. So, what do plans do? Plans are doing this through a variety of strategies. They enter into value-based arrangements with providers where those providers are actually holding themselves financially accountable for the quality of care that they're providing their patients. Plan share real time provider feedback so that it helps those providers understand if they are operating as an outlier, if they're not following clinical evidence-based standards. And then last, plans use targeted evidence based prior authorization that focus on those clinical areas that are prone to extreme variation and cost or misuse that harms patients or saddles them with unexpected costs. The prior authorization process, I have to say we all agree, can be burdensome for all of us. For providers, for patients, for plans. And again, that is why it is incredibly important that we all work together.

This is a slide that you just saw from Ms. Carroll and this is exactly as she indicated what we did. In 2018, we all came together - all six of these national associations came together. And in a really public way, committed to improving prior authorization. One of the things that I do want to point out in this consensus statement, because it was significant, is that it recognized not only that the prior authorization process is burdensome but it also recognized that prior authorization was important. And you can see, as it says in this consensus statement, it's important because there's wide variation in medical practice. So as trades, all of us agreed to five areas of opportunity: selective application, program review and volume adjustment, transparency and communication, continuity of patient care, and automation ti improve transparency and efficiency. That was real low hanging fruit, as Ms. Carroll said. So, what have health plans been doing since 2018 to take action? They have been taking action and again, I think it's really important to recognize this because I think that you have probably heard about this consensus statement in your states. You have heard that plans may not have been taking action, but they have. Plans have been leveraging prior authorization by using electronic systems. A survey of our plans on the use of prior authorization in 2019 and 2022 showed that more insurers are streamlining their prior authorization electronic process more than ever before. Plans are also providing support to providers. They're helping them understand why using outdated manual systems is really hard on them. It's an administrative burden but it also doesn't achieve the best in terms of patient care. In 2020, and I think I've spoken to this before, AHIP and our partners launched what is called the Fast Path Initiative and it actually took technology into physicians' offices and helped them understand if they used electronic prior authorization what it meant. It meant faster time to decisions. Faster time for patient care and better understanding in terms of when prior authorization was needed. And the more the providers used it, the better they said the system worked for them.

It also meant that there was less burden from phone calls and faxes and so it was really important. You'll see here just a really quick case study of Elevance, where it actually showed that using electronic prior authorizations really is quicker. The other thing I will say just real quick is plans are also waiving and reducing prior authorization requirements as providers take on financial risk. I mentioned that more plans are using gold carding programs based on ongoing provider performance and consistent adherence to evidence based standards. These

gold carding programs are most effective when they're targeted and when provider performance is closely monitored and partnered with risk-based accountability and they're used for certain services where the clinical guidelines are clear. So, let's talk about where there may be some real synergy and where we may align. I think Ms. Carroll and I can both agree where automation is a real opportunity, which is the major barrier today. So, while health plans are building and offering electronic prior authorization, a significant percentage of providers are still using fax and mail. And I think the AMA's own survey showed that it was reported that the most common way they're submitting prior authorizations is by phone. So, despite the fact that if they used electronic prior authorizations, it could be quicker, as I said, quicker decisions, quicker patient care, better understanding of when it's needed - we're still using outdated manual systems. We have to change that. We have to improve this two way process by providers and I really think that this is a bright spot as we think about next steps. States here, as I said, are already leading the way. They're already understanding that not using a two-way electronic system is a real barrier to moving forward. You can see here over the past few years, at least nine states and D.C. have passed this two-way legislation. It not only requires the health plan to build and make available the system, but it requires the provider to use the system so that we're not building a bridge to nowhere.

I won't spend much time on this because Ms. Carroll talked about it, but not only are states leading the way, but there's certainly a lot of activity at the federal level to make sure that this electronic prior authorization and this technology is being used to build bridges to advancement. The federal rules, as Ms. Carroll talked about, will require and health plans to create API's but they will also importantly require providers to build this workflow into their electronic health record so that they can use this real time information. I think we all believe that this is really encouraging. So in closing, just a couple of thoughts. I can't stress enough that prior authorization is an important tool. It helps make sure that patients' access to coverage for safe effective care is supported by the most updated clinical guidelines. Some important considerations I think for policymakers as they are objectively evaluating proposals are, are the providers in your state actually using electronic prior authorizations? Or are they using phones to submit their prior authorizations? So, does that proposal actually build a bridge to somewhere? Will the providers be held accountable for high quality care? Are they in value-based relationships? How does the reform actually impact patient care? And essentially in those proposals, are we tolerating a certain level of low value care for patients? And then ultimately how does the reform impact patient affordability? Again, there's some studies here that you can look to in terms of what the real financial impact is, not only here but I know as states have considered these proposals and you all have looked at what the financial impact is going to be, whether it's applicable to your state employee program, whether it's applicable to your Medicaid programs, and you've seen the financial impacts. In lots of instances the application of those proposals gets pulled from those state plans because there's a recognition that it will be expensive and that shift then is ultimately given to the small employers that will pay for that. So again, thank you for the opportunity to spend some time with you on this really important issue. We look forward to additional conversations. I mentioned the study and the survey that we did of our plans in 2019 and 2022. We are actually in the process of updating that right now and it should be ready early next year. I look forward to the opportunity to come back and show how plans continue to advance and where there may be some other gaps and opportunities for alignment.

Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, stated that I appreciate the work of everyone trying to work together and coordinate. Is there any effort to harmonize what prior authorizations are required? Because in a practice when you have 300 or 400 different health plans and then all of a sudden, particularly Medicare Advantage plans, they tend

to drop a prior authorization that you didn't know about and then the claim gets denied. Is there an effort to harmonize what's required for a prior authorization? Ms. Motter stated that a couple of things come to mind. First and foremost, prior authorization focuses on those areas and services that are prone to misuse, overuse, where clinical guidelines are really important to follow, and where there may be cost implications. The other thing I would say is prior authorization largely follows what your coverage looks like. So, as a purchaser of health care, whether it's Medicare, whether it's the state and Medicaid, whether it's the employee or the employer in terms of employer coverage, how the purchaser of that healthcare wants to make sure that there's high quality care and there's affordable care, it really aligns with that. So I would say there continues to be this focus on evaluating the services that are prior authorization but in terms of industry coordination around a particular kind of service for a variety of reasons, I'm not aware of any of that happening right now.

Ms. Carroll stated that I would say some of the disconnects sometimes in an office may come from different clinical criteria so you may have one plan that uses a set of clinical criteria that they have purchased and manipulated whereas another plan will use a different set of clinical criteria. So, one patient service or drug could be medically necessary under that plan's criteria and if they were on another plan, it would be different. So, I think that certainly leads to some hardship on the practices and certainly the patients as well. Rep. Ferguson stated that you can understand as a practitioner how difficult it is when you have hundreds of insurance plans to keep up with who requires what prior authorization. I just think the industry should get together and sort of agree on some standards.

Sen. George Lang (OH) stated that a few things confused me from the presentations since there was some contradictory things. Ms. Carroll, you said it can take up to 72 hours for urgent prior authorization. Ms. Motter, you said 70% are instant, 95% are in 24 hours. I know last week I had an urgent medical need that I had to get a test for which I'm scheduled for next week and it took 15 minutes. So, the 72 hours, is that an outlier? Ms. Carroll stated that our policy actually is that urgent care should be turned around in 24 hours. There are lots of places where there are no requirements around that. Certainly, automation has helped improve the turnaround time but a lot of state laws attempt to really push that into 24 hours and that's what we would suggest. Fifteen minutes is fantastic but that's certainly not the case for most patients. Ms. Motter stated that as Ms. Carroll said, some states have taken action in terms of requiring certain time frames. That 72 hour reference is sort of the outlier and the outer limit. The other thing that I would say is that many health plans, because there may be a Medicaid plan, it may be a state requirement there that they are an accredited plan based upon a national accreditation. And even if you don't have a state specific requirement, plans are held to turn around times based upon keeping that accreditation. Now the 70% that you mentioned, that's when both the health plan and the provider are accessing and using that electronic prior authorization process and that's really I think the sort of light at the end of the tunnel. That's the goal. If there's two-sided utilization of that process, it's much faster and if there are questions or real time further information that is needed, it can be done through that electronic system to get the answer quicker.

Sen. Lang stated that in my private business, I remember how amazing it was when the fax machine came out. I saved money and things were a lot quicker and I thought nothing could ever replace it that technology. Today, nobody uses a fax machine. When I saw the statistics about the phone being a primary way of doing this, isn't that part of the problem that we are relying on archaic systems when there's new technology there? Ms. Carroll stated that it's certainly part of the problem. And the investment for physicians, many of which are independent practices or small physician practices, in the technology that is needed is a huge

hurdle. So, we are working on solutions related to that but I will say that's part of the problem. I really want to stress how much we support automation but the volume of prior authorization is also part of the problem. So if we can both move forward on automation but also address the volume and the other barriers that are part of this, I think we can have a solution – it's not automation alone.

Rep. Tom Oliverson, M.D. (TX), NCOIL President, stated that I have two quick observations and one of Ms. Motter's slides was interesting to me. While you were talking, I did a quick medical literature scan on hyaluronic acid in the knee, and did you know that there was a British Medical Journal article that concluded it was not very much a benefit and literally that same year there was a systematic review that came out that said that it was. And so, when we talk about low value care versus high value care, are we really sure of the literature when we make these statements? Or is it just sort of we're picking and choosing the data that supports our conclusion because of cost factors. I don't really want you to comment on it, I just want to point that out that it literally took me 60 seconds to figure out that the medical community is not universally agreed upon whether or not hyaluronic acid in the knee is actually beneficial or not. The second thing I was going to say is, could we all agree that using the word "prior" means something that should happen before the medication is prescribed? Because what I see and what I have personally experienced as a patient is that my doctor continues to get hit with prior authorizations for medications I'm already on. I'm on a very expensive medication for cholesterol. It's this new one that you have to inject and it's expensive. But we failed everything else and I've had side effects with other medications. We've already gone through the prior authorization process and I haven't changed insurance. And yet every three to six months, my doctor gets slammed with another prior authorization for a medication that I'm on. Now that just disrupts continuity of care and harms a patient's ability to manage chronic disease. So, can we agree that maybe that's not a good application for these kind of tools? That if you go through the process once and you've passed, you don't get to keep dragging people back through the prior authorization process every six months?

CONSIDERATION OF NCOIL VALUE BASED PURCHASING MODEL ACT

Rep. Dunnigan stated that we'll now consider the NCOIL Value Based Purchasing Model Act. The sponsor of the Model, Sen. Mary Felzkowski (WI), is at our conference but had something come up and couldn't be at this committee meeting. It is our intent to vote on the Model as we've been working on this for a year and we haven't heard of any opposition.

JP Wieske, VP of State Affairs for the Campaign for Transformative Therapies, thanked the Committee for the opportunity to speak and for consideration of this model which is very simple. The model allows but does not require Medicaid and drug companies to negotiate what's called a value-based arrangement which allows supplemental rebates to pay for effectiveness of the medical care. So, for example, one of my clients has the hemophilia gene therapy, which costs $3 million. They're willing to warranty the effectiveness of that with Medicaid and if it does not work within the first year, we fund most of that money back. So that's what this model does. It allows but does not require anybody to enter into these arrangements.

Hearing no questions or comments, upon a motion made by Rep. Carl Anderson (SC) and seconded by Sen. Justin Boyd (AR), the Committee voted without objection via a voice vote to adopt the model. Rep. Dunnigan thanked everyone and stated that the Model will now be placed on the Executive Committee's agenda for final ratification.

CONTINUED DISCUSSION ON NCOIL IMPROVING AFFORDABILITY FOR PATIENTS MODEL ACT

Rep. Dunnigan stated that we'll now continue our discussion on the NCOIL Improving Affordability for Patients Model Act (model). At our Spring Meeting in April, we had a good introductory discussion on this topic and then we continued it in July with some model language that was floated for consideration. Since that time, Rep. Ferguson and Rep. Oliverson have agreed to sponsor the model. You can see it in your binders on page 38 and on the website and on the app. We won't be taking any action on this today, just continuing our discussion.

Rep. Ferguson stated that I really support this model and I'm grateful to Rep. Oliverson for agreeing to sponsor it since I'm leaving the legislature in January. We'll hear more from our speakers today, but ultimately the model prohibits healthcare facilities, including hospitals, from inaccurately imposing hospital facility fees on outpatient services. It makes it difficult for private practice physicians to compete with the hospital rates and it ultimately saves patients a lot of money if they're not billing hospital facility fee rates for truly outpatient procedures.

Rep. Oliverson stated that I appreciate Rep. Ferguson's leadership on this and I'm honored to be able to sponsor this. I can just tell you as a physician that the real problem here is that we have a loophole that's allowing facilities to charge facility fees for things that are done in the office by doctors or other providers that ten years ago, you would have just gotten one bill. Now you're getting two bills for exactly the same thing. We're not talking about MRI's. We're not talking about labs or physical therapy. We're talking about going to the doctor and seeing the doctor. You get a bill from the doctor, and now you're getting a bill from the hospital because it turns out the hospital actually owns your doctor and that's something that I think is problematic on two levels. Number one, there's no added value being provided for that service but there is a duplication of charge now being provided. And the argument is being made that that's in order to make sure the doctors are getting a fair reimbursement. But by my calculations, in no circumstance does 100% of the fee collected on the facility side make its way into the hands of the physician. If there was a reimbursement issue that needed to be addressed, then the way to address that is to address the reimbursement issue, not to create an avenue to allow a facility to suddenly leverage a healthcare provider's business.

And secondly, to Rep. Ferguson's comments, it deeply disturbs me to see the rise in consolidation in health care and how corporate the practice of medicine has become. I don't think that's good for consumers. You have to ask yourself when the doctor's practice is owned by the hospital or the health plan, who's the patient advocate there? There are secondary gains and entanglements that cloud that medical practitioner's decision making and we need to be doing whatever we can to not incentivize more physician practices to become owned by large consolidated, typically tax exempt or not-for-profit entities that may have a very different set of financial goals and drivers than your traditional doctor. Finally, I think there's a middle ground here and I hope that my hospital friends can see that what we're not talking about here is limiting the ability to charge a facility fee in the setting where facilities are being used or there's ancillary services that are being performed or it would lend itself to a fee. What we're specifically talking about here is charging a facility fee for the privilege of being in the doctor's office and there's no evidence whatsoever to suggest that there's any improvement in the level of service or care or additional services that are provided or quality that's provided by going to see a doctor who happens to be owned or who's practice is owned by a large system versus a private practitioner. So, I really strongly believe in this model. I do think there's a middle ground here and I would urge everybody to come to the table and let's work this out. But let's get rid of the duplicate billing. I had a mother of a patient reach out to my legislative office on Friday,

complaining that the large Children's Hospital in my district had just recently sent her a big bill because her daughter went to go see a sports medicine doctor and had a 15 minute consultation in the office and got a charge from the doctor. Two weeks later, she got a $200 bill from the hospital. The patient never set foot in the hospital. There were no additional services provided. It was just a simple consultation and exam. So, we have to do something about this.

Karen Davenport, Senior Research Fellow, Center on Health Insurance Reforms, McCourt School of Public Policy, Georgetown University, thanked the Committee for the opportunity to speak and stated that I think we've already had a very helpful discussion of what facility fees are and what some of the issues are around them. I'll just say, facility fees aren't new. It's normal and accepted practice for in-patient hospital care, for example, for patients to see separate bills from the surgeon and the anesthesiologist and other treating physicians as well as charges for the hospital. And we see that as well as more care moves to the outpatient setting for procedures that patients receive. But as hospitals buy outpatient practices, consumers are seeing more facility fees attached to routine ambulatory care and office visits that don't require hospital admission or a hospital level of care. And I think that's where the consternation largely lies certainly on the side of consumers, and payers as well because the quality, and safety, and intensity of the care you get may often be totally unchanged just because your physician's practice has been purchased by a hospital and is now operating as a hospital outpatient department. So, why should policymakers be concerned about the wider application of facility fees including in settings that before a merger were a plain vanilla doctor's office and still look like a plain vanilla doctor's office to patients who continue to see the same healthcare professionals that they've always seen? In our research, we talked with consumer advocates, insurance plans, and other academics, and several reasons came up.

First, consumers are facing higher out of pocket costs for outpatient care. That's partly because they're carrying larger deductibles so they really feel any extra bill. But also with two bills, even patients who have met their deductibles or have low deductible plans can face significant cost sharing. That's because two bills can generate two cost sharing payments. Perhaps a copayment for the physician visit. But also, coinsurance for the hospital's bill. Consumers, and for that matter, their employers, also face higher premiums thanks to higher spending on outpatient care with that spending driven in large part by the growth of facility fees and the application of those fees to regular office visits. Consumers who can't afford to pay cost sharing related to facility fees may also decide that they need to find a new provider who practices independently and therefore doesn't charge facility fees. That is if they can find them given the higher level of vertical consolidation that we have in so many health care markets. And between the higher costs that consumers experience and often the frustration of not even knowing if they would be hit with higher out of pocket costs, consumers experience a lot of confusion and anger. Payers are also incurring increased costs for ambulatory care as is the healthcare system at large. And to the degree that facility fees create an incentive for hospitals to acquire more ambulatory practices, insurance plans have less leverage as they negotiate rates for outpatient care, since they must negotiate with larger, sometimes must have systems for their networks, and end up paying more for these services.

Some states have enacted legislation or pursued regulatory reforms related to facility fees. We did what felt like an exhaustive look at all 50 states, plus the District of Columbia on the reforms that some of these states have taken and we see reforms that typically seek to address one or more of three issues. That is the problem of increased consumer out of pocket cost exposure, rising health care system costs, and limited information on facility fee billing and outpatient practice ownership. We've categorized the responses that states have taken into five buckets: banning facility fees for some or all outpatient care; new billing and ownership transparency

requirements; public reporting requirements related to facility fee revenue; limits on consumer cost sharing for facility fees; and consumer notification requirements. You can see that effectiveness meter down there on the lower left. We have a cheat sheet for policymakers that I think is in your materials and is also available on our website that goes through all of these solutions and makes some assessment of how effective they are. We also have on our dedicated webpage things that highlight our facility fee research such as a series of active maps that quickly illustrate which states have pursued which reforms and gives a little bit of a snapshot of what those reforms are. I'm going to go through a few of those, but probably not all of them in the interest of time. So, the most assertive policy response states have taken to the growth of outpatient facility fees is to simply prohibit facilities from billing commercial payers for these fees for some or all outpatient services. State laws typically define these prohibitions by types of service or by setting or both. A number of states have banned facility fees for telehealth services while others have banned them for preventive services. Indiana prohibits nonprofit hospitals from charging facility fees for off campus services and Connecticut prohibits facility fees for outpatient services provided both on and off the hospital campus that are billed to evaluation and management or assessment and management codes so, for a basic office visit, essentially. And then Maine prohibits facility fees for services provided in on and off campus office settings. That ends up having a fair degree of interpretation but that is the language of the Maine statute. And I've noted on the slide that these prohibitions help consumers with costs related to facility fees. Arguably, these bans may also reduce system wide costs but that really depends on the subsequent rate negotiation between the providers and the payers where they may be able to negotiate higher rates for other services, for example to compensate for reduced facility fee billing.

Another strategy that is generating attention, including in federal legislation although I don't think that bill is going to go anywhere in the next six weeks or so, relates to billing transparency. Right now, payers often cannot tell where care is delivered because the facility can bill at the sort of umbrella or enterprise level and use the main campus address or sometimes even the billing address which can be out of state. And three states now require off campus hospital outpatient departments to acquire and use location specific unique national provider identifiers (NPI) when they bill for facility fees. This requirement gives payers and potentially researchers and policymakers more information about when and where hospitals are billing outpatient facility fees and for which services. In particular, it allows payers and researchers to link healthcare professional bills and hospital bills to understand how much is really being billed and paid for giving services delivered in a hospital outpatient department. You can see that these have so far passed in Colorado, Nevada and Nebraska. I'll also say it's not reflected on this map, but Colorado and Massachusetts also require hospitals to provide updated information on their affiliated outpatient practices so those unique NPI’s can also be mapped to the larger systems that own those practices. I'm going to skip over public reporting and oversight other than to say that a number of states do require hospitals to report on their revenue, often by service and also by volume related to facility fees. And then three states have had recent studies on facility fees. Maine and Colorado have wrapped up those studies and then Maryland has just kicked one off that was required by legislation in 2024. I'm also going to skip over coverage and cost sharing protections because we only have those in Colorado and Connecticut but those are other strategies for limiting consumers’ out of pocket liability related to facility fees. And then finally, I'll touch on consumer notification requirements because those are by far the most popular approach that states have taken so far. States have required facilities to notify consumers about the facility fees that they charge at the time that the patient makes an appointment or via signage at the point of service, or both. Some states also require facilities to notify practice’s patients when they acquire an outpatient practice and alert them to the fact that they will now be charged a facility fee when they receive care at the practice. I think that certainly improves

transparency for patients to know that they will incur a facility fee and I suppose there's a glimmer of a chance that this can also reduce system costs but I think that's ultimately unlikely particularly if you learn about a facility fee from signage when you're in the office, which was my first experience with facility fee billing. Patients often grit their teeth and go ahead with their visit and deal with the bills when it comes through. Patients can also try to choose to change providers and thus avoid the fee but that can be a very difficult thing to do in markets where there's a high level of vertical integration so it could be more theoretical than a real option.

John Hawkins, President & CEO of the Texas Hospital Association, thanked the Committee for the opportunity to speak and stated that I very much appreciate Rep. Oliverson's intro into this as what we're really looking at is trying to deal with the bad actors out there but not do it in a way where we limit access to care or actually shift costs on to other areas of the system. And I appreciate the hearing you had earlier this year where we teed this up. We're concerned about a broad prohibition on facility fees because we believe there are cases where those fees are legitimate. I will point out that a lot of what we're dealing with in the healthcare system unfortunately is cost shifting from other areas that have to be recovered in those fees and I would argue that's appropriate. But we ought to be looking at strategies to manage those costs down ultimately and I'll touch on a few of those. I'll just remind you, hospitals are the only sector of the healthcare system where we're required by federal law to take all comers regardless of ability to pay, and that's a key part of the commitment to communities that come with a hospital license. Hospitals and health systems are not monolithic. They all have different payer issues related to the communities that they serve. Hospitals provide standby capability and disaster response. There is no explicit funding for those safety net services. And then we're continuing to deal with inflationary challenges and certainly coming out of the pandemic, nursing shortages, physician shortages, other allied health professions, that cost is being borne by the healthcare system as well. That's why we asked last session for our legislature to invest in the workforce pipeline and they stepped up and did that. Again, those aren't immediate, but those are long term things that could help us going forward. Hospitals typically care for a higher proportion of Medicare and Medicaid patients and I'll remind you that Medicare typically pays about 82 on the dollar. So, that's about $100 billion annually in care that is not reimbursed, it's getting shifted elsewhere. Medicaid typically pays about 87 cents on the dollar. That's another $31 billion dollar shortfall. Add to that care for the underinsured, uninsured, and uncompensated care in a state like Texas that leads the nation in the number of uninsured, that equals $3.1 billion in uncompensated care, just in Texas. And that's at cost and it's not just the government payers. We are dealing with insurer underpayment in other areas, particularly in behavioral health. We have data that shows there's about a negative 35% margin across all payers for behavioral health services because those are not paid for equitably under private coverage. And then we had a discussion earlier about all of the red tape from insurer requirements and that's a cost that has to be dealt with.

I do want to just talk a little bit about the commentary about consolidation and I think that is an issue that needs to be dealt with. We know that most of the consolidation actually has been in the payer health insurer and in the private equity space and that is certainly not helpful. I would argue that in most cases, particularly in more rural areas of the state, our hospitals are stepping in because the physicians who are reporting their inability to continue to practice because of their inability to negotiate with payers and the red tape from dealing with those payers, they are looking to exit the market. And so they have the option of going to their hospital health system, going to private equity, or going to a payer group. And most of the time our hospitals are stepping in to partner with those groups to ensure those services stay within the community and that involves some level of subsidy. I'll agree with Rep. Oliverson there’s probably a legitimate discussion about how much of that actually ends up in those practices but really that is the last

case to keep the ability to keep those services in the community. And so we wholeheartedly support increased physician rates for Medicare, Medicaid and in the private space to reduce that incentive for that consolidation. Because there are legitimate cases for facilities. There are not legitimate cases. But that forced consolidation is, as Rep. Oliverson pointed out, is not necessarily helpful to the overall practice of medicine.

Sen. Lang thanked Rep. Ferguson and Rep. Oliverson for bringing this Model forward. I think this is a very important Model and Mr. Hawkins, I understand what you said about these fees are necessary but quite honestly, I'm really not buying that. But I do think we need to give some consideration to the hospitals in this scenario and I'd like your input on this. I assume when you buy a practice you may base it on a multiple of earnings before interest, taxes, depreciation, and amortization (EBITDA) - let's pretend it's EBITDA. And instead of giving a six times multiple knowing you can recoup a higher investment from charging a higher facility fee you may offer an eight times EBITDA just to sweeten the pot for the practice. So, my concern and I'm assuming your pro forma is a five to seven year break even pro forma only based on my experience in the private sector. I don't understand your business model. So, these assumptions of mine may be way off. My concern is if we put this in place and we just make it across the board, we are forcing hospitals to take a loss under pro forma and it will result in cost shifting. They're not going to eat that loss. They're going to shift the cost. And Rep. Oliverson, I'd like you maybe to weigh in on this because of your private practice experience. Do we give any consideration to a grandfather clause, and I'll make these numbers up - if a practice was purchased in the last five years there's a three-year grandfather clause where they don't have to comply with any new practice and then on a go forward basis it has to comply immediately. That way we are not forcing the hospitals to lose money based on an offer they made three years ago in a pro forma based on the rules at the time that since have changed. I'd like everybody's input on that.

Mr. Hawkins stated that I think that makes. Obviously, there are business considerations that have been dealt with in those situations and sometimes that can be problematic. I would argue ultimately the market is going to normalize some of that distortion if there are folks out there who are outliers or bad actors. But again, I would certainly entertain something that would look at grandfathering. I don't want to protect necessarily bad actors, because I recognize those aren't helpful, but it's worthwhile for discussion.

DISCUSSION ON DEVELOPMENTS IN VISION CARE SERVICES LEGISLATION

Rep. Dunnigan stated that on page 49 in your binder we have laws from Texas and Oklahoma that will be referenced during this discussion. The goal of the discussion by the committee today is to get an update on these laws and see if there's an appetite to further discuss these issues next year.

Jon Pederson, O.D., State Gov't Relations at the American Optometric Association (AOA), thanked the Committee for the opportunity to speak and stated that I'll provide an introduction to the topic of vision benefit managers (VBMs). VBMs are entities that sell vision plans and utilize their market powers to gain significant control over the vision care industry. Vision plans typically provide wellness eye exams and discounts on contact lenses and glasses. So, they are not entities that cover medical eye care, such as glaucoma, macular degeneration, diabetes, things like that. All of the medical eye care is the coverage provided through medical plans. So right now we run into the same issue that has been discussed this morning with vertical integration in market share influencing care. Right now, there are two VBM's. They control about 70% of the market share and I think at some point there will probably be a slide shown where it shows a plethora of vision plans and there's really two of them that control the most. In

over 40 states, there's one plan that has a plurality of covered lines in that state. So when the VBM's have this market share, it does dictate and limit choices for patients and providers and it interferes with the patient doctor relationship.

Tommy Lucas, O.D., Director of Advocacy for the Texas Optometric Association (TOA), thanked the Committee for the opportunity to speak and stated that definitely this is a story of vertical integration that we've spoken about this morning, and also market concentration. So what issues do us as optometrists have with the VBMs? Let me say first off that having patients that have a vision plan is generally a good thing. We want patients to have coverage to get an eye exam, because what optometrists do is detect eye disease and we help people fix their optical misalignments, their optical correction. Those are needed services obviously that are important to society for a multitude of reasons. When we have a wellness eye exam benefit it helps us detect those diseases, catch them early, save costs. All of those things. The contention between us and the vision plan industry, the VBM market, is not that vision plans are not valuable, it's the controlling techniques and the impacts on small business like my practice and practices just like mine all across the country and the patients that I serve. Knowing that vertical integration and market concentration are the main issues, the five bullet points on the screen you see there are more of the specifics of what's going on. So, we see specific instances of anti-competitive behavior towards optometry practices. VBM's have now bought up the entire supply chain from manufacturing, wholesaling, distributing, retail, and they own the vision plan that steers patients to those particular products.

When you're an independent optometrist and you're having to care for your patients in this environment, obviously those incentives to use those products impact your business and impact the quality of care that you're providing to your patients. When a VBM is dominant in a particular community or state, basically the contracts that we're presented and that's how this works, an optometrist like myself will just get on the internet and say, "I'd like a provider contract for the biggest VBM company" and I'll apply for that. They'll send us a contract in many cases and then that contract is basically non-negotiable. When I first started working in this space on vision plan reform, I did not really understand what a contract of adhesion was but it's kind of what we're dealing with here from a legal circumstance. We basically have a non-negotiable contract where if we want access to the patients that are covered under that we have a take it or leave it situation and then in that contract there are a lot of issues where the VBM will force the doctor to use a certain product that the VBM owns. They'll force the doctor to use a certain lab that the VBM owns. They will have specific auditing techniques, they'll have other provisions as well. So that's all a big problem. Access to care concerns are important, obviously, and when the VBM is controlling all of this, where does it stop? Where does it end where we're going to have enough providers to care for the patients or are they all going to be forced to go to the locations that they own? Interference with the doctor patient relationship is also a concern. Rep. Oliverson alluded to this, when there's a financial incentive to that doctor to do a certain thing, we lose that sanctity of that doctor patient relationship where there's an incentive in the middle of that relationship and then you're not actually getting unbiased proper care in many cases or in sometimes quality care.

So those are some of the impacts on optometry practices that we're having with VBM's. And this is why VBM reform is needed. Of course we want to maintain healthy competition. We see market concentration on the retail side where the services are actually being performed. The monopoly conversation or in this conversation more of a duopoly is going on and like the last conversation we've acknowledged that there were rising rates and prices in the context of market concentration. Well, that is where this story in the vision plan market will end too, naturally. And we're obviously concerned about that. Patient choice is also a big problem. If a

patient only has a certain menu of items that they can get with their care, that's a problem because it may not be appropriate for that patient. Improving transparency generally is also a problem. Sometimes the benefit plans are fairly convoluted and patients and doctors don't understand those plans and whether that's done on purpose or out of necessity, either way, it's a barrier to care. And then maintaining clinical independence is important. At some point, we have to let the doctors guide the course of care for that patient as opposed to letting an insurance company dictate that level of care. So what's been done about VBM abuses? This is not a new consideration. This has probably been about a decade long effort where states have looked at these issues and decided to make various reforms. Right now, we have 27 states across the country that have had some measure of VBM reform and of course, Texas is one of those and I want to kind of highlight that.

This is where it gets a little bit more in the weeds about the prohibitions that the Texas law and the Oklahoma law set forth, which are the two most comprehensive state laws at this point. You'll see that the law in Texas now prevents any price fixing on non-covered services. Obviously, that's very important to a small business when a plan covers what they cover for the price that they're covering it for and determining the actuarial science that goes into that. Interfering with non-covered services impacts that small business in a very significant way. The laws prevent the misrepresentation of what covered services are. Sometimes language is used that makes things seem covered when they're not. Dictating the glasses manufacturing lab is a very big deal. A lot of times, optometrists can make glasses quickly and sometimes in their own lab or a lab in the community versus a lab that's many states away that may have a lower quality of care that's being dictated. So the laws in Texas and Oklahoma and many states prevent that forced lab choice at this point. The steering of patients is a big deal. At this point we have the Texas law prevents for the first time steering to self-owned to locations. As the VBM's have started buying up retail locations, the Texas Legislature decided that having that VBM push patients into their self-owned locations is not in the best interest of access and care. So that has happened in the Texas law. The tiering and ranking of doctors was also occurring and still is occurring to this day. What will happen in this case is on a doctor locator, the VBM will give a gold star to a certain doctor versus a silver star to another doctor. And what the gold star is based on is how much product that doctor is buying from that VBM. It's no indication of quality of care or anything like that. It's just simply how much money are you sending our direction and re-selling that to the patient. And hiding out of network benefits is a problem. What we've seen in response to the law is the two top VBM's immediately closed their panels in Texas following the passage of the law. They "evergreened" contracts as well, so most doctors are actually operating under their previous contract before the law went into effect. Now they have sued the state of Texas over this law and that's working its way through federal court. They have also threatened unintended consequences in many settings and they have purchased more large retail optical chains. About a month ago, the largest vision plan in the world bought a very large retail group that provides care at 250 locations. And you see their revenue and this probably a $1 billion to $1.5 billion transaction so the profits that these VBM's are making are being used to buy up the industry.

Dr. Pederson stated that on this slide are some of the other things that are being done on the federal level. The Dental and Optometric Care (DOC) Access Act, that is something that is being done unfortunately with a lot of these plans. Our ability to fight this at the state level is troublesome because there are Employee Retirement Income Security Act of 1974 (ERISA) plans at the national level that allow the VBM's to skirt around the issue in that sense. Congressman James Comer (KY) is opening an inquiry on his Committee into the vertical consolidation and transparency. These on that slide are some of the things that will be mentioned as reasons not to consider VBM reform. As far as cost going up for premiums, the

premiums are not the profit center for these plans. As Dr. Lucas mentioned, vertical integration is the major problem here and the profit centers come from them owning retail locations, material locations, electronic health record systems, even the system that we use to file most of our claims is owned by one of the major VBM's. The premiums are not going to go up, really the cost will go to the patients because the patients will be forced into situations where they are buying products through these vertical integrated plans. In general, these are companies that are making tens of billions of dollars. We're a very small driver in the healthcare cost market.

Lisa Anne Hurt-Forsythe, Vice President of Government Affairs for the National Association of Vision Care Plans (NAVCP), thanked the Committee for the opportunity to speak and stated that I just wanted to respond to some of the comments and introduce some data that I think will be interesting for you. This is a very recent study that I think is really important because it shows the value of vision care as a critical benefit. This was a Harris Poll done recently and it showed that 94% of full-time employees age 25 and over said vision benefits were very valuable. So they see value in having vision care insurance. And 82% cited it as equally important as having general medical insurance. And I think my colleagues would agree that there is definitely value in having vision insurance. Vision health was also ranked as very important by 75% of the folks that responded to the survey. The other thing that's important is that demand for vision care is rising and quite frankly, myself included, there are a number of us in this room that fall into the category of the aging population. And screen time quite frankly, has contributed to more of us needing optometric care. So there's a greater demand actually for the services of the folks sitting at this table. As my colleagues mentioned, regular eye exams are really important. They do detect underlying health conditions and you see several of them listed there on this slide, particularly for the high blood pressure and the heart disease. Those are some that you might not necessarily think of. If they are identified early on by practitioners, it can help when there's communication with the primary care physicians to get involved in those medical conditions early. Maybe that's something you didn't think about when you think about vision care.

In terms of access to vision care, I put a slide here to show you what percent of covered lives of folks have general health care coverage versus vision care coverage and you can see there's room for growth in the vision care market. For example, if we're looking at state government employees, 95% have some sort of medical coverage which is probably not surprising to anyone in this room. But only 42% have vision care so there's some room for growth there. And then you can see some of the other categories here as well. So here's where the rubber meets the road. Affordability is what drives the access to vision care. For the vast majority of the population, how much money someone has to pay out of pocket will determine whether they will go seek vision care or whether they won't. This is from the Kaiser Family Foundation's recent study that was trying to find out what kind of medical services by type do people forego if they don't have insurance coverage, meaning they can't afford it. The first is dental and some of us might forego dental even if we have coverage but that was the first category. The second category is vision. If they don't have that coverage, that's the second most likely category that someone is likely to forego altogether or delay if they don't have the coverage. So where vision plans add value is that we help to mitigate those out-of-pocket costs. We help people to manage those expenditures. Insurance coverage is an independent predictor of vision health, i.e. if you have that coverage, you're more likely to go and seek vision insurance and you're more likely to have better eye care and have things detected earlier. You can see here on this slide, one third of the patients surveyed reported that they had eye exams less frequently than they would have liked to simply because they didn't have the insurance to cover it. So here's an easy $0 to $20 average copay if you have vision insurance to go and get that wellness exam that my colleague mentioned. If you don't, you're looking at $200. For some people, $200 isn't a big deal. For a lot of people, $200 is a huge deal and might make the difference between

making your rent payment or not making your rent payment. If you are in that category, of which there are a lot of folks, this is what leads to what I was saying on the prior slide that people just say, I can't do it cause I don't have coverage.

I want to shut down this VBM business. That is not a thing, that is a manufactured acronym that is designed to create an analogy between vision care plans and pharmacy benefits managers (PBMs) but there really is nothing similar about the two whatsoever. This slide sort of shows you the difference between the two. PBM's operate largely in a black box. People don't know what's going on. It's opaque. They don't save money for folks. They are a cost driver. And as I'll mention in a moment, our vision care plans have kept costs lower for consumers, not only for premiums, but also for their out-of-pocket expenditures. If we were to be operating as a monopoly from an economic standpoint, we are doing a horrible job because our prices have actually gone down. When we're thinking of a monopolistic impact on an industry, we expect to see a reduced supply and increased costs and instead, we've seen the opposite in our industry. So if we were doing what has been alleged, we're doing a very poor job at it. There was some mention about vision care being a crowded field. There are lots of players in the field. There are not just two. There are many folks that are operating in this space and there's a lot to be done in this space. As I mentioned, there's a lot of room for growth and there's a lot of opportunity in this market. I mentioned vision premium rates have trended downwards. They've trended downwards because the number of lives has increased. It's basic economics, as the number of lives increases, the price per life goes down. That is not true if you look at the graph on the right hand side. And I'm sure I don't even need a graph to tell you this, healthcare expenditures overall have skyrocketed. So we're sort of one of the few bright spots in healthcare from a price and a consumer perspective. This slide is talking about the number of optometric practices. Contrary to some assertions that have been made, the number of optometric practices, this is Census Bureau data, has increased to a high level that it's never seen. It’s at the highest level that it ever has been. This is in stark contrast to physician practices, which you will see on the right-hand side, many of which were discussed earlier with regards to being bought up by larger practices, etc. We're definitely seeing that consolidation in merger and acquisition activity on the physician side, but not on the optometric side. And this data bears itself out state after state. So really this is good news that we are expanding the number of practices.

We talked about legislative solutions. There can be some negotiated middle ground solutions and these are some states where that's happened, where there has been an open discussion about how to approach any issues and come to a collaborative solution. There on the slide are some states where that has been successful. The focus needs to stay on patients, access to care, and the end cost to the consumer. That's what we need to stay focused on. Patients and consumers. I want to talk a bit about the Texas legislation that was mentioned and the Oklahoma legislation. The Texas legislation was enacted last year and its constitutionality is being challenged in federal court. There is already a preliminary injunction in place and it was concerned with the anti-competitive nature of some of the terms in that legislation. So it has been prevented from being enacted at this point. We expect to see some further information over the next couple of months. There was also legislation introduced in Oklahoma. Again, there was significant opposition to many of the terms that were contained in that legislation and it was in fact vetoed by the Governor, largely over concerns again on the impacts to consumers and patients. In closing, the vision care insurance market is stable. It's affordable and it's essential. As I mentioned before, employees overwhelmingly value having vision care insurance. It's a critical healthcare need. The demand for vision care overall is increasing and there's great market expansion potential in this area. Vision insurance helps these folks to manage their out-of-pocket expenditures, which therefore makes it much more likely that they

will go out and seek care. And going and seeking care is associated with better vision health and early detection of underlying medical problems. The number of optometric businesses is continually increasing as I showed on that graph before and it has outpaced in a great way the growth rate of physician practices overall. So it is an inaccurate statement to say that the number of optometric practices is going away or decreasing. The data just does not bear that out. And as I mentioned, collaborative legislative solutions are definitely what is needed. We need to come to the table to work through any potential issues that might exist and make good public policy decisions that are data based as opposed to assertion based.

Sen. Justin Boyd (AR) stated that regarding the slide where we're increasing the number of optometric practices, we see the PBM's in pharmacy and they come in and they say pharmacies are actually not decreasing. And what's happened in the pharmacy world is now that the world is so complex with insurance and government, that many brick-and-mortar pharmacies actually have to have more than one NPI number. So are you actually measuring the number of brick-and-mortar practices when you report that? Or is optometry becoming complicated and now you have to have more than one NPI number? How are you actually getting to the number to show that the practices are increasing? Ms. Hurt-Forsythe stated that's an excellent question. I actually pulled the data directly from the Census Bureau using the county level tables and those are from tax filings of individual businesses so that is the number of optometric businesses and it's right from the census data and you can pull it all the way down to the county level.

Sen. Boyd stated that I hadn't heard of a VBM till until today, but I've certainly heard of PBM's. And the Federal Trade Commission (FTC) has come out with a report that showed there was a leukemia drug where it was $27,000 at the preferred pharmacy, $19,200 at the PBM home delivery pharmacy and $97.00 at the non-preferred pharmacy. And so when the same people who are setting the price and making the payment and own the entire supply chain, doesn't that create a lot of opportunities to have mis-incentives for the consumer? Ms. Hurt-Forsythe stated yes, theoretically, and certainly that's been seen in the PBM market. But VBM is a non-existent acronym that's been created to sort of create this artificial connection between vision care, insurance and PBM's, and sort of draft off of that type of example that you just mentioned, which is excellent. What we've actually seen in terms of pricing in the vision market is the premiums have actually decreased and prices have held very stable. So we really haven't seen that kind of variability that you're describing that definitely permeates what is seen in the PBM market.

Rep. Dunnigan thanked everyone and stated that if there are any legislators that want to continue this discussion or pursue this for next year, please contact myself or NCOIL staff.

INTRODUCTION OF HEARING AIDE CLASSIFICATION MODEL LAW CONCEPT

Rep. Dunnigan stated that last on our agenda is a brief introduction from Rep. Deanna Frazier Gordon (KY) on a potential topic for next year regarding a hearing aid classification model law.

Rep. Gordon stated that in your binders on page 77 and on the website and the app is a bill I sponsored in Kentucky that is very straightforward and is something that I'd like this committee to consider taking up next year. It deals with changing state law in light of recent regulatory change from the U.S. Food and Drug Administration (FDA) regarding a new classification of over-the-counter hearing aids, thereby making traditional hearing aids prescription devices. That classification has resulted in confusion among practitioners and policymakers at the state level which is why the change in law is necessary to clarify things. Because the FDA does not have jurisdiction over practitioner licensure, it's up to the states to further define. I am an

audiologist, so I can speak firsthand to the confusion that this has generated and I look forward to discussing the issue further here next year.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Brenda Carter (MI) and seconded by Rep. Matt Lehman (IN), the Committee adjourned at 11:30 a.m.