NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2026 NCOIL SPRING MEETING – LOUISVILLE, KENTUCKY
April 18, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Hyatt Regency in Louisville, Kentucky on Saturday, April 18, 2026 at 2:00 p.m.

Kentucky Representative Michael Meredith, Vice Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Justin Wilmeth (AZ)
Rep. Elizabeth Wilson (IA)
Rep. Matt Lehman (IN)
Rep. Erika Hancock (KY)
Sen. Jason Howell (KY)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Tim McGough (NH)
Rep. Tim Barhorst (OH)
Rep. Meredith Craig (OH)
Rep. Brian Lampton (OH)
Rep. Greg Scott (PA)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Stephen Meskers (CT)
Rep. Brett Barker (IA)
Rep. Peggy Mayfield (IN)
Sen. Beverly Gossage (KS)
Rep. Mike Clines (KY)
Sen. Donald Douglas (KY)
Rep. Daniel Grossberg (KY)
Sen. Franklin Foil (LA)
Rep. Mike McFall (MI)
Sen. Keri Heintzeman (MN)
Sen. Jeff Barta (ND)
Sen. Kristin Roers (ND)
Sen. Bill Gannon (NH)
Rep. Julie Miles (NH)
Rep. Kellie Deeter (OH)
Sen. George Lang (OH)
Rep. Perry Warren (PA)
Rep. Yusuf Hakeem (TN)
Rep. Barbara Dittrich (WI)
Sen. Jamie Wall (WI)
Sen. Cale Case (WY)

Also in attendance were:

Will Melofchik, NCOIL CEO
Christa Rapoport, NCOIL General Counsel
Pat Gilbert, Director of Policy, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Sen. Lana Theis (MI) and seconded by Sen. Jason Howell (KY) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Meredith Craig (OH) and seconded by Rep. Brenda Carter (MI), NCOIL Secretary, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 14, 2025 and March 12, 2026 meetings.

DISCUSSION ON THE 340B DRUG PRICING PROGRAM

Rep. Michael Meredith (KY) stated we're going to start today with a discussion on the 340B drug pricing program. As many of us know, this is a topic that's been frequently discussed at both the state and federal levels over the past several years. Last year, Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, expressed interest in discussing this at NCOIL. Before we go on to the presenters, I'd like to recognize him for some brief remarks.

Rep. Oliverson stated I'm not sure about other states, but the 340B Program is one thing that we talk about all the time in Texas with regards to health insurance that we as state lawmakers can do very little about, despite the fact that it appears that not only the house is on fire, but the garage is on fire, and the neighbor's house is now catching on fire. Our friends in Washington don't seem to want to be able to do a whole lot about it. So, I became aware of a law that had recently passed in Indiana that was a transparency piece. It got me thinking that although we cannot control the structural nature and who qualifies and who should be in the Program and how much money should they be able to make off the Program, and what are they doing with the money, we can certainly require participants in our states to identify their costs for purchasing the drugs, the amount that they're selling the drugs for, and what exactly are they doing with the money that they're getting.

I believe that would be very eye opening. As someone who sits on the Appropriations Committee in Texas, people come into my office all the time and say if they don't get this amount of money, they're going to go bankrupt. And so I would like to know how much this Program actually means to the various participants and what exactly they're spending the money on because it helps me make better decisions at the state level. I would propose this for something that we could consider as a model law. We've done transparency Models before at NCOIL and they've been highly successful and adopted by a great number of states and so this would be yet another transparency Model which I think would better inform us and our states about a program that is consuming an ever larger portion of the pharmacy spend in our states.

Bill Smith, Senior Fellow and Director of the Life Sciences Initiative at the Pioneer Institute thanked the Committee for the opportunity to speak and stated let me just make a couple of preliminary remarks before I go into my slides, and I'll try to do them quite quickly. One, I think it's inaccurate to describe the 340B Program as either a bad program or a good program. I have a much more nuanced view of it and that is, there are some good actors in the 340B Program who use the resources from 340B to extend care to low income people and patients and then there are some not so good actors in the 340B Program who see it largely as a revenue generator and a profit center. With that, I want to explain where it came from and how it works. The history of 340B goes back to 1990 when Congress passed a reconciliation bill where they required drug makers to give the best prices to the 50 state Medicaid programs in the country that any customer got. This created a problem for some safety net hospitals because pharmaceutical companies were extending discounts voluntarily to some hospitals, in safety net hospitals, all around the country. And so, the hospitals were fearful that the drug companies were going to yank those discounts because of the requirement that they extend the lowest prices to all 50 states.

So, the hospitals went to Congress, and in 1992, they passed the 340B Drug Discount Program where they require the discounts be given to the hospitals. You just have to understand the scale of this Program. It is massive. In 2000, the Program had about $1 billion in sales running through it. In 2025, according to the Berkeley Research Group, $215 billion in sales went through the 340B Program. And in 2000, there were 9 contract pharmacies that contracted with hospitals to give out 340B drugs. Today, there are 32,000 contract pharmacies. So, this is a massive program. One in 4 branded prescriptions are

340B prescriptions. How does it work? Well, how do hospitals and clinics get revenue from this program? The way they get it is they arbitrage the discounts. And what does that mean? Arbitrage is a Wall Street word. It just means you buy low and sell high if you want to make a profit. So, a Medicare patient, they go into a 340B hospital. This is an anecdotal example. And they're prescribed a $100,000 cancer drug. That hospital can potentially buy that cancer drug for $25,000. And then they can bill Medicare at 106% of average sales price, or about $95,000. So, the hospital's profit on one prescription is $70,000. And that's what I mean by arbitraging the prescription.

And the same thing happens with commercial insurance. Patients go in, the hospital buys the drug for $25,000 or so and the health plan is billed $75,000 and the hospital makes a profit of $50,000. Now notice the incentives. So, if an uninsured patient comes in, and the hospital buys that product for $25,000 and they give it to the uninsured patient for free, the hospital has zero profit. So, the incentives are balanced towards ensuring patients have good insurance, that's how the hospitals profit the most. This has unintended consequences. For example, there are massive takeovers of oncology and rheumatology practices going on by hospitals all around the country because they want access to those wealthy patients and patients with good insurance. The program has unbelievable growth, as I said and the most disconcerting thing, I think, is that charity care levels peaked. Despite this growth in this program, charity care levels by 340B hospitals peaked in 2013 and fell from 3% of operating revenue to about 2% of operating revenue. This is Rand Corporation data on charity care by 340B hospitals. You'll see in 2013, it peaks at about 3% of operating revenue and now it's gone down to 2% last year. Now, that said, there are hospitals that are doing the Lord's work as far as charity care. Cook County Hospital, for example, in Chicago gives 11% of its operating revenue in charity care. And the national average again is 2%. So, there are good actors and bad actors in this scenario. Here's the charity care numbers for Disproportionate Share Hospitals (DSH), which qualify for 340B through their Medicaid population. And, you'll see the charity care is declining, while the sales in 340B is rising, which shouldn't be happening. And again, this is another slide on the growth of the program. Again, less than 1,000 pharmacies in 2010 and now 22,000 pharmacies.

This an advertisement for the Pioneer Institute's web tool. We created this web tool where we loaded as much data as we possibly could get. We got it from the Health Resources and Services Administration (HRSA), we got charity care data from Rand Corporation, and we created this web tool. You'll see the data set on program growth and you'll see that the line is straight up for both contract pharmacies and hospitals participating in the program. This is a neat tool that we created called Legislative District Mapping. So, you can go on the website, and you can look up your legislative district, and you can see 340B resources in your legislative district. And we did this for every legislative district in the country because it was our impression that 340B resources were over-serving wealthier areas and under-serving certain low-income communities. And I went on the website, and I looked at Beverly Hills, California, and I compared it with South Central, L.A. Beverly Hills had more 340B resources, contract pharmacies, and clinics than South Central did. So, this is the kind of data you'd pull up, the number of hospitals, the number of health centers, the number of clinics and the number of pharmacies and the poverty rate in each legislative district. And you also can go on and look at contract pharmacies and where they're located within a district. For charity care, you can do charity care not just nationally, you can do it on a state level what the average state level charity care is. Texas is number one in charity care. New Jersey is number two, which is strange because New Jersey expanded Medicaid and generally, what you see is States that have expanded Medicaid have lower charity care rates than states that have not.

And again, you can go on the charity care website at Pioneer, and you can look at individual hospitals and how much charity care they're giving out. You also can go to the state one pager section of the website, and you can see where contract pharmacies are located. You

can see in Massachusetts and New York, 64% of the contract pharmacies for 340B hospitals are located in upper income areas, not low income areas. So, I want to agree with the remarks of Rep. Oliverson. What this Program needs more than anything, particularly because there are some good actors in this Program that you don't want to harm, is some transparency. We need to know exactly how much revenue a 340B institution is taking in and where exactly are they spending it. I would even improve upon the Indiana bill. I would make the hospitals deposit their 340B revenues in a separate account that could be audited, and the expenditures could be audited so that you could see exactly where they're spending. I would also use the Pioneer web tool to look at your state and find out if wealthy areas are being overserved by 340B and poorer areas are being underserved.

Bharath Krishnamurthy, Director of Pharmaceutical Policy at the American Hospital Association (AHA) thanked the Committee for the opportunity to speak and thanked Rep. Oliverson for his interest in the 340B Program. I'm going to of course offer a different perspective from Mr. Smith, but I think there is something that we can agree on and that is the 340B Program is about patients first and foremost. It is about delivering access to care for patients. I'm going to start where Mr. Smith started as well, and that is why was the Program created? Mr. Smith kind of laid out the timeline, but the reason the 340B Program was created was for one reason and one reason only, and that is because drug prices have continued to increase dramatically. It was true in 1992 when the program was created and as you can see on the graph on the left here, it is even more true today. As you can see, the delta is growing more between inflation for pharmaceuticals compared to other commodities. You can see on the table on the right here, just a smattering of some brand name drugs. Some of these are used to treat cancer. You can see the percent change in their prices over time. So, this is why the 340B Program was created, to allow eligible providers that care for high numbers of low income and other underserved populations to be able to access medications at a discount and then use those savings to further access to care. Don't take my word for it, Congress told us what the purpose of the Program was. They said it was to allow eligible entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.

I highlight the word "more" here that shows up twice in this purpose statement because it was the intent of Congress for the Program to reach more people and to enhance access to care for more populations. It was never meant to be this small little program. It was meant to reach more and more patients, and that is exactly, as I'll talk about in a minute, what the program has achieved. Mr. Smith talked about how the Program works, so I won't belabor that point but I do want to highlight two things. One thing is the 340B Program was structured in a way that the discounts go to the hospital or other covered entity, as we call it. That's because Congress recognized that the hospital or the provider is best positioned to determine how to deploy these savings that they're generating through their program. Nonprofit hospitals every 3 years have to do what's called a community health needs assessment that tells them what are the healthcare needs of the patients and communities they're serving. So, they're able to leverage that community health needs assessment to determine how to use their 340B savings to address the unique healthcare needs of the communities they're serving. As you can imagine, the healthcare needs in rural Kentucky may not be the same as the healthcare needs in inner city New York. That is why the savings go to the provider and the provider determines how best to use those savings. I do want to highlight one of the big misconceptions that I often hear when I go and speak about 340B around the country - the discounts in the program are not funded by taxpayer dollars. They're funded directly by the discounts that pharmaceutical companies have to offer.

And let me also add that drug companies don't have to participate in the 340B Program. It is optional for them. There are several drug companies in the United States that do not participate in the 340B Program. But if they want their drugs to be covered by Medicare Part B and Medicaid, then they do need to provide these discounts to safety net institutions. I just

want to make that point. I also want to emphasize that when we talk about 340B savings, we often hear that it's the difference between what the hospital purchases the drug at and how much they're reimbursed. But that's not accurate because in most cases, the insurance reimbursement, whether you buy the drug at the 340B price or a non-340B price is the exact same. Mr. Smith talked about Medicare paying 106% of the average sales price. That is the same reimbursement that a hospital gets whether they're purchasing at 340B or not. When we talk about 340B savings to the hospital, it's really the difference between what the hospital would have paid for the drug, absent the 340B Program and what they did pay for the drug under the 340B Program. That is what 340B savings really is. I have two examples really quickly here that illustrate this. Just like Mr. Smith talked about a drug with a $100,000 price tag. Under 340B, the minimum statutory discount is 23.1% for brand name drugs. So, the acquisition price is $76,900. As you can see, the insurance reimbursement is the same under both scenarios. Ultimately, the margin is the difference between the reimbursement and the acquisition cost. But the actual savings that the hospital generates is the difference in that net margin between buying a drug at 340B and not buying a drug at 340B. And those savings then go directly to patients.

I want to highlight another example. Here, the 340B discount is not 23.1%, but it's 50%. The only reason that the discount can go above 23.1% is if a drug company chooses to raise the price of that drug faster than the rate of inflation. They then get hit with what's called an inflationary penalty that pushes the discount higher. So, as drug companies increase their prices, they have to pay more of a discount and that's what you see in this example here. Instead of a $3,100 discount, it's now a $30,000 savings all because the drug companies have decided in this particular scenario to raise the price much faster than the rate of inflation. So, they were hit with a higher penalty and a lower 340B price. And so, Mr. Smith talked a lot about charity care and charity care is important. As he alluded to, there are many hospitals that provide a lot of charity care to their populations. But charity care is only one, albeit important, way that 340B hospitals use their savings. There are so many other services and costs that hospitals incur that are supported by their 340B savings. For example, if you look at uncompensated care, it's charity care as a part of that, but there's also bad debt from government payers. There's also total unreimbursed care. So, these shortfalls that hospitals incur from government payers. There's also a whole host of specialty services that are made possible by 340B. Think in your rural communities, many rural communities have access to oncology care because of 340B, because your hospital has 340B in your community. If not for 340B, those communities would not have cancer care. I was just at a hospital a couple weeks ago in Yakima, Washington. They were telling me that if they didn't have 340B, their patients would have to travel two hours over the mountains to the Seattle suburbs to be able to access oncology care and because of 340B, they're able to make cancer care available to their patients in their local community, which is so important for a family and a person going through cancer treatments.

These are just some of the many ways that 340B savings are used by hospitals. Charity care is again important, but certainly not the only way. And a myopic focus on just charity care does a disservice to the amazing benefits that the Program affords patients and communities across this country. I want to end by talking about a couple of different things that have been raised about the 340B program. Mr. Smith talked about this. The 340B Program has grown over time, and it certainly has. I'm not here to tell you that the 340B Program has not grown. It certainly has. But I think it's important to put that growth in context. When we look at, for example, between 2017 and 2022, the 340B Program grew by $30 billion, which is a lot of money. I understand. But if you compare that to the growth in the U.S. drug market, $300-plus billion in pharmaceutical revenues, it pales in comparison to what we're seeing across the board or at the very least it follows what's happening across the broader market. And the biggest growth driver of the 340B Program, as I alluded to earlier in my examples of how 340B savings work, is high and increasing prices. The more drug companies increase their prices, the more discounts they have to provide and that ends up growing the Program.

There's also other phenomena happening across the board that have nothing to do with hospitals that are also helping to drive growth in the 340B Program. A couple of examples is one, there is more regulatory effort from the federal government to shift care from the inpatient setting to the outpatient setting. So, 30 years ago, procedures that were being done in the inpatient setting are now being safely done in the outpatient setting. And as a result, since this is an outpatient program, when more care is delivered on the outpatient side, that helps to grow the 340B Program. The other thing that's happening is there have been a number of scientific advancements that have allowed drugs to substitute care for what otherwise would have required complex medical procedures. The best example of this is GLP-1s. A great breakthrough and they have been around for a long time, but they're now being used to treat obesity and other weight related issues that may have required complex gastric bypass surgeries or other costly interventions that now can be achieved using drugs. And so, the more we use drugs, the more that especially on the outpatient side, that helps to grow the 340B Program.

I think the question that we should be asking ourselves is not whether the 340B program has grown. Yes, the 340B program has grown. But the question we should be asking is, if the 340B program has grown, have the benefits that Congress intended for the Program to achieve for patients and communities also grown? And the answer is unequivocally yes. When you look at the growth in 340B discounts, and you compare that to the growth in the community benefits that hospitals are providing to the communities that they serve, you see that the growth in community benefits is outpacing the growth in 340B discounts. I like this sentence I put here which is, in 2022 for every $1 in a 340B discount that a hospital received they provided $2 in benefits to the communities that they served. Now, I don't know what everyone's opinion is on return on investment (ROI) and I hate to put it in sort of economic terms when we're talking about patients, but I would argue that's a pretty good ROI. That for every $1 in discount that again is not funded by taxpayer dollars, that's funded by pharmaceutical discounts, is resulting in $2 in benefits to the community - I think that is a successful program. In the interest of time, I won't talk about this, but happy to take questions on program integrity.

I think that when we talk about some of the allegations that have been put out there that there's rampant abuse in the program, that is just not supported by the data. The data that the drug companies are using, as you can see here from some of the citations I've pulled from recent letters by the drug companies, they're citing data back from back in 2018. The more recent data show that there is simply not the level of "abuse" that they are alleging. I want to end again by saying that 340B hospitals are committed to transparency. Transparency is important in any program, not just 340B. And hospitals are committed to transparency. That is why the AHA created the Good Stewardship Principles of which approximately 1,300 hospitals around the country have signed on to. It's a publicly available list. You can look it up online. In fact, many Members of Congress have asked for this list, and we provide it to them because they want to know if hospitals in their district have committed to transparency, and many have. And it requires them to communicate the value of the program, disclose how much they're saving from the program, and of course maint rigorous internal review of their 340B programs. What can you do and what can states do to protect 340B? Many states have passed legislation to protect against the drug companies' efforts to restrict contract pharmacies. But I think when we talk about transparency, it has to be equally applied across all stakeholders. This can't be a one-sided effort. There needs to be transparency in the 340B Program, but it can't all be about hospitals. It needs to be about drug companies as well. How they disclose their price increases. Require them to justify why a drug should increase by 100% in two quarters. Require them to provide an itemized list of what their costs are for production. How much margin they're producing on each of these drugs that they're selling for tens of thousands of dollars. And what their sales and marketing dollars are for these drugs.

Rep. Mike McFall (MI) stated the Michigan Hospital Association has been fighting tooth and nail when we've tried to do transparency. If hospitals and the associations are so committed to this why are they fighting so hard on any transparency? I cannot even begin to tell you how hard they are fighting and it does not make the hospitals look very good in my opinion, because it looks like you're hiding something. Your presentation was really good explaining what the 340B Program is and the importance of it and I don't dispute that. But on the transparency aspect, you're asking for the drug companies to be extremely transparent, which in our state, the drug companies were actually on board with the more stringent transparency, and it was the hospitals that would not support that legislation. Can you explain to me why that would be?

Mr. Krishnamurthy stated I don't know exactly what was in the Michigan law or bill but a lot of what I've seen including in the Indiana law, is that a lot of the data that's being required is duplicative. Hospitals already provide a pretty comprehensive accounting of their costs and their revenues in their annually filed Medicare cost reports with the federal government. I also will note that a lot of the laws that I've seen have again, a myopic focus on charity care, which I think does a disservice to the broad range of benefits that the 340B Program affords. If you just compare charity care to how much a hospital saves through the Program, then yes, you're going to get a very skewed picture of the benefit of the 340B Program, and we don't want that. We think if you're going to have an accurate accounting of the 340B Program, you have to look at the broad range of services and costs that hospitals incur. I can't speak for the Michigan Hospital Association, but I can tell you from the AHA perspective, we would be supportive of efforts that provide meaningful transparency, not transparency for the sake of transparency, but actually meaningful transparency that allows a hospital to tell you everything that it's doing with its 340B savings. Because if it's not for 340B somebody's going to have to pay for these services. It could be the state, it could be the federal government, but it's not going be the hospital because a lot of them have limited resources. So, that would mean that services go away unless somebody else pays for them. I think it's important that if you're going to do transparency, that you allow hospitals to explain all the different things that they're doing for their patients and community.

Rep. McFall thanked Mr. Krishnamurthy and stated to Mr. Smith, I went to that website that you had and is there any way to update that? We had a federal lawsuit that caused us to have to redistrict and my district is still the old district. Mr. Smith stated yes, we're in the process of updating it currently. The last data on there is 2022, so we are working to get 2024 data on there.

Sen. Beverly Gossage (KS) stated that I've chaired two committees in Kansas on 340B. What I've yet to find out is, what is the cost to the private payer? Because the individuals that are really bearing the cost of 340B is the private payer that has to pay more to make up for this "discount" that's going. Can somebody answer that question? Mr. Smith stated if I were you, I'd look at the treasurer's report from North Carolina on 340B. The treasurer, who's responsible for running the state employee plan, pointed out that the oncology drugs that they were paying for in the state employee plan were marked up 5 or 6 times what the acquisition costs were. That may be due to price increases, but I think more transparency would help all of this. And hospitals, as my colleague here has pointed out, there are all these community benefits that are paid for by 340B, okay, what are they exactly? What are they and exactly what did you spend the money on? That's the problem. We don't know.

Sen. Gossage thanked Mr. Smith and stated I'm one of 7 commissioners that oversees our state employee plan, and we are finding the same. Where can we find out how much money each hospital in my state is making on 340B? Shouldn't we be able to know that? Mr. Smith stated it's not available. Sen. Gossage stated, how would we know then what the savings is if we don't know how much money they're making? Because what I'm discovering is that if a

hospital is a 340B hospital and I come to get a prescription filled there, I'm now a 340B patient whether I'm low income or not, is that true? Mr. Smith stated yes.

Rep. Brenda Carter (MI), NCOIL Secretary, stated that I come from one of those populations that the 340B Program is supposed to support. I stay on the phone with the A. Philip Randolph Institute that is livid because the intent of the Program is not reaching the very populations they're supposed to serve. In this particular case, it's not reaching the African American community. But you can do some research, and you'll find out that a lot of the 340B Program is going to our more affluent communities instead of the underserved communities. And I echo the sentiments of Rep. McFall as it has been brutal trying to pull the truth just with transparency and before I make a vote on this type of program, I have to answer to my community and if my community is saying they're not getting the services they're in need of or some of the things that we're going through may jeopardize our federally qualified health centers then it really makes it very difficult. All we need to know is just one thing, where is the money going? Why is that so difficult? Mr. Krishnamurthy stated I appreciate your comment and I think that the way I would characterize it is, when you're talking about 340B savings, I point to the fact that it is not revenue coming in, like other things where it's a line item that you can easily track. It is savings that you are earning because you're purchasing the drug at a lower price. So yes, hospitals track this information. And again, we encourage hospitals to share this information with their community, so that they know what the kind of programs and services are being supported by their participation in the 340B Program. But I don't want to undersell how complicated it is to track all of this because it's not just like revenue coming in through the door. It is basically savings that they're they're accruing, and it's not like it's bucketed into sort of different cost centers at the hospital. Hospitals are buying these drugs at a lower price and then because they're able to buy those drugs at a lower price, that frees up more money across the board to be able to do all the things that they are doing to serve their community. Rep. Carter stated what is the intent of the 340B program? Mr. Krishnamurthy stated the intent is to stretch scarce federal resources to reach more patients and to provide more comprehensive services.

Rep. Meredith Craig (OH) stated there were a lot of things said that I could debate but I'll point out a few things that I disagree with. So, you say it's not taxpayer funded, it's a subsidized program. As soon as you start subsidizing anything, someone else is going to pay. So, we have data that was given to us and from Ohio alone, 340B costs the Ohio employee health plan and taxpayers $50.2 million. So, while it is pharmaceutical manufacturers that are providing the discount, you're subsidizing that and someone else is going to pay and it's the taxpayers. I just wanted to clarify that. Second point, I guess you're talking about fraud in the Program. There's a situation in my district with the Cleveland Clinic. They have a family medical practice that's just right up the road from my community independent hospital. My independent hospital lost their 340B status, but Cleveland Clinic right up the road has theirs because they have learned to leverage this Program. Do you think that is fraud? Do you think that's something that needs to be looked at and addressed?

Mr. Krishnamurthy stated I'm not aware of this specific situation, so I don't want to comment on something I don't know but I absolutely think hospitals like Cleveland Clinic that provides state-of-the-art care to millions of patients every year is deserving of 340B. The Cleveland Clinic is a comprehensive cancer center and provides care for some of the rarest diseases that patients from across the world come to. I think they should be deserving of the 340B Program. Mr. Smith stated let me go back to your first point about taxpayer money. I think that's one of the most misleading statements by supporters of the Program, that there are no taxpayer monies. Medicare pays billions of dollars to reimburse for 340B drugs and last time I checked, Medicare was a taxpayer funded program.

Sen. Justin Boyd (AR) stated I don't want to belabor the point about taxpayer funded dollars but the simple question is, do taxpayers ultimately not pay for these discounts by subsidizing

it? The real question kind of gets to the root of what my concern is with what I perceive is going on in the market. Why should the government mandate an incentive to some providers but not all the providers of a service? Isn't this one more way the government is saying, "Hey, this provider is going to be the winner. This provider over here is going to be the loser." Mr. Krishnamurthy stated in order to qualify for the 340B Program, there's a calculation to it. Either you have to be a rural provider, or you have to treat a specific patient population like cancer or children's hospitals. But then you need to maintain a certain percent of your population that's low income. It works out to about 28% of your population needs to be either low-income Medicare or Medicaid. That's not a low bar in my view. That is a significant amount of your payer mix that has to go to your low income population. So, I don't think it's picking winners and losers. I think it's providing resources to hospitals that care for a bulk of the low income patients in the communities that that they're serving. Mr. Smith stated there are many community-based oncologists that feel like they need access to those discounts in order to compete with the hospitals and they don't get them and they're losing money and they're getting bought up, and I personally would favor more community-based care, and they end up being captured by the hospitals.

Rep. Oliverson stated I appreciate this conversation. Obviously, it sounds like a lot of folks are very interested in this. I welcome your support. I welcome your co-sponsorship of a model law if you're so inclined. I will point out to our guests from the AHA that NCOIL already has a pharmaceutical price transparency model, so we don't need to add that to this because we've already done that. In fact, that's actually been adopted by a great many states across the land. I'd love to work with anybody that wants to work with me on this.

CONTINUED DISCUSSION AND POTENTIAL CONSIDERATION OF THE NCOIL INDIVIDUAL COVERAGE HEALTH REIMBURSEMENT ARRANGEMENT MODEL ACT

Rep. Meredith stated next on the agenda is the continued discussion and potential consideration of the NCOIL Individual Coverage Health Reimbursement Arrangement (ICHRA) Model Act. We had a great discussion on this at our Fall Meeting, as well as during an Interim Meeting last month. Based on how this discussion goes today, we may entertain a vote if that is how the sponsor, Rep. Craig, would like to proceed.

Rep. Craig stated as Rep. Meredith noted, we have had two great conversations on ICHRAs and I'm proud to be sponsoring this Model. You can view it in your binders on page 123, and it's also on the website and app. As many of you know, this Model essentially mirrors a bill that I am sponsoring in Ohio and we used Indiana language to start. This concept is something that has bipartisan support at both the federal and state level and it was formed really to enable flexibility for both employers and employees when it comes to health coverage. Importantly, this model doesn't involve any type of mandate. If a state adopts this Model or similar type of law, it just enables them to use a framework for ICHRAs. I think that's part of the reason why this has such widespread bipartisan support. I also think this is great timing for NCOIL to be discussing this because it really is a trend across the country. States are already working to implement this and Mississippi recently became the latest state to have this signed by their Governor.

In response to some feedback, I have agreed to make a couple of changes which are underlined in the Model here, specifically in new section 4(E) on page 124, I've included language that requires taxpayers that claim the tax credit to report to the Department of Insurance whether or not that taxpayer continued to offer the ICHRA or reverted to a traditional employer-sponsored plan. This is something that Indiana included in their law, and I know Rep. Matt Lehman (IN) brought it up in our Interim Meeting earlier this Spring. Also, beneath that language is a drafting note that says that states may wish to give a specific expiration date to the tax credit. In Ohio, we're having conversations on runaway costs and trying to narrow the cost to the state as best as we can so that's something there that states

may wish to consider if they have a fiscally conservative legislature like we do in Ohio. I think this Model is in a great place. As Rep. Meredith noted, we have moved pretty quickly on this Model and I would love to see us vote on this today. I know it's a little bit quicker than usual, but this is a great Model and bipartisan. We passed it out of the Ohio House unanimously, and I know other states have passed it unanimously as well.

Brooke Tiner, Director of State Gov't Affairs at Oscar Health, thanked the Committee and thanked Rep. Craig for her leadership on this issue. We have been before you a number of times. I lead state government affairs at Oscar, which is a healthcare company that is solely focused on the individual market where ICHRAs are offered. This is obviously a very important policy issue for us and we are very encouraged by the attention that this is getting across the country. Rep. Craig mentioned some of that. I will mention there is a study committee being considered in Arizona right now regarding ICHRAs application to the state health plan and school districts. As Rep. Oliverson knows well, there have been interim charges issued in Texas and a special select committee on affordability in Texas to study more broadly the issue of affordability and accessibility and ICHRAs will be part of that discussion. So, we really look forward to all of these discussions across the country and utilizing this Model to work with the states on their laws and with the individual stakeholders. We appreciate the opportunity and encourage a yes vote on the Model.

Brendan Cossette Senior Director of Public Policy at Centene Corporation, thanked the Committee and thanked Rep. Craig for her willingness to move this important issue forward. This doesn't need to be rehashed as it's been discussed quite a bit but ICHRAs simply are a vehicle to offer more choice in healthcare for both the employer and the employee. And while ICHRAs can be used for large and small employers, this one is especially important, because only 56% of small businesses in this country offer health insurance. So, this is a really strong incentive for small businesses to not only get more people covered and offer benefits, but to additionally be able to compete with larger businesses for talent and employees. I will note regarding bipartisanship and agreement, the vote in Mississippi on their bill in the House was 113 to 0, and the Senate vote was 48 to 2. Additionally, there are bills being considered in New Hampshire, Connecticut and Georgia so this is something that is percolating around the country.

Bruce Johnson, Head of Policy at Thatch, thanked the Committee and thanked Rep. Craig for her leadership on this Model. Thatch is a health benefits administrator. We focus specifically on ICHRAs. We work directly with employers of all sizes, but particularly small businesses, and help them manage and offer ICHRAs to their employees. We also work directly with employees and give them the tools they need to take a look at the individual market, select the plan and enroll in the coverage that they own. I wanted to share briefly why we believe this Model matters, particularly for small businesses and workers who we particularly serve. Today, you actually heard a statistic about the percentage of small businesses that offer health care coverage. When you drill down to just those businesses under 50, the very businesses addressed by the Model, it's a little bit more stark than that. For businesses with fewer than 50 employees only about 1/3 of those businesses offer health coverage today. And so that leaves millions of working Americans with a very difficult choice. If your employer doesn't offer coverage, you can either go uninsured, you can pay full sticker price for individual market premiums, or if you happen to qualify, you can seek a government subsidy. And that's a recipe for higher uninsured rates, greater dependence on government subsidies, and a small business sector that can't meaningfully compete for talent. ICHRAs changed that equation. They give small employers a straightforward, easy to manage, tax advantaged way to contribute toward their employees' health care coverage without taking on the complexity and cost of a traditional group plan. And they give employees genuine choice to select a plan that fits their specific needs.

This isn't a theoretical issue for us. At Thatch, 87% of the employers on our platform have fewer than 100 employees and 60% have fewer than 10. And yet they're able to offer healthcare because of the innovation offered by ICHRAs. Many of them are offering coverage to their employees for the very first time because of ICHRAs. This is exactly the kind of outcome that this Model supports and is designed to encourage. As Rep. Craig stated, this is not a mandate. It simply gives businesses that choose to act a little bit of an on-ramp to offering health benefits. There is real momentum, and you heard about some of that in other states today. It's important that momentum has been largely bipartisan. There is clear consensus with this policy. It's field tested and it works. We are proud to support this Model and we think it's sound policy that expands access to quality, affordable health coverage. And importantly, it supports small business competitiveness. We also think that it serves a central purpose in driving our health insurance market to a more consumer-centric model which will ultimately help to drive down costs and continue to put employees, people who own the coverage, in the driver's seat for making their own health choices.

Miranda Motter, SVP of State Affairs and Policy at America's Health Insurance Plans (AHIP) thanked the Committee and thanked Rep. Craig for bringing this concept forward. AHIP is supportive of tax credits that as you heard provide employers choice. We stand ready to partner with any of you, certainly, as legislation may be brought to your state to tailor it or make it state specific.

Sen. George Lang (OH) thanked everyone for being here today to talk about this very important Model that's going to help to level the playing field between the large guys, the self funded guys, and those that are stuck under our regulatory authority. My only concern with the Model has to do with section 5, Unfair and Deceptive Practices. This would exclude or induces us to exclude or cause the exclusions of an individual from coverage under an existing provided health benefit plan. It would prevent someone from steering an individual to coverage under an existing employer provided health benefit plan and it would prevent an employer from offering individuals financial or other benefits as incentives not to enroll in the plan or to terminate enrollment in the plan. And my only concern with these is currently, if you are under the Employee Retirement Income Security (ERISA) model, you can discriminate any way you want, as long as you don't discriminate in favor of the highly compensated employees. Now, there are some legal opinions whether this has to be done on a voluntary basis or if you can do it through a scheme known as a foundation model and make it a mandatory basis, but currently, it's being practiced on a voluntary basis with high participation, helping those that are truly sick to leave the plan or incentivizing those with other coverage to take the coverage elsewhere. So, why would we not get rid of some of those definitions for unfair or deceptive practices to help level the playing field even more between the small employer risk pool and the large self- funded groups?

Rep. Craig stated this language was actually raised from a few health plans back in Ohio. There are certain situations happening where litigation is pending, where they are, in fact, using these steering practices to get folks off of their employer sponsored plan into an actually unregulated plan and so that was something they raised with us. They wanted to make sure that's clarified in the Model here. I don't think there's really any intent to hold the employer, to arm wrestle them down, and by any means they can choose what's best for their employees and have those conversations. So, this was mainly to address other situations that are currently happening. Sen. Lang stated I appreciate that. So currently, if you're under ERISA, you can incentivize your employees to leave your plan, go on your spouse's plan or any other plan that you are entitled to or eligible for benefits. And you can pay the cost to go into that plan. You can pay the deductible. You can pay the copay. So, for the employee, their costs go to zero. And I'm not just talking about a spousal carve out. I'm talking about moving the kids, the cats, the dogs, moving the spouse, the employee, moving the entire family over. And giving the employee incentives to do that, financial incentives which will significantly lower the cost of the base plan. Is there anything in your Model that

would stop that from happening? Rep. Craig stated no - nothing in this prevents that from taking place. Sen. Lang stated thank you - I withdraw my questions and concerns.

Sen. Gossage stated I'm so pleased that we're talking about ICHRAs. I'm proud to have helped with that federal legislation. Just to clarify for the body, 100% of the expenses for an ICHRA for the employer are 100% tax deductible as a business expense. They are completely tax free to the employees so they're a great idea. They're going to be even greater if we could get rid of the Affordable Care Act (ACA) guidelines because as it is now the employee must declare that they receive an HRA or have an ICHRA, and they would lose all subsidies on the exchange causing the employer to pay more for this plan than what they could have qualified on the ACA. So, if I could just address what was mentioned about coercing an employee to pick another plan, that's actually against the Department of Labor (DOL) rules and they could be heavily fined for doing anything like that by the DOL. As to state guidelines, I'd like for someone to address if they're 100% tax deductible as a business expense, is this double dipping if they're exempt from state tax?

Mr. Johnson stated as a benefits administrator, we see the tax incentive in the form of a tax credit as being a meaningful on-ramp for small businesses. Currently, all employer-sponsored insurance is tax deductible for small businesses. Yet only 1/3 of small businesses of this size offer insurance today. So, clearly the tax deduction as it currently exists isn't a sufficient incentive and this is a way that allows those businesses and basically gives them an incentive to lean in and think about how benefits can be part of their compensation design and the tax credit is fairly modest in the states that have introduced them. Most states have introduced tax credits of $400 per year per employee and we think that really just gives the opportunity for a business to get started, get their feet on the ground when it comes to offering benefits. In our experience, when businesses start with ICHRAs, they tend to stick around. We have greater than 100% retention rate because we know that businesses, when they find this model, they realize how much it works for them and their employees.

Sen. Gossage stated on the federal level, we're looking at trying to allow you to pay your premium from your Health Savings Account (HSA). That's some of the reform we're trying to look at for HSAs, which would actually be even better because if you could pay for your premium directly out of your HSA, you would have that 100% deduction, as would the employer if they were to contribute to that. You could still go out and pick the plan you like. I'm not opposed to ICHRAs at all. I think it's a very great idea. I'm just a little bit concerned about the state credit for that. It seems like we're going to be double dipping in giving them this kind of a credit.

Rep. Meredith stated that per NCOIL bylaws, all NCOIL votes are voice votes except that a roll call vote shall be taken at the direction of the Chair or upon the request of a committee member in instances where there are dissenting votes. Hearing no further questions or comments, upon a motion made by Rep. Brian Lampton (OH) and seconded by Sen. Boyd, the Committee voted without objection via a voice vote to adopt the amendments to the Model as described by Rep. Craig. Then, upon a Motion made by Rep. Lampton and seconded by Sen. Boyd, the Committee voted without objection via a voice vote to adopt the Model, as amended. Rep. Meredith thanked everyone and stated that the Model will now be placed on the Executive Committee's agenda for final ratification.

PRESENTATION ON DATA FROM THE NO SURPRISES ACT BALANCE BILLING INDEPENDENT DISPUTE RESOLUTION PROGRAM

Rep. Meredith stated we'll move on to our final agenda item for today, which is data on The No Surprises Act (NSA) balance billing independent dispute resolution (IDR) program. The Federal No Surprises Act, very importantly, set forth an IDR process to deal with balance bills, which can be incredibly harmful for consumers. As we will hear today, the law contains

very important consumer protections, but there have been issues with the IDR program since it was enacted. This will be a great opportunity to hear about the data from the program and what we should know going forward.

Kennah Watts, Research Fellow at the Center on Health Insurance Reforms at the McCourt School of Public Policy at Georgetown University thanked the Committee and stated that I'm going to be talking to you about the NSA and in particular, I'm going to zoom in on the costs associated with the IDR process within the NSA. I'll also get into a little bit of detail about how states could potentially engage and hopefully reduce costs for consumers. So, before I dive into the data, I just wanted to refresh everyone on the NSA. When the law was enacted about 5 or 6 years ago, it had a dual purpose. The first purpose was to protect consumers from balance bills and reduce out of pocket costs associated with these surprise bills. The second objective was to more broadly contain costs in our health care system and with out-of-network costs in particular. What we've seen since the law's enactment is that this first purpose has been successful. Consumers have been successfully protected from surprise bills in the scenarios outlined in the law, and then when mistakes have happened, they have been rectified. So, that has been an incredible consumer protection over the last 5 years.

As far as the second objective to contain costs, the law has been slightly less successful. This has to do with the IDR process within the law. So, because the law prohibits providers from balance billing patients, which used to cover the costs that plans would not pay, the plans and providers now have to negotiate privately to find the ideal payment for those services covered. When these plans and providers cannot do this privately, they can go to the IDR process, which is a third-party arbitration process where a neutral party selects one of the payment offers from either party and binds them both to it. And this process was estimated to reduce premiums and overall health care costs as it would have incentivized providers to move in network and thus reduce rates. But early evidence has shown that this is not necessarily the case. In fact, our research shows that in over two and a half years of the IDR process's implementation, over $5 billion has been spent on this system alone. And these costs come from four main categories. The first two are merely administrative costs. So, the first are fees paid directly to the federal agencies to handle the portal associated with these disputes and just kind of keep the system running as intended.

The second contributor to costs is the fees paid directly to the arbiters or the IDR entities. The third and, the second biggest contributor to costs here are providers and plans internal costs to engage in this process. So, this really is just the mechanical process of filing the papers, engaging in negotiations, engaging in the dispute process. While this is quite a hefty sum, $1.9 billion across a two and a half year period, we expect that this also likely an underestimate because it does not include the parties' costs to engage in litigation surrounding these issues, which has been quite a litigated subject in the last few years. And finally, what we see is the major contributor to costs within this system are payment awards that exceed in-network rates. So, the IDR process included a Qualifying Payment Amount (QPA) which was meant to serve as a benchmark and indicator or proxy of sorts for plans' in-network rates for a given service and a given geography. And so, expecting that most disputes would come in around this QPA, that most disputes would be resolved around network rates, we would have expected this payment amount to be much lower. In fact, probably close to zero. But instead, because these awards are being paid out at such high amounts, this has incurred more than $2.25 billion in just a two and a half period alone. And so there is a bit of lag in the data here. I'm talking about 2024 data. We're in 2026. Unfortunately, because there is this difference in when the data is released, the most up to date numbers we have are from quarter two of 2025. And so, while we haven't rerun that cost estimate to include the entirety of 2025 yet, what we can see from the first 6 months is quite shocking. And that's in this 6 month period alone, the fees spent just to administer this program and paid to the IDR entities are nearly equivalent to the same fees paid for the two

and a half year period prior. So, I think for that reason, we were really expecting our $5 billion estimate to be a severe underestimate once we update for the 2025 data.

So, how did we get here? How did this system end up incurring billions of dollars of costs? I think it's because this process has not played out as the agencies or other stakeholders expected. Prior to the beginning of the IDR process, the agencies expected about 22,000 disputes to enter the IDR process per year. So, across kind of the three year period we're analyzing here, that would be about 72,000 disputes. But instead, the reality is far different. In fact, as of quarter two of 2025, more than 3.4 million disputes have been filed. And that is quite staggering. I think that's because the agencies and other stakeholders expected this to be a last resort for providers and plans when all else had failed in private negotiations. But instead, what we've seen is that providers have flooded the system and have found that it can be a successful way for them to win often and win big. And I'll dive into that in a bit more detail. We can see that providers really initiate the vast majority of disputes going into this process. So, looking at this graph, you can see that there's been a steady growth in disputes initiated in nearly every quarter. Really the only exceptions we see here are when disputes were not being filed because there were pauses due to litigation. We can see that in the last two quarters alone, more than 1.2 million disputes were filed to the IDR portal. And this is more than double the volume from the same time period in the year prior. And not only are providers winning big, not only are they submitting often, but they're winning big and they're winning often as well. So, looking at this graph to the left, this is showing you the provider win rate in every quarter. While it averages out to about 84% across this two and a half year period, in the most recent quarter, providers won 88% of all disputes. So, they're not only initiating a majority of disputes, but they're also seeing they can win the majority as well. And when they win, they're winning at upwards of 4 and 5 times in-network rates. Looking at that graph to the right, you can see that the median prevailing provider offer in 2024 was 450% of the QPA. So, if we use the QPA as a proxy for in-network rates, this is more than four and a half times in-network rates.

And this is also 4.5 times more than plans win. So, when plans win, they're coming in at about 100% of QPA, which would make sense because that's their in-network rate, and that's what they're hoping to pay for the service. And while providers across the board are quite successful, I think this success is also highly concentrated to a few provider groups in particular. As you can see in this pie chart, 5 provider groups account for nearly two thirds of all the disputes going to IDR, and 4 out of 5 provider groups are backed by private equity. That includes Radiology Partners, Team Health, AGS Health, and SCP Health. And I make this call out to private equity, not only for the profit motive that is inherent to these actors but also because these are the same groups that fought tooth and nail against the passage of the NSA 5 years ago because balance billing was such a profitable scheme for these provider groups. So now they've just shifted their profit mechanism to the IDR rather than balance billing patients. And the fifth provider group here, I think is really the most interesting and that's Halo MD and while not backed by private equity, this provider group is really fascinating because they emerged after the IDR process was initiated solely to handle disputes on behalf of providers. So, this is essentially a middleman entity that makes a commission off of the awards that they can secure for providers by handling their dispute in IDR. In 2023, Halo MD accounted for less than 1% of all claims going to IDR. They were a minuscule player. But now you can see that as of quarter two, 2025, they are the leader in initiated disputes and account for nearly a quarter of all claims going to IDR.

In addition to being kind of the top initiator here, Halo MD is also among the most successful provider groups. So, in quarter two of 2025, Halo MD secured a medium prevailing offer of 820% of QPA. Again, that's 8 times in network rates. And this wasn't even their most successful quarter. There was one quarter in 2024, where Halo MD's median award was over 1,000 times QPA or 1,000% of QPA. So more than 10 times in network rates. And so, I just say this all to really underscore that there's a clear profit motive here. And the more

that actors like Halo MD submit disputes and the more they continue to win they'll continue to win at higher award amounts. And I think this profit incentive holds true for the private equity backed groups too. As you can see on the slide, Radiology Partners secured a median award of 590% of QPA in quarter two of 2025 and was followed by SCP Health and Team Health at about 375% and 275% of QPA respectively. And what's also interesting about these private equity backed groups is not only are they winning larger awards than providers overall, but they're also winning more often. So, Radiology Partners, SCP Health and Team Health all won about 95% of disputes in quarter two of 2025. So, these providers know they can go to arbitration. They're most likely to win, and they will win a high award amount which is why we've seen the continued trends in volume and costs that we have.

I think while patients have been successfully protected and they are not receiving balance bills directly, I think there is real concern that these ever-growing trends and costs will eventually be passed down to consumers through higher premiums. In fact, we've heard from one private plan as well as one state employee health plan, that their premium increases this year are directly attributable to the costs incurred by the IDR process. And so, what can we do about this? How can we make sure that these costs are not continuing to be passed on to consumers? I think as we consider reforms, many state IDR systems might serve as a good starting point. So just as a reminder, while there is the federal IDR system, this only covers self-funded plans, whereas state IDR systems can cover fully funded and state-regulated plans. Because of this difference, states can also set different guardrails that the federal system might not have. We've seen in some states with public reports that because of these guardrails, they see far fewer cases, and they see more balanced outcomes than the federal system. For example, Virginia only had about 250 disputes enter its state system in a year period, and providers only won about half the time and we see similar trends in California, Colorado, and Washington. I think these states might serve as examples for how to adjust the federal system. And I think what else is really interesting is that some states, like Virginia and Washington, have created opt-in options for self-funded plans. These plans can choose to have disputes settled in the state system rather than the federal system. And so other states might consider this approach, too, as a means to kind of redirect the volume going to the federal system.

And while I say all this, I do also want to caution that while there are some promising states, there are some state systems that are inflationary as well. So, Texas and New York see very high volumes of disputes, very high provider win rates and very high award amounts and are more closely aligned with the federal system than these other state systems. I think as states look to take action here, a great first step might be to look to the state system and better understand what's going on and to really gauge whether or not the state system is inflationary. And if not, I think it might be worthwhile to consider opt-in options for self-funded plans in non-inflationary states. I know that was a lot to cover in about 15 minutes. I welcome any questions you might have. And for folks who are interested in reading more on the data or the litigation around this issue, please feel free to scan the QR code for our most recent publication.

Rep. Oliverson stated I enjoyed your presentation but I would challenge you a little bit in that I think your entire presentation rests on a fundamental assumption that I think is false, and that is that the QPA or the in-network rate is 100% accurate in terms of the fair market value of whatever that service is. And of course, 100% of these disputes are out-of-network situations where there is no agreement about what the value of the service is. So, if the in-network rate were adequate to begin with, I would submit to you that, that in and of itself would solve a lot of these problems in terms of the number of arbitrations because there wouldn't be a dispute because essentially the provider would have agreed to accept whatever the plan was offering as full payment for the services that were rendered. So, there's this fundamental disconnect, I think. And this is part of the problem that I think that was dealt with at the time in 2019 when we passed the Texas law and then that was taken to

Washington and that became the NSA or at least the blueprint for it, is that the big question at that time was, should we just go to a single payer system and benchmark everybody to a standard rate and take away providers ability to negotiate in good faith completely? That's what IDR was designed to solve. It's no mystery why providers initiate so many of the arbitrations. If they were happy with the initial payment that was offered to them, they wouldn't go for arbitration. Essentially the health plan makes an offer, the provider says that's inadequate, they can't work it out, so they go to arbitration. If they just accepted what was initially offered, they wouldn't go to arbitration. If the rates were actually adequate, they wouldn't go to arbitration. So, that makes sense. It also makes sense that the providers would win more frequently if the rates were inadequate and the QPA by itself was not a fair measure or benchmark for what I mean. All of these IDRs are done by an independent mediator who is not affiliated with a plan or provider, who's looking at a variety of data points and making a decision about what the actual fair market value of the service should be.

So, it's not a stacked deck for one side or the other. It's basically looking at the data that's available and trying to make an objective decision about what would be a fair market value for that service. The fact that providers are winning more frequently than plans tells me that the rate that's being offered in-network is inadequate. The hope was that over time, these providers and these plans would recognize that there's a happy medium there, and they would agree that this is what the fair market value is, hence this is what the in-network rate has been. But that hasn't happened. I'm wondering if you have thoughts on why it is that we haven't seen networks grow and why we haven't seen in-network rates increase. If plans are just getting their teeth kicked in an IDR, maybe they should increase their in-network rates.

Ms. Watts stated I think to your first point on the QPA, I agree that there have not been robust audits conducted by the agencies despite their authority to do so to see if plans are correctly calculating the QPA. Obviously, there's a lot of litigation about whether or not the QPA is a correct formula period or whether plans are calculating it correctly. Until we see those audits from the agencies, I can't speak to whether or not the QPAs are being accurately calculated. But I think as intended, they should ideally serve as a proxy for these in-network rates. Now to your question about network negotiations, I think this is another underlying point of the entirety of the NSA was whether or not it would bring providers in network. I believe there was a recent study either from the Government Accountability Office (GAO) or Assistant Secretary for Planning and Evaluation (ASPE) or both that did see some increase in networks and providers are coming in network and network rates are somewhat increasing I think to reflect that transition in network. So, I think to that extent, I do think this is working, and plans are realizing that to bring providers in, there does need to be a bit more negotiation there. But I think what's also really interesting is that when we kind of do more qualitative interviews with folks, we hear complete opposite sides of the story here. The plans say that the providers refuse to come in network because they're winning so high and so often in IDR. And the providers say the plans are pushing them out of network because it's cheaper for them to go through the IDR process than to pay the providers in-network rates. And so again, without kind of an objective data source there, there's no way for us to square these completely opposed stories. I do think that underscores that there is still a lot we don't know about this process. But I would say the early findings from either GAO or ASPE, and I'd be happy to share that report with you, show some indications of in-network movement.

Sen. Gossage asked has there been any effort that you're aware of to consider rather than the standard rates that they're using right now offered by carriers and instead a regional reasonable and customary amount as we do with some medical providers? Also, there's the Medicare plus rate. Has there been any movement in that direction? Ms. Watts stated not that I'm aware of. I think the QPA was intended to kind of be that benchmark of sorts for both offer submissions as well as for the IDR entities to kind of gauge where the offers were coming in. But I think it would be really helpful. I think to the earlier point, these IDR entities

are these neutral third parties and don't necessarily have expertise on every service and every payment that is adequate for a certain service. And all they see is the information that's provided to them by both the plan and the provider in their submissions. I think to the extent that we could offer more data to the IDR entities to help them benchmark and understand where these offer amounts fall, say within Medicare rates, within broader state averages, within broader plan averages for a given service would be helpful to make sure that they are understanding both of the offers they're considering fully. I think anecdotally, we've heard that some providers are securing payment amounts through IDR that even exceed billed charges, and I think there's no way we can even justify that. So, I think all this kind of comes back to my point that I think more information here would be helpful both to the arbiters as well as to folks outside of the system itself.

Rep. Stephen Meskers (CT) stated this is a two-part question. So am I understanding that private litigation is involved in this system and therefore that not only are we reimbursing the professionals, but we're reimbursing headhunters, if you will, or money hunters in the system right now. Is that correct? Ms. Watts stated I think that is fair. Yes, the costs that plans are using to litigate issues surrounding the IDR, those costs will ultimately be passed on to consumers by higher premiums. Is that the is that your question? Rep. Meskers stated that's exactly where I was headed. The second question is, do you have data on the nature of the procedures that are most showing up in terms of reimbursement? Because as Chair of Commerce and sitting on the Insurance Committee in my state, my problem is with the American Medical Association (AMA) and the limitation on the number of medical seats in the university system and the number of providers that we've scoped out. We don't have an adequate number of providers. And on the insurance side, we don't have an adequate or broad enough scope of service. So, the costs are just spiraling out of control. I'm not sure if we have procedures in the database as well? Does your report deal with where the concentration of disputes are?

Ms. Watts stated yes, we do have data on services and which services are most common. I think, as you would expect, because the NSA covers emergency services out of network, that's obviously a high proportion. But interestingly when we look at the award amounts for emergency services, they tend to be lower than the award amounts given to other kind of top services that come into IDR. So, what comes to top of mind to me is radiology, and that is a service that is paid out at very high amounts compared to emergency services and also occurs quite often in the IDR system. And I think that I want to call that out too, because we know radiologists were also pretty prevalent balance billers prior to the NSA. So to me, that just kind of is another data point that potentially these same providers that used to balance bill are now just shifting their kind of profit mechanism into the IDR system as well. But if you want to follow up with me afterwards, I can give you more specific data points on certain services and the outcomes we see.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Sen. Gossage, the Committee adjourned at 3:30 p.m.