NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE AND HEALTH RETIREMENT ISSUES COMMITTEE
OKLAHOMA CITY, OKLAHOMA
DECEMBER 8, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health, Long Term Care and Health Retirement Issues Committee met at The Renaissance Oklahoma City Convention Center Hotel in Oklahoma City, Oklahoma on Saturday, December 8, 2018 at 8:30 a.m.

Assemblyman Kevin Cahill of New York, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Sam Kito (AK)
Rep. Deborah Ferguson (AR)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Lois Landgraf (CO)
Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Rep. Bart Rowland (KY)
Sen. Dan "Blade" Morrish (LA)
Rep. Michael Webber (MI)
Sen. Jerry Klein (ND)
Asm. Andrew Garbarino (NY)
Asw. Pam Hunter (NY)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Sen. Travis Holdman (IN)
Rep. Steve Riggs (KY)
Sen. Gary Dahms (MN)
Sen. Paul Utke (MN)
Sen. Paul Wieland (MO)
Rep. Joe Schmick (WA)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

A motion was first made by Asw. Pam Hunter (NY) and seconded by Rep. Tom Oliverson, M.D. (TX) to waive the quorum requirement which the Committee approved without objection by way of a voice vote. Upon a Motion made by Asw. Hunter and seconded by Rep. Oliverson, the Committee approved without objection by way of a voice vote the minutes of its July 14, 2018 meeting in Salt Lake City, UT. Upon a motion made by Rep. Deborah Ferguson (AR) and seconded by Sen. Jason Rapert (AR) – NCOIL President – the Committee approved without objection by way of a voice vote the minutes of its Oct. 25, 2018 interim conference call committee minutes.

DISCUSSION/CONSIDERATION OF NCOIL PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

Sen. Rapert – sponsor of the NCOIL Pharmacy Benefit Managers Licensure and Regulation Model Act (Model) began by offering two sponsor's amendments to the current version of the Model. The first amendment serves to delete the language in Section 8(c) and replace it with: "Nothing in this Act is intended or shall be construed to be in conflict with existing relevant federal law." Sen. Rapert stated that the purpose of that amendment is to avoid any issues related to preemption and the Employee Retirement Income and Security Act of 1974 (ERISA). The second amendment serves to delete the drafting note following Section 8 and preceding Section 9 in its entirety. Sen. Rapert noted that said drafting note dealt with the proposed independent dispute resolution (IDR) system and that after discussing that issue with stakeholders he thought it was best to remove the language from the Model and leave it up to the Committee to decide if it would like to discuss the issue separately in a more thorough manner at a later time.

Josh Keepes, Regional Director of State Affairs for America's Health Insurance Plans (AHIP), stated that AHIP appreciates Sen. Rapert's decision to remove the drafting note related to IDR. AHIP does have some issues with the remaining drafting notes and removal of those drafting notes would remove AHIP's opposition to the Model and that is why AHIP has supported the Committee going back to the prior version of the Model that the Committee discussed in October.

Melodie Shrader, Senior Director of State Affairs for the Pharmaceutical Care Management Association (PCMA), stated that PCMA supports the two amendments offered by Sen. Rapert today and that PCMA's primary remaining concern is the drafting note in Section 7 that lists issues without any context. PCMA has grave concerns that there is not enough guidance in that drafting note for states to understand what this committee means for them to do. Ms. Shrader also stated that PCMA continues to have concerns related to the Model and ERISA-preemption, and that PCMA looks forward to working with members of the committee going forward if the Model is introduced in any of the committee member's states.

Ronna Hauser, PharmD, Vice President of Pharmacy Policy & Regulatory Affairs for the National Community Pharmacists Association (NCPA), stated that since the Committee met in July in Salt Lake City, Ohio has found that their PBMs have pocketed $224 million dollars in spread while simultaneously underpaying pharmacies by over $350 million dollars. Pennsylvania's Auditor General is currently investigating PBMs' use of tax dollars in PA and his report will be released in the upcoming days. In addition, West Virginia will soon release data showing extraordinary savings by taking management of their Medicaid pharmacy program away from PBMs and putting it back into the state's hands.

Ms. Hauser stated that NCPA believes that the Model is a very positive step in the right direction to address these PBM practices. NCPA requests that the exemption for self-funded plans be removed from the Model and therefore supports the amendment to Section 8 offered by Sen. Rapert this morning. The extent to which federal law will permit the regulation of self-funded plans is a determination that is best made by the states. Currently, 32 state Attorneys General have filed an amicus brief in the U.S. Supreme Court defending state's rights to regulate PBMs. The states are fighting to get the U.S. Supreme Court to overturn an 8th Circuit ruling (*PCMA v. Rutledge*) that prevented Arkansas from regulating PBMs. The states are arguing that the 8th Circuit interpreted ERISA too broadly in deciding that ERISA preempted Arkansas state law.

Ms. Hauser stated that if the 8th Circuit's ruling became the law of the land, states might not be able to provide a check on PBM reimbursement and billing practices, at a time when those practices have raised significant concerns about healthcare affordability and access.

Ms. Hauser closed by stating that the drafting note in Section 7 of the Model is consistent with the spirit of the Model which is to provide a framework to the state insurance commissioner to draft rules, and the drafting note is completely permissive in nature. NCPA supports the committee's adoption of the Model, as amended, and believes that the Model is a robust chassis that will put state insurance commissioners in a better position to regulate PBMs.

Sen. Rapert stated that he appreciates everyone's comments on this issue since the discussion started earlier this year. Sen. Rapert stated that, as many are probably aware, Arkansas passed a comprehensive PBM law earlier this year that actually contains much of what is seen in the drafting note in Section 7. Sen. Rapert further stated that he is pleased that the news was shared of 32 state Attorneys General challenging the *PCMA v Rutledge* decision. Sen. Rapert then made a Motion to move adoption of the Model, as amended, which was seconded by Rep. Oliverson.

Asm. Cahill then opened up the discussion on the Model to any legislators present. Rep. Lois Landgraf (CO) asked if Section 6(b)(1) of the Model could possibly be a Health Insurance Portability and Accountability Act (HIPAA) violation since the provision permits the state insurance commissioner to have access to people's medical records. Ms. Shrader stated that she understands how the provisions could raise questions related to HIPAA but that she would have to defer to a HIPAA expert as to whether the language was in fact problematic. Rep. Oliverson stated that, from a clinician's perspective who has to be HIPAA-trained every year, the statute states that the person who is entitled to have access to protected health information that is necessary in order for them to do their job is bound by the conditions to protect the privacy of that information. Rep. Oliverson stated that the only change that he could potentially envision is if the insurance commissioner was suddenly having access to protected health information in a situation where they previously did not have access to any such information which he would find hard to believe; and even in that scenario, there is no issue so long as the person handling, who has been authorized to handle, breaches the duty to protect the information.

Asm. Cahill also noted that Section 6(b)(2)(A) and (B) state that "the information or data acquired during an examination under subdivision (b)(1) of this section is: (A) Considered proprietary and confidential; and (B) Not subject to the [Freedom of Information Act] of this State." The Honorable Tom Considine, NCOIL CEO, stated that it is a daily ongoing function at insurance departments around the country as part of their examination functions to, when examining all types of health insurers, come into contact with HIPAA-protected information, so the referenced provision in the Model is consistent with their functions.

Asm. Ken Cooley (CA) – NCOIL Secretary – stated that Section 6(b)(1) is very limited in that it simply lets the insurance commissioner enforce the Model to determine compliance with the Model and agrees that it is consistent with how things are done all the time. Asm. Cooley stated that as a lawyer looking at that provision, and if he were advising the legislature as to whether the provision constituted a sound practice, he

would state that the power of enforcement cannot be created without providing the capacity to enforce, and those two concepts are in alignment in Section 6(b)(1) as it is not overbroad at all. Asm. Cooley stated that if an examiner was trying to gain access to information that went beyond trying to simply enforce compliance with the Model, then an argument of over broadness could be proffered, but that is outside the framework of the Model.

Asm. Cooley then asked the panelists if any of them had ever been in a state and been in a fight with a regulator whom they thought was acting in an overbroad manner beyond the scope of their authority. Mr. Keepes stated that type of dispute has come up from time to time but not on this particular issue. Ms. Shrader stated that in her previous life she had represented health plans for about 15 years, in only 1 state, but there was always a concern when working with legislators about what gets put in writing to make sure that they had enough guidance so that they did not overstep their authority. Ms. Shrader stated that oftentimes when she is working with legislators, she will discuss how the current insurance commissioner would never do certain things, but then note that it is important to legislate for the future.

Asm. Cooley stated that as someone who has advised CA lawmakers on public policy for decades, he has a personal philosophy that the National Association of Insurance Commissioners (NAIC) passes model regulations and laws, and he would always advise lawmakers that even if the NAIC adopts a model regulation, it should be adopted in CA by statute; it should never be a wide-open tool in the regulator's hands to let them do whatever they want. That sort of philosophy is protective of the inherent powers of a legislative body.

Accordingly, Asm. Cooley stated that he believes objections to the drafting note in Section 7 is misguided because the drafting note is a message to legislators that they may wish to give specific guidance in these areas, rather than just giving regulators a broad general grant of authority by saying "you may adopt rules not inconsistent with this Act", which actually is a very expansive phrase. Asm. Cooley stated that the drafting note tells legislators that if they think there are some companion ideas from the areas in the list, direction may be provided to regulators.

Asm. Cooley stated that if he was in the position of a state advocate, he would be returning home to tell his colleagues and members that they should be educating lawmakers as to why they have a stake in these issues and that the rules are balanced. If in any given state, the regulators start pushing ahead in an area that a group believes is improper, the group can then discuss with legislators that they should provide specific guidance. Asm. Cooley's belief is that regulators are code administrators and it is the legislature that writes the code. Therefore, the drafting note is actually an advantageous provision for those concerned that a regulator could get "creative" and enact overbroad regulations.

Ms. Hauser stated that while NCPA would like to see the language in the drafting note in Section 7 be part of the Model, NCPA still fully supports the language in drafting note-form. Ms. Shrader stated that she agrees with Asm. Cooley in that she would want a lot of context and language in legislation in order to tell regulators how to regulate certain issues. Ms. Shrader stated that her point was that she was concerned that the drafting note in Section 7 would be given to states as an open-ended list of regulatory topics without any specific guidance from this Committee. Asm. Cooley stated that the drafting

note is actually an “arrow in your quiver” for the reasons he previously stated. Ms. Shrader stated that her experience has been that there are typically very specific issues that arise from state to state and that it is better to have an organic conversation as opposed to a laundry list of regulatory topics in a statute that may not be appropriate in certain states.

Rep. Landgraf stated that she is concerned that Section (b)(1) is very broad in that it does not provide any specifics on when the books and records of a PBM can be examined or audited. Rep. Landgraf asked Asm. Cooley if he was concerned about that because a drafting note in that section could offer guidance on such specifics. Asm. Cahill answered as Chair of the Cmte and stated that the concept of the current version of the Model is very different from the original version introduced earlier this year. The original version was a comprehensive, exhaustive approach to regulating PBMs. Over the course of the year, through discussions and debate, Sen. Rapert decided to go with a “chassis” approach, which is what the current version reflects. The chassis approach takes the form of guidance and a signal to state legislatures across the country that NCOIL is taking the position that there should be regulation and licensure of PBMs. Additionally, Sen. Rapert made sure that each state would have the flexibility to address it as they see fit.

Asm. Cahill noted that the point made by Rep. Landgraf regarding the specifics of PBM examinations and audits has been brought up in NY and he has discussed it with the NY Dep’t of Financial Services (NY DFS). Asm. Cahill noted that he intends on debating the issue with the NY DFS and that is the beauty of a chassis Model law approach. If the Model set forth specific audit requirements, then you run into the situation of straying from the Model as opposed to providing states with a signal that it is time to license and regulate PBMs and the states can take into account their unique needs. Asm. Cooley agreed with Asm. Cahill and noted that Section 6(b)(1) is permissive since it states “may” as opposed to “shall” and it also incorporates the option of an examination which is less stringent than an audit. Overall, Asm. Cooley stated that the Model provides for state flexibility and is not overbearing.

There being no further comments, Asm. Cahill then returned to the Motion made by Sen. Rapert and seconded by Rep. Oliverson to adopt the Model, as amended. Asm. Cahill asked if anyone objected to the vote being in the form of a voice vote. Hearing no objections, the Committee voted affirmatively to adopt the Model by voice vote with Rep. Landgraf being the only voice in opposition.

Sen. Rapert thanked everyone for their comments throughout the entire process and stated that he is proud of NCOIL for providing leadership on these issues and that he is very appreciative to all of the supporters of the Model.

DISCUSSION ON EFFORTS TO OFFER MORE AFFORDABLE INSURANCE OPTIONS TO CONSUMERS

Randy Pate, Director of the Center for Consumer Information and Insurance Oversight (CCIIO), and Deputy Administrator for the Centers for Medicare and Medicaid Services (CMS), stated that CMS supports high-quality patient care, competition, and a meaningful move away from fee-for-service and towards value. Value-based care isn’t something CMS would just like to do, it is something that must be done. By 2026, 1 in every 5 dollars spent in the U.S. economy will be spent on healthcare. The current

trajectory for healthcare spending must be addressed and improvements to the sustainability of our healthcare system must be made. Over the past year and half, CMS has introduced several initiatives including Patients over Paperwork, Meaningful Measures, and MyHealthEData aimed at doing the things necessary to finally achieve the long-talked about goal of value-based and patient-centered care. If the final steps are going to be taken, patients must be activated as they are the most powerful force in our healthcare system for creating value. Patients must be at the center of cost and quality decisions, empowered with the information they need to make the best choices for themselves and their families.

Mr. Pate stated that in the area of Medicaid, CMS' vision for the future is to reset the federal-state relationship and restore the partnership, while at the same time modernizing the program to deliver better outcomes for the people it serves. CMS and the current Administration wishes to empower all states to advance the next wave of innovative solutions to Medicaid's challenges – solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner. In the area of drug-pricing, lowering prescription drug prices is a top priority for the Trump Administration. In the "American Patients First" Blueprint, President Trump has outlined a sweeping set of policies to lower drug prices, which fall under four goals: Lowering list prices, reducing out-of-pocket costs, increasing competition, and strengthening negotiations.

CMS has already taken a number of steps to promote drug price transparency and lower drug prices. CMS will continue to execute on President Trump's blueprint, including to encourage value-based purchasing. Drug pricing is a particularly acute issue for CMS. Combined, Medicare and Medicaid represent 40% of the U.S. drug market – making CMS the largest purchaser of prescription drugs in the country and maybe the world. The Medicare program must be protected and strengthened for current and future beneficiaries. In 2012, Medicare spent 17% of its total budget, or $109 billion, on prescription drugs. Four years later in 2016, this had increased to 23%, or $173 billion. That is an increase of $64 billion in just four years. This is not sustainable. As we see innovation in biomedicine, it is incumbent to also modernize payment policies. Over the past year CMS has been evaluating existing value-based payment models in order to assess performance and identify opportunities for improvement.

Mr. Pate then transitioned to discussing the work of the Center he directs—CCIIO. CCIIO's primary focus is on the individual market; but it also has oversight authority over small group. The individual market is often thought of as a residual market where people go when they don't get another offer of coverage through an employer or public program. However, the individual market plays a very important role in the economy—particularly for seasonal workers, retail workers, people in the gig economy, entrepreneurs, and so on. That's why CCIIO is working so hard to make sure this market works for the approximately 16 million people who rely on it. Mr. Pate noted that CCIIO is making progress on bringing competition to the markets around the country. Issuer participation in the Exchanges has increased with 155 total state level issuers in plan year 2019, up from 132 in plan year '18. Five states in plan year '19 will have only one issuer; down from eight states in plan year '18. CCIIO is pursuing policies across the board to reduce barriers to entry, provide more flexibility to states, and encourage competition.

Mr. Pate stated that 20% of current enrollees will have only one issuer to choose from, down from 29% in plan year '18. The average number of qualified health plans (QHPs)

available to enrollees is 26 for plan year '19, up from 25 in plan year '18. As you can see from the graph, while there is a positive uptick in the number of issuers overall between 2018 and 2019, there continue to be disparities in the number of issuers available between rural and Counties with Extreme Access Considerations (CEAC) areas and metropolitan areas. CCIIO will continue to focus efforts to close this gap. The average monthly premium for the second-lowest cost silver plan (SLCSP), also called the benchmark plan, for a 27-year-old decreased by 1.8% from plan year '18 to plan year '19. This year is the first time that CCIIO has seen the premium for SLCSP decrease nationally. That obviously varies from state to state, but it's a great sign for the future. Mr. Pate stated that a big part of the impact on premiums decreasing comes from state innovation. The impact of the reinsurance 1332 waivers that have been approved in 7 states now has been significant and the waivers are having an impact on rates and people's ability to purchase coverage. But, CCIIO still sees this as an area where everyone has lots of work to do.

Mr. Pated noted that on October 12, 2017, President Trump issued the executive order (EO) "Promoting Healthcare Choice and Competition Across the United States." The executive order aimed to address the failings of the ACA, which limited the choice of healthcare options available to many Americans and produced large premium increases in many state individual markets for health insurance. Among the many areas where previously issued regulations limited choice and competition, the EO focused on the following: association health plans (AHPs); short-term, limited-duration insurance (STLDI); and health reimbursement arrangements (HRAs).

With regard to AHPs, Mr. Pated stated that on June 21, 2018, the Department of Labor (DOL) issued a final rule to expand access to affordable health coverage options for America's small businesses and their employees through AHPs. This reform allows small employers–many of whom are facing much higher premiums and fewer coverage options–a greater ability to join together and gain many of the regulatory advantages enjoyed by large employers. Under the rule, AHPs can serve employers in a city, county, state, or a multi-state metropolitan area, or a particular industry nationwide. Working owners of businesses, such as sole proprietors, who meet certain criteria, as well as their families, will be permitted to join such plans. In addition to providing more choice, the new rule can make insurance more affordable for small businesses. Just like plans for large employers, these plans will be customizable to tailor benefit design to small businesses' needs. These plans will also be able to reduce administrative costs, strengthen negotiating power with health care providers, and achieve greater economies of scale.

With regard to STLDI, Mr. Pate stated that on August 3, 2018, the Departments of Health and Human Services (HHS), Labor, and the Treasury issued a final rule to help Americans struggling to afford health coverage find new, more affordable options. The rule allows for the sale and renewal of STLD plans that cover longer periods than the previous maximum period of less than three months. Such coverage can now cover an initial period of less than 12 months, and, taking into account any extensions, a maximum duration of no longer than 36 months total. This action will help increase choices for Americans faced with escalating premiums and dwindling options in the individual insurance market.

With regard to HRAs, Mr. Pate stated that on October 29, 2018, HHS, Labor, and the Treasury issued a proposed rule that would expand the usability of HRAs, which give

working Americans greater control over their healthcare by providing an additional way for employers to finance quality, affordable health insurance. HRAs allow employers to reimburse their employees for medical expenses in a tax-favored way. Current regulations prohibit employers from using HRAs to reimburse employees for the cost of individual health insurance coverage. Because medical expense reimbursements from HRAs are tax-preferred, HRAs provide the same tax advantage enjoyed by traditional employer-sponsored coverage. The proposal would not alter the tax treatment of traditional employer-sponsored coverage. It would merely create a new tax-preferred option for employers of any size to use when funding employee health coverage. While the employer would fund the cost of individual health insurance coverage, the employee would own the coverage, allowing the employee to keep the coverage even if he or she left the employer and was no longer covered by the HRA.

With regard to 1332 waiver guidance, Mr. Pated stated that on October 22, 2018, CMS and Treasury released new guidance related to section 1332 of the ACA. This action was taken so states can increase choice and competition within their insurance market. The guidance gives states more flexibility to address problems caused by the ACA and to give Americans more options to get health coverage that better meets their needs. Under this new guidance, states will be able to pursue waivers to improve their individual insurance markets, increase affordable coverage options for their residents, and ensure that people with pre-existing conditions are protected. Specifically, the guidance provides information about the requirements that must be met for the approval of these waivers, including the Secretaries' application review procedures, the calculation of pass-through funding, certain analytical requirements, and operational considerations. This new guidance replaces the guidance related to section 1332 of the ACA that was previously published on December 16, 2015 (80 FR 78131).

Mr. Pate further stated that on November 29, 2018, CMS released four waiver concepts for states' use to promote more affordable, flexible health insurance coverage options through State Relief and Empowerment Waivers (SREW). The concepts illustrate ideas that the Administration supports and fit within the framework outlined in section 1332 of the ACA.

The four waiver concepts are: a.) Account-Based Subsidies - Under this waiver concept, a state can direct public subsidies into a defined-contribution, consumer-directed account that an individual uses to pay for health insurance premiums or other health care expenses. The account could be funded with pass-through funding made available by waiving the Premium Tax Credit (PTC) under section 36B of the Internal Revenue Code (IRC) or the small business health care tax credit under section 45R of the IRC. The account could also allow individuals to aggregate funding from additional sources, including individual and employer contributions. An account-based approach could give beneficiaries more choices and require them to take responsibility for managing their health care spending. This approach could also allow a consumer greater ability to select a plan based on the individual's or their family's needs, including a higher deductible plan with lower premiums;

b.) State-Specific Premium Assistance - States can use the State-Specific Premium Assistance waiver concept to create a new, state-administered subsidy program. A state may design a subsidy structure that meets the unique needs of its population in order to provide more affordable health care options to a wider range of individuals, attract more young and healthy consumers into their market, or to address structural

issues that create perverse incentives, such as the subsidy cliff. States may receive federal pass-through funding by waiving the PTC under section 36B of the IRC to help fund the state subsidy program;

c.) Adjusted Plan Options - under this waiver concept, states would be able to provide financial assistance for different types of health insurance plans, including non-QHPs, potentially increasing consumer choice and making coverage more affordable for individuals. For example, states could choose to expand the availability of catastrophic plans beyond the current eligibility limitations by waiving section 1302(e)(2) of the ACA. Used in conjunction with the Account-based Subsidy waiver concept, states could provide subsidies in the form of contributions to accounts, allowing individuals to use the funds to purchase coverage that is right for them and use any remaining funds in the account to offset out-of-pocket health care expenses; and

d.) Risk Stabilization Strategies - to address risk associated with individuals with high health care costs, this waiver concept gives states more flexibility to implement reinsurance programs or high-risk pools. For example, a state can implement a state operated reinsurance program or high-risk pool by waiving the single risk pool requirement under section 1312(c)(1) of the ACA. Reinsurance programs have lowered premiums for consumers, improved market stability, and increased consumer choice. To date, States have chosen to use a variety of models to operate their state-based reinsurance programs, using flexibility available under section 1332. These models include a claims cost-based model, a conditions-based model, and a hybrid conditions and claims cost-based model. If the state shows an expected reduction in federal spending on PTC, the state can receive federal pass-through funding to help fund the state's high risk pool/reinsurance program.

Mr. Pate closed by urging states interested in applying for section 1332 waivers to reach out to HHS and Treasury as soon as possible – the sooner the better – and to e-mail stateinnovationwaivers@cms.hhs.gov for assistance in formulating and enacting a plan that meets the requirements of Section 1332.

Asm. Cahill asked how the 2018 premium increases compare to 2011, 2012 and 2013 – right after the ACA was put in place. Mr. Pate stated that the premiums from 2014 – when the ACA's main provisions went into effect – up until 2018 increased by over 100%. Asm. Cahill then asked Mr. Pate if he has any opinions on whether there should be some sort of waiver process for ERISA, considering that such a process exists for the ACA in 1332 waivers, and for other laws. Mr. Pate stated that he would defer to the DOL on that question. Asm. Cahill re-phrased the question to ask Mr. Pate if he agreed that there are impediments to states in enacting health reforms because we cannot have waivers under ERISA. Mr. Pate stated that he is not an ERISA expert but for purposes of a 1332 waiver, if a state wants to assess its insured lives to fund the program, the reinsurance program under a 1332 waiver is blind to how a state goes about getting that funding, and that CMS and CCIIO are supportive of state flexibility.

INTRODUCTION OF NCOIL MODEL LAW FRAMEWORK ON DRUG PRICING TRANSPARENCY

Rep. Oliverson – prime sponsor of the NCOIL Model Law on Drug Pricing Transparency - stated that for those that are new to this topic, the introduction of it actually dates back to the NCOIL Spring Meeting earlier this year in Atlanta where then NCOIL Vice

President, Vermont Representative Bill Botzow, and current NCOIL Secretary, Asm. Cooley, had introduced laws from their respective states for distribution to the Committee. Their legislation focused on reporting and notification requirements for prescription drug manufacturers. The idea at the time was for those laws to serve as the starting point of an NCOIL Drug Pricing Transparency Model Law drafting discussion.

However, after that meeting, with the departure of Rep. Botzow from the legislature, it took some time to put pen to paper and arrive at a starting point for what a framework of an NCOIL Drug Pricing Transparency Model Law should look like. Rep. Oliverson stated that over the course of the summer, after discussions with Sen. Morrish, he eventually landed upon the drug pricing transparency bill that had passed in Louisiana as what should be used to start this committee's drafting discussion. However, in an effort to follow the NCOIL tradition of bi-partisanship, Rep. Oliverson stated that he looked for another successful drug pricing transparency law from a predominantly Democratic state and accordingly decided to incorporate some language from Connecticut's law into the document that is before the Committee.

Before opening up the topic for discussion, Rep. Oliverson noted that the draft language seeks to shed light on drug prices and manufacturer investment, the flow of manufacturer rebates and other discounts through PBMs, and the impact of drugs on insurance premiums. Rep. Oliverson noted that it is important to do this right which means that we have to look at the entire drug supply chain so we can identify where the cost increases are coming from and why they are occurring. All of the information submitted by manufacturers, PBMs and insurers must be posted publicly by the insurance department. The information submitted will be aggregated and include additional protections against disclosure of confidential or proprietary information, as needed.

Rep. Oliverson stated that Section 4, which primarily applies to the drug manufacturers, requires them to: report wholesale acquisition cost (WAC) information for all of their products on a quarterly basis; report information following a price increase of 50% or more, including the price change, date of the price change, company-wide R&D spending, and history of new drugs that were approved by the FDA and that lost exclusivity over the previous 5 years; and notify the state within 3 days of the launch of a high-priced drug. Section 5 applies to PBMs and requires them to report the annual aggregated amount of rebates, fees and other payments collected from manufacturers; and report the amount of such payments that is passed through to insurers and the amount passed to patients. Section 6 applies to insures and requires them to: report the top most frequently prescribed drugs; report the increase in net spending on prescription drugs and their contribution to premium increases; and report utilization management requirements for specialty drugs and their contribution to premium decreases.

Asm. Cahill then noted that a representative from the Pharmaceutical and Manufacturers Association of America (PhRMA) had intended to be here for the discussion but had to unexpectedly leave the conference early. A copy of PhRMA's comment letter on the draft framework can be found on the conference app and on the NCOIL website.

Ms. Shrader thanked Rep. Oliverson for his leadership on this issue and stated that PCMA agrees that the high cost of drugs is an issue that everyone is dealing with, not just as companies, but as individuals and consumers. Ms. Shrader then noted that a publication from the American Academy of Actuaries (AAA) stated that in 2016, the U.S.

spent $3,337 billion ($3.337 trillion) dollars, or 17% of the U.S. GDP, on healthcare alone, and of that number $329 billion was spent on prescription drugs. The publication then discusses the cost-drivers which are the high cost of drugs, increasing utilization, and the changes in drug mix. PCMA looks forward to working with the committee on the draft framework and noted that the reason PBMs came into existence is because their clients, health plans, wanted an expert in holding down the cost of drugs and that is what PBMs do in the supply chain.

Mr. Keepes stated that the high cost of drugs is one of the most pressing issues facing consumers, health plans, PBMs, and pharmaceutical companies. Of all the issues impacting the healthcare system, this spans the entire spectrum. AHIP has been very active with these issues on the state level and has supported transparency bills in several states. AHIP has been supportive of legislation requiring reporting of general costs of drugs as well as cost increases. AHIP does have some changes it would like to see made to the draft framework but they are meant to be tweaks to the underlying substance and AHIP looks forward to working with the committee. Mr. Keepes also noted that AHIP is pleased that PhRMA has been engaged in this process and looks forward to working with them. Lastly, Mr. Keepes noted that the committee should keep in mind the language contained in the recently adopted NCOIL PBM Model when considering the PBM reporting requirements set forth in Rep. Oliverson and Sen Morrish's draft framework.

Rep. Matt Lehman (IN) – NCOIL Treasurer – pointed to Section 4(b)(1) which requires drug manufacturers to report an increase in WAC of 50% or greater for a drug with a WAC of $100 or more for a 30-day supply, and asked how the figure of 50% was decided upon. Rep. Oliverson stated that percentage was chosen simply because it comes from the LA law and that was a fight and negotiation that had already been completed. Accordingly, 50% is simply a starting point for the Model and it is certainly ultimately up to the will of the Committee as to what percentage should be in the Model.

Rep. Lehman thanked Rep. Oliverson and stated that he looks forward to discussing that issue as it is somewhat ironic that there would be riots in the streets if there was a 20% increase to auto insurance premiums, but 40% increases to drugs are not viewed the same by everyone. Rep. Lehman further stated that a lot of the problems that arise from drug pricing stem from what is built into the wholesale cost. Part of it is tort reform because it seems as if every other commercial on TV is providing legal remedies to those who have taken certain drugs. Rep. Lehman would like to know what PhRMA's members spend in tort claims.

Rep. Oliverson thanked Rep. Lehman for his comments and stated that his intent with the Model is not to enact any form of price controls, but to rather promote transparency and get a better understanding of why the prices of drugs are increasing; class action lawsuits and multi-million-dollar settlements may very well be a cause for the increases. Rep. Lehman applauded Rep. Oliverson and Sen. Morrish for bringing this Model forth.

Rep. Oliverson stated that he and Sen. Morrish look forward to working with everyone throughout 2019 and that they urge committee members and stakeholders to contact them and NCOIL staff with any other comments or suggestions.

ANY OTHER BUSINESS

Asm. Cahill stated that during Thursday's general session titled: "Examining the Role of ERISA in the State Based System of Insurance Regulation: Can Meaningful State Reforms be Achieved in an ERISA-Dominated Marketplace?" – Prof. Elizabeth McCuskey of the Univ. of Toledo College of Law indicated a number of ways to deal with the preemption issues associated with ERISA, and one of her proposals was having an ERISA waiver-process for states to utilize.

Asm. Cahill stated that Prof. McCuskey's waiver proposal will be circulated to Committee members and posted on the NCOIL website. Asm. Cahill further stated that he hopes that the Committee can further discuss the waiver concept for purposes of improving and expanding state flexibility and economy at the NCOIL Spring Meeting in Nashville.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:30 a.m.