

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
AUSTIN, TEXAS
DECEMBER 11, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the JW Marriott Hotel in Austin, Texas on Wednesday, December 11, 2019 at 2:30 p.m.

Assemblywoman Pam Hunter of New York, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Deborah Ferguson (AR)	Sen. Vickie Sawyer (NC)
Sen. Jason Rapert (AR)	Rep. Tracy Boe (ND)
Asm. Ken Cooley (CA)	Rep. George Keiser (ND)
Sen. Jack Tate (CO)	Sen. Jerry Klein (ND)
Rep. Richard Smith (GA)	Sen. Shawn Vedaa (ND)
Rep. Martin Carbaugh (IN)	Asw. Maggie Carlton (NV)
Rep. Peggy Mayfield (IN)	Asw. Ellen Spiegel (NV)
Rep. Joe Fischer (KY)	Sen. Neil Breslin (NY)
Rep. Dean Schamore (KY)	Asm. Andrew Garbarino (NY)
Sen. Dan "Blade" Morrish (LA)	Rep. Tom Oliverson, M.D. (TX)
Sen. Paul Utke (MN)	Del. Steve Westfall (WV)
Sen. Paul Wieland (MO)	

Other legislators present were:

Sen. Matt Lesser (CT)	Rep. Donna Pfautsch (MO)
Rep. Doug Gutwein (IN)	Rep. Bruce Grubbs (MT)
Rep. Chris Judy (IN)	Sen. Jim Perry (NC)
Sen. Andy Zay (IN)	Sen. Roger Picard (RI)
Rep. Edmond Jordan (LA)	Rep. Julie Johnson (TX)
Del. Mike Rogers (MD)	Rep. Eddie Lucio III (TX)
Sen. Gary Dahms (MN)	

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, NCOIL General Counsel
Cara Zimmermann, Assistant Director of Administration, NCOIL Support Services

QUORUM

Upon a motion made by Sen. Jerry Klein (ND) and seconded by Rep. Martin Carbaugh (IN), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Sen. Jack Tate (CO) and seconded by Rep. Carbaugh, the Committee approved the minutes of its July 13, 2019 meeting in Newport Beach, CA without objection by way of a voice vote.

CONSIDERATION OF NCOIL DRUG PRICING TRANSPARENCY MODEL ACT

Rep. Tom Oliverson, M.D. (TX), Vice Chair of the Committee and sponsor of the NCOIL Drug Pricing Transparency Model Act (Model), stated that it is hard to believe that this Committee has actually been discussing the issue of drug pricing transparency since March of last year; and has been discussing the Model since December of last year. Rep. Oliverson thanked everyone involved for their input. The Model has come a long way since it was first introduced and although it does not give everyone everything they want, it is something that everyone can live with and that is usually a good place to be.

Rep. Oliverson then noted the changes that have been made to the Model since it was last discussed, including sponsor's amendments that have been proposed since the 30-day materials for the meeting were issued. Regarding the sponsor's amendments: first, at the end of Section 4 – which deals with drug manufacturer requirements – Rep. Oliverson proposed adding a Drafting Note that states: States may wish to raise or lower the percentages and dollar amount set forth in Section 4(b)(1) depending upon each state's economic environment as it relates to prescription drug prices. Rep. Oliverson stated that the thresholds that trigger the reporting requirements are a tricky issue because there is a fine line between making them too high so as to be essentially meaningless, and too low so as to make the amount of data being reported very burdensome for state agencies to handle. Accordingly, Rep. Oliverson stated that he wants to make clear that, while the thresholds in the Model are strong, he does not consider them to be perfect and the drafting note is a good compromise that provides states flexibility when considering the thresholds.

Next, in Section 6(a)(2), Rep. Oliverson stated that he would like to remove the language at the beginning of the second sentence: "For any health [carrier/insurer] with an affiliated pharmacy benefit manager with fewer than five (5) clients." Rep. Oliverson stated that was more of a drafting error than anything and that language did not belong in that section. Before closing, Rep. Oliverson noted that each industry that the Model covers is present today and he thanked them for all of their input. As is always the case with NCOIL Models, states are free to change any provisions as they deem appropriate.

Saiza Elayda, Senior Director of State Policy at Pharmaceutical Research and Manufacturers of America (PhRMA), stated that PhRMA opposes the Model and feels that the Model does not provide anything meaningful to patients when shopping for insurance. The Model slightly misses the mark on helping patients understand certain things. PhRMA was hoping that the Committee would consider other reforms such as capping copays or limiting out of pocket maximums.

Brendan Peppard, Regional Director of State Affairs for America's Health Insurance Plans (AHIP), thanked Rep. Oliverson and the Committee for the dialogue surrounding the Model and noted that there are some changes to the Model that AHIP would still like to see but the Model is much improved. AHIP believes that this is an important issue because of the rising drug prices that are hitting consumers every day. Mr. Peppard

noted that it is the pharmaceutical manufacturers alone who set the price of drugs and it is important to remember that. Mr. Peppard noted that AHIP does believe that the reporting threshold numbers should be lowered to 10% which is a level that many pharmaceutical manufactures have already agreed to in principle. AHIP appreciates the drafting note but Mr. Peppard stated that if the Committee really wants to tackle drug price increases, perhaps something such as a medical consumer price index (CPI) should be examined.

Mr. Peppard stated that AHIP believes that language should be included in the Model regarding launch price information and suggested using language that was enacted in Oregon. AHIP believes that language would be very useful. Regarding Rep. Oliverson's recent amendment to Section 6, pending review of the language, AHIP believes the amendment is proper and thanked Rep. Oliverson for making that change. However, regarding the aggregation language in Section 5 relating to pharmacy benefit managers (PBMs), AHIP believes that there needs to be broad-based aggregation language added. AHIP believes that without that language, there is the possibility that publicly released information for any individual company could be used to back into specific proprietary confidential business-sensitive information. Mr. Peppard noted that as Section 5 is currently drafted regarding the "less than 5 client" issue, in many markets that language would only apply to one PBM which means that the language would be nullified and there would be no aggregation. AHIP would appreciate further discussion regarding that language as it does not believe the Model is ready to move forward without that issue being addressed.

Melodie Shrader, Senior Director of State Affairs at the Pharmaceutical Care Management Association (PCMA), thanked Rep. Oliverson and the Committee for the time dedicated to the Model. Ms. Shrader noted that rebates are paid on brand name drugs that generally do not have generic equivalents. PBMs negotiate those rebates with manufacturers in order to reduce the price that the client ultimately pays for the drugs. The average cost of a brand name drug, excluding specialty drugs, is about \$350. According to a recent study on PBMs, on average PBMs reduce that cost by approximately 25% so the price of the drug is decreased to about \$268. Of that, PBMs keep about 4% and the manufacturer keeps about 88% of that dollar and pharmacies keep about 7%. It is important to understand the value of rebates in keeping down the cost. That is the system which we work within today. 90-95% of all of those rebates go back to the client and it is the PBM's goal to keep it to the lowest net price.

Ms. Shrader noted that the Model is very similar to what was enacted in Texas this past legislative session, but there are some significant differences. Ms. Shrader stated that the drafting note amendment sponsored by Rep. Oliverson is important because in Texas the number is 40% and in the Model it is 60% before triggering a reporting requirement. That is a fairly significant difference so the drafting note is important. Ms. Shrader noted that the rebates are negotiated in private contracts between savvy and sophisticated parties. The reason PCMA is concerned that the data for a PBM with more than five clients is not aggregated before being published is that said data is proprietary information. PCMA is concerned that if that proprietary information is put out into the marketplace, it could be a disruptor. PhRMA already knows what rebates they pay to each PBM; they know what their market share is and they know what their competitor's market shares are. With another piece of information, such as the rebates paid to one PBM versus another, it will be a piece of information that is only going to be useful to PhRMA. PCMA is very concerned about that. PCMA agrees with the

Committee that the rising cost of drugs is alarming and with providing rebate information to regulators. However, PCMA must oppose any publication of proprietary information. PCMA supported the final version of the Texas legislation but must oppose the Model in its current form and requests that an amendment be considered before adopting the Model. PCMA requests that the same amendment referenced by Rep. Oliverson in Section 6 be made to Section 5.

Rep. George Keiser (ND) asked if there has been any discussion on the rebating side on the rebates from pharmaceutical manufacturers to pharmacists. Rep. Oliverson stated that issue was not included in the Model and that was because as he and others looked for policies that were already out there in certain states, it was found that there was an emphasis on three main segments of the marketplace: drug manufacturers, PBMs, and health insurers.

Asw. Maggie Carlton (NV) asked who the Model actually applies to because there are numerous insurance schemes in each state including self-insured groups, health and welfare trusts, the Blues and standard health insurers. It is known that what is put in statute does not affect every insurance scheme in the state. Rep. Oliverson stated that as implemented in Texas, and as proposed in the Model, the goal was to cast as broad of a net that could be cast while not applying to things that states would not have the ability to regulate such as federally preempted health plans. Asw. Carlton stated that the Model would apply to a very small group in Nevada because the other groups have most of the coverage in the state. Rep. Oliverson stated that is correct but noted that if Nevada is like Texas, which he suspects is, the state's largest health plan in terms of numbers of covered lives is probably teachers or employees and those definitely would fall under the Model so you would get a fair amount of data from that group. Asw. Carlton stated that Nevada is actually the opposite of Texas in that regard.

Upon a Motion made by Rep. Oliverson and seconded by Sen. Dan "Blade" Morrish (LA), NCOIL President and co-sponsor of the Model, the Committee voted without opposition to adopt the Model, as amended, by way of a voice vote.

CONTINUED DISCUSSION ON NCOIL SHORT TERM LIMITED DURATION INSURANCE MODEL ACT

Rep. Martin Carbaugh (IN), sponsor of the NCOIL Short Term Limited Duration Insurance (STLDI) Model Act (Model), stated that the Committee had a good discussion on the Model at its last meeting in Newport Beach and noted that some changes have been made to the Model since then. First, the title of Section 3 has been changed from "Preferred Provider Plan Requirements" to "Network Based Plan Requirements" as there are multiple types of network-based plans, such as ones that use exclusive provider networks. Relatedly, the term "preferred provider plan organization" was added to the definitions section of the model. Second, Section 4(b)(2) was revised to clarify that when an individual exceeds the duration limit in subdivision (1), a new policy must be issued as it is not a renewal, but rather a new enrollment. Lastly, in Section 7 - which deals with disclosure requirements - language was added to require the insurer to specify the essential health benefits where no coverage is offered.

Rep. Carbaugh noted that at the July meeting in Newport Beach, there was a lot of discussion regarding the Model's requirement to have the short term insurance plan have an annual limit of at least \$2 million dollars. Rep. Carbaugh acknowledged that

said limit is arguably a departure from current practice but it is important that if the plans are being bought for a longer period of time that there be a substantial limit as we see healthcare costs continuing to rise. Also, as stated in July, the difference in premium between a plan that has a \$250,000 limit versus a \$2,000,000 limit is really negligible. Rep. Carbaugh noted that he is still open to further changes to the Model and hopes that the Committee can vote on it at the Spring Meeting in March.

Brian Blase, President & CEO of Blase Policy Strategies, stated that he served as Special Assistant to President Trump at the National Economic Council for 2.5 years. One of the main focuses of the Administration was expanding affordable coverage for Americans. President Trump signed an Executive Order (EO) titled "Promoting Healthcare Choice and Competition Across the United States" which contained an expansion of association health plans (AHPs), short terms plans, and things called health reimbursement arrangements (HRAs). The actions were meant to benefit two main groups: middle class families, including the self-employed who didn't have an offer of employee coverage, and small businesses and their workers as small businesses were frequently not offering coverage. The fact is that the Affordable Care Act (ACA) exchanges are not working as intended. Although enrollment has been stable since 2015 at about 10 million people, 70% of enrollees have an income below 200% of the poverty line which is about \$50,000 for a family of four. Enrollment is 60% below expectations as the plans are not attractive unless the people receive large subsidies or have significant medical needs.

Mr. Blase stated that unfortunately, individual market enrollment outside the exchanges is deteriorating. Between 2016 and 2018, 2.5 million fewer unsubsidized enrollees had coverage in the individual market, a decline of 40%. Despite the strong economy, the number of people without insurance between 2017 and 2018 increased by 1.6 million for individuals 300% above the poverty line which is about \$75,000 for a family of four. Small employers are also finding it increasingly difficult to continue offering coverage. Between 2010 and 2018, the proportion of workers at firms with 3 to 49 workers covered by an employer plan fell by more than 25%. The Administration took three actions to help those individuals. First, the Administration opened a second pathway for employers to form AHPs and gain the regulatory advantages and economies of scale that large employers receive when offering coverage. The new pathway allowed any employers within a state to join together and form an association and also to open up the association to sole proprietors. Unfortunately, a federal judge in March ruled the new pathway to be an invalid interpretation of ERISA. The Department of Labor (DOL) appealed and that appeal was heard by an appeals court a few weeks ago.

Second, the Administration issued a rule to expand STLD insurance. Such coverage is exempt from federal mandates and premiums can accurately reflect risk. Such plans can be tailored to what people need and are generally much less expensive than ACA plans. In a late 2016 rule, the Obama Administration severely restricted these plans as people were increasingly choosing them rather than ACA plans. The Obama Administration limited coverage to 90 days and prevented renewals. Such actions harmed people who got sick by leaving them without coverage after the three month period ended as people can only buy ACA plans during a six week period each year. For those reasons, the National Association of Insurance Commissioners (NAIC) opposed the Obama Administration rule. The Trump Administration rule largely reversed those restrictions. Said rule restored the 364 day contract period, permitted renewal of plans for up to three years, and clarified that people could combine short term

plans with separate insurance products dubbed “renewal guarantees” that people could purchase to protect them from undergoing medical underwriting in the future. The rule also required short term plans to include a disclosure requirement urging consumers to carefully review benefit designs and indicating that such plans do not meet ACA requirements. Such plans will likely resemble a typical non-group plan offered before 2014.

Mr. Blase noted that Chris Pope of The Manhattan Institute conducted an extensive study comparing ACA plans to short term plans. According to his findings, for equivalent insurance protection, the premiums for short term plans are much lower, in some cases about half the cost. Moreover, Mr. Pope found that narrow network health maintenance organizations (HMOs) are often the only type of ACA plans available and that short term plans generally cover a much broader set of providers. An initial legal challenge to the Trump Administration’s short term plan rule failed. In total, the AHP and short term plan rules, combined with the elimination of the individual mandate penalty, significantly improved people’s ability to purchase coverage that works best for them. The White House Council of Economic Advisors estimated that the net economic benefit of the AHP and short term plan rules, combined with the elimination of the individual mandate penalty, is about half a trillion dollars over the next decade.

Mr. Blase stated that there is a role for state action on both AHPs and short term plans. States should permit their residents to fully benefit from such plans and where it makes sense, implement common sense regulation such as solvency requirements for AHPs and appropriate disclosures for short term plans. Several states took action last year to expand their resident’s ability to benefit from AHPs and short term plans. However, Mr. Blase strongly cautioned against consumer protection type legislation that mostly restricts consumer choice. People should be able to purchase plans that work best for them and we should be careful in substituting government’s judgment for what people need for the judgment of consumers who have different needs and preferences.

Mr. Blase stated that the third regulation may be the most profound – the expansion of HRAs. In part because of the tax exclusion for employer-sponsored insurance, employers have a lot of control over a worker’s health insurance. Choices are often restricted and 80% of firms that offer plans only offer a single option. In June, the Administration released a final rule that provides employers another method of offering coverage in a way that promotes choice and portability for workers. The benefit is through HRAs which are tax advantaged mechanisms for employers to reimburse employee healthcare expenses. As a result of the HRA rule, starting next month employers can provide workers with tax free contributions for the workers to buy coverage in the individual market. A defined contribution for health insurance is similar to 401K plans and 403B plans for retirement savings where employers provide a set amount of funds with workers having control over the investment. The Administration estimates that in about five years, 800,000 employers, nearly 90% of them with fewer than 20 workers will offer an HRA and more than 11 million people will be enrolled in the individual market. Mr. Blase stated that the HRA rule, which permits integration only with ACA compliant plans, should show that the Administration was focused on expanding available coverage through all means. With common sense reform to the individual market, the HRA rule holds the promise to revolutionize health coverage with families in greater control with more portable options.

Mr. Blase then discussed the 1332 waivers which the Administration has been approving. The Administration approved several of them for state reinsurance programs to help subsidize the cost of people with high claims. Such waivers have generally resulted in premium decline in states that have had them of 10-15%. Last year, the Administration released new guidance making it easier for states to modify aspects of the ACA and improve their markets through 1332 waivers. States should take a close look at such guidance and Georgia should be commended for developing the first waiver consistent with the new guidance. Mr. Blase stated that no issue troubles American families more than rising healthcare costs. One year ago, the Administration released a 120 page report "Reforming America's Healthcare System Through Choice and Competition." It is a bold and thoughtful report that contains more than 50 recommendations to improve the healthcare system. As state legislators embark on their important work, it is worth remembering that there are two ways in which policy can lower healthcare costs: one is to align incentives and provide information so employers and consumers can be the best possible shoppers of care; and the other is to inject competitive forces in the provision of care. Anything that advances those two aims is likely a step forward.

Steve Kline, Director of Gov't Relations at the National Association of Insurance and Financial Advisors (NAIFA), stated that NAIFA supports the Model and feels that its duration and disclosure provisions largely mirror the federal short term rule which NAIFA supports. The Model expands upon that federal framework in some other ways particularly with the provider network and benefit requirements. NAIFA supports the availability of short term plans in the market as there is an important role for such plans in a number of circumstances. For example, individuals may be in the middle of a job transition and discover that COBRA payments may be too costly; folks that are new retirees seeking new health insurance coverage while they wait to enroll in a Medicare plan; or clients going through a life transition such as early retirement or divorce.

Mr. Kline stated that some of NAIFA's members have stated that short term plans can also provide some important supplemental coverage. For example, self-employed persons who want additional coverage to complement their major medical plans, as well as individuals maybe looking for supplemental coverage to defray the high cost of prescription drugs. Mr. Kline stated that short term plans can provide an affordable option to some policies in the individual market. Many consumers do reside in areas where there are very few options for health insurance and what is available can be very costly. In that circumstance, a short term plan may be the only affordable option, especially those consumers who may not qualify for an ACA premium tax credit. For example, one of NAIFA's members had a client who was a 49 year old male in need of health insurance. The client discovered that the least expensive plan on the individual market would have cost him over \$700 but he was able to get a short term plan for about \$400 which included all of the client's preferred doctors. Mr. Kline closed by stating that short term plans ensure that consumers can maintain some critical but temporary health insurance coverage, provide some supplemental benefits, and in certain markets perhaps serve as an alternative to some individual market plans. The Model helps ensure that short term plans stay on the market and for those reasons, NAIFA supports the Model.

Asw. Pam Hunter (NY), Chair of the Committee, stated that during the Committee's July meeting, Michelle Lilienfeld of the National Health Law Program (NHLP) stated that the majority of the short term premiums collected goes towards administrative costs. Asw.

Hunter asked Mr. Blase's thoughts on that and for comments as to whether an amendment should be made to the Model relating to medical loss ratio (MLR) requirements. Mr. Blase stated that there is not great data surrounding short term plans. The NAIC is actually engaged right now in a data call surrounding such plans. Mr. Blase stated that he does not believe therefore right now that there is a really good understanding of what the MLR really is for short term plans. Mr. Blase stated that he is not a huge proponent of minimum loss ratios as they contain pretty bad incentives for insurers to increase spending. Essentially, they cap profits at a percent of spending which does not create an incentive on the insurer's side to have the lowest possible spending.

Sen. Matt Lesser (CT) stated that he is glad to hear that the Committee will not move forward with voting on the Model today given the legal and regulatory uncertainty that is hanging over the proposed expansion of short term plans. Sen. Lesser stated that he hopes moving forward that the Committee can be mindful of the name of the product – short term limited duration plans. Connecticut has adopted laws that prevent renewal of such plans and also requires that they be consistent with essential health benefits (EHBs) required elsewhere in the marketplace. That is important as it still allows for pre-existing condition exclusions and other changes that will lower the cost relative to other plans in the marketplace but it captures the original intent of the legislation establishing such plans which is to provide a limited duration option for people in between other options.

Rep. Deborah Ferguson (AR) stated that she is concerned that a lot of short term plans have \$1,000 daily maximums which won't even touch what a daily hospital visit costs. Rep. Ferguson stated that she would like to see something in the Model protecting the daily limit in addition to the annual limit.

Rep. Oliverson stated that he agreed with Rep. Ferguson and noted that a \$2 million dollar limit could also be easily thwarted if there are not protections put in place for caps on individual spending. For example, you could have a \$2 million dollar policy but if there is a \$50,000 cap per individual then essentially the \$2 million number is meaningless if someone is diagnosed with a serious illness.

DISCUSSION ON NCOIL HEALTH CARE SHARING MINISTRY MODEL ACT

Rep. Carbaugh, sponsor of the NCOIL Health Care Sharing Ministry (HCSM) Model Act (Model), stated that the Committee had a great introductory discussion on the topic in July. Rep. Carbaugh noted that he brought this topic forward for discussion at NCOIL mainly because of a scenario he became aware of regarding a friend of a friend who was involved with a HCSM – essentially, all of the medical bills that he and his wife thought were eligible to be shared with the HCSM were not. Rep. Carbaugh noted that as an agent, he is contracted with a HCSM, and has only sold the product to one person although he has presented it as an option to several people as there is a lot of interest in more affordable healthcare options. Rep. Carbaugh stated that he thought NCOIL would be a good forum to have this discussion as there is not a lot of regulation surrounding HCSMs. Rep. Carbaugh stated that he is not proposing a ton of regulation but believes there needs to be registration and minimum reporting requirements. Rep. Carbaugh noted that he looks forward to hearing from the panel and further discussing the Model.

Asw. Hunter asked Rep. Carbaugh to provide a brief explanation on what HCSMs are as there are several legislators present today who were not present at the Committee's July meeting. Rep. Carbaugh stated that HCSMs are essentially a medical bill sharing arrangement where people of similar faith agree to pay (you cannot call them premiums) monthly allotments to an organization or sometimes directly to other members when they have bills that are eligible to be shared. You cannot call it an insurance claim because it is not insurance and it is not a contract. Consumers need to be aware of the complexities of HCSMs. Most HCSMs are good actors and go above and beyond to tell the consumer that they are not buying an insurance contract – it is a promise that people of similar faith will make to help pay medical bills that arise providing there are no pre-existing bills and that you meet the requirements of the plan, such as no smoking.

Keith Hopkinson, Of Counsel at Winstead PC, stated that he has represented Christian HCSMs (Christian) for the last 18 years and has been well informed about how HCSMs operate. Christian is the oldest, the original, and the largest sharing ministry in the country but most people have probably never heard of it and there are several reasons for that. The way that they develop their membership is through word of mouth and they do a lot of reach out at various Christian conferences and the like, and they also have a good network with a lot of the Christian churches across the country. Christian does not advertise in national media whereas other HCSMs do which is a big distinguishing characteristic. Christian also does not use insurance agents – it does everything by word of mouth and everything is essentially between the ministry and the members. Mr. Hopkinson stated that Christian's goal has always been to stay in their lane and on their side of the fence as they are not insurance and that is emphasized repeatedly with its members. Their website also makes that clear and they go to great lengths to avoid the potential for any confusion in any aspect of a prospective member's consideration of sharing as a possible opportunity for them to exercise their faith as well as to meet their health needs.

Mr. Hopkinson stated that Christian has reviewed the Model and at the outset they applaud it as a very strong effort. The reality is that we are in a very difficult time for sharing and there is a lot of unsavory behavior that has crept into the world of sharing that has given the concept of legitimate sharing a black eye. Mr. Hopkinson stated that it is probably inevitable at this point in time that as sharing became more known by the consumer that there were going to be elements that crept into it that have different agendas other than faith. Clearly there is a problem with bad actors. Christian believes that the Model makes a substantial effort to address many of the concerns heard from both legislators and regulators across the country as to the sharing ministry problem. Christian believes that the Model does a key thing which Christian has embraced and advocated for – embracing transparency and sunshine. Sunshine is a great antiseptic for rooting out some of the behavior that has crept into the world of sharing in the last couple of years.

Mr. Hopkinson then discussed a few highlights of the Model. Mr. Hopkinson first noted that somewhere in the Model there is a zero missing from a citation to the federal code as it should be 5000 and not 500. The meat of the Model is that it requires certain information from HCSMs for purposes of registration. The Model asks that the HCSM prove that it is a certified sharing ministry at the federal level under the definition that is currently law in the country under the ACA. That is important because there needs to be some type of standardized definition as to what a HCSM is. The Model does a good job of defining what a HCSM is conceptually but around the country there is sort of a

patchwork of definitions in addition to the federal definition and there should be just one. Mr. Hopkinson stated that the Model also asks for disclosure of third party vendors which is very interesting and is in the context of enrolling members or negotiating with medical providers or the aspect of the financial sharing of a member's medical needs. Christian believes that is a good place for sunshine because vendors are typically a profit third party entity outside of the ministry which is not to say that it might not be beneficial to a ministry's membership if the ministry had some type of outside vendor providing services in one or more of those arenas. Christian notes with some concern that is one of the areas where there is a possibility for abuse and taking advantage of the ministry. There may be conflicts of interest with respect to officers or directors that are on the board of the ministry but also involved with the vendor. Christian believes that there is no reason to not make that disclosure so that the consumer can make an evaluation as to whether they are comfortable with a ministry that has a third party vendor setup.

Mr. Hopkinson stated that it is Christian's view that all ministries are supposed to be non-profits which means that you are maximizing the benefit that the member receives for their dues. When you start having expense items that are outside of the ministry, that means you are starting to load up expenses of a pure non-profit model whereby money that might be available for needs is going somewhere else. Christian believes that a legitimate ministry would have no problem explaining how each aspect of the ministry helps members. Mr. Hopkinson stated that Christian really likes that the Model parallels the concept that already exists at insurance departments with the risk purchasing group and risk retention group act. There is a federal authorization that allows for all of that and the states then have a registration requirement for those risk purchasing groups or risk retention groups. Accordingly, this is something that insurance departments are already comfortable with and insurance departments are the ones getting complaints regarding HCSMs.

Mr. Hopkinson stated that Christian found the Model's anti-fraud provision to be very interesting. There might be some sort of boogeyman reaction to that from some folks in the ministry arena but from Christian's perspective, it is not a problem and it is a beneficial two way street because it allows the ministry to report fraud that they encounter.

Asw. Hunter asked Mr. Hopkinson to explain why Christian does not use insurance agents. Mr. Hopkinson stated that Christian is very focused on avoiding any possibility of consumer confusion on the part of prospective members regarding the fact that sharing is not insurance. Christian has a very difficult time of understanding how anyone sitting in an insurance agent's office is going to understand that the product is not insurance although they purchase their auto insurance and other insurance from the agent. The mere appearance of the potential for confusion or impropriety is reason to not use insurance agents. Another reason is that agents are an expense item and Christian is a non-profit. There should be no need for a ministry to pay commissions – and Christian has heard of some egregious numbers from some of the bad actors – which is money that is basically taken away from the consumer and not eligible for sharing. That leads to a non-profit entity built on generating incentive and profit for third parties outside of the ministry.

Joann Volk, Research Professor at the Georgetown University Center on Health Insurance Reforms (CHIR) stated that CHIR began researching HCSMs last year and talked to some regulators about them as well. Ms. Volk first noted the research CHIR

did last year in which they researched five HCSMs, one of which was Christian, and talked to state regulators in 13 states about what their views of HCSMs were. Ms. Volk then noted research CHIR did last year in which they spoke to brokers in six states, and an online broker, about how they view the changing individual market, particularly after the zeroing out of the individual mandate. In those discussions, CHIR heard that for those looking for more affordable options than the ACA, brokers will often refer them to either short term plans or HCSMs as a legitimate alternative to insurance.

Ms. Volk stated that HCSMs typically limit membership to those who share a set of religious beliefs and you may have to sign a pledge saying such. Most HCSMs serve individuals but there are some out there marketing to small employer groups. You do have to pay a monthly payment or “share” to cover the expenses of others and they are prescribed based on age, level of coverage and in some cases health indicators. There are un-sharable or member responsibility amounts that are akin to deductibles which you must cover on your own before you can submit bills for sharing. Ms. Volk noted that the administration of HCSMs varies as sometimes you are referring your share directly to another member in need and in other cases you are sending it to the ministry to distribute to put into an account that can be accessed and shared with others.

Ms. Volk stated that the ministry determines what is sharable as it has a defined set of benefits that will often eliminate pre-existing conditions and might also have other limits on services and conditions that might not comport with religious beliefs. Some ministries condition reimbursement on factors other than a defined benefit so even if it fits the description they might say that before a claim can be submitted for sharing, even after you have hit your un-sharable amount, you must show that you tried to access the charity program at the hospital for help paying the bills and you also might authorize the ministry to negotiate on your behalf with providers to obtain a discount first. Some ministries also ask that you first pursue a legal case if there is a possibility that someone else could pay before it can be shared. Ms. Volk noted that the first research she referenced earlier has details as to how HCSMs operate with respect to pre-existing conditions, benefit exclusions, and dollar and visit limits.

Ms. Volk stated that HCSMs are not insurance because there is no promise to pay or cover claims and HCSMs are careful to avoid using insurance terms so that people do not believe they are subject to a deductible and have to pay a premium. But even so, CHIR found from research and by speaking to regulators that there are many aspects of HCSMs that are similar to insurance and therefore could lead to consumer confusion. Some HCSMs will refer to provider networks; borrow language from common insurance language terminology like suggesting the product is available in gold, silver and bronze levels; a defined set of benefits and cost-sharing as the guidelines lay out what exclusions are and what is covered up to certain amounts and what is covered after a waiting period. Some HCSMs may also require the consumer to get prior authorization to determine medical necessity before he or she can consider it sharable, and there is a claims processing feature when submitting claims for some HCSMs.

Ms. Volk stated that one of the big gaps that the Model could address is that there is no independent data as to how many people are enrolled in HCSMs. Ms. Volk stated that the only number she has seen and used frequently is that the Alliance for HCSMs (Alliance) has said that membership grew from fewer than 200,000 prior to the ACA to more than 1 million today. Many HCSMs use brokers, have sophisticated websites and will run advertisements during open enrollment specifically when people are shopping for

insurance to suggest that they might consider a HCSM. A recent uptick has been seen in HCSM marketing from both CHIR and state regulators. Ms. Volk stated that the regulators CHIR spoke to stated that the cost of the ACA plans was the primary driver of HCSM membership. Ms. Volk stated that based solely on price, if you are looking for something more affordable and you don't qualify for premium tax credits, HCSMs certainly seem to be a much more affordable option.

Ms. Volk stated that regulators do not have a systematic way to collect data on enrollment and they are concerned that a lot of the marketing of insurance-like features contribute to consumer confusion that they don't understand what they are getting when a consumer buys into a HCSM. There was not a concern that there was going to be risk segmentation against the ACA marketplace but without knowing how many people are enrolled it is hard to assess that. CHIR found that states can perform oversight regardless of HCSM safe harbor status.

With regard to features that may lead to consumer confusion, there is a defined benefit package and the different benefit packages may be sold at different rates much like health insurance. The benefits are contingent upon paying a monthly share and they come with what is akin to deductibles, copays and coinsurance. Ms. Volk then provided an example of a Christian offering which used gold, silver and bronze levels with different membership fees just as you would with health insurance for gold, silver and bronze plans. Ms. Volk then noted Christian Care Ministry's disclosure that there is no deductible but there is an amount that must be paid before medical bills may be shared; and that there is no premium but an amount that must be paid monthly to be a member.

Ms. Volk also noted that some HCSMs suggest that there is a defined provider network and if you go to a preferred provider, much like with insurance, you will pay less out of pocket than you would for an out of network provider. Ms. Volk then provided an example of Medishare material which refers to a preferred provider organization (PPO) and outlines the consequences if you choose a PPO versus a non-PPO. Ms. Volk noted that it looks a lot like an insurance plan that has a network.

Ms. Volk stated that HCSMs may be sold by insurance brokers and the commissions can be substantial. Covered California recently did a survey of their certified brokers and found that where brokers are paid a 2.6% commission for ACA plans, the HCSMs are in the 15-20% range. Ms. Volk also noted that HCSMs are also sometimes referred to as a replacement for insurance that might provide similar financial protections. Ms. Volk then referenced the website of a HCSM, Sedera Health, which states that it is a "proven alternative to health insurance" and suggests other features that are a lot like insurance.

Regarding the regulatory framework surrounding HCSMs, there is an exemption under the ACA's individual mandate section for those that are in a HCSM that meet a certain definition. However, that was exclusively for the purposes of the individual mandate and does not at all affect state's ability to regulate or legislate in this area. CHIR found that there was some confusion about that – that there should be a hands off approach to HCSMs because the ACA sort of sanctioned them. No state currently regulates HCSMs as insurers and in 30 states there are "safe harbor" laws which specifically exempt HCSMs that meet a certain definition from insurance regulation. Some states borrow from the ACA's definition but others go beyond that. For example, Pennsylvania has a much more robust safe harbor and the exemption only includes those ministries that do

not use any financial incentives for enrollment and do not use member funds towards administration and do not directly or indirectly suggest that claims will be paid or that there is a history of covering people's bills.

Ms. Volk stated that state safe harbor laws do define which HCSMs are exempt from insurance regulation but not all HCSMs meet that definition. Most safe harbor laws require each HCSM to provide a written disclosure that the entity is not an insurance company and most require participants to be provided with a monthly statement identifying total qualified claims and some require publishing the share of qualified claims that are assigned to other members to pay. A minority of the safe harbor laws require an annual audit prepared by an independent CPA that must be available upon request.

Ms. Volk stated that CHIR has been talking to state regulators and has a publication arriving soon focused on how states can get a closer handle on monitoring the market and understanding who is enrolled and how HCSMs operate. CHIR has also seen some state activity surrounding HCSMs which will be in the publication. To give a preview, CHIR suggests that at the very least, states should be: actively evaluating whether HCSMs meet their safe harbor definitions; requiring transparency about the operations that goes beyond the reporting of enrollment to also include not just the qualified expenses and those assigned but how many claims have been submitted and paid; and requiring submission of marketing materials to see if they are confusing to consumers. Ms. Volk noted that the claims information is not only for regulators but also for prospective enrollees so that they can better assess the likelihood that their bills will be covered by other members. Ms. Volk noted that states should also consider what role, if any, producers should have in facilitating HCSMs.

Covered California is now telling its certified brokers that they have to do a full disclosure and screen participants first for ACA subsidies because in the case of one HCSM, more than half of its members had an income that would qualify them for a subsidy for a comprehensive ACA plan. Massachusetts, which still has an individual mandate, is tightening up the exemption from the definition for HCSMs from said mandate to state that the ministry cannot use brokers and cannot use money on administrative costs. Texas and Alaska recently reissued bulletins reminding brokers of their liability if they sell unlicensed or unauthorized insurance and their liability for covering unpaid claims.

Bradley Hahn, CEO of Solidarity Healthshare (Solidarity), stated that his background is as an attorney for 21 years dealing with a lot of religious law and conscience protection issues. Solidarity exists to meet the demand of Catholics, many of whom have moral and religious concerns about traditional health benefits. Solidarity partnered with a Christian Mennonite HCSM to form a true partnership with the Mennonite and catholic church. To this day, people are still joining and Solidarity appreciates all of the support it has received along the way. Mr. Hahn stated that the core elements of Solidarity are focused on protecting the conscience rights of Christians concerned about many issues that various insurance offerings may have. Solidarity also aims to provide members with meaningful support to cover their healthcare costs and to build an authentic and vibrant Catholic community. Building a community is a bedrock of Solidarity which means it resists approaches for more rapid growth that may come at the expense of forming a true community. Solidarity believes that focusing on conscience and helping address the cost for members help achieve the goal of community.

Mr. Hahn stated that as of today there are roughly 9,000 families and almost 24,000 total members in all 50 states. Solidarity's members must sign a Christian statement of faith and comport to a lifestyle that is informed by Catholic teachings. There are three sharing programs to meet different budgets. Solidarity deals with pre-existing conditions in a different way: if the pre-existing condition can be improved by a lifestyle change there is a Solidarity well/coaching program to try and coach members into wellness and be a full member of the community. There are also other expanded offerings as well such as a telemedicine program to try and limit the cost for members. Solidarity's main focus on the process is on reducing costs so there is a lot of energy applied there. Solidarity negotiates amounts with healthcare providers to try and achieve the greatest possible level of savings for members. Solidarity also uses reference based pricing models and other cash pay models to try and determine what fair and just pricing is for a procedure or service. Solidarity is also trying to build awareness among providers and members on how the billing process works and to advocate for transparency in medical billing.

Mr. Hahn stated that so far in 2019 Solidarity has had roughly \$39.8 million dollars worth of medical bills submitted and \$16.7 of that has been shared which means that it received a 58% reduction in medical bills on behalf of its members. Going forward, Solidarity wants to maintain that level of affordability for its member and also look at other issues as well such as how to control drug prices for its members. From the beginning, Solidarity has been very careful to avoid engaging in any activities that could be construed as the business of health insurance. Mr. Hahn stated that he has thoroughly studied the federal and state HCSM exemptions and noted that for example, Solidarity does not use brokers and does not pay commissions to people that are members. Solidarity is careful to make sure that any marketing materials are not misinterpreted and do not contain any promises of insurance or promises to pay. Solidarity's efforts are mostly targeted at the Catholic community such as Catholic radio, Catholic events and Mr. Hahn speaking about healthcare reform and conscience protection in healthcare reform. Solidarity is excited about its future and members who want to join because of the overwhelming interest in protecting religious and moral convictions while building a vibrant ministry.

Mr. Hahn stated that looking ahead, Solidarity is very optimistic about the continued success of Solidarity as it tries to fill a gap in the larger healthcare system. Solidarity is focused on policy reforms at the federal and state levels to foster a robust marketplace while at the same time providing for protections for the ministries and the individual members. The overarching goal is to make sure there is no confusion in the marketplace regarding what health sharing is about. Mr. Hahn thanked Rep. Carbaugh for his leadership in this area with the Model and noted that Solidarity supports guardrails and protections for ministries and ministry members. Solidarity wants to work with the Committee to ensure that legitimate HCSMs continue to operate with clear parameters to avoid the blurring of HCSMs with insurance activities as well as ensuring consumers clearly understand the difference between insurance and HCSMs.

Mr. Hahn stated that ideally, he desires a system in which HCSMs are free to operate without threat, including the threat of coverage mandates or other actions to coerce sharing of morally objectionable services. In exchange for operating under clear guardrails such as those set forth in the Model, HCSMs want to make sure they do not blur the line with insurance activities. Mr. Hahn stated that he is eager to continue these discussions and is confident that HCSMs can continue to co-exist with traditional

insurance. Mr. Hahn believes that Solidarity is fulfilling an important need and its focus on conscience, cost and community coupled with its commitment to negotiating member's bills will result in future stability. Mr. Hahn thanked the Committee for inviting him to speak about Solidarity and how it fits within the HCSM landscape.

Kevin McBride, Attorney for Sharable LLC which is a technology provider for health care sharing, stated that Sharable supports some of the HCSMs present today and have also been contacted by non-Christian entities who are interested in doing health sharing. Sharable supports stronger consumer protections than those that are currently in the Model and also requests that the Committee focus on the federal definition of what a health care sharing entity is. The federal definition allows health sharing among "members who have a common set of ethical or religious beliefs" yet there is also a provision in the federal statute that limits health care sharing to only entities that have been in existence since 1999. The only entities in existence since 1999 are the Mennonite group that Mr. Hahn referenced and traditional Christian groups that Mr. Hopkinson represents. Sharable has been contacted by a Jewish group in New York who have not been in existence since 1999 but would like to do healthcare sharing. Sharable would like to support them in doing that and Sharable strongly supports consumer protections, fraud protections, and transparency in every respect. Accordingly, Sharable supports the Model and asks that the Committee consider making the abovementioned change regarding the definition of a HCSM.

Shanee Tracey, Director of Gov't Affairs at Christian Care Ministry (CCM), stated that CCM operates a HCSM called Medishare which has over 400,000 members across the United States. As a Christian faith community, Medishare has been facilitating the voluntary sharing of its medical expenses among its members since 1993 as an exercise and expression of its beliefs. Since its inception, Medishare members have shared over \$3 billion dollars in medical expenses incurred by its members and during that time, Medishare members have fully shared every incurred medical expense eligible for sharing in accordance to the guidelines adopted by the members which CCM believes reflects God's faithfulness to its ministry. Ms. Tracey stated that CCM fully supports the objectives of the Model to promote transparency and to disseminate clear and relevant information regarding the HCSMs operating within in each state. To that end, a number of the provisions set forth in the Model largely mirror provisions that CCM is currently promoting in other states. CCM thinks that the Model can be improved by incorporating, among other things, specific federal tax requirements for exempt organizations, state consumer protection laws, and more clearly defined and targeted enforcement authority. Ms. Tracey stated that CCM welcomes the opportunity to contribute to the development of the Model and thanked the Committee for the opportunity to speak.

Sen. Jason Rapert (AR), NCOIL Immediate Past President, stated that he believes the bottom line with this issue is that there is a lot of money getting involved so a lot of people are getting concerned much more than they used to be. Sen. Rapert stated that in some ways this issue reminds him of the long held divisions in the fight between banks and credit unions. Banks do not like the credit union non-profit status along with a host of other issues. Sen. Rapert asked how is it that we should go down the road of states requiring non-profits things that the federal government and the IRS do not require, especially when it comes to dealing with faith. Sen. Rapert noted that Ms. Volk emphasized that there is nothing that prevents states from regulating HCSMs and stated that it is almost as if Ms. Volk is inviting and urging states to cross lines that the federal government does not cross as it relates to non-profits.

Ms. Volk stated that she believes the important distinction is that the states regulate insurance and part of the recent attention to this issue is that there is one HCSM, Alieria, that has been shut down by about five states and other states have issued warnings about it. In that case, the regulators said that what Alieria was doing was insurance and therefore was illegally operating and selling insurance. Accordingly, that is an important distinction – it is not just a non-profit, it is a non-profit that is providing people something that is held out to be an alternative to insurance and will provide financial protection. Ms. Volk stated that she is skeptical of states relying on just disclosures and noted that many states have issued consumer alerts about Alieria and HCSMs in general. Colorado conducted focus groups with people who had various forms of coverage, some of which had Medishare, and their statements included “I know it’s not insurance but it is essentially the same”; “I have hoops I have to jump through with my insurance company so this is the same.” Accordingly, Ms. Volk stated that if someone is just looking for a more affordable alternative to insurance as opposed to the original intent of HCSMs, you can see how one could fall victim to some of the terminology.

Sen. Rapert stated that with regard to Alieria and the comments made regarding how states can take action if necessary against HCSMs, it seems that the current regulatory process works as a bad actor was held accountable. In Arkansas, there are fraud laws which would come into play that are enforced by the Attorney General so anyone that is conducting an unfair trade practice or anything amounting to fraud can be held accountable. Accordingly, Sen. Rapert asked why should a new body of regulation be promulgated for these entities when they are specifically exempted, and why should the veil of the IRS non-profit status be pierced. This is seen all the time with arguments to tax churches when you try and pierce through that veil. If “bad” HCSMs have been dealt with through Attorney Generals, why is a new avenue of regulation being sought?

Ms. Volk stated that she believes what is going on is that there is a regulatory vacuum which has invited bad actors and much more aggressive marketing. Alieria, which has been shut down, is now an FBI investigation and Ms. Volk stated that she is suggesting that states should pay closer attention to HCSMs before any of them become an FBI investigation that leaves people with huge unpaid bills and serious medical conditions. Relying purely on complaints about bad actors is not an effective approach to regulation.

Sen. Jack Tate (CO) stated that today is the first time he has heard about any consumer confusion or bad actors relating to HCSMs and noted that he is curious if there is any information that would lead to any statistically significant amount of confusion and bad acting in the HCSM space before there is a rush to regulate over anecdotal stories.

Mr. Hopkinson stated that the Alieria situation is important because the conduct was clearly fraud but the way the state’s were able to have authority over the situation was because Alieria was also selling insurance and was using unlicensed insurance agents and using unauthorized unfiled and unapproved insurance products. That was the hook that allowed states to go after them. The reason that CHM believes that the Model is important is because the Model allows the state to get the picture of who is operating in the state as well as giving the state some sort of regulatory authority to say “if you are not registered here and you meet this criteria then we have the ability to automatically go into unauthorized insurance issues” and that opens up the ability of the Attorney General. CHM believes that the Model is necessary because at this point the concept of HCSMs is being polluted by bad actors. CHM doesn’t have the ability to go out and stop someone it believes is acting improperly so there needs to be somebody out there that

has the authority to go out there and do something. CHM believes the Model walks the fine line of not having the states regulate too much and allowing the states to step in if there is a HCSM that does not report properly.

BRIEFING ON UPCOMING HEALTH COMMITTEE TOPICS

a.) Introduction of Patient Dental Care Bill of Rights Model Act

Rep. George Keiser (ND), sponsor of the NCOIL Patient Dental Care Bill of Rights Model Act (Model), stated that if this issue has not arrived in other states yet he believes it will soon – it has arrived in North Dakota. The issue deals with creating transparency and addressing contract rights relative to dental benefit plans. The current version of the Model is solely for introductory purposes and there has already been a lot of input from interested parties. Rep. Keiser urged the Committee members to review the Model as it is relatively self-explanatory. Rep. Keiser then noted a few of the issues that the Model addresses. The dentists in North Dakota are concerned when they contract into a network and subsequently find that the network has now contracted with additional networks and they feel that the additional network customers are not qualified to be served by that dentist and the dentist had no authority or input into agreeing to that. There are many other areas where the dental health networks are taking some very aggressive steps that benefit them at the expense of the dentist. The Model seeks to address that and create transparency and address the legitimate contract rights of all the parties.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA) stated that it is no secret that patients around America are confused by their coverage. The ADA feels that the issues set forth in the Model provide a step forward in terms of transparency and helping patients and their doctors properly use the coverage that they have. The Model deals with five reforms: network leasing; medical loss ratio; retroactive denial; virtual credit cards; and prior authorization. Regarding retroactive denial, insurance carriers audit their claims payment and adjudication activities to ensure accuracy and efficiency both before and after payments. That is something that dentists can agree to but what is unfair is coming back years later asking for repayment and then that occurring and then a surprise bill having to go to the patient. That is the kind of issue that is addressed in the Model and the ADA believes it warrants the Committee's consideration.

Mr. Peppard stated that AHIP is still reviewing the Model and noted that AHIP is generally in favor of transparency but has significant concerns about the way the Model has been drafted. AHIP looks forward to working with the Committee to make changes and hopefully get the Model to a place where everyone can support it.

Eme Augustini, Executive Director of the National Association of Dental Plans (NADP), stated that she is here today on behalf of NADP as well as its partners at AHIP, ACLI, NAVCP and AAPAN. NADP opposes the Model and has concerns with it because it would not improve dental patient welfare and wouldn't lower the cost of or access to dental care. The Model contains five disparate topics and the thread running through them is regulating the relationships between dentists and carriers rather than patient rights. If the idea is to improve the welfare of dental patients and consumers there are some other policy options that the Committee could explore. An example could be allowing hygienists or the concept of midlevel providers like dental therapists to perform

basic dental procedures which could increase access to care especially in more rural areas. NADP is always of course sensitive to concerns expressed by providers and NADP routinely works with dental associations to address the issues as they are raised. NADP looks forward to working with Rep. Keiser, the Committee, and interested parties on the Model going forward.

Karen Melchert, Regional VP of State Relations at ACLI stated that while ACLI disagrees that the Model is a patient's bill of rights, ACLI agrees that there are ways to work together on the Model to achieve greater transparency and disclosure associated with dental network leasing and on other aspects of the Model that will ensure that customers have access to the coverage they want and care by their chosen dental providers. Ms. Melchert noted two issues in the Model that ACLI would like to address: leasing provider networks – many insurers do not have extensive networks in all states and can only meet adequacy by leasing provider networks and while the industry is eager to work to improve the transparency of the network leasing process, ACLI believes it is important to do so in a way that enables leasing to occur to meet consumer needs. Also, with regard to the application of the medical loss ratios to dental plans, ACLI finds that problematic. The ACA sets very high medical loss ratios for qualifying major medical coverage, however, there are significant differences between medical and dental coverage that render medical loss ratios inappropriate for dental coverage and ACLI would like to address that going forward. ACLI looks forward to working on the Model to ensure something is created that is helpful to dentists and consumers and those that provide the coverage.

b.) Prior Authorization Reforms

Mark Pratt, SVP of Public Affairs at CAQH, stated that CAQH is not an advocacy organization but was rather asked to come speak today about the meaningful progress that stakeholders are making working collaboratively to improve the prior authorization process. CAQH commends NCOIL in examining this important issue. Prior authorization is obviously an important issue to policymakers and it is also an issue that legislators deal with from a constituent service standpoint and it is important to make sure the process works as effective as possible. CAQH is a non-profit and develops shared initiatives to standardize, streamline, and automate healthcare business practices with the objective of reducing administrative costs and burden and complexity in the healthcare system. CAQH partners with about 800 health plans, hospitals, health systems and other provider organizations and routinely engage more than 1.6 million providers who CAQH offers its services to at no charge.

CAQH Core is led by its own distinct board and is a multi stakeholder board consisting of an equal number of health plan and healthcare provider representatives. It is supported by well over 100 organizations that participate in work groups, pilot projects and the like. Its mission is to develop operating rules that support standards, accelerate interoperability and align administrative and clinical activities to benefit patients, providers, and health plans alike. CAQH Core has been designated by the Secretary of HHS as the authoring entity for operating rules for HIPAA administrative transactions. Mr. Pratt stated that you can think of operating rules as analogous to something that the banking industry did many decades ago to facilitate the ability for folks to use their ATM card in any financial institution across the country. CAQH Core developed the rules of the road so to speak around various transactions in healthcare. Some of its earlier work relates to eligibility and benefit verification, claims status, claims payment and the like.

One example of an eligibility rule that was developed with stakeholders was that when it comes to patients at the point of care having to work with their providers and determine what the copay and deductible would pay, the rules allow that to happen in real time at the point of care.

With respect to prior authorization, it is important to note that CAQH Core does not get into questions that are confronted during the legislative process such as “should there be prior authorization or not” or “what services should be subject to prior authorization.” Rather, the rules that CAQH Core works with stakeholders on are designed to specify how information regarding these transactions is exchanged on an electronic basis. That is important because there is a lot of room for progress with respect to automating the prior authorization process. CAQH Core conducts an annual survey each year that aims to benchmark the progress that is being made to move to electronic transactions. While a lot of progress has been made on other transactions, we are not where we want to be with respect to prior authorization. Only about 12% of prior authorizations are fully automated according to last year’s survey and just over half of all prior authorizations are still done manually, i.e. phone, fax, e-mail.

CAQH stated that the work it is doing with stakeholders is designed to move the ball forward to make progress to enable a more optimized process and drive industry wide adoption so as to make the system work better for everybody involved. That involves providing information within standard transactions to enable automation, developing timeframes and consistent experiences for turnaround time for prior authorization and to support the exchange of clinical documentation. Mr. Pratt stated that the work CAQH Core is doing is currently before its board and hopefully CAQH Core can present the final work product at the Committee’s meeting in March. After the board acts and CAQH starts socializing the work with stakeholders there will be a lot of interest in the work that stakeholders have done to move the process forward. Mr. Pratt noted that state governments can become involved with CAQH’s in two ways: participate in its work groups at no cost to state agencies, and achieve certification that they have achieved conformance with the operating rules that have already been developed which is sort of a good housekeeping seal of approval. Over 360 organizations have achieved certification and the Texas Medicaid agency was the first state agency to date to achieve certification across all phases of rules that CAQH has adopted. Mr. Pratt thanked the Committee for the opportunity to speak and noted that he looks forward to being a resource moving forward as the Committee considers these issues.

c.) Update on Biosimilar Landscape

Daren Sink, Senior Director of Gov’t Affairs at Pfizer, stated that he would like to provide a brief update on the biosimilar landscape as a follow-up to the general session that took place at the Summer Meeting in July. One of the things to be aware of heading into legislative sessions is to consider biosimilars when looking at pricing issues and looking at cost savings and whether or not it is being maximized in states. Right now, biologics account for about 1/3 of the spending of all medications to the tune of about \$320 billion dollars worldwide. Biosimilars only account for about 1% of that and right now the biosimilar market worldwide is about \$10 billion dollars. The familiarity with these medicines and where they are going has become significant. Additionally, a number of biosimilars have been approved globally in the last two years. In 2017 there were 19 approved; 23 approved in 2018; and another 10 in 2019. So, familiarity with them has become significant and the use of them has picked up greatly.

Mr. Sink stated that the big five countries in Europe account for the majority of that use and the uptake in the U.S. has been limited particularly at the state level largely because of educational/familiarity reasons, becoming comfortable with the medicines, and the market system that can make them available. Mr. Sink stated that as state legislators consider these issues it is important to make sure nothing is left on the table. Right now, the savings being generated by the use of biosimilars in the states is about \$243 million dollars. If it is fully vetted out it is believed that about \$71 billion dollars worth of savings could be achieved over time that would be repetitive – that is data from the Pacific research Institute. Mr. Sink offered Pfizer as a resource for any states considering these issues and noted that it is very important that this uptake occur because the market needs to turn. Like we have seen with the generic market before, the importance of turning that market to allow for affordability with innovative therapies for new medicines coming out is vital.

d.) Introduction of Vision Care Services Model Law Concept

Asw. Hunter noted that Sen. Bob Hackett (OH) is sponsor of the proposed Vision Care Services Model Law (Model) and as he is unable to be here today so this topic will be briefly introduced for further discussion in 2020.

Robert Holden, State Gov't Affairs Director for the National Association of Vision Care Plans (NAVCP), stated that NAVCP represents the 16 largest vision care plans operating nationally. NAVCP supports the Model as it is important to address the vision care services industry specifically. NCOIL has previously addressed non-covered services for purposes of the dental industry and NAVCP is interested in NCOIL considering that for the vision care industry as well. The vision care market is unique because it combines a healthcare service which is typically an annual eye examination along with the purchase of eyewear at retail so it stands apart from most other forms of healthcare in that way. Consumers have an increasing number of options to purchase eyewear and they are increasingly looking at online options of the purchase of eyewear through large retailers. The industry and NAVCP's member plans support consumers having strong options of getting their eyewear through their independent optometric practice. NAVCP believes that the Model strengthens that and allows plans to work together with optometrists to do that. NAVCP looks forward to working on the Model with the Committee in 2020.

Mr. Peppard stated that AHIP supports the Model and looks forward to working on it with the Committee in 2020.

ADJOURNMENT

There being no further business, the Committee adjourned at 4:15 p.m.