

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
BOSTON, MASSACHUSETTS
JULY 17, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the Westin Boston Waterfront Hotel on Saturday, July 17, 2021 at 10:30 A.M. (EST)

Assemblywoman Pam Hunter (NY), Chair of the Committee, presided.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Rep. Deborah Ferguson (AR)	Rep. Tracy Boe (ND)
Sen. Mathew Pitsch (AR)	Sen. Shawn Vedaa (ND)
Sen. Jason Rapert (AR)*	Asm. Kevin Cahill (NY)
Asm. Ken Cooley (CA)*	Sen. Bob Hackett (OH)
Rep. Matt Lehman (IN)	Rep. Wendi Thomas (PA)
Rep. Joe Fischer (KY)	Rep. Tom Oliverson, M.D. (TX)
Rep. Deanna Frazier (KY)*	Del. Steve Westfall (WV)
Rep. Jim Gooch (KY)*	
Rep. Bart Rowland (KY)	
Rep. Edmond Jordan (LA)*	
Sen. Paul Utke (MN)	

Other legislators present were:

Sen. Keith Ingram (AR)	Rep. Carlie Kotyza-Witthuhn (MN)
Rep. Steven Meskers (CT)	Sen. Mike McLendon (MS)
Rep. Chad McCoy (KY)*	Sen. Randy Burckhard (ND)
Rep. Lori Stone (MI)	

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Asm. Ken Cooley (CA), NCOIL Vice President and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a motion made by Asm. Kevin Cahill (NY), NCOIL Treasurer, and seconded by Rep. Fischer, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 17, 2021 meeting.

INTRODUCTION AND DISCUSSION OF NCOIL ACCUMULATOR ADJUSTMENT PROGRAM MODEL ACT (Model)

Sen. Jason Rapert (AR), NCOIL Immediate Past President and lead sponsor of the Model, stated thank you, Madam Chair. I'll be very brief and I'm really looking forward to being there in person for our next meeting in November in Scottsdale. I'm proud to sponsor this Model law as it mirrors a piece of legislation I sponsored in Arkansas that was signed into law just a few months ago. In fact, this type of legislation has been a growing trend across the country as states such as Arizona, Connecticut, Georgia, Illinois, Oklahoma, Tennessee, Virginia, and West Virginia have all passed legislation on this issue. The issue that such legislation and this Model deals with is that it seeks to prohibit accumulator adjustment programs which prevent copayment assistance that helps patients pay for high-cost prescription drugs from counting towards their annual deductible or maximum out-of-pocket costs. I truly believe that this is a good piece of consumer legislation when families are strapped already this allows them to enjoy those benefits themselves rather than them being taken up by a greedy middleman in the process.

Accordingly, the Model and the laws across the country simply state that no matter who is paying for these funds whether its pharmaceutical manufacturers, copay systems, a go fund me page, aunt or uncle - those funds and third-party payments should be counting towards a patient's cost-sharing requirements. The language you see before you on page 374 in your binders essentially mirrors the language that was discussed during our last Committee meeting that is supported by the American Medical Association, American Cancer Society Cancer Action Network, AIDS Institute, National Hemophilia Foundation, Cancer Support Community, American Kidney Fund and many others. What's great about this issue is that it is truly bipartisan – both red states and blue states have enacted legislation on this issue, and I am thrilled that my colleagues and Committee members from both sides of the aisle have joined me in sponsoring this Model: Madam Chair – Assemblywoman Hunter from New York – and Madam Vice Chair – my colleague Representative Deborah Ferguson from Arkansas – have signed on as well as former NCOIL President Representative George Keiser of North Dakota. I look forward to the discussion today and I am confident that we can get to a place where the Model is ready and adopted at our Annual Meeting in November. I appreciate the opportunity and I look forward to a robust discussion to get to a place to vote on the Model in November with any suggested amendments if they are out there. Thank you.

Members of the All Copays Count Coalition - Stephanie Hengst, Manager of Policy & Research at The AIDS Institute, and Kollet Koulianos, Senior Director of Payor Relations – began the discussion. Ms. Hengst stated that I'll be quick given time limitations. The AIDS Institute has been working on this issue for quite awhile now and it's part of our larger work on health insurance benefit design and looking at how those benefit designs are structured, the ways in which they are changing and the ways those changes are putting more financial responsibility onto patients. We know that patients are already subjected to utilization mgmt. techniques such as step therapy or prior authorization so now we are seeing copay accumulator adjustment policies on top of that and copay assistance has really helped patients afford their meds which ultimately also reduces health inequities in healthcare so that's kind of how we've come to this issue and as part of our contribution to the advocacy has been to document how common these copay accumulators are and how they have proliferated in recent years.

In a report issued by the AIDS Institute published earlier this year, I did some background research and looked at all of the ACA marketplace plans across the states so we looked at all 45 states plus D.C. and pulled out five states that as previously mentioned passed legislation

going into the 2021 plan year but when we looked at all those other states we saw that every single state had at least one plan in their marketplace with a copay accumulator in it and when we broke that down even further there were at least 14 states that had a copay accumulator in every single plan. Here is a nice visual of kind of what the landscape looks like across the country in terms of percent of plans in states with copay accumulator policies and you might say I live in an orange state where residents have a 50-50 chance of selecting a plan that may honor their copay assistance however then you get into network adequacy issues where many people may be living in an area or region where there is only one issuer offering plans and their chance may be that one plan has a copay accumulator in it. Bottom line is that for patients such as those living with HIV or hemophilia or other rare diseases is that they are really having no options to select plans that's going to honor their copay assistance and have it counted towards their out of pocket (OOP) costs as intended.

So, these next two slides will go kind of quickly but they are also shared and they are also in the report I mentioned that we published. What they demonstrate is that over the course of a plan year what a patient pays OOP and ultimately what the insurer or pharmacy benefit manager (PBM) is collecting so when there is a copay accumulator in place or a copay maximizer as there are variations on the policies, the insurer and/or PBM is collecting a significant amount more than under a standard plan design when there is no copay accumulator in there and ultimately when a patient is paying all of their money up to that annual limit on top of that is the copay assistance being collected and copay assistance is not a discount its still money that is being collected so these accumulator programs can really be thought of as an income tax generator for insurers or PBMs.

This slide also shows what Sen. Rapert was discussing at the beginning how at the beginning of 2021 there are already five states that have passed legislation and since the Spring its been kind of like a popcorn effect with lots of other states passing legislation which is great and lots of advocates have been working with legislators to introduce legislation in states as you can see. There are now 11 states that have passed legislation plus Puerto Rico and we're hopeful that in the upcoming session that there will be much more success with all of this momentum happening. The All Copays Count Coalition has drafted model legislation that NCOIL is considering and as you note this is the legislation that has largely been utilized in the states that have passed legislation and that has also been introduced. Its very short and sweet and to the point to address the issue and what it does is require an insurer or PBM to count payments that are made by or on behalf of the enrollee towards their OOP so again its very simple and addresses the issue and will protect patients and their copay assistance so that they can afford their medications. There is a lot more I can discuss on this and I am happy to connect with anyone offline if they are interested in state specific information.

Ms. Koulianos stated basically what is copay assistance – we're talking about coupons, discounts cards or other programs provided by either manufacturers, non-profits and as you've heard grandmas, grandpas, aunts, uncles, go fund me pages, there are various mechanisms in which patients have had to get help in order to receive their life saving treatment. When do patients receive the assistance – they receive the assistance only after a doctor or physician has deemed the right therapy to meet their treatment costs and only after the insurance company has already sent them through the prior auth process to make sure the drug is on the preferred drug list so its not circumventing any plan design. High deductible health plans (HDHPs) – we did a survey along with other chronic disease groups at the beginning of this year and 55% of patients with chronic diseases stated that they are on a HDHP and regarding income levels, 69% of the individuals with an income under \$40,000 have a HDHP and also

33% of patients surveyed who reported being unable to afford their medications or treatments because their copay assistance ran out were persons of color.

There are racial, ethnic and income based disparities that exist here. We look at even the lowest silver plan on the marketplace the average deductible is \$4,879 so this is absolutely unattainable for so many people to be able to hit that kind of deductible and your insurance doesn't pay until you've paid the entire deductible and so I'm clear when you have a high cost chronic disease like hemophilia or other conditions that have been mentioned the assistance you receive is capped, so even if they allow the assistance which is what the insurance companies are saying you can use the assistance but it doesn't count, so by month two or three that assistance has run out for the year if you have a \$4,879 deductible and then the patient has to bear that full responsibility before they can get their meds or they are held hostage at the pharmacy counter literally. So health plans are changing the rules on the way this assistance program counts. We're asking lawmakers to enact policies to require plans to count the assistance. Legislation to ban copay accumulator adjustment programs does not conflict with existing 2004 Internal Revenue Service (IRS) guidance on HDHPs with health savings accounts (HSAs). The clear intent of The Department of Health and Human Services (HHS') regulation allowing plans discretion on whether or not to count manufacturer cost-sharing assistance toward the Affordable Care Act's (ACA's) annual limitation on cost sharing only applies "to the extent consistent with state law." So ill end there since we are on a time limit, but I also have my contact info within the slide deck and I'm happy to speak to anybody offline.

Brendan Peppard, Regional Director of State Affairs at America's Health Insurance Plans (AHIP), stated that rising drug prices impose a heavy burden on all Americans, a direct result of high list prices determined solely by drug companies. While pharmaceutical companies are posting record profits, too many hardworking Americans must choose between paying their bills and accessing lifesaving medicines. You already know from our previous testimony that we believe coupons are tools intentionally used by drug manufacturers for financial gain allowing them to skirt the responsibility to lower drug prices for all Americans. As you know the federal gov't protects taxpayers from this scheme prohibiting the use of coupons in certain markets. Pfizer is currently litigating this issue to attempt to undue this prohibition and according to one of HHS' lawyers "to upend decades of settled law and agency guidance in this highly regulated space." We've given you info about our concern with coupons in our written comments so I wont focus on that more today. Instead, I will talk about the problem that you have clearly identified – the high price of drugs and how that makes it difficult for people to afford their prescriptions and some proposed amendments we believe will help improve the model and get at the problem. Before I discuss the problem and the proposed amendments I would like to reiterate that the model in its current form is harmful in that it does nothing to address or control high drug prices that drug companies alone are setting and it takes away a lever that health plans have to control market manipulation created by coupons and hold drug companies accountable.

I would like to turn to the problem you have identified – 96% of voters agree that lowering drug prices is an important challenge facing Americans and 86% of voters say drug makers are responsible for rising prices. This model as drafted does not address the high prices but instead narrowly focuses on the OOP costs facing certain individuals. OOP costs for all services, drugs and devices are based on the underlying cost of the product or service. Since the model focuses on limiting the ability of health insurance providers to properly account for OOP spending in some circumstances, instead of on the problem of high drug prices, we think the committee should consider some amendments which get at the fair and equitable offer of the aid from drug makers and expand on the good work of transparency already begun by NCOIL.

In the purpose section we recommend that the committee remove language that is incorrect. First, make clear that drug costs are high because manufacturers set high list prices. More importantly, remove the incorrect assertion that insurers use accumulator programs to “double dip.” At no point in the use of coupons or other cost sharing assistance do health insurers or PBMs receive the value of coupons. Generally, a coupon is created by a manufacturer, given to a patient and then it goes to the pharmacy along with any remaining consumer payment. The value of the coupon is then given back to the manufacturer as payment for the drug. Health insurers and PBMs may not even be aware that a coupon is being used because coupons include their own identifying info that results in them being processed separately from a consumers’ insurance.

Now, turning to the body of the Model. First, we recommend that you limit the accumulator ban to cover drugs that have no lower cost alternative. This model should not facilitate drug manufacturers efforts to circumvent formulary mgmt. and give patients the ability to go off formulary for the same price. That will just harm our ability to negotiate lower prices for all consumers in the future. Instead, limit the manipulation of pharmaceutical manufacturers where there are less expensive options available either as a generic, another brand that the insurer has placed on a lower formulary tier or when a drug is available in an alternative form. Next, require patient assistance to be provided to all enrollees for the entire plan year and require advance notice of discontinuation. This amendment is entirely for patient protection – patients who rely on medication for long periods of time should not be concerned about their assistance being halted suddenly. Additionally, if patient assistance is allowed manufacturers cannot be allowed to discriminate when deciding who can use a coupon. Finally, provide additional transparency to understand the full impact of third party payments on healthcare spending and aid insurance provider ability to administer the Model. We applaud NCOIL’s past transparency efforts. As mentioned, health insurance providers are often not aware a coupon is being used because coupons include their own identifying info which results in them being processed separately from the consumer’s insurance. Without inclusion of the notice we recommend adding there is a risk that health plans may have difficulty complying with the model because we may not know that a coupon has been used. Thank you for the opportunity to speak and we stand ready to work with you on any amendments you consider.

Kevin McKechnie, Executive Director of the American Bankers Association (ABA) HSA Council, stated that we represent 94% of all the HSA’s in the U.S. and we can tell you from our research that is just now available based on 2020 data we insure 1 in 3 working Americans – not ourselves of course but the companies that are members – and that nets out to about 65 million people in the country that look to HSA qualified insurance to finance their major medical experience. We’re here to visit with you today because there is an irony – I find myself visiting with you time to time to talk about what the IRS says a HDHP plan is and it’s the irony of my career that I tend to represent the IRS pro bono at this point which I don’t want to do much anymore. They are the arbiters of what a HDHP plan is and isn’t and they are the arbiters of what an eligible individual is and those two things have to match for someone to be able to contribute to their HSA. So we’re not here today to offer comments on whether or not a copay accumulator is a good idea or not or what the relationship is to that with a drug company may or may not be. We’re here to offer comments about how it affects a federally regulated HDHP and affects the 65 million people covered by them and their ability to contribute to their account and here’s why.

When there are coverages that the IRS determines are other coverages which are prohibited you lose your contribution eligibility and usually that means the HDHP ceases to be a HDHP and if one or the other happens you are no longer able to keep you major medical insurance

and have to find alternate coverage so we've seen this in the past and so have you in your capitols when people talk about this procedure or that procedure such as breast cancer screening or colonoscopy screening that should be done without cost sharing which is a perfectly laudable goal except that if you have a HDHP and you are a HSA contributor a bill like that cancels your eligibility and throws you out of your health plan and you have to find some other plan. So we've gone from capitol to capitol and said these are perfectly reasonable bills and we're not here to debate them rather we are here to suggest to you that you provide a carve out for people insured this way so that to the extent whatever mandate you're discussing may affect their contribution eligibility it would not affect their contribution eligibility which means you are able to go forward with your plans in your capitol and people insured with these plans are able to keep their plan going.

We'd like to note to you that we've sent to NCOIL staff a letter the IRS wrote to the Illinois Department of Insurance (DOI) where they sorry to say took a contrary view to the info you saw in the presentation – a copay accumulator strategy is completely in contravention of IRS rules. Now there is something else to look at and the reason we are asking for an exception to be made in this case is because we have looked through the carriers that we do business with that are on our board – none of them process claims in exactly the same way and we don't have any intention to force them to which is why the exceptions seem to make more sense because it was easier to accomplish and it lets other businesses continue to do business the way they have done so before but I wanted to offer an example that's from the IRS letter. If a drug cost \$500 and the coupon was \$400 and it was going to net out to \$100 the IRS says that \$100 is what goes to your OOP - that's it. It would be perfectly reasonable if the coupon for \$400 was contributed to your account because as Sen. Rapert says and he's right, anyone can contribute to an HSA and its deductible to you – your aunt can, your company can, your grandfather can – we have no trouble there and if that's how this issue plays out for HSA qualified people well then great which means people have money in their account but that's not how the issue is playing out as a practical matter today with respect to how these claims are adjudicated from carrier to carrier and because that's the case what we're asking for is an exception be made in your model law for people insured with plans manufactured under IRS section 223 which is the HSA statute.

Asw. Hunter asked if there is proposed language that will be forwarded to the Committee relative to the recommendations. Mr. McKechnie replied yes and that will be ready very soon.

Rep. Wendi Thomas (PA) asked in states that have passed this language did it only impact the fully insured plans because self insured plans are guided by the Employee Retirement Income and Security Act of 1974 (ERISA)? Mr. McKechnie stated that we are at the case where states decided that this is how these claims will be adjudicated so it will affect for fully insured plans for certain because you are in charge of what is and what isn't in your borders. The IRS is in charge of determining what a HDHP is nationwide and so this is where the conflict arises where a state DOI or a legislature says this is how we treat drugs in our state and how we think these claims are adjudicated and its in contravention to the way HDHP rules run then that's where the disqualification problem arises. Rep. Thomas stated that she understands that but I'm asking more self-insured vs. fully insured plans because it's my understanding that state legislators cannot legislate requirements for self insured plans and 7 out of 10 people at least in my state are covered under a self insured plan so I'm not opposed to the model because I think its good I'm just trying to be clear as to whether the states that have adopted it does it impact only fully insured plans?

Ms. Koulianos replied that the legislation only impacts fully insured plans. Rep. Bart Rowland (KY) stated that we passed a similar bill this past session and it's my understanding that it only applied to fully insured plans and it even didn't apply to the state employee health plan because its self-insured. Mr. Peppard stated I'm not familiar with all of the laws passed but its my understanding that generally speaking the laws would only apply to fully insured plans.

Jeff Klein, Of Counsel to the ABA HSA Council through McIntyre & Lemon, PLLC, stated that I wanted to make the point that we understand as we follow the model and legislation in states that this is intended to be a consumer protection device so if I can make a very simple comment even though we obviously have a proprietary interest in HSAs we don't want there to be an unintended consequence for those who have their own HSA accounts and be restricted from using them whether its for reproductive services, opioid or insulin treatment and our intent is aligned with yours and is not in any way intended to derail the model. The second point I wanted to make is that we saw some maps about legislation that has been drafted on copay accumulators but we've also been pleased to work with many of your members in the statehouses across the country in AR, KY, IA and NE and in AR and KY we actually got a fix similar to this model and our proposal we submitted is based on an AR bill and there were several bills in IA and NE that were introduced but were not passed so we are trying diligently wherever we can and it's a problem because it's a defensive action and an uphill battle. The third comment in the interest of time is that the National Association of Insurance Commissioners (NAIC) is actively concerned about this as well and their health committee staff which is about the best we've seen in any of the committees there including Brian Webb and Jolie Matthews have recently surveyed their insurance dept's and the IL IRS letter has been widely distributed among insurance dept's so they are looking at that issue and have similar concerns that we do.

Rep. Deborah Ferguson (AR), Vice Chair of the Committee, stated that I know there is some disagreement bout the IRS notice and if it does apply so maybe at the next meeting we can here from the opposing side on the notice. The bottom line is that we can't lose focus on why the model was brought – doctors are finding that patients were not taking their specialty medicine because their OOP costs were so high so all of these assistance programs were to help people afford their medicine and if you take that ability away we're going to be back where we were before the programs started in that patients that are very sick and may die and they cannot afford their medicine and will not take their medicine because they just can't afford the OOP costs.

CONTINUED DISCUSSION ON NCOIL TELEMEDICINE AUTHORIZATION AND REIMBURSEMENT MODEL ACT (Model)

Asw. Hunter, sponsor of the Model, stated that we are hoping to be able to vote on this in November and we've made good progress with lots of discussion and hopefully this will be the final discussion before a vote. Today we're going to hear about network adequacy and provider directories and how they interact with telemedicine with an eye towards determining whether any provisions relating to those topics should be included in the model.

John Weis, Board Member, President and Co-founder of Quest Analytics (QA), thanked the Committee for the opportunity and said he is here today to provide education and discuss the importance of consistent network adequacy standards across all programs and really share how we see telemedicine aligns with brick and mortar for in patient care that is essential in today's society. For a little bit of background on QA for those of you who may not know us well, we provide the lens into healthcare networks for both state and federal regulators as well as the

health plans allowing them to measure, monitor and manage their provider networks and to ensure appropriate access to care for all Americans. We're often asked to provide input to legislators to help them understand the pros and cons of policy with regard to network adequacy when changes are being discussed. We've been the innovators of the industry for the last 30 years and created the vision and delivery of network adequacy into the industry and we pioneered the concept of measuring directory accuracy and the importance of that and transparency and we were the pioneers that introduced the GeoAccess reporting to improve transparency through Medicare and Medicaid in the marketplace as well as the commercial plans. We're used by over 95% of America's health plans today and we're also the partner with both state and federal regulators to make sure that they are reviewing these plans on a consistent basis. As I said earlier we're often called in for our expertise and industry insight in regard to network adequacy so today I really wanted to focus on how telemedicine and network adequacy are essentially hand in hand

As I always like to say, telemedicine isn't going away – the paste is out of the jar. We've squeezed the toothpaste out and it's not going back in but I think we need to be really consistent on how we look at this and I think the folks at the Centers for Medicare and Medicaid Services (CMS) have really done a smart job of baby stepping into this process. They came out with a methodology that said telemedicine isn't a replacement for brick and mortar, it's a complement. So what they did is said well we're going to look at what specialty types can you apply a telemedicine visit and then we're essentially going to relax the standard for network adequacy as opposed to replacing that standard. So this is what they started with and basically they picked about a dozen specialties and said we're going to allow telemedicine visits for these types of specialties and then we are going to complement the network adequacy by reducing the percentage by 10%. Previously they said 90% of the beneficiaries need to be within a certain time and distance and they said if you are able to show telemedicine in that specialty we are going to give you a credit and allow you to discount that by 10%. The other thing that we're seeing in the marketplace is the requirement for a health plan to essentially notate which providers provide telemedicine services and which ones don't to allow the consumer to have that indication and preference of I can receive care within that provider for telemedicine or I can receive care at that provider for brick and mortar.

The other thing that I caution the committee to understand is that we are really in the infancy when it comes to telemedicine. We are trying to understand what specialties adapt well to telemedicine and what specialties really need to have an in-patient visit. We also really don't have a tremendous amount of data because we are probably 15 months into the telemedicine and we really need to understand is telemedicine a cost saver or is it a cost inflator and I think as we go further we're going to have an understanding of how many telemedicine visits also require an in patient brick and mortar so therefore my cost of care was inflated versus saved. We're going to know more in three years than we do today and again I think that the way that we need to do this is to be consistent and essentially we need to baby step into this versus saying telemedicine is the future and the only way that someone can receive care. I think we still need to have considerations that we still need to have appropriate access to medical care and as a consumer I need to choose to do that either in-patient or via telemedicine.

Mr. Peppard stated that as I have previously testified, we wholeheartedly believe in investing in new ways to provide access to care and one of the major ways is telehealth as patients can receive more services where they are and have the ability to access a wider variety of providers and specialties than those who are physically practicing in their area. This can help patients who wish to receive services from providers with a particular expertise, who are from a similar race or background or gender to align with their unique circumstances. As the use of telehealth

grew significantly during the pandemic we believe that it will be a regular part of some patient's care going forward. To plan for a more permanent use of more telemedicine we do urge you to consider to allow health plans to use telemedicine as an integral part of network development. We believe that network adequacy standards should reflect the healthcare delivery options in these markets. Any standards adopted should also leave room for future innovations. For example, the NAIC's Health Benefit Plan and Network Access and Adequacy Model Act allows the commissioner to determine sufficiency of a network using a number of data and criteria including healthcare service delivery options such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care. I'll stop there and I am happy to answer any questions.

Asm. Cahill stated that my experiences is that the CMS network adequacy standards usually exceed most of the ones that we have in states if states have them at all in terms of formal network adequacy standards. The proposal here that we are considering must continue to recognize that telehealth is a supplement not a substitute for healthcare and so when we look at what the gentleman just presented about a 10% reduction in the standard and I looked at the specialties I'm not so sure that making it more difficult for somebody to do an in person OBGYN or in person cardiac care is an advancement in healthcare. Brick and mortar is still the way that we deliver healthcare and until technology proves to the point where everything can be done mechanically and otherwise in a remote fashion we still need to have those basic standards. We usually talk about this in terms of the access of patients but we also should be considering seriously the impact on health systems in our communities. If a health plan is able to contract with a group of providers who say yes ill cover these rural counties out in the distant areas telehealth-wise we are probably depriving those communities of developing an adequate healthcare system in and of themselves so I would just urge that we continue to consider network adequacy both in terms of telehealth and also independent of that that we consider creating some models for network adequacy standards generally speaking.

Rep. Ferguson stated that in addition to what Asm. Cahill is saying, I do think we need to be very careful that these insurance carriers are not steering patients to telemedicine companies that they contracted with instead of their own physician. Their own physician with telemedicine should be the priority over a telemedicine doctor that's never seen the patient. We can actually harm rural healthcare because if you're diverting and steering all these patients to a big telemedicine company that the doctor has never even seen the patient the local doctor is not going to be able to stay in business in that community and that's a real consideration for steerage and incentivizing telehealth over you own provider.

Sen. Bob Hackett (OH) stated that he doesn't disagree with his colleagues but remember the major problem with healthcare in this country is the cost and one of the real abuses of healthcare is that people use the emergency room for the wrong reasons at times and so I think one of the great things that's come out of this is the amount of telehealth that's being used to direct people to the right thing. I totally agree with my colleagues that on specialties that the doctors would rather have in person visits for certain things and I don't necessarily disagree with that but it's really important that there are a lot of in patient visits that could be done through telehealth and it's not really cutting out I mean they almost get the same reimbursement not quite the same, but almost the same. All of the doctors I see now are all telehealth so I just think I agree that we shouldn't cut out specialties but when you go see your primary care physician he is going to order all these tests and order the same test when you go see a primary care physician for a physical when you go in and see them in that scenario so I think we're trying to be smarter and use telehealth correctly and where we have the abuse is the

emergency room and it helped tremendously in helping people not go there as they used to for normal colds and flus.

J.P. Wieske, former deputy commissioner in the WI insurance department, stated that he was the chair of the NAIC network adequacy group that put the standards together so it's in that context that he would like to make some comments. I think in context when we looked at the issue we had a long discussion on it and it went on for months and the reason we added the language that Mr. Peppard focused on is that I was focused on the issues such as Rhinelander, WI where literally there are no dermatologists available and how are you able to get access and we had issues inside ACA plans that would have not allowed the plans under the CMS standards to be able to operate in any of those counties which would have left us bare and we were left with a very problematic series of acts that attached in especially rural communities so I wanted you to have that context for that discussion as its important and I appreciate the concerns which we also discussed around whether or not there would be a movement out of telehealth at that time and I think the feeling was with a lack of specialties and a lack of availability and on top of that even if folks are able to get to it it's a significant drive and there are providers offering telehealth in a unique atmosphere where you can drive to a site and there are camera capabilities and nurses who pull in doctors to have those discussions and that's still technically telehealth and its available in those areas.

Asw. Hunter asked Mr. Wieske if he could respond to Rep. Ferguson's questions relative to networks or plans directing patients to their specific providers and not their own. Mr. Wieske stated that its interesting and we talked about that as well as an issue – increasingly you are seeing a number of insurers getting into the business of operating clinics that is not just telehealth clinics but physically operating clinics you're also seeing a trend I think in a good way of large employers putting clinics inside paid for through their self-funded benefit but administered sometimes through the insurer to get it so it becomes a very difficult issue because there are significant access issues. On top of that they typically are contracting with outside entities for a discount and providing one and there is a variety of things that provide access on a national basis so in order to be able to get the better rates they typically do that as a national contract is available 24/7/365 instead of just in the local municipality but I think the goal is if you look at how most of the telehealth bills are designed and how they are put together I think the idea is to ensure some access to local providers being able to provide that and I agree that's an important feature of it and provides an important access point. We actually visited in WI when I was there in the dep't that there were some possibilities that if you designed this correctly in your state that it could be a differentiator and start attracting if you have a good environment for doctors and in WI we had good medical malpractice, then you might be able to use telehealth as a way to bring in more medical care in specific areas and for the rural communities to be able to have broader access to attract providers who have a better quality of life there and are able to practice telehealth as well so I think it's a complicated issue.

Asw. Hunter stated that we are going to take all of this into consideration and get into hopefully voting on this model our November meeting.

CONTINUED DISCUSSION ON NCOIL MODEL ACT REGARDING AIR AMBULANCE PATIENT PROTECTIONS

Asw. Hunter stated that having been Chair of this Committee for a couple of years this model has been a point of conversation and has changed along the way since it's been introduced as we've had an introduction and amendments and federal legislation and state legislation and lawsuits so it's a of developments almost akin to a soap opera. We want to make sure we have

as much info as we possibly can and if you recall we had a great discussion at our last meeting in April and towards the end of the meeting we decided we need to further examine the legal issues surrounding this type of legislation so today we have legal experts who are closely involved with the litigation surrounding this type of legislation and they can help us clarify a few things. We'll take questions at the end and much of the conversation will focus on the Eighth Circuit Court of Appeals opinion (Guardian Flight, LLC v. Godfread) if you have your binder it's on page 367 and also before you is an analysis of that opinion provided by one of our speakers today, Professor Dan Schwartz, Fredrikson & Byron Professor of Law at the University of Minnesota Law School. Before we start the discussion, I note the list of sponsors of the model has grown since our last meeting which now include Rep. Thaddeus Jones (IL) and Rep. Deanna Frazier (KY) joining Rep. Tom Oliverson, M.D. (TX) and Del. Steve Westfall (WV).

Chris Brady, Senior VP and General Counsel at Air Methods Corporation (AMC), thanked the Committee for the opportunity to discuss state's ability to regulate air ambulance memberships under the McCarran-Ferguson Act (MF). At the outset I think its important to confirm that AMC agrees with other air ambulance providers that only laws regulating the business of insurance (BOI) can avoid the preemptive scope of the Airline Deregulation Act (ADA). Where we continue to disagree however is whether an air ambulance membership product that pools consumer risk qualifies as the BOI such that they would be subject to state regulation under MF. AMC is aware of the WV district court recent decision and its earlier progeny including Guardian. I won't waste this committee's time with a line by line analysis of where we think the court got it wrong but simply note that we fundamentally disagree with the court's conclusion. The WV cases and Guardian however are instructive in the test that courts look to to determine whether MF preemption applies. There are three elements to this test: 1.) does the practice in question have the effect of transferring or spreading policyholder risk; 2.) is the practice an integral part of the policyholder relationship between the insurer and insured; 3.) is the practice limited to entities within the insurance industry.

What I would say is that at this point there really can be no debate about the first point. Every court that has looked at this has agreed that there is sharing of risk between the issuer and the buyer. Membership programs operate exactly like an insurance pool with providers pooling risk that exceeds the value of the membership plan. On the second question of whether the practice is an integral part of the policy relationship between the insured and insurer and the third question is the practice limited to entities within the insurance space what we've seen is very light analysis in courts on this and some engagement in semantics of whether a contract is a policy or whether a policy has to be expressly called a policy to qualify. From our perspective that is a largely academic pursuit and I wont dive deep into that but what I would do is point you to Prof. Schwarcz's memo where he discusses this test in great detail and remarkably comes to the same conclusion as AMC regarding the three factor test. On page 10, he states that the three factor test does suggest that air ambulance memberships constitutes the BOI. Now, to be fair Prof. Schwarcz offers further explanation suggesting that courts should use different factors to look at this but that is a test that no courts which have looked at this have applied but again to be fair he suggests that MF would not apply and that states would continue to face legal headwinds.

However, this analysis is turning on whether the membership issuer rates or underwrites these products or just uses them to offer medical services. From AMC's perspective, this is akin to letting the fox run the henhouse. Whether or not providers rate or underwrite their products should not and cannot be the definitive determination as to whether these products are insurance products. AMC really remains cognizant that the underlying driver of these discussions started out as consumer protection discussions. Membership products are

marketed and sold as insurance products, consumers commonly identify them as such and they treat them like other health insurance products even delaying care to ensure they are transported by a covered provider. AMC records indicate that over 200 patients have delayed care to wait for a covered air ambulance membership provider rather than take the closest most appropriate provider for emergent care. Further, just this year, a medical patient in CA refused transport with AMC to wait for their air medical membership provider. The air medical membership provider was not available for several hours and that patient died in the hospital before they could be transported even though there were other providers available ready and willing to transport. This is a tragedy, its egregious and it's a direct result of consumers being offered these products on the basis of fear and insurance yet providers continue to suggest that the MF act gives the states no ability to regulate these products.

The federal gov't has entrusted states to protect consumers in the insurance realm and reaffirmed that commitment through the MF act. AMC remains committed to finding a solution to prevent these tragedies from occurring and committed to working with this body to navigate these legal challenges.

Prof. Schwarcz stated that I would like to start off by explaining my role here as it's a little different. I was hired to be an independent consultant – I'm a law professor – and to provide my legal analysis of Guardian and so everything I'm about to tell you is my independent judgment and I was hired to provide that and my independent judgment is that there is a very clear legal issue and that is that states don't have the authority to regulate air ambulance subscriptions as insurance under the MF act and so to explain that I just want make sure we are all clear on the framing and then ill go through my analysis and explain some of the characterizations of my report which has been given to you and I apologize for it being quite lengthy and it was very much mischaracterized by the prior speaker as I very much came to the conclusion both that states don't have this authority and states don't have this authority either under the Pireno test or any other test. So, with that in mind I think it sounds like we can all start with the assumption that if air ambulance subscriptions constitute the BOI under the MF act then states have the authority to regulate them but if they don't constitute the BOI under the MF act then in fact there is ADA preemption so the first really important framing point to understand here is that this is not a question of state law and whether or not you want to define air ambulance subscriptions as the BOI under state law it's actually not pertinent to the legal analysis because the legal analysis turns on the meaning of the phrase the BOI in the MF act which is a federal statute and as you no doubt are aware, state law cant supply a definition to a federal statutory term.

So, what that means is we have to answer this analysis and conduct this analysis looking to federal precedent regarding the meaning of this federal statutory language and my report details that I actually think that the federal precedent is absolutely clear and the U.S. Supreme Court is absolutely clear that air ambulance subscriptions are not the BOI and hence that states don't have the authority to regulate them. This decision is of course consistent both with Guardian and now the WV district court. Now I'll explain why I reached this conclusion. If you look at Supreme Court precedent its true that the Pireno test is out there and its relevant and important and you can conduct the analysis under that test. But there are a number of factors that in my view make it absolutely clear even without clouding ourselves with Pireno that air ambulance subscriptions do not constitute the BOI. The Supreme Court has been absolutely clear that the BOI involves, you won't be surprised to hear this, underwriting and rating risk – charging different prices to different people depending on the amount of risk that they pose and potentially not offering insurance to unduly risky indivual applicants – that's not what air ambulance subscriptions do. They are offered to all comers on a fixed fee. Moreover, Supreme Court precedent including the Royal Drug case makes it absolutely clear that in assessing

whether or not a product is insurance, one has to look at whether the product is being offered for the principal purpose of risk transfer or merely to facilitate the provision of services. In fact the Supreme Court says in Royal Drug that pre-paid medical services are not considered the BOI under the MF act because that's not what Congress understood that language to mean when it enacted the MF act in 1945.

Well, if you look at air ambulance subscriptions, why are they offered by companies and by GMR - they are offered not because GMR is interested in becoming a large insurer and transferring risk. They are offered to facilitate the provisions of a service – air ambulances which is what GMR does - they provide air ambulance services just like AMC. They are not focused on the spreading or transfer of risk they are just using that to help facilitate their provisions of services and this is actually very much analogous to a case the Supreme Court discussed at length in Royal Drug which is discussed in my lengthy report. Next, air ambulance subscriptions don't actually require payments to anyone. They don't require payments to third parties; they don't require payments to a consumer. All they specify is that any amount that's owed will be cancelled and won't be charged against the consumer and courts have been very clear that such debt cancellation contracts don't constitute the BOI. Why – because the BOI usually involves you sell a product and you have to enter into a reserve and you anticipate this is how much we are going to have to pay in the future and you then have to invest in assets to match those reserves. None of that happens with debt cancellation contracts like those issued here. There is no reserving and no investing in assets to match those reserves and again – different Supreme Court precedent on the same point makes clear that in general, insurance involves insurers taking on investment risk.

Now I want to discuss specifically Pireno because talk about out of context quoting of the report. The quote you heard and ill repeat it because it really shockingly mischaracterizes what I say. There is a quote that says the Pireno test does indeed suggest that the sale of air ambulance subscriptions constitutes the BOI. What was left off – the start of the sentence: “if one assumes this to be the case.” What are we assuming? If one assumes that the sale of air ambulance subscriptions constitutes the BOI, then the Pireno test is satisfied. So what I'm trying to establish here is that in my view part of the reason why courts have had some difficulty with the Pireno test is that its actually not a perfect fit for these circumstances – it's certainly true that courts have applied the Pireno test and we can both apply the Pireno test as my counterpart described as using different semantics but as a semantic game of are we going to call the sale of air ambulance subscriptions insurance, are we going to call those people who buy them policyholders? If we do, the Pireno test comes out one way. If we say no its not insurance and no they are not policyholders the test comes out another way and so in my mind the real reason why some people get a little bit confused about this is because they are not focusing on the right questions which is are air ambulance subscriptions insurance products and once you focus on that question the Pireno test actually becomes very simple and I actually walk through the proper application of the Pireno test on the top of page 11 of my opinion where I say if one starts from the premise that air ambulance companies that sell subscriptions are not insurers, then the Pireno test deals the opposite result and of course my entire report is about why that is the proper starting assumption.

So in my mind and again I want to emphasize I don't really have a bone to pick in this and frequently I'm hired and I look into an issue and I come back and say it's not the answer you want but in this case I was hired and the more I looked into this just as an independent academic who has been working with the MF act and working with insurance matters for several decades, the more I became convinced that there is not a question here in my mind in terms of whether or not these laws are going to be upheld. Efforts by states to regulate air ambulance

subscriptions as insurance will continue to be struck down by federal courts. Its not a fluke that you have the Eighth Circuit and the WV district courts striking down these laws and they are going to continue to do so. So, my advice to you is simply that's going to continue to happen and efforts to avoid that are not going to successful. That is my conclusion and I'm happy to answer any questions you may have about it.

Before moving to the next speaker, Charlotte Taylor, Esq. Partner at Jones Day, Asw. Hunter noted that Prof. Schwarcz made mention several times that he was hired and asked him to make mention of who hired him. Prof. Schwarcz replied he was hired on behalf of GMR.

Ms. Taylor thanked the Committee for the opportunity to speak and first agreed with Asm. Hunter's earlier statement that this matter has mirrored a soap opera and I think a big question is what is going to be a productive use of the resources of state insurance legislators going forward and I agree with Prof. Schwarz that trying to regulate air ambulance memberships as insurance is not going to be a productive avenue, its going to be a dead end. I will touch on some of the similar issues but hopefully not be too repetitive. I just wanted to start by reviewing how we got to this space and it all starts with the ADA which may be familiar to some of you but the ADA is a federal statute that gives exclusive regulatory authority over air carriers to the federal gov't when it comes to air carrier rates, routes and services so any state law that regulates the rates, routes or services of an air carrier is going to be preempted by the ADA.

Air ambulance providers are federally regulated air carriers and all of GMRs providers have certificates with the Federal Aviation Administration (FAA) and the Department of Transportation (DOT) and memberships are effectively a way of paying for the services of an air carrier and a way of saying in advance ill pay this small fee and then if I'm transported that's going to be my entire OOP cost. The air carrier will recover from the insurer as applicable but that's all that the consumer will be charged and over the years the Supreme Court has looked at for example frequent flyer programs offered by airlines and said those are ways of effectively paying a discount for air carrier services so state efforts to regulate those are preempted and numerous courts have looked at the GMR membership in particular and come to a similar conclusion - this is a way of paying for a portion of the fare essentially when a patient is transported and therefore ADA preemption applies to state laws that try to regulate that. We saw the Fourth Circuit come to that conclusion in Cheatham; we saw Guardian and portions of its analysis; and the two WV courts that have recently addressed this have also looked at the specific membership and found that preemption applies.

So that's the baseline and then the question that has come up over and over is whether the MF act offers a kind of key that's going to unlock this and AMC's position has been that it does but that is just not what the law says under the MF act and there is not going to be another way to spin this around to change that conclusion. So, Prof. Schwarcz already spoke about the MF act reverse preemption and I don't want to repeat too much of what he said but essentially it's a federal statute that saves state laws from federal preemption for example by the ADA if they are regulating the BOI and the two key points to me again repeating what Prof. Schwarcz said is that phrase the BOI is a federal statutory phrase so there are instances where many states will regulate a product that they consider to be insurance but for federal law purposes its not the BOI and I go back to a 1959 Supreme Court case Securities & Exchange Commission v. Variable Annuity Life Insurance Company of America that talked about variable annuity contracts and many states regulate those as insurance but the Supreme Court said for federal law purposes this is not the BOI under the MF act because there is no investment risk taking on the part of the companies offering those products so changes to state law or categorizations

that you can make under state law aren't going to alter the analysis that the Eighth Circuit for example the conclusion that it came to.

The second point that I would emphasize is that going back to Royal Drug which Prof. Schwarcz talked about, case after case has held that debt cancellation contracts or prepaid discounted services contracts are not the BOI. Now many of these are now in the air ambulance membership area but it's not limited to that so Royal Drug looked at a prepaid medical services plan called the group health plan and said this is not the BOI because the purpose of this arrangement is not to pool risk and use actuarial analysis to calculate what reserves are necessary, etc. – the purpose of this is to get people health services and so building on that foundation and there has been a dispute about the Pireno factors and we think those do not point in the direction of this being the BOI but also just taking a step back you have the Royal Drug that says prepaid medical services plans are not the BOI then in 1990 there is a case called First National Bank of Eastern Arkansas v. Taylor and the Eighth Circuit said a debt cancellation contract is not the BOI. You have an Eleventh Circuit case from 2014 called Federal Trade Commission v. IAB Marketing Association that was a case where someone was offering a membership plan that gave you discounts on medical services and the Eleventh Circuit said this is not the BOI under the MF act and you have Guardian coming to that specific conclusion with respect to the GMR membership and you have the two different judges in the southern district of WV also coming to that conclusion.

What we've seen in the air ambulance space specifically is that it doesn't matter how different state laws have tried to get to trigger MF act reverse preemption it all comes to the same place. North Dakota had enacted a complete ban on the sale of air ambulance subscription plans and the Eighth Circuit found that it was preempted and invalid. Wyoming had passed a law saying that air ambulance membership plans count as disability insurance. After Guardian came down the WY folks recognized that it was not going to be a viable path going forward and GMR worked with them on an alternative solution. In WV the first case involved the insurance commissioner had proposed to apply the general definition of insurance and say I'm going to define memberships as insurance and that was enjoined and subject to a preliminary injunction and in the second WV case the legislature passed almost the exact bill that AMC has been advocating for and again the judge there found that's not the BOI and said calling the sky green does not make it green – calling something insurance does not make it insurance for purpose of the MF act. I'll stop there and leave time for questions but I think that the answer is that this is not going to be the magic key that unlocks this – the law is very clear and there is numerous precedents in this area and its not going to a productive use of legislators time to have another try with a different version of this.

Asw. Hunter stated that I think as legislators I think I know as one it is always our responsibility to make sure that anything that we are promoting and putting forward has the best interests of our constituents which are our friends and neighbors and organizations in the community and we've been talking about this for many months and we want to make sure that the best possible model product that we can produce obviously is put forward, regardless of whether it's a blue purpose or red state, that is a foundation that we can put forward so leading us in that direction with respectful conversation I want to now open it up for our legislators who would like to ask questions.

Del. Westfall stated that with all the states you named trying to do something to regulate this industry there has got to be a problem and I think there is a problem in WV which is why we passed the law we did which the courts didn't agree with. My question is - is it your position that states cannot protect consumers from bad actors without preemption by the ADA – is there any

way we can do that as we're trying to protect our people so what do you suggest? Ms. Taylor stated that GMR has advanced a model bill that has consumer protections in it with an emphasis on transparency, disclosures in advance, and opening up avenues for consumers to lodge complaints and to see those addressed and in states like WY, GMR worked with the legislature to come up with a solution like that which was mutually acceptable. I would also say that the DOT is another place where consumers have recourse and that's very clear in the ADA that the Secretary of Transportation can enjoin any unfair practice so it's not the case that GMR is saying we want to absolutely escape any consumer protections but it has to be something that's navigated consistent with the applicable law.

Prof. Schwarcz stated that my role is to help you understand what things you can do that will actually survive and be effective and it's probably the least effective way to help consumers to pass a bill that several years later is going to be struck down by courts and then you have done anything but create uncertainty so that's my only goal and it's in that vein that I offer my advice just from a legal perspective that attempting to do what you want to do by declaring that air ambulance subscriptions constitute the BOI will not work and it's not an effective strategy. I have a lot of ideas on what might be effective strategy but I'm not an expert in that arena and I don't want to pretend that I am but I am an expert in insurance law and it's in that spirit that I offer you that advice which is attempting to solve this problem by a solution that will be struck down by courts is probably not the best use of your resources and time and I would encourage you to find an alternative solution among the options that are being discussed.

Del. Westfall stated that NY and FL have passed legislation trying to regulate air ambulances and GMR has not challenged those but they did challenge what we passed in WV. Why did they not challenge the FL and NY laws? Ms. Taylor stated that I can't speak to all the details of that but I will say that GMR has made a concerted effort on a state by state basis with the legislators and insurance dept's to figure out how we are going to be in that state and in a couple of instances a decision was made simply not to offer memberships to residents of that state and in WV there are a number of memberships there and there are many members who rely on that and that was in place before the law was passed. Del. Westfall stated to Asw. Hunter that he thinks we need to continue to look at this and maybe at a different route or perhaps the same route but what we passed in WV was struck down but I still think it's a problem otherwise we wouldn't be talking about it.

Asw. Hunter stated that as a follow up to that I'd like to ask Mr. Brady for some responses to the differing views on these issues as clearly we have heard today that there are varying opinions. Mr. Brady stated that I think looking at FL and NY as guides is important and I think there is not clarity from us and it doesn't sound like there is clarity from this committee as to why those laws are ok and others are not. I think even in WY, providers have worked with states and I think as we think about how to take care of consumers and work with this body it's a difficult path for us to navigate and we are committed to doing that and we'll continue to look at states like NY and FL that have not taken challenges to their laws as instructive and we'll go back because from what we can tell it does not seem to be an issue with other air ambulance providers.

Asw. Hunter stated that she had asked many months ago and she does not believe she received a response – with all of these questions and going back to the consumer and our states law enforcement agents and Attorneys General across the country have there been any consumer protection lawsuits from any Attorneys General relative to subscriptions or consumers coming forward saying I've been duped and bought something that was not reported to be what it is. Mr. Brady stated that on behalf of AMC we are aware of at least three class actions that have been brought not by Attorneys General but by consumers on behalf of consumers who

purchased these membership products and then were subsequently billed after the transport for OOP costs or for proceeds from other insurance policies related to a tragic accident or some type of larger medical emergency. I think the public record on those speaks for itself but I think the providers of those memberships have relied on the ADA to suggest that there is absolutely no recourse for those consumers. Asw. Hunter asked if those were personal lawsuits brought and not by states relative to an organization. Mr. Brady replied yes and I'm not aware of any states that have brought any actions through Attorney General offices.

Rep. Frazier stated that my first question is for Ms. Taylor – with the new federal balance billing act preventing air ambulances from balance billing, it would appear that the only benefit the company membership products would provide to customers is covering cost sharing amounts that are determined by third parties – do you have a comment with regards to that. Ms. Taylor stated that once the NSA is effective for patients with private commercial insurance there will not be balance bills but that first of all is a limited category of patients and copays and deductibles are really substantial expenses and we heard some testimony early today about plans with a \$4,000 deductible and there is also a 20% copay amount for all Medicare transports and that is a huge portion of the market so the idea that patients will not have really significant OOP expenses after the NSA act is law I think is not accurate.

Rep. Frazier stated that her next question involves a trauma patient in CA who insisted on waiting for their free air ambulance to arrive while other air transportation was readily available and tragically that person ended up dying while waiting on their membership helicopter to arrive. Do you have knowledge of other cases where this may have happened? Ms. Taylor stated that she does not have knowledge of any cases where that happened and Mr. Brady made some representation about that case and I don't know but I do know that the GMR membership terms and conditions state very clearly that members should in a health emergency take the first available transport and they make it clear that the GMR provider is not always going to be available to be the first called.

Rep. Chad McCoy (KY) stated that my question is for Prof. Schwarcz – the comment in the WV case that you can't just call something green really does bring up a state's rights/federalism issue and looking at the GMR model that I heard you say was proposed, how is it going to withstand constitutional scrutiny and what is the legal analysis around that which gets us around the preemption. Prof. Schwarcz stated that I would say that it is true that in that opinion and I think accurately what it stated is that states can't supply a definition of a federal statutory term so states do have the authority to define the BOI for a variety of purposes but in this unique circumstance the issue turns on the interaction of several statutes so I think that's the first point. Your question goes to whether or not there would be preemption under the ADA of the alternative models and on that point I think the question really is we don't get to a legal question if there is a political settlement so if everyone is satisfied with the language it may not even get to that and I will say I have not analyzed that so I don't want to speak to the preemption analysis as the preemption analysis under the ADA asked about state regulation of rates and services and so that would be the question whether or not the regulations that are focusing on transparency constitute that and I think there can be arguments on that which wouldn't turn on the definition of the BOI and again I want to stay in my lane because I only want to offer you opinions on things of I am very confident in and consistent with my expertise and where I am very confident is attempting to get around the ADA through the mechanism of labeling this as insurance will not work.

Obviously if you have a compromise settlement of some type or an understanding that a transparency related measure is not going to be challenged under the ADA you might justify that

by saying it doesn't constitute an attempt to regulate rates or services whereas its very clear and many courts have held that attempting to regulate subscriptions directly constitutes regulation of airline rates so I think that's why the issue is different and I think that would be the way in which you can reach that type of negotiated settlement. Rep. McCoy stated that it sounds like that's saying we agree we won't sue you but if we did we would win and if we are making bad policy that still sounds like bad policy to me.

Asm. Cooley stated that in CA we've looked at some of this and obviously there is a very important state interest to the extent that state dollars fund medical care, costs not be outrageous and there is a consumer interest to have people knowing what's going on and I think at the state level the state interest of protecting the public's purse and the consumer interest of being protected are important values the state can bring to the table even under the ADA and I think that is how you can start to approach it and make the argument that this is fit for state regulation. I do note that just a month ago today the leadership of the NAIC sent a letter to the DOT which has established an Air Ambulance and Patient Billing Advisory Committee under the 2018 reauthorization of the ADA that basically asked the DOT to look at how you might give states jurisdiction on some of these consumer protection issues specifically with respect to air ambulances so I think for us as lawmakers it's going to be very important to take note of the NAIC's approach to kind of reach out to the federal govt and build a case for some tweak to their relevant law so I think that this is a very large and animated conversation on many fronts at this moment including at NCOIL and the NAIC.

Rep. Oliverson stated that I just wanted to correct the record from our previous meeting because it turns out that I had spoken out with regard to a particular company that I became aware of as we were advancing legislation in TX which is similar to the GMR proposed model and there was some conversation in committee and I spoke about it at our last meeting about Helimedica which is a supposed subscription service and I expressed to the committee that some of the facts and details about this company were not correct but I just wanted to clarify that in fact upon further investigation my office has been unable to reach anybody in the company and the airport where supposedly they are going to have air ambulances has no record of them ever being at the airport or any request and our Secretary of State has no record of this company incorporating in Texas to do business so it very much seems like a Frye festival type operation and I feel very misled and I'm very disappointed and I have to say as I'm listening to this conversation with all due respect to Prof. Schwarcz I am encouraged by what I've heard with respect to the NAIC and it may be worth our efforts as well at NCOIL since I do believe this is an ongoing consumer issue for us to join them in their efforts in asking the DOT to clarify with respect to the ADA this very important issue.

My understanding is that this is one of the largest medigap products that consumers do purchase even though they may already have coverage or do have coverage through Medicare and that this product is sold widely to Medicare beneficiaries and yet it's supposedly completely beyond our reach besides numerous consumer complaints that we receive across our state so I really commend Del. Westfall for staying the course and I'm sad to report in TX our efforts at compromise legislation were not very well supported and went absolutely nowhere and I would encourage us to continue to work aggressively on this issue at the state and federal level.

Asw. Hunter stated that we will work with Del. Westfall and others as we move forward to our annual meeting in November to try to get to some sort of conclusion. For anyone with comments or questions or concerns please address them and send them to NCOIL staff and we will make sure they are addressed accordingly.

CONSIDERATION OF RE-ADOPTION OF MODEL LAW – EMPLOYEE-SPONSORED GROUP
DISABILITY INCOME PROTECTION MODEL ACT (ORIGINALLY ADOPTED 11/16;
TEMPORRAILY RE-ADOPTED 4/21)

Hearing no questions or comments, upon a motion made by Asm. Cahill and seconded by Del. Westfall, the Committee voted without objection by way of a voice vote to re-adopt the Model.

ADJOURNMENT

Hearing no further business, upon a motion made by Del. Westfall and seconded by Rep. Rowland, the Committee adjourned at 12:00 p.m.