NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
LAS VEGAS, NEVADA
MARCH 6, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at Harrah's Las Vegas in Las Vegas, Nevada on Sunday, March 6, 2022 at 9:00 a.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Asm. Ken Cooley (CA)
Rep. Matt Lehman (IN)
Sen. Robert Mills (LA)
Sen. Paul Ukte (MN)
Sen. Jerry Klein (ND)
Sen. Shawn Vedaa (ND)
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Brenda Carter (MI)
Rep. Emily O'Brien (ND)
Rep. Lacy Hull (TX)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

Upon a Motion made by Asm. Ken Cooley (CA), NCOIL President, and seconded by Sen. Jerry Klein (ND) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer and seconded by Asm. Cooley, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 18, 2021 meeting in Scottsdale, AZ.

CONTINUED DISCUSSION ON 340B DRUG PRICING PROGRAM

Asw. Hunter stated that before we hear from our speakers I just want to make a few remarks about the background for this topic. We had a very good introductory discussion on this issue at our last meeting in Scottsdale. Since that time, the National Association of Community Health Centers (NACHC) and 340B Health, both who are here today, have submitted draft language for

consideration to use as a starting point for developing a model law. That language will appear on page 235 in your binders. As you can see, there is no sponsor attached to this at this point. It's for discussion purposes for now. I'll note that I am interested in sponsoring a model but we want to hear more about it and our colleagues actually had a lot of questions at our last meeting, so we want to dig deep into this and it may be a case that after hearing this, it will result in maybe not even creating a model at all. As you may know, I used to work at a federally qualified health center. That health center is now in my district that has several locations. This is a very important issue to me as 340B really affects some of the fiscal issues that the center has so before we get started I just also want to note that this topic will be transferred to the Joint State-Federal Relations & International Insurance Issues Committee. Since 340B is a federal program, I think it's proper for that committee to have jurisdiction over this issue.

R. Logan Yoho, PharmD, RPh, BCAP, 340B ACE, Director of Pharmacy, Apexus Certified 340B Expert at Hopewell Health Centers thanked the Committee for the opportunity to speak and stated that I'll be talking about the impact of 340B in community health centers. Like Asw. Hunter said, she has a past history in federally qualified health centers and I am also in that space. I am the Director of Pharmacy at Hopewell Health Centers. I'm also Apexus Certified 340B Expert and I am the current Vice President of the Ohio Pharmacist Association. Hopewell Health Centers is a federally qualified health center. We currently have 27, soon to be 29 sites in southeastern Ohio. We cover nine counties all of which are very rural. We're a tier three patient center medical home and we serve approximately 39,000 patients annually – 10%of those are uninsured and 47% are Medicaid. So, our patients are very underserved and high-risk patients for being part of the healthcare safety net. We have a variety of services including primary care, behavioral health, psychiatry, dental, as well as other services. The 340B program's intent it is to stretch scarce federal resources as far as possible reaching more eligible patients and providing more comprehensive services.

Everything we do with the 340B program meets this intent. It allows us to treat more patients and be able to stretch our grant dollars that are a large part of funding even further. So, the 340B savings, the basic idea is that we pay less for the drug and we're able to bill that drug for patients and the savings, the difference is reinvested into patient care. We do that in multiple ways. One of the ways we've done it at our health center is providing a clinic pharmacy. We opened a pharmacy in our busiest clinic and we have a full staff providing both dispensing pharmacy services as well as clinical pharmacy services. You can see there my staff with one of our state legislators there. We have free prescription delivery that delivers to our entire footprint. That is a big cost expense for our health center because we cover 4,400 square miles of Ohio. So, it is a big expense to have three full time drivers as well as vehicle upkeep that we wouldn't be able to do without the 340B savings. In addition, we have a sliding fee prescription discount for patients that are at or below 200% of the federal poverty level. This allows us to provide things like insulin and EpiPens, which I'm sure you all know how expensive those items are to these uninsured patients, for just dollars. We basically give them that medication at our cost plus a dispensing fee. So, we're able to provide these medications at something that is truly accessible to them.

With the 340B savings we also are able to do things like have programs where we're able to reach out to our patients to provide services that they need and we meet that on a case by case basis. So, we might have patients that are needing blister packaging. That's a very time-consuming process that a lot of pharmacy's charge for and that's something we do for our patients at no charge to be able to increase their adherence to their medication and make it easier for them to understand. In addition to our clinic pharmacy, there's many other things we can do with our 340B savings. We have several school-based clinics, so we actually have

primary care clinics that are embedded into high schools and middle schools. We're able to increase vaccination rates. One of our clinics has a dental operation and we've been able to increase the dental health of our students in those schools. We've had a great relationship with these schools and in fact they've asked us to expand services beyond primary care. So, that's when the dental health came in as well as now we're starting to have psychiatric and behavioral health services within the schools as well. In fact, we opened a clinic in one of the schools in our area last January and they've already asked to double our space and they gave us more space within the school in order to expand services because it was so valuable to that underserved area.

For those that don't know, dental reimbursement is not the greatest and often these clinics cannot pay for themselves if they rely on their dental services alone especially when it comes to our Medicaid patients. It is very difficult for Medicaid patients to find a dentist that will take Medicaid because reimbursement is so poor. So, with a 340B program we're able to expand those services and have dental clinics in places where there is really a desert. It also has allowed us to start mobile dental services. So, we have a dental hygienist and a dental assistant that will travel to clinics that don't have dental services available and they will provide that dental hygiene in between visits. One of the biggest ways we've been making an impact with 340B has been the opioid epidemic. As anyone from the Midwest knows, it has hit us hard and Ohio and our neighbors have been pretty much ground zero for the opioid epidemic. So, with the 340B program it has allowed us to expand our medication assisted treatment program. We use a drug called Vivitrol that we're able to get these patients totally opioid free and able to resume their daily lives and the amount of lives we have saved has been incalculable because of this program. It would not be possible without 340B. These shots are very expensive to obtain and if we didn't have 340B we would not be able to stock them in the clinics.

So, we're able to keep a stock that way when the patient is ready to get their shot, we can give it at that same time and we don't have them waiting because in the past when we couldn't do that the patient may relapse between our client and the pharmacy to go get the shot. So, it also allows us to open additional sites in underserved areas because where I'm from, we are very rural. A lot of these places are healthcare deserts, there's not a single option for healthcare in some of these small towns. So, being able to open community health centers in those areas has really increased the healthcare of the patients there and ultimately lengthen their lives. This is not something we do but a lot of my colleagues in other health centers have also used the money to purchase mobile health clinics. So, they might have a bus that goes around to indigent areas and one of my closest colleagues in urban Columbus has actually done this with their 340B funds and visits areas that don't have any healthcare and may not be the best areas in town and is able to provide hope to those patients. So, all that brings us to where pharmacy benefit managers or PBMs intersect with the 340B program. Because covered entities like myself, that's the term in the law that describes any 340B providers, purchase the medication significantly less for the drugs, PBMs have identified a potential increase in revenue so they're paying us less. This had started about five or six years ago and has progressively gotten worse.

Health centers like my own are required to be law, regulation, and mission to reinvest a 100% of those dollars back into healthcare so every bit of that money is going back to that intent - stretch our scarce federal resources in order to be able to treat more patients. So, there have been multiple methods used by PBMs such as decreased reimbursement rates for medication at 340B pharmacies. When I was doing some analysis on what this looked like, I was able to find one PBM that was paying me as low as 3% of what their competitor PBMs were on similar claims. That is devastating to the pharmacies. That same PBM, every time I administered a shingles shot to a patient, I lost $45. So, it was just that I wasn't being paid as much and I'm actually

paying to administer that drug but we do it, because we're there to help patients but that's not sustainable over the long term. There's also PBMs that have totally excluded us from their 340B networks, or from their pharmacy networks all together. So, there's one PBM that I'm thinking of that excluded me completely. I could not enroll as a pharmacy with them because I had a certain percentage of 340B claims and they would not tell us what that threshold was so I was excluded altogether and it was a pretty large commercial plan in my state and then also, there have been some PBMs that have leveraged fees against covered entities that are not leveraged against pharmacies of a similar size elsewhere. So, all of these methods are just pulling money away from the intent of the program. The bipartisan intent of the program was to stretch these resources and allow us to reinvest into healthcare.

So, during 2020 Ohio 340B covered entities worked with Ohio legislators including one of your own, Sen. Bob Hackett who was our bill sponsor, to create a bill that would protect 340B pharmacies. This was a little complicated during the pandemic to get a bill through before the end of our general assembly in Ohio but we did it in the nick of time. The bill created a structure by which we could be fairly paid for the services we provide, while at the same time maintaining those 340B savings to stretch federal resources. We did not want to have a leg up. We just wanted a level playing field. At least 16 states have passed similar legislation but it's a constant improvement on our bills because there have been loopholes that have been found in the bills so we constantly have to improve the bills and improve that and make sure that we're protecting these covered entities so we can protect the most vulnerable Americans.

Abby Reale, MHA, Director of Advocacy for Mountain Health Network thanked the Committee for the opportunity to speak and stated that Mountain Health Network includes two hospitals, Capital Huntington Hospital, and St. Mary's Medical Center in Huntington, West Virginia. We are a border area. We also have Pleasant Valley Hospital which is Point Pleasant along the Ohio River as well. For us and 340B in West Virginia, you will see that we had over four closures and two bankruptcies of hospitals in West Virginia. Rural providers are struggling even more so with COVID right now. For us and our health system, there's a little note there that over $200 million in uncompensated care is what we do throughout our health system every year. Our 340B drug savings is a quarter of that if that gives you any idea. The programs that we have been able to do in our health system are critical to our area as over 38% of our payer mix are capitated, so that's Medicare, Medicaid, PIA, which is our state insurance - it's all rates that they're telling us what they're going to pay us and that's what you get. So, we only have about 12% to 15% commercial payers essentially so when we're looking at uncompensated care it's pretty large for us but we do have clinical pharmacists throughout our region and throughout our hospitals. We are not able to bill for those services other than for commercial payers. So, being able to have that clinical pharmacist working hand and hand with our physicians every day is critical.

We also have a cash card program for patients for any type of drug savings or anything like that. We also have a meds to beds program. So, whenever you're being discharged from the hospital, you're able to go home with your medication that day. We also have our mom's program which this goes into I'm sure everybody has heard of West Virginia and our substance use problem. We were able to create a mom's program for our mothers suffering with substance use disorders that give birth and are not in a current program. They enroll in this six months to a year program through our health system. We have seen huge strides in that program. We also have a neonatal therapeutic unit. We were the first in the country to do that. So, one of our newborn intensive care unit (NICU) nurses saw babies that were withdrawing and we created this unit. We have anywhere from 18 to 32 babies within that unit at any given time and their stays can be anywhere from 30 to 60 days and that's where our mom's program intersects with that. I actually used to be a baby cuddler that would volunteer and go up during my lunch hour

and cuddle babies and you would never see the parents and until we started the mom's program, you now see the mothers and fathers being very integrated into caring for that baby so this has been huge for us.

Also, financial spiritual care is provided at PRO-ACT which is a unique program that also is for substance use and includes medication assisted treatment (MAT), we also have a pharmacy there. We also have other community health screenings and clinics throughout the area. We provide one every Fall which is a free screening as well as medically indicated food boxes. We recently did a medically indicated food box program at our Dialysis Center which is for our patients there and we've seen a 30% reduction in readmissions which is huge especially for that patient population. We've also been able to provide free care and then school based clinics is what our fellow federally qualified health centers (FQHC) that we partner with are offering throughout the state. So, with West Virginia the importance for us is hospital programs. Over $300 million of 340B goes into West Virginia. Without 340B there's no doubt in my mind that you will see more hospitals and entities shutter.

This is our PBM reform within West Virginia and we started in 2017 with the Pharmacy Audit Integrity Act, which essentially started auditing and licensing PBMs in the state which is critical and key. You'll notice that with PBM regulation, 340B discriminatory language actually intersects and intertwines throughout but we actually didn't start that until 2019 where we instituted 340B protections and for us, within the health system, within the hospitals throughout the state, especially FQHCs, other community providers, that was a big deal for us. Ever since 2020 there was Rutledge v. PCMA which was a U.S. Supreme Court decision that allowed for legislatures to regulate Employee Retirement Income Security Act of 1974 (ERISA) plans. So, of course in 2021 we did legislation to include that. We also did a lot of reform that year on rebates that go back to the patients at the point of sale and we're still working through that one but we also did more 340B protections and in 2022 we currently have legislation right now that codifies our legislative rules that we did in 2021.

So, within the Pharmacy Audit Integrity Act, I cannot express how important definitions are as well as the licensure of the PBMs. So, for us we worked very closely with the insurance commissioner who really went in when it came to legislative rules as well as our process in West Virginia is a little different from other states where it goes before the legislature - you have a whole year before that they go through the legislative rulemaking process and then the legislature essentially approves it. We had no issues with our legislative rules as the chair of that committee knew about PBMs as his mother was a pharmacist but with 340B specific protections within the legislative rule, that was really key for us in moving forward in the 2022 legislative session and one thing being in politics all my life is I really like to see legislation you can actually use and it was very exciting for us to be able to see all of our legislation over the past couple years be used whenever Express Scripts, which is a PBM, back on February 24th of last year put out a mandate that we would have to start retroactively identifying drugs dispensed at a 340B safety net providers and our pharmacies.

This would have been unduly burdensome, especially during a pandemic and we actually filed a complaint so we were able to use our legislation that we passed in 2021 and our insurance commissioner heard that complaint, came back and actually agreed with us and recommended a decision. And you'll notice in the last part there, that since the cost associated with the change would be assessed on 340B entities and not upon other similar entities, that's the key part of having 340B protections within our legislation, especially on the state level because we are being discriminated against compared to other pharmacies. In this session we actually do have a freedom of choice pharmacy bill that will actually be heard on Tuesday in our Senate Health

Committee. It's passed the House and that actually allows for freedom of choice to our patients to decide what pharmacy that they would like to use. So, an example is last year we had a two year old boy that was in our cancer center that was going to have to wait three weeks to get their life saving meds because they were going through what we call white bagging, which is an interesting thing to try to explain, especially to legislators who are wondering why it's called white bagging but essentially your PBM or your health plan tells you that it has to come through a certain pharmacy. And so that patient, the two year old boy, who was waiting for their cancer medication was going to be waiting three weeks. A complaint was filed by the parents which is something we recommended, and the insurance commissioner came out with a special bulletin saying that they were violating our law, which they were.

And so, that boy got to have their cancer meds that day given in our cancer treatment center. That is what we're talking about when we're looking at this type of legislation. It directly affects our patients' lives. Our providers, they are writing prescriptions for patients that then go into 340B and if there's something being done on the federal level what we've seen on discriminatory practices, that can affect our patient care. They may have to switch to a different medication that they might be able to afford because if a 340B's discriminating against it, it's hard to get that coverage and we've seen a huge attack as I think our 340B has gone down by millions due to multiple attacks on the national level and also on the state side. So, essentially the 340B protections go hand and hand with PBMs.

Regarding recommendations, on a state level looking at a comprehensive PBM regulatory structure. That's the first thing that we did. We were successful with that and having a strong regulator helped. So, I kept mentioning our insurance commissioner, which was The Hon. Jim Dodrill at the time, he was amazing and we were able to work with him on many things as well as the 340B discriminatory reimbursement provisions prohibiting modifiers or adjustments as that is key and is something that we had put in in 2019. And we've kind of further worked on that type of language throughout our legislative roles as well as including broad definitions. So, you'll see that our 340B covered entity doesn't just include the hospitals or FQHCs. It also includes our contract pharmacies. So, within my own hospital I actually have a contract pharmacy. Capital Huntington Hospital partners with Marshall University's Pharmacy program, so they own our pharmacy within our outpatient clinic so that meds to bed program that I was telling you about actually goes through Marshall Health's Pharmacy.

So, for us that's considered a contract pharmacy but is under 340B and so that's something that we use every day, our patients use every day, and it's where we have our prescriptions filled. So, having any type of discriminatory actions against contract pharmacies is key for us as well. Including protections for all 340B covered pharmacy types, which I was just explaining, and contract pharmacies, that's important. Providing network adequacy provisions is important and that's what we're doing this session and that is the pharmacy choice and freedom of choice for patients. In West Virginia we have very limited pharmacies and so for us, being in our area, you're not going to come across another hospital pharmacy for at least 30 minutes or an hour if not more. So, for us contracting with say a local pharmacy called Truth Pharmacy, they are going to be in a county like Lincoln or Wayne, or Mingo, or Logan, where there might be another entity and so having that connection is key for our patients as well. Also, PBMs cannot pay a 340B covered entity less than others is an important provision and is something that we've even learned more of recently - that we are being paid way less than what they normally would pay another pharmacy. Providing patient choice is the key to this legislation. I can't express how much 340B has really helped our patients, our community, and being able to provide access to care, that is what we are about. Also, allowing for broad rule making is important as for us it was very different as our state is set up differently with legislative rules but that is key as well.

Greg Doggett, Vice President and Legal and Policy Counsel at 340B Health, thanked the Committee for the opportunity to speak and stated that certainly we can get more into the details and any questions that you all have about the draft model legislation but when you review it, I would say that really the most important thing to keep in mind that was really behind the intent of it when my organization worked collaboratively with NACHC on developing it, s that it is really there to ensure that the 340B financial benefit, the benefit of participating in 340B, stays with the covered entity and that is not eroded by certain PBM practices or policies or that there are not requirements put in place that would really impede the access of the covered entity to being able to use 340B drugs so they can retain that benefit and do all of the different types of things that Mr. Yoho and Ms. Reale talked about. We now have over a dozen states that have these laws and there are over another dozen states that have introduced proposals so there is a lot of momentum for this issue at the state level. When we developed this language, we did not have to reinvent the wheel. We were largely able to borrow what we thought were some of the best provisions and practices that we saw in different states so this is really growing out of that legislative development at the state level, and I think there there's a real opportunity here to develop some model legislation that hopefully will allow additional states to adopt these laws and bolster the laws of states that already have them and ensure greater level of uniformity among those laws. I'll now turn things over to Jeremy Crandall, Director of Federal and State Policy at NACHC. Mr. Crandall stated that I really have nothing to add as I think we've covered it all. I would just say thank you to NCOIL for considering this issue.

Nick Doherty, Director of Policy for the Pharmaceutical Research and Manufacturers of America (PhRMA) thanked the Committee for the opportunity to speak and stated that I cover the New England region and just want to let the committee members know that we did receive a copy of the draft model legislation. We're going through it now and we want to we're basically going to do a crosswalk of the draft model and what has happened in other states and we just want to stress a willingness to participate in the conversation as the committee members move forward and address this issue.

Asw. Hunter stated that regarding these FQHCs in different locations that actually have the opportunity to have this 340B program, we're always talking about access and affordability and I want to know if you can quantify what would happen in some of your health centers if they took these savings away. In New York, they're talking about wanting the savings to go back to the state and I know that would be devastating to our health center. Is there any data that you have to quantify what that would look like for your patients or for the health care delivery if they clawed back these savings?

Mr. Crandall stated that it really depends on the health center to be honest. I've heard anywhere from 25% to 50% of overall operating revenue. I would happily get back to you on that. It is just such a moving target, and it is information that really just depends on the health center but I would just point back to Mr. Yoho's presentation where he walked through all those specific services that an individual health center provides. There's a health center in West Virginia that is specifically been able to fund a community health worker position and in the case of another health center, mammography and hepatitis C treatments. So, it really just depends on the health center and what they do with that savings but I'd happily give you some specific examples and follow up with the committee with some specific examples from individual states. Mr. Yoho stated that I will echo a lot of what Mr. Crandall has said. One of the biggest ways is to look at it as the services that will be lost without it. It's hard to quantify that in dollars but I do know, dollarwise, that our health center, and I'm sure others, would be in the red if it wasn't for our 340B savings. They keep us operating and they keep patients' lives affected for the positive and if we didn't have the 340B savings we would have to shutter a lot of our clinics.

Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary, stated that you mentioned that after the law was passed that PBMs choose a lot of loopholes to get around the law. Can you address some of those so we know what we're looking at to try to include in the law? What was the biggest way they avoided complying? Mr. Yoho stated that I think the biggest thing that we're just getting into in Ohio is that there was some language that wasn't referring back to the proper language up at the top. So, there was a way that they could say that they were paying us equivalent to non 340B pharmacies without paying in the structure provided in the law. So, it's just making sure that your references match back to the proper lines. I think it'll be a simple fix in Ohio but I know in other states they found other things and I don't know the specifics but we'd be happy to get back with you on those.

Mr. Crandall stated that one of the main reasons that we're sitting here today, is that because at this point approximately 15 states have enacted some version of the model before you. We're really learning on a daily and a weekly basis how to continue to update this and in fairness to other interest groups that are interested in this issue, they are also pursuing amendments that we would argue would weaken the legislation as well. But one other item I'll add is it's also really important the role of whether it's the insurance commissioner or whatever regulatory body ultimately enforces it because, it is sometimes hard for a pharmacy to know whether they're being treated differently than a non 340B pharmacy and so I would just also emphasize that regulatory piece as well.

Asw. Hunter asked if the claims identifier process could be described. Mr. Yoho stated that in some of the bills there have been requests to put in claims identifiers and it happened in Ohio after the bill but it's not in the bill. We didn't prevent it. Some of the insurers came back and said that you had to identify your claim with so in the pharmacy we have a thing called the submission clarification code and we have to put this code in before the claim is processed. There's a big problem with this. When we're in our health center pharmacy, the one I run in my health center that's not a problem, because they're my staff and I can train them to put that in. We can even automate it so it's done automatically. The problem is at our contract pharmacies, they do not know at the point of sale whether a patient is 340B eligible or not. So, it's done after the fact. We hire companies that do that - they identify whether a claim is 340B eligible or not. So, since the pharmacy staff does not know the eligibility at the time of filling there's no way for them to enter that claim modifier so those are really devastating if those get entered.

Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer, stated that the 340B program I think is a great program, and obviously I'm a huge fan of FQHCs and what they bring to rural parts of my state and medically underserved communities in my state some of which are maybe not even rural, just underserved. But I keep hearing that there are situations where large either for profit or not for profit healthcare systems acquire rural facilities for indigent clinics and stuff and now suddenly the whole system's participating in the 340B program. That's really not what it was designed for, am I right? Is there a way to compartmentalize the savings to make sure that these benefits are staying with the folks and the facilities that are actually trying to keep the lights on and taking care of vulnerable populations? That's what it's designed for, right?

Ms. Reale stated that in order to qualify to be a 340B entity, you have to meet certain thresholds and for us we are a safety net provider and there's only a couple of us in the state of West Virginia and you have to meet those certain thresholds and you also have to be nonprofit. So, with those thresholds I think that speaks to what you're serving. Rep. Oliverson stated that I hear what you're saying, but I kind of disagree. At least where I come from, it seems like the most profitable healthcare systems are all non for profit, certainly the largest healthcare systems,

and my question is when you get to a common tax ID type situation where it's a system, you have wealthy facilities that are making money hand over fist and benefiting from the same program as a small clinic that may be in a medically underserved community taking care of medically fragile people or those that are underserved or in a rural place. And we're seeing that and I'm wondering to what extent that actually enhances and fuels consolidation within the marketplace where you have these large not for profit systems that are just for whatever reason going out into the rural communities and acquiring these small rural hospitals that are clearly not making a profit?

Mr. Doggett stated that first off, and I think you were sort of suggesting this, only non profit or public hospitals can participate in 340B. Most categories of hospitals to be in the program, they have to demonstrate that they serve a large volume of low-income patients, Medicaid patients, and low income Medicare. So, if a hospital or health system were acquiring a clinic simply because they were just looking to add more commercial paying patients, ultimately that would probably put their status in the program in jeopardy because you have to be able to demonstrate that. If you're a hospital that doesn't really serve a lot of low-income patients, you're not going to be in the program and you're not going to be able to participate. The other thing that I would add is that I think as probably someone who lives in a rural area I think you're probably very well aware of the trend of a lot of rural hospitals closing. One thing we hear from a lot of rural hospitals is 340B makes the difference between them being able to stay open or not. This is a little bit of maybe a theory in this moment, but I would say that probably sometimes those rural facilities and those rural hospitals join a larger system because it allows that clinic and that facility to actually stay open because they are able to tap into maybe not necessarily great resources but of the greater relative resources of that larger organization.

Rep. Oliverson stated that I hear what you're saying but I think my point is that we have a program that's designed to help folks that are engaged in I would say, really humanitarian type healthcare, where it's not about the money, it's about helping people find the care that they need and there are very low margins and it's difficult to keep the lights on. This is supposed to be a mechanism by which it makes it easier for them to stay in business and it concerns me when I see a long list of participating providers who are some of the more well off, well endowed, wealthier larger gross revenues annually systems in our country that are all 340B providers. That's not what the program was designed for, right? Mr. Doggett stated that one thing I would mention is that we've done a lot of research comparing 340B and non 340B hospitals and one thing I will note is that when you look at their profit margins and you look at large hospitals on down to small hospitals, the profit margins of 340B hospitals are smaller across the board. The other thing too is that they do serve, even though they are less than half the hospitals in the country, they make up the lion's share of hospitals in terms of the number of Medicaid patients they treat. So, I hear the question you're asking, and it's a good one but I think that the data supports the idea that this program is getting to the proper organizations and that it's being used in ways that it was intended.

Rep. Oliverson stated that I hear what you all are saying, and I agree with you - we need to make sure that the revenue stays with the facility as that's what it was designed for. But again, I reiterate the fact and to my colleagues as we continue to look at this, we need to be clear about whether facilities that are participating in this program really needed the help to begin with because there are some that are clearly struggling and need it and there are others I think that view it as another pot of money, so let's see if we can tap into that and that's what frustrates me.

LESSONS LEARNED FROM COVID-19 AND PREPARING FOR THE NEXT PANDEMIC

Steve Landers, M.D., MPH, President & CEO of the Visiting Nurse Association (VNA) Health Group, thanked the Committee for the opportunity to speak and stated that by way of background, I'm a family doctor and geriatric medicine physician and all of my clinical work as a doctor has been primarily doing home visits or house calls for homebound seniors and that love of homecare, and elder homecare, led me to become the President and CEO of the VNA Health Group. We are one of the largest and oldest nonprofit home and community health organizations in the country. We're headquartered in New Jersey and we serve people throughout the state of New Jersey and we also have programming through the VNA of Ohio, in northeast Ohio, as well as in southeast Florida in partnership with Cleveland Clinic Florida. Our teams are incredible and includes about 3,000 employees - mostly registered nurses, home health aides, personal care workers, occupational and physical therapists, and social workers are out in the community helping people on their days of most need, particularly helping older people and other people that are medically fragile. Our services also include an array of public health services, and maternal child health outreach and programs to prevent HIV/AIDS and the like.

This organization makes over one million home visits a year and actually, our incredibly brave caregivers made over one million home visits in 2020 and early 2021 before there were even vaccines to protect them from the COVID-19 virus. So, they were true heroes. I can't not note that one of our past volunteers and advocates and incredibly supportive leaders in the community for our organization is Commissioner Tom Considine, NCOIL CEO, and I bring from our teams an incredible amount of gratitude for his volunteerism and community leadership on issues of home and community based care. Our organization throughout the pandemic was recognized in over 100 publications including media outlets, Good Morning America, and CBS's Gail King show and I was invited to testify in front of the U.S. Senate Special Committee on Aging by Senators Collins and Casey because of the work that our incredible teams have done throughout the pandemic. The things that brought recognition to our people were helping in the immediate crisis where the hospitals were getting overloaded and there was no bed capacity and the emergency rooms were flooded and we quickly set up models to bring people straight home from the emergency room with special supportive care at home - almost like a hospital at home type of concept in order to get people safe care and also decompress the hospitals.

Our teams also stepped up to help make sure that seniors who were medically fragile had long term care at home options as an alternative to nursing facilities and particularly in my home state of New Jersey, the nursing homes had horrible outbreaks early in the pandemic that led to many deaths and there was a lot of fear and concern about providing a home care option so a safe home care option was critically important. And finally, we received a lot of recognition and have done a lot of work of taking vaccines and COVID-19 tests to the hardest to reach populations. Actually, I don't have a way to fully prove it, but I believe that I did the first in-home COVID-19 vaccination for a homebound elder who had had a stroke who needed access to a vaccine. Actually, her daughter is a home health aide and she was going to get exposed as they spent more time together hopefully and having the vaccine was protective for her, but she was homebound, unable to get out of the house. And so, we've done hundreds of homebound vaccinations and thousands of vaccinations at community sites, motels, boarding homes, homeless shelters, for migrant workers and the like. And so, we've tried to get vaccines to the hardest places.

I think I was asked to speak about preparing for the next pandemic and I certainly take on this request with a lot of humility as I think any of us that have been in public health or healthcare leadership roles that have gone through the last couple years, if you haven't been humbled and been wrong a few times, then you're probably not looking in the mirror and so, I think that it's

critical that I come to you with much humility. I think it's important to think about, hopefully there won't be a next pandemic anytime soon and we've still got problems with the one we've got, it in the context of demographics. I think there's a major strategic issue facing our country that as a geriatric medicine doctor I feel obligated to talk about but I don't believe it's being spoken about enough. From 2000 to 2060 in this time period where we're going from having one older person in our country for every five people of working age to having two older people in our country for every five people of working age. It's doubling, what's called our old age dependency ratio is doubling and that is going to put enormous stress onto our care system and also, a lot of the people that are aging in our population are our workforce and I'm going to touch on that in a minute but I don't think I have time for a top ten list of things to do to prepare for the next pandemic.

So, I want to offer you three things that I think came up as critically important and I'll tell you them in order of the most important is going to come last. The third issue that I want to mention is surveillance. Certainly, infectious disease surveillance is of critical importance and is of national security importance and we need to continue to think about how do we ramp up our surveillance but one thing that happened in the home health world that many of you may not be aware of - when the pandemic first arrived in our country in early 2020, it might have actually arrived a little bit earlier, and the hospitals are flooding with patients in my home state of New Jersey and we had people that needed to come home from the hospital, and they needed home oxygen concentrators in order to support their respiratory condition in most cases temporarily in order to get home. And so, as a home care provider we had to find home oxygen concentrators and shockingly, when we had this kind of surge, we couldn't find oxygen concentrators and I called one of my former colleagues, I used to work in Ohio before New Jersey, and it was one of the largest manufacturers of home oxygen concentrators in the world and I said, "we need some oxygen concentrators in New Jersey, do you have any? We've got a big problem." And he said, "Steve, a few months ago we shipped most of those overseas."

So, we had something as basic as home oxygen concentrators in our world and there was no tracking surveillance - it was just a product, not viewed as sort of an indicator of what might be happening from a healthcare standpoint in public health. We had similar issues with things like ventilators, masks, and shortages of these things. So, I think surveillance is critically important. Not just surveillance of an organism but also equipment and critical pieces to our protection. The second thing I want to point out, and I sort of did indirectly in my talk about the recognition that my team had received, is the importance of home and community-based care for an aging nation. Most older people would prefer to be supported in their homes and communities. Even though father time seems to always win. Ultimately, even with great medical care we do run into issues with chronic disease and other conditions of aging and most of us, if we live long enough, will need some type of help and support and we much prefer to get that at home. And so, we need to focus on strengthening that home and community-based care infrastructure across many aspects, both acute care at home, post-acute and rehabilitative care, and long term care at home. And virtual care at home, and telehealth, that's becoming a very prominent way and depending on how our future regulations are borne out, particularly at the federal level, I think with Medicare it will determine how much home care is actually virtualized.

But finally, and most importantly, I think you've seen this news but I want to put a unique twist on it - the healthcare workforce, our army of skill and love, is depleted. There are shortages across almost every type of healthcare worker in the industry and it has happened because of a whole myriad of reasons related to pandemic but also related to our demographics. And so, we were walking on a balance beam in many respects before this pandemic as a workforce and all the stressors, economic issues, mitigation policies, has led to even worsening shortages and I'm a

doctor and I think doctors are important and I believe in we're not training enough doctors, particularly not enough primary care doctors, but nurses are the linchpin of a compassionate elder care system. We have to have enough registered nurses because they're not just the director care providers, they're also the leaders and the team leaders and the coaches and the family caregivers supports and the lifelines. We need enough registered nurses. The Bureau of Labor Statistics says that we need about 200,000 new nurses every year over the next decade because of retirements and because of new demands for care because of an aging population. Right now, our nursing schools are only graduating about a 180,000 nurses each year that pass the licensure exam.

And a good chunk of those exam passers don't go on to work as registered nurses. Some go into graduate programs and become nurse practitioners which is important, but it depletes the supply of registered nurses. So, we have a 20,000-30,000 a year gap in the number of registered nurses we're training. Now, one would ask, well how do we encourage more people to go into nursing? Well, it turns out that's not the problem. Every year our nursing schools are turning away about 80,000 qualified applicants. There are young people, passionate, bright, loving young people that want careers in nursing and it will change their lives and their families lives if they get this opportunity and it will also help solve some of the issues we face as an aging population and they're not being given a chance to go to nursing school and it has to do with, to some degree, how rigid nursing school expansion can be. It has to do with faculty shortages. We need to innovate as this should be a period of great innovation and experimentation in nursing education. Most nursing education has been bottlenecked because it has to happen in hospitals. Well, I just told you my team does one million home visits a year that are very rich and interesting for learning, but very little of it involves learning and teaching. We have to figure out how to create more learning opportunities using the breadth of the healthcare industry, not just a few hospitals. So, that nursing shortage is critically important. We also have shortages of physicians, primary care physicians, and there are young people in our country that absolutely want to go into these fields, yet our education system is not providing enough slots. I appreciate the chance to share some thoughts about our pandemic experience and hope I've provided some useful information for your planning.

Asw. Hunter thanked Dr. Landers and stated that as we're having the conversation relative to next steps and I know how your background obviously is with an older population, it seems to me especially working through this as a legislator for the past couple years, we hear from the public more than I would say most people for everything and if you're talking about unemployment insurance, we were hearing about that. And it just seems like after two years, some of things that I think really need to be focused on, as I'm sure you're aware, is a universal disaster preparedness plan and I know you didn't make mention of that, but it seems to me in a state like New York where we were very aggressive and some could say too much, in other states they were doing nothing. It makes it very difficult to stop the spread of something if everyone is doing something different. So, we were in Boston and the Massachusetts Governor talked about having to use the New England Patriot's owner's plane to get personal protective equipment (PPE) supplies so we were not prepared even here to have masks and you were talking about oxygen.

And the other thing is, and we have mentioned this here at NCOIL and you mentioned it as well, what they call the silver tsunami. I think it was one of the plans that mentioned that but I think it's important to note that as that population ages, you're talking about having a lack of healthcare resources and really some of the things that were keeping people alive were able to be having them be at home. That makes it very difficult. And I don't think that we're putting enough focus on trying to do that. In New York, we had a huge amount of nursing home death and people just

could not go back to their homes. They weren't prepared to be there. So, I don't think there was enough of focus on that. And you mentioned demographics, but I would offer that there definitely needs to be more conversation about low income rural vulnerable populations because we saw, especially as far as the spread, lower income, populations of color, communities of color where folks were not getting vaccinated and were not getting access to care. We saw in some census tracts where there definitely were more hospitalizations and deaths. We definitely need to be making focus on that as we're hopefully not having to prepare for one but it seems like something like this may be inevitable going forward.

Rep. Lehman stated that regarding demographics, Indiana's going down this path of managed care in that Medicaid and Medicare space for certain people but when we talk about the demographics of the rural areas, I represent a very rural district, there seems to be a greater desire to go into a community facility because a lot of it is your small communities and we have fantastic nursing homes. So, when you talk about the in home aspect and what people wanted to age in home, do you have a breakdown of the demographics there? Does that run the gamut closer to more urban areas? And maybe more rural people might want to go more into the facilities that would be more a sense of community?

Dr. Landers stated that is a great question and in terms of the survey data on people's preferences I do not know a source that breaks it down related to rurality or in urban areas. I think that it's incredibly important that we have a robust and vibrant system of elder care facilities because there will be people both because of preference and because of circumstances that their quality of life will be improved and it'll be essential that there be wonderful facilities. But beyond that, in order to expand the health system we need to support people at home both because of preference and because of need. To give you an idea, in the Medicare system, if somebody comes home from a hospital after lets say a hip fracture surgery and needs support at home, the next 30 days of aftercare costs Medicare about $1,500. If we don't have that home-based infrastructure to provide that service at home and the primary pathway is to go to facility based aftercare, that next 30 days of care costs Medicare about $15,000 and if the people are appropriately selected, they are equivalent or in some cases better. So, we have a combination of providing options for people as well as there's a health system efficiency issue as well that we have to address.

Rep. Lehman stated that when you're talking about the nursing shortage, I'm curious moving forward because the biggest reason we saw nurses exit the market in Indiana was because of the vaccine. We had a lot of nurses who said, "I was a front line caregiver until I was mandated to get the vaccine. And I don't want to get the vaccine, so I'm just going to exit." So, how do we move forward as we plan for the next pandemic as to having nurses who choose not to go that path? Dr. Landers replied yes, no doubt and I think the shortages have been multi-factored as you had everything from people being out on quarantine to childcare issues related to how the schools had been managed to issues related to mitigation policy, employer vaccine and testing policy. I'll say that in my teams we did not see a lot of people that are not in the workforce because of the vaccine mandate although there were a lot of people applying for religious and personal medical exemptions and there were more people out of the workforce in the direct care workforce – with personal care workers and home health aides, attendance was definitely more of an impact in that group. And you've got these multi-factored issues and stresses from the pandemic on top of an existing nursing shortage before the pandemic. The pipeline just isn't there. We have a math problem when it comes to nurses. If we look at the output versus the projected needs, it just doesn't match up. And the good news is, we've got a lot of young people who are passionate, bright, and loving people that want to go into these fields and if we focus on that educational system, we're going to be able to solve this problem but in the short run certainly

all sorts of issues have exacerbated this in various locales, be it vaccination policies and the likewise. But this is a much more complex situation that requires long term strategic interventions to get it right for the next next pandemic.

Rep. Carl Anderson (SC) stated that one thing I want to say is in South Carolina in my area, we have from the general assembly poured money into colleges and nursing programs and even with pouring the money in, there's still not enough because there's a long waiting list. One of the colleges from out of state is now opening up this month in Myrtle Beach nursing classes there. So, I think all over the world we need more nursing colleges and buildings around and it would help because in our area the numbers are there to attend we just didn't have the facility and enough teachers to do what is needed. So, the nursing program is really much needed and I think since the pandemic, and I think Dr. Landers can attest to this, with many people retirement age and beyond retirement age, they just decided that now it's time for me to come out. So, we do need to work real hard but I'm saying to those around the table, just make sure that your area is pouring money into the universities and technical colleges where students could come and get that degree in nursing.

THE UNFUNDED MANDATE OF COVID-19 TESTING

Brendan Peppard, Regional Director of State Gov't Affairs at America's Health Insurance Plans (AHIP) thanked the Committee for the opportunity to speak and stated that I was asked to provide an update on the federal requirement that carriers cover over the counter COVID tests. From the beginning of this pandemic, health insurers have taken action to cover the costs of tests to diagnose and treat COVID-19 and we do continue to do so. Testing once again became an urgent issue with the Omicron surge last Fall and the federal government responded with this requirement that carriers cover over the counter tests. We had already been covering tests that were sent to labs. Health plans worked quickly to implement the guidance in ways that are simple for consumers and we've continued to make improvements. In this case, over the counter means self-administered and self-read tests. Tests that are sent to a lab for processing are outside of the scope. In order to prevent and detect fraud, waste, and abuse, plans are allowed to restrict coverage to established retailers who would typically be expected to cover over the counter tests and plans can also require members to submit reasonable documentation including proof of the product and the retailer.

Within the guidance that the tri-agencies issued they created a safe harbor. This is a non-enforcement safe harbor where plans can limit the amount reimbursed for over the counter tests for non-network retailers. Plans must provide direct coverage by ensuring adequate access to over the counter tests with no out of pocket expenditures and plans must also make tests available through at least one direct consumer shipping program and one in person mechanism and both of these things must be done in order to be within the safe harbor. These are some examples on the left side of this slide of how to provide direct coverage - of course you can have a pharmacy network. You can have an alternate test distribution site, a non-pharmacy retailer, and then of course the direct to consumer shipping program, which is also required. There was some additional guidance - plans may be able to limit the direct coverage program to tests from a limited number of manufacturers and the federal government indicated that they would not take enforcement action if a plan is temporarily unable to provide adequate access through the direct coverage program due to supply shortages and people may remember that back in January we did in fact have, at least in certain areas of the country, problems getting access to tests.

On February 3rd, the Centers for Medicare and Medicaid Services (CMS) announced that starting in the early spring it will begin covering over the counter tests for Medicare beneficiaries.

Medicare had not been able to cover these tests when the original announcement was made and they've now indicated they will be. I just want to touch on the issue of price gouging as it's very important because we have seen it and there is a concern about the costs of tests. So, in 2021 AHIP conducted a survey of health insurance providers in the commercial market to gather information on prices charged by out of network providers for COVID-19 tests. Now, again these are the lab tests, not the self-read tests. The results found that out of network providers charged significantly higher prices, more than a $185, when the average is $130 for more than half of the tests. This is an extraordinary time and plans have been pleased to be able to step up and help wherever we can. This requirement however is a deviation from the traditional role of insurance which is to improve individual health and not monitor public or workplace health. We feel strongly that while we've been happy to step up and provide this coverage for over the counter tests, we believe this should sunset with the conclusion of the public health emergency.

Asw. Hunter stated that with over the counter tests, I know in New York that there's the honor system whether people got the free test kits in the mail or they can go to a pharmacy and pay and the honor system is if you happen to test positive for COVID, you're supposed to call the Department of Health. I like to think that my neighbors are good citizens and they would do that but I have to imagine that the response rate is probably not high. Is there any information you have relative to the correlation of home test kits and actual forwarding that to the positivity number rate? Mr. Peppard stated that's a very good question and the problem is there's no mechanism to require people to report. As you said, these are take at home tests and you read it at home and we did this as my son had COVID back in January and he didn't like it very much when we did the test but it came out positive and we reported to the school but there's no requirement to do that and there's no mechanism to make it happen. We do not have any data on it but it may be that the rate is quite low.

Asw. Hunter asked if an overall number could be provided as to how much do the tests cost overall how much have we spent? Mr. Peppard stated that within the safe harbor plans are able to limit it to $12 per test but regarding how much we are spending on it, I don't have that information at this time as it's still a relatively new item.

Rep. Oliverson thanked Mr. Peppard for bringing this up and we certainly have seen this in Texas because, as you well know, we have a certain freestanding ER problem as well and I didn't hear you mention this but I was wondering if you could talk briefly about it's not just the cost of the test, but one of the things that we're seeing at least in our state is that for a drive through testing location adjacent to a freestanding ER there may be a facility fee being charged that may be in excess and in some cases we had some charges in excess of $5,000 to $10,000, out of network, of course. And then the insurance company's left with this difficult decision of this person needs a COVID test, should we just not cover it? And then who's the bad guy now? So, can you talk about that a little bit? Mr. Peppard stated that I'm not sure that the survey we had included information on the facility fees, I think that was just the tests, but that has been a problem. It's my understanding that the tests are being covered as we're required to cover the tests but the issue is how much are we paying out as a result of that and it's been a serious concern. We had the discussion about surprise billing from a couple days ago and obviously some of the dispute resolution pieces are now up in the air but I don't know that I have information about how much we've seen of this. We certainly know those fees, and some fairly outrageous fees, have occurred, and I don't believe it's widespread, but it has happened.

Rep. Oliverson stated that the issue that I was informed about was that it was one of these difficult decisions of it's an out of network charge and it's obviously unreasonable but then the question is from the insurer standpoint, in the middle of a pandemic do you just deny the claim?

And then of course, it's "Oh we see how you are" - now you're denying people access to getting coverage for this testing in the middle of a pandemic so it's sort of like a catch twenty-two. I was just wondering if you'd heard that at the national level or if that was just a local thing? Mr. Peppard stated that I have not heard that carriers were widely denying claims. Rep. Oliverson stated that they weren't and that's my point - they were paying the claims so it's not really a surprise medical billing or a balance billing issue because they're paying the claims because they're sort of afraid not to pay the claims. Mr. Peppard stated that and within the context of the pandemic it was important that people get access and not have to worry about should I go get the test or not so it was a problem but it wasn't one that was insurance saying we're not going to cover it because we were required to and we thought it was the right thing to do.

VALUE-BASED CARE: BETTER OUTCOMES FOR ALL

Miranda Motter, Senior Vice President for State Affairs in Policy for AHIP, thanked the Committee for the opportunity to speak and stated that AHIP is the national trade association that provides health insurance coverage to millions of Americans through employers and through public and private partnerships looking at market based solutions to providing coverage to many individuals in your states. I appreciate the opportunity to come and spend a couple minutes talking about value based care. This is a really an opportunity and a follow up I think to some of the conversations that we had in November about healthcare costs and about utilization management and so I just wanted to spend a couple minutes talking about what value based care is looking at the traditional sort of predominant historical fee for service system and some of those challenges and how value based care actually provides solutions to that. In a very overview way I'll just provide a brief description of some of the models and those payment structures because they are very unique. They are very layered and complicated depending upon what model and what population states and employers are focused on.

And then certainly, it's always important to measure progress in terms of how many dollars are actually going into value based care and how does that look? So, I'll just spend a couple minutes talking about that and a couple minutes talking about COVID as that really provided I think some good lessons to learn specific to where we're at in value based care and the importance of accelerating that work. And then just quickly I'll talk about what's next from a payer's perspective in terms of the future of value based care. So, as many of you know, now more than ever employers, public payers, whether it's Medicare or Medicaid, recognize the critical need to move away from the traditional fee for service system or models of payment to a value based care payment program or model really to help deliver better coordinated care for patients while at the same time either controlling or at least leveling the high cost of care. So, before I go into some more details, I just wanted to spend a quick moment running through some key terms because I think sometimes as we talk about this issue some of these terms are used interchangeably and some of them are used depending upon if we're talking about a federal program versus a state program. And so, when we talk about value based care, we're really looking at the idea of improving quality and outcomes for patients.

When we talk about value based payment, some of you may know that these terms are used interchangeably. So, value based payment, value based care, this simply refers to value based care that involves a payment model. Alternative payment model or APM - I know that many of you in your states quite frankly are either looking at APMs or talking about APMs and this is really a term of art that Medicare uses for a value based payment model. So again, sometimes those terms are used interchangeably. Accountable cure organization again is another sort of popular APM model or value based care model. Fee for service, as I said, is the predominant historical payment system that the United States has used and how it pays providers for each

and every service that is rendered. And then lastly, quality measures. Certainly, this is the sort of foundation of value based care. So, this really means a predefined set of agreed to quality measures in terms of definitions and what they are that look at safety outcomes, and patient satisfaction that those payments may be benchmarked up against.

So, as we think about what a value based care model is, I think it's really important to understand and remember that there is no one size fits all. There is no single approach to an APM or a value based model that will work for each and every provider, or practice, or specialty. Value based models are outcome based. They're outcome driven. So, as we think about the traditional fee for service model which again is the predominant model and the historical model that the U.S. healthcare delivery system was built on, that pays providers for each and every service that is rendered and as you can see it incentivizes volume in care because it pays for each service. In contrast to that, paying for value basically ties those reimbursements to an agreed upon objective and to agreed upon quality benchmarks to make sure that the services being provided and the care that is being provided is actually improving outcomes and improving the quality of care that that patient may be receiving. The other important thing to remember about value based care or value based models is that there is a level of financial risk embedded in those models.

So, value based payment models entail some sort of degree where the provider actually agrees to take on some level of responsibility in ways where they actually have control and some flexibility in how they provide the care to those patients. That financial risk looks different in terms of it may be a one sided risk versus two sided risk and there's certainly lots of variation and ultimately the goal is that the model gives physicians and providers flexibility in how they provide the care to their patients. I just wanted to provide a chart that shows certain things as you think about the traditional fee for service system, and what it stands for, what it does, and the challenges that it has and really how value based care can provide a solution to that. Fee for service pays only for a defined set of services. What is the challenge? The challenge is that lots of times that does not reimburse for things phone calls, e-mails, care management nurse visits, and use of technology. So, a lot of those things that we think about either as social determinants of health are things that we found were incredibly important and obviously as we're in COVID, the value based system allows provider flexibility to change the number and the types of services because it really looks at the patient specifically and is looking at what does the patient need?

Fee for service rewards volume of services. This can encourage utilization. It can discourage cost efficient care. And the other important thing is, dovetailing into the conversation that we had back in November, lots of times the fee for service system pairs utilization management tools whether it's prior authorization or other strategies and they really frustrate providers and patients. And so, when you look at a value based care model, those that include this financial risk and financial accountability by adjusting payment up or downward, it really gives the providers that flexibility and allows them depending upon where they're at in that model to utilize their own utilization management internally as opposed to that payer requirement. Fee for service does not consider quality of care and it does not measure it so from an employer perspective, they have no idea what they're paying for and on the value based system side, the quality metrics are defined and so that really is a solution to understanding what you're paying for.

Also, fee for service does not consider patient acuity. So, lots of times, when you may have a patient that is sicker that may need more care it may actually contribute to inequities. It may discourage a provider from wanting to care for that patient but when you look at value based, there is risk adjustment built into that and those things are built into the payment structure. I am not going to go into details here but the reason for the visual of this is really to understand the

payments actually sit on top with the model sitting on the bottom and as you move from left to right, we're talking about providers taking on more risk. So, on the very left hand side of that, a provider may just be taking on upside risk and what that means is if the quality and outcomes have improved, they may take on the savings from that, but as you move further to the right, that provider may be taking on up and downside risks. So, for example, if they don't meet those outcome benchmarks, they actually assume the financial risk for that. The other thing as you move from left to right is what I talked about regarding utilization management tools. Prior authorization and maybe therapy - those sorts of things, the provider has more control over those.

Those are things that the health plan may not assume because that provider takes on the financial risk for that. A quick example is if you remember the prior slide with some of the types of payment models, one of the examples is an episode of care. So, if we look at an episode of care, and those are normally paid, what you may hear is a bundled payment and I know that many of your states whether it's through Medicaid or your employer community are actually doing a lot of this work. So, what it basically does is there is a defined service. You'll have a defined side of providers and a defined budget over a period of time and it really creates this incentive to hit outcome goals and to hit spending goals and then where those goals are met there can be some shared savings back with those providers. Another example as you move further across that continuum that we saw is if you talk about population based care. These are really models that look at certain patient population and say alright, we want to improve diabetes management within this certain patient group and as a result, this is really a much more risk model where the provider is taking probably up and downside risk, and they're actually getting paid a prospective payment to care for that patient and they have a lot of choice in terms of how they provide those services.

Measuring progress is very important and with The Health Care Payment Learning & Action Network (HCPLAN or LAN), I would encourage you if you have interest in this to go to this website. There are a lot of resources but LAN is a public private partnership and AHIP is a member. There are many health plans, there are many providers, there are many employers, and policymakers that are part of this group and their goal is really to accelerate value based care in the U.S. healthcare system and not only accelerate that care but actually measure how it's going. So, recently the data shows that the adoption of these two sided risk models that I talked about has increased steadily. So, I wanted to make sure I showed you both in terms of payment, healthcare spent, and actually in terms of covered lives that we've actually seen over the past few years the dollars that are actually going into value based care models are increasing. And likewise, the number of lives that are impacted and are in value based care, meaning that there is accountability for outcome and quality, is increasing.

You'll also see there at the bottom that it's also increasing across markets. So, this is happening in the commercial market, this is happening in the Medicare original market, and the Medicare Advantage market, and it's also happening in Medicaid. Again, I know many of your states particularly in the Medicaid market are really driving to value based care. This again is just a graphic that identifies the most recent measurement that was done in 2020 – 40% of U.S. healthcare payments, represented approximately 238 million Americans which is about 80% of the covered population flows through categories three and four. This next slide actually shows you what category three is - value based model that may be sitting on top of a fee for service system and then category four are those population based models. So again, to the extent that you've got interest I'd encourage you to look further at some of this.

COVID really taught us some really good lessons about value based care and what we found was that those providers that were part of value based care programs really fared a lot better than those providers that were relying upon fee for service. So, as we saw, COVID required specific care, whether it was testing, vaccines, treatments, and there was a very big concern about continuity of care for patients in many states across the country and at one point or a time having elective services was delayed and so those systems that relied upon elective care services from a financial perspective and were in a fee for service model really struggled. Regarding telehealth, we spent a lot of time talking about how providers had to build those systems and what we found is that providers that were in a value based model had the resources and flexibility to be able to build those platforms that were needed. Lastly, what do we think is next? You'll see here some percentages and some data – 87% of payers really believe that value based adoption will continue to increase and the other thing I would say is that there is really a lot of innovation in this space and it really allows you to do things like build health equity issues and social detriments in these kinds of models and that's really the direction and a lot of the focus in innovation that's happening right now.

J.P. Weiske thanked the Committee for the opportunity to speak and stated that I'm with the Campaign for Transformative Therapies. It is an organization that includes insurers, patient groups, and drug manufacturers. We're focused on outcomes based arrangements. The QR one-pager before you will enable you to download our fresh hot off the presses paper. What we found when we started interviewing Medicaid agencies is that there is no policy developed on this so we decided to set out and put together a policy document around outcome based arrangements for gene therapies that that are in the pipeline which will cost potentially millions of dollars per treatment and to try to figure out a way to structurally pay for those treatments through Medicaid and other services.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Hearing no questions or comments, upon a motion made by Rep. Anderson and seconded Rep. Lehman, the Committee voted without objection by way of a voice to re-adopt the: Model Act Regarding Air Ambulance Insurance Claims; Out-of-Network Balance Billing Transparency Model Act; Patient Safety Model Act; Rental Network Contract Arrangements Model Act; and Model Act Banning Fee Schedules for Uncovered Dental Services.

ANY OTHER BUSINESS

Asw. Hunter stated that I just want to quickly make mention that at our next meeting, we're going to be having a conversation about biomarker testing and that falls right in line relative to what Mr. Weiske was just mentioning. It's an innovative and targeted way to look for gene proteins and other substances that can provide information about cancer. I've introduced a bill on this in my home state of New York and a copy of that bill appears in your binders on page 282. I'd like to start te process of developing the bill into an NCOIL model. We will discuss this further in July but I'm happy to hold any conversations about this bill before we get to New Jersey in July. If there are any questions please feel free to reach out to me.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Deborah Ferguson, DDS (AR) and seconded by Rep. Oliverson, the Committee adjourned at 10:30 a.m.