MINUTES

Health Insurance Mandate Review Committee

Wednesday, November 3, 2021

MEMBERS PRESENT

Senator Jason Schultz, Co-chairperson
Senator Sarah Trone Garriott
Ms. Jeanne Gutierrez
Mr. Dave Shutt
Ms. Marcie Strouse
Mr. Jackson Webster
Ms. Stacie Maass
Representative Shannon Lundgren, Co-chairperson
Representative Lindsay James
Mr. Scott Sundstrom
Mr. Doug Ommen
Ms. Liz Matney
Ms. Sonya Sellmeyer

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I. Procedural Business

Call to Order and Adjournment. The Health Insurance Mandate Review Committee was called to order at 10:00 a.m. on November 3, 2021, in Room 103, Supreme Court Chamber, of the State Capitol. The meeting was adjourned at 12:26 p.m.

Opening Comments and Introductions. Co-chairperson Lundgren welcomed the members of the committee and other attendees and invited members to introduce themselves.

Committee Organization. The committee elected temporary Co-chairpersons Schultz and Lundgren as permanent co-chairpersons and unanimously adopted the proposed rules.

Committee Charge. Co-chairperson Lundgren reviewed the charge of the committee:

"The committee is required to identify and analyze each health insurance mandate contained in the 2021 Iowa Code and possible future health insurance mandates, identify the approximate number of Iowa residents covered by certain types of insurance, and identify and analyze related information. The committee shall submit a report to the General Assembly by December 31, 2021."

Co-chairperson Lundgren explained that each legislative session the General Assembly receives many requests for insurance mandates (mandates) to cover certain health conditions. Rather than move forward with passing further mandate-related legislation last session, the General Assembly decided to request an interim committee to review how mandates affect those who are covered by a specific mandate, how each mandate will affect premiums, and which Iowans specifically each mandate will help.

Co-chairperson Lundgren commented that in 2017 one of the first bills she worked on was a bill on an insurance mandate for step therapy protocols. A young man, Barrett, and his mother came to the Capitol to advocate for passage of the health insurance mandate, making it very difficult to say "no." One of the issues the subcommittee and committee heard was that mandating coverage would increase insurance premiums in the state. The legislative committee wanted to support passage to help Barrett, but Co-chairperson Lundgren conceded that at the time she was a bit naïve as to what insurance policies were actually subject to mandates. Part of the charge of the committee is to talk transparently and openly about what health insurance policies the General Assembly can actually affect with specific mandates and then develop a process to determine whether or not a specific mandate will affect premiums for the rate payor. She said she was not on the committee to protect insurance companies or insurance companies' profits, nor to pass laws that make people feel good but do not actually help people. Over the years, the General Assembly has enacted the mandates listed on documents included in the members' packets. Co-chairperson Lundgren asked that the committee review the existing mandates to determine if they actually help those advocating for the change, and how they affect all of the insureds in the affected insurance pool. She also asked that the committee review the proposed mandates as it is very important for legislators to have adequate education and information and to be fully transparent, so decisions made in the future affect Iowans for the better. Co-chairperson Schultz added that the work of the committee is the type of work Iowans expect from the General Assembly all year so during session members are prepared. His constituents expressed support of such meetings for legislators to listen and learn. Finally, he stated that as he is relatively new to the commerce and insurance area he would be listening intently.

Co-chairperson Lundgren added that the purpose of the meeting was to discuss the agenda items, determine how the committee would like the final report to look, and to decide what data the General Assembly will need to make educated decisions moving forward.

II. Definition of Mandate

The first agenda item discussed was the definition of a mandate. The meeting packet included a working definition developed by the co-chairpersons defining "mandate" as "health insurance coverage of any treatment or condition as required by Iowa law or rule, and that is not preempted by federal law."

Commissioner Ommen commented that the Insurance Division (division) compiled a list of what the division identified as coverage mandates. At both the state and federal level there are requirements surrounding minimum coverage. Some mandates relate to the process, but all mandates impact the bottom line. When the division does rate reviews, insurers also provide information about costs related to compliance with other legal requirements that impact rates.

Mr. McKinney stated that the Federation of Iowa Insurers (Federation) asked its members to define a mandate, noting context is important. If the context includes identifying all health or insurance mandates, it would include coverage and process mandates, and theoretically any relevant requirement in the Iowa Code could be considered a mandate. The Federation tried to use a reasonable approach in terms of identifying coverage mandates, service mandates, and process mandates. The Federation asked its members to come up with a list to provide to the committee that would be meaningful and material. The Federation's list should not be interpreted as the Federation identifying "bad" mandates or policy, but rather trying to accomplish the committee's goal of identifying existing mandates.

The commissioner noted that the Federation included step therapies in its list and that insurance companies are required by law to cover step therapies to address the needs of their customers. The division, however, did not include step therapies because the division focused on coverage mandates. The commissioner noted that all of these requirements do add to the overall costs associated with rates.

Mr. Sundstrom agreed with the discussion and that it can be hard to define a mandate because anything that is a legal requirement could be considered a mandate. The insurance industry is heavily regulated, including on the financial side, with requirements related to such things as reserves and the filing and approval of rates. Mr. Sundstrom suggested the committee focus on mandates that affect coverage, such as requirements related to coverage of a particular service, provider, treatment, or drug, as well as requirements like step therapy. There are clear requirements for coverage of certain things, but also requirements relating to the process for determining coverage. He stated that while Iowa Code chapter 514C is the "easy button" and contains the majority of the clear mandates, there are other mandates scattered throughout the Iowa Code and the Iowa Administrative Code. From his perspective the scope of the committee is whether a mandate affects coverage, not how much money an insurer is required to have in reserves or how much an insurer pays in taxes.

Ms. Maass noted that the list the Federation submitted did not include the Medicaid program, and stated that many of the mandates for the Medicaid program are largely dictated by federal or joint federal and state requirements or agreements.

Mr. McKinney shared the definition of "health insurance mandate" developed by the Federation and used in compiling its list:

"Any requirement under state law or rule that is not preempted by federal law that requires a health insurance carrier to do one of the following:

1. Provide coverage for any specific treatment, condition, service, drug, or device.
2. Provide coverage for any individual or enrollment group.
3. Require or prohibit any specific process which is intended to manage the utilization of a specific treatment, condition, service, or drug.

4. Require an insurer to contract with any provider or any group, or dictate the terms or conditions of a carrier's contract.
5. Reimburse a provider at a specified rate or implement a specified process for determining reimbursement for a covered treatment, condition, service, or drug."

Senator Trone Garriott expressed her appreciation for the input and suggested that the definition of mandate depends on the priorities and the perspectives of those sitting at the table. She proposed that at the next meeting the committee include input from consumers representing interested constituencies and health care providers, as they are part of the larger system. Co-chairperson Lundgren noted that the Consumer Advocate of the division is a member of the committee and can provide input from consumers. Ms. Gutierrez added that as an independent insurance agent she is an advocate for the consumer as well. Senator Trone Garriott stated that while she appreciates input from these members, consumers should have the opportunity to speak for themselves and proper notice and access to that opportunity must be provided. While there is a public comment period at the end of the meeting, there was not much advance notice for the public and it is difficult for members of the public to appear in person, especially when the committee is dealing with an issue that impacts people who may have disabilities or significant health issues. She concluded her remarks noting that transportation, mobility, and accessibility are factors in a person's ability to attend and the committee should ensure peoples' voices are heard.

Co-chairperson Lundgren agreed that although a mandate may potentially encompass more than coverage for a specific health condition as both the division and the Federation suggested, for the purposes of the committee, the focus should be on mandates requiring coverage for certain conditions such as those conditions specified in the legislation: infertility, phenylketonuria (PKU), PANS and PANDAS, and nonmedical switching. She stated that while the General Assembly understands that any mandate has administrative costs, the committee is really focusing on whether passing a coverage mandate is going to help an Iowan or drive up the cost of insurance premiums in that subset of insureds. The packet provided to the committee includes data about insurance in the state of Iowa — specifically the number of individuals who are insured under each different type of plan. When the General Assembly considers an insurance mandate for PKU, for example, it affects a small subset of insureds. If, for example, 1 percent of the population in Iowa suffers from PKU, the question is what portion of that population is covered by a plan that will be subject to the mandate.

Ms. Matney proposed that the committee also focus on the types of coverage to which a proposed mandate applies. The Department of Human Services (DHS) goes through the process of requesting an exclusion for the Medicaid program each time a new mandate is proposed by the General Assembly, so it would be helpful to know if Medicaid is intended to be included or excluded in a proposed mandate. Co-chairperson Lundgren asked what control the state has over instituting mandates in the Medicaid program in Iowa. Ms. Matney responded that mandates related to coverage, provider rates, and other similar requirements for the Medicaid program are generally included in the annual health and human services appropriations legislation. The appropriations process generally is used by DHS to inform legislative decision-making regarding Medicaid mandates, including cost information, so that any mandate is accompanied by a related appropriation. The managed care organizations (MCOs) under contract with the state for the Medicaid program are, to some extent, under the division's purview, so it is helpful to provide some clarity as to when the MCOs are included or excluded from mandates. There is less concern from a fiscal impact perspective if there are either existing federal regulations or state policy in place for the Medicaid program that reflect what is being mandated in the private market. However, if mandates are added that may either conflict with federal guidance or state policy, or create an additional unfunded mandate for the Medicaid program, this presents a greater concern. In response to a question by Co-chairperson Lundgren, Ms. Matney responded that DHS has generally

been successful in carving the Medicaid program out of insurance mandate legislation, many times because the Medicaid program already includes such a mandate making it unnecessary to layer the state mandate on top of the existing Medicaid program mandate. If state law mandates a new therapy that is not approved by the United States Food and Drug Administration or that is not rebate accessible under the Medicaid program, the mandate may result in a significant cost to the state. Ms. Maass added that at times a legislative mandate that is under consideration requires approval by the United States Centers for Medicare and Medicaid Services (CMS). In that situation, the state may not have the authority to mandate coverage without federal approval through a state plan amendment or other process.

Co-chairperson Lundgren suggested the committee continue to work on the language of the definition but for discussion purposes agree that the definition focus on a health policy that mandates specific coverage for a specific subset of individuals. Mr. McKinney noted that one thing that stood out to the Federation was whether the definition included specific treatments for specific conditions. He provided the example of nonmedical switching which may not necessarily be applicable for a specific condition but rather be the process by which coverage of a drug is determined to be appropriate or not appropriate.

Co-chairperson Lundgren clarified that the legislation establishing the committee included all of the mandate requests from the 2021 Session, and nonmedical switching was one of those. She suggested, however, that moving forward the committee focus on specific conditions for the purposes of the data points the committee is trying to address. She further clarified this does not mean a mandate for nonmedical switching will not be reviewed in the future, only that the committee's focus would be on the specific conditions for which a mandate was proposed to the General Assembly.

Ms. Matney suggested that while mandated telehealth parity is not necessarily coverage for a particular condition, it has a big impact on the system. Co-chairperson Lundgren agreed and reiterated that while discussions about other mandates may occur outside of the committee, to facilitate the work of the committee the members will focus on mandates that involve coverage for a specific condition. Co-chairperson Lundgren clarified that while she was not trying to oversimplify things, she cautioned that if a constituent approaches a legislator with a request for a coverage mandate, the legislator needs to have data to determine if the mandate will apply to and affect the constituent's particular insurance policy, and if the mandate may increase another person's premium.

Mr. Sundstrom remarked on the complexity involved in the subject of mandates and that the committee cannot solve or discuss every issue. However, there is a nuance in determining if a condition is covered by a mandate: is a specific treatment for the condition also covered. For example, insurers that cover PKU might only cover certain treatments. There is a question concerning the scope or the types of treatment that may be the subject of a requested mandate for a specific condition.

Co-chairperson Lundgren asked whether a health savings account (HSA) might cover certain options for treating PKU. For example, if an insurer covered some options for PKU but did not cover protein-free bread, might HSA funds be used to purchase the bread? Committee members suggested that while HSAs are broader in coverage as to what a qualified medical expense is, regulation of HSAs lies with the Internal Revenue Service (IRS) not the division. Commissioner Ommen stated that the IRS regulations for HSAs indicate an HSA may be used for prescriptions, but cannot be used for dietary needs unless a medical practitioner prescribes a dietary or nutrition change. Ms. Sellmeyer added that she had received a complaint regarding this subject and suggested the consumer use their HSA. The consumer responded that the HSA funds could not be used for food items even though he had a prescription. Ms. Maass added that with the public health emergency some of the restrictions on HSAs had been relaxed.

Representative James, as a point of clarification, noted that Mr. McKinney had listed five areas that should be included in a definition of mandate, but Co-chairperson Lundgren had suggested the committee focus solely on the listed conditions and some of the treatments surrounding those conditions. Co-chairperson Lundgren agreed with the clarification and suggested staff refine the definition based on committee discussion.

III. Identification of Existing Mandates and the Number of Iowans Covered Under Each Type of Insurance

Commissioner Ommen reviewed a document submitted by the division that included a chart titled "Iowa Total Health Insurance Coverage Chart" the back of which included a breakdown of individual medical insurance both post-Affordable Care Act (ACA) and pre-ACA. Commissioner Ommen said the division often receives questions from consumers who are covered by self-insured plans and the division has to explain that the state is preempted by the federal Employee Retirement Income Security Act (ERISA) from regulating these plans. Per the chart, almost one million Iowans are covered by an employer self-insured plan or other type of coverage. Administrators of these plans include companies such as Wellmark. A consumer may complain to the division because they have a Wellmark-administered, employer self-insured plan; however, these plans are subject to ERISA and the state has no authority to change the plan requirements. For the over 300,000 people covered by large employer group insurance, state mandates generally do apply. The small group market of 150,000 people and the individual coverage market of 95,000 people are subject to state regulation. The division also provided information to the committee about the carriers who provide small and large group, and individual market insurance available both pre-ACA and post-ACA.

Mr. Sundstrom agreed with the commissioner that this subject matter is very confusing, difficult, and complex. The bottom line is that individuals who have coverage through a very large employer are generally receiving coverage that is self-funded. The employer pays claims out of the employer's funds and hires someone like Wellmark to administer the plan. The employer bears the financial risk and has control over what is included in the plan coverage. Employers will work with the plan administrator to determine coverage, but federal law preempts state law as the plans are regulated under ERISA. Mr. Sundstrom explained that when ERISA was passed by Congress in the 1970s, the intent was that it would apply to both health insurance and retirement income, and provide a uniform set of standards across the country. As far as the numbers of covered lives, self-funded plans provide coverage to the majority of people who have commercial market coverage. Excluding Medicare, Medicaid, or other government programs, the majority of Iowans who have a Wellmark or United insurance card in their pocket are actually covered by an employer self-funded plan that is subject to ERISA. When a mandate is passed by the General Assembly, it does not apply to the ERISA-regulated plans; however, Mr. Sundstrom noted that there are times when a plan administrator will incorporate the mandate into self-funded coverage either because it makes sense or for ease of administration. Mr. Sundstrom shared an anecdote about people advocating for a certain mandate decades ago. One of the advocates worked for a health system that provided health insurance coverage through a self-funded plan that did not include coverage for the condition for which the person advocated. Because the advocate's health insurance was an ERISA plan, the plan was not subject to the mandate that was passed. Mr. Sundstrom added that under Iowa Code section 514C.6, which he believed was enacted in 1991, the language references uniformity of treatment in benefit plans. The intent was to express an understanding that if self-funded groups or employer welfare benefit plans were not subject to a requirement under federal law, then the state should not legislate a mandate that applies to the state-regulated segment of insureds. That is why most mandates usually begin with "notwithstanding section 514C.6." He stated that this is a

fundamental recognition of the disconnect, inconsistency, and unfairness in how large employer group plans are treated compared with state-regulated plans.

Commissioner Ommen added that the division regularly sees this type of confusion. When the division conducts annual rate hearings and the public comes to express concerns about cost, if the plans are ERISA plans the decision maker is not the commissioner but the company offering the coverage. The state has no control over these coverage decisions. Some constituents may complain about not having access to coverage; however, the decisions related to coverage are not made by the plan administrator or the General Assembly but by the employer offering the plan.

Co-chairperson Lundgren asked what those who work directly with consumers hear and see when a consumer needs certain coverage. Part of the issue is educating the public about the complexity of insurance regulation under state and federal law.

Ms. Gutierrez agreed that it comes down to education. Consumers are confused and do not understand who actually pays their claims. They see the third-party administrator as the "big bad wolf" so agents try to work with their employer groups to educate consumers about who actually pays their claims. As an example, agents are often contacted when an insured is going through a difficult time with a cancer diagnosis or infertility issues. The consumer talks to their employer and the employer does not know how to communicate the appropriate information. The question becomes how can agents help to educate consumers about what is paid by the insurance company as opposed to the employer? People misunderstand mandates and think mandated coverage is free. They do not understand that a self-funded employer is the one making the decisions related to mandated coverage.

Ms. Strouse noted that when clients come to agents in situations where the client thought something was covered, or when a prior authorization was not approved, the agent has the opportunity to walk the client through the process. The majority of the time there is a resolution. As an example, she had a client who was having a proton cancer treatment specific to the patient at the Mayo Clinic. The insurance carrier denied coverage and the appeal went to the division for third-party review, where it was approved. In another case, a client's wife had a serious health issue while out of state. The agent was able to coordinate the woman's care and get her into a hospital in the other state. Ms. Strouse has had the privilege of often working with the Office of the Consumer Advocate to resolve issues and it comes down to consumers understanding they have an advocate. She sees issues on social media and wishes people would talk with their insurance agents because insurance agents are there to make sure consumers get what they pay for from their insurance policy. For example, under the ACA, small group and individual health insurance plans are standardized using metal tiers to meet specific actuarial values. If a state mandate is added, out-of-pocket costs may increase or another benefit may be eliminated in order to comply with the actuarial requirements.

Commissioner Ommen added that depending on a specific mandate, CMS approval may be required on the Medicaid side, or the mandate might not be included as a tax credit on the federal side. Mr. Sundstrom stated that even putting aside ERISA and self-funded plans, there are areas where state law is preempted completely by other requirements. While there is a universe of plans the state can regulate, the state is not the only regulator of these plans. In the last couple of decades, health insurance has gone from mainly being state regulated to being primarily federally regulated including under the federal Health Insurance Portability and Accountability Act (HIPAA) and the ACA. Many of the laws have positive attributes like providing consumer protections. For example, every plan subject to the ACA that has not been grandfathered in must comply with baseline coverages and include certain essential health benefits. The ACA also requires coverage for certain preventive services without imposing out-of-pocket costs on a consumer. As Ms. Strouse noted, there are also platinum, gold, silver, and bronze metallic

tiers. For these tiers, within very narrow ranges, the plans have to pay a certain percentage of the average person's health care costs and the remainder becomes out-of-pocket costs. Actuaries must develop benefit plans to fit within the ranges. When a mandated benefit is added to the plan, something has to change to maintain the actuarial value requirements of the plan, and that means either reducing or eliminating coverage for another benefit, or increasing costs. There are endless requirements, some of which are good, including provisions to increase consumer confidence that plans sold in the state have broad coverage, broad minimum benefits, and good consumer protections. The federal requirements, however, also add complexity that makes state regulation more complex than it might appear on the surface.

In response to a question from Co-chairperson Schultz as to whether the actuarial requirements for metallic plans apply to all plans, Mr. Sundstrom clarified that the requirements apply to ACA individual market and small group plans with fewer than 50 employees sold after 2014. Commissioner Ommen directed the members' attention to the document provided by the division that relates to individual medical insurance and the ACA broken out by companies. He noted that Ms. Strouse and Mr. Sundstrom were referring to the individual small group ACA markets.

IV. Process for Determining Fiscal Impact of Existing Mandates

Co-chairperson Lundgren commented that based on committee discussion, it seems the state does not have as much control over individual and small group plans as she had thought. She asked the committee to focus the subsequent discussion on determining the fiscal impact of a mandate, and the process insurers go through to administer the mandate. Using PKU as an example, she asked the committee to consider if the General Assembly passed a mandate to cover PKU for plans that the state regulates, what the process would actually look like for insurers to administer and effectuate the mandate. She noted the impact may be either the loss of a different benefit or an increase in out-of-pocket costs or premiums.

Mr. Sundstrom began the discussion noting that when a mandate bill is proposed, a legislator interested in the bill requests a fiscal note from the fiscal division of the Legislative Services Agency (LSA). Fiscal notes reflect the fiscal impact to the state of Iowa so that legislators can consider the impact on the state budget. As a practical matter, the fiscal note for an insurance mandate only demonstrates the fiscal impact to the state employee health plan which is a self-funded plan administered by Wellmark. LSA generally sends a fiscal note request to the Wellmark actuarial team. The membership in the state of Iowa plan is roughly 52,000, including both employees and their families, and the Wellmark actuaries limit their analysis to those 52,000 members under the specific plan design for the state of Iowa. The state plan is not subject to the metallic tiers because it is self-funded, but it is roughly equivalent to a platinum-level plan. The first step for the Wellmark actuarial team is to review what the state currently covers. If the mandate is for something already covered, the fiscal impact may be zero. If the mandate is for broader coverage, the actuarial team researches the effect of the broader coverage, including how often the benefit may be used and the percentage of people who may use the benefit in order to determine a projected utilization number. Next, the actuary makes an informed actuarial judgment using the projected utilization number to try to calculate the projected cost. The actuary multiplies these numbers together to get the estimated fiscal impact for the state of Iowa. The actuary submits the information, including an explanation of the methodology, to the LSA for review. LSA may respond with questions and adjustments may be made. This fiscal impact does not apply to the small group market, the individual market, or to cities, counties, or schools, because none of these are paid for directly through the state budget. To calculate the mandate's overall impact on all market segments, Mr. Sundstrom indicated the state number would need to be multiplied by approximately 12. Multiplying by

12 may not be entirely accurate because people move in and out of plans and the underlying coverage differs. There may also be mandates that have less of an effect on the state plan than on the plan of a struggling small business because the state plan is a richer plan. The state plan is self-funded and the state has almost complete control over what is covered. The state plan is subject to state mandates because the state can control public plans. Co-chairperson Lundgren clarified that when the General Assembly asks LSA for a fiscal impact of a proposed mandate, the fiscal note is based on what is known about the state employee plan. Ms. Matney added that the only exception is when the mandate impacts Medicaid. If Medicaid is included, DHS reviews the same types of information, such as rates of prevalence and cost of coverage, and multiplies the numbers together to arrive at the additional cost incurred due to the mandate.

Mr. Sundstrom cautioned that one limitation inherent in the current process is that the actuaries are doing a static analysis, or looking at a snapshot. If a mandate is proposed, the actuaries estimate at a point-in-time how many people will obtain health care that is covered under the mandate and how much it will cost. The analysis, however, does not take into consideration the future behavioral changes that might occur once the mandate is in effect. For example, if something is required to be covered, it may have a potential effect on both utilization and cost. These variables are hard to understand over time and there is no simple way to accurately capture these variables for the purpose of determining a fiscal impact.

Co-chairperson Lundgren asked if the best approach moving forward when the General Assembly wants to determine the fiscal impact of a mandate for a specific condition is to start with a request to LSA for a fiscal impact on the state employee plan. Mr. Sundstrom agreed that the process works well, and that the Wellmark actuary team is on call during the legislative session for just that purpose. Wellmark's actuarial team receives a lot of fiscal note requests, and the LSA publishes the majority of the notes. Mr. Sundstrom said that from the perspective of the administrator of the state of Iowa plan, Wellmark does not have any suggestions for changing the process. Ms. Matney stated that in thinking about how Medicaid can be included in fiscal notes for future legislative sessions, in determining the fiscal impact DHS also evaluates whether there are other costs that may be offset downstream by the addition of a mandate for a particular type of coverage. Mr. Sundstrom concurred that Wellmark's actuaries also try to take offsets into consideration. He used the example of the Governor's proposal to expand coverage for contraceptives. The actuaries reviewed countervailing effects of such coverage. On the one hand, there might be increased utilization and cost. The countervailing effect, however, is that if there are fewer unintended pregnancies, there are savings in pregnancy and delivery costs. The actuaries try to work through countervailing effects and they will continue to do this when appropriate.

Senator Trone Garriott noted her appreciation of Ms. Matney's comments and stated that she would like to see articulated in a fiscal impact the long-term impact of individuals not having any coverage, or lacking coverage; the impact to individual Iowans on their financial health and medical debt load if they are underinsured or uninsured; and the impact to the health care system and providers, especially given the rural health care crisis. She stated that while this information is not necessarily something the LSA has within their wheelhouse, it should be considered because all of those aspects are included in the big health care ecosystem. She suggested that addressing all of these aspects goes back to who is at the table with the committee to provide input. She suggested including this additional information in the process and identifying partners to provide this information. Representative James echoed Senator Trone Garriott's concerns. She stated that it is extremely important to understand not only the costs to the insurance industry, but to Iowans. A fiscal impact cannot be determined without evaluating the human cost. The conversation must include input from providers and a sufficient number of actual consumers.

Co-chairperson Lundgren reiterated the intent of the meeting is for the committee to determine what the General Assembly does not know, and needs to know, when presented with a mandate proposal. Hearing the stories of someone like Barrett is heartbreaking, but in making decisions it is important to know what plans and individuals will or will not be impacted. Knowing that a mandate might result in another benefit being eliminated for a group of insureds, legislators cannot make decisions based only on heartbreaking stories because other Iowans under the same plan might be negatively impacted. Having this guidance moving forward and deciding how the final report is going to look will allow legislators to weigh the consequences of what Iowans will lose or gain under a specific mandate. Until the guidance is available, the General Assembly is not going to make headway. She respectfully disagreed on the issue of needing input from health care providers, but stated that consumers are the most important consideration and the General Assembly cannot give false hope by enacting mandates that do not result in real change. Policymakers need to know if adding a mandate that benefits one family in a plan takes away another benefit from 500 families in that plan.

Ms. Strouse commented that the state is losing providers, including mental health providers, in rural areas. Competition is a challenge. The focus is on how insurance companies are managing and processing mandates instead of addressing the actual cost of care. Any time a mandate is enacted, it automatically increases the cost for everyone. People are struggling to be able to afford even high-deductible health plans with $7,000 out-of-pocket costs. The tradeoff is becoming whether a person can even afford to have catastrophic coverage. This is the balance insurance agents and employer groups are managing all the time. Health care is the number two budget item after payroll. At some point the numbers will be so high that there will not be a system anymore. She cautioned that there should be a focus on identifying the actual true costs of health care not just looking at how to mandate coverage and manage the insurance process. Insurance exists to manage risk and to help people gain access to certain treatments. She shared her story dealing with infertility and being the mother of two children with disabilities who were in the neonatal intensive care unit for three months when they were born. Her family incurred substantial health care charges. Even though no mandate was in effect at the time, her insurance provider covered the costs. She recalled receiving the first hospital bill for $400,000 for one of her children which was for room and board only. She suggested committee members want to make sure people have access to the care they need and are fighting and advocating for that every day, but there is a tipping point where it is necessary to ensure that everyone has access to coverage for the catastrophic events rather than a small group of people having coverage for something that only impacts them. She shared that she supports holistic medicine and does not want insurance companies impacting holistic products. She also wants to be able to go to doctors she chooses, and will pay cash to do so, because that is important for her and her family. She stated that insurance is there for the things that a person cannot plan for and this has been a really hard conversation insurance agents have had since the ACA was enacted.

Representative James appreciated Ms. Strouse sharing her story, noting the costs associated with the health care provided to Ms. Strouse's children were extreme and that the committee should have a conversation with providers about such costs. Iowans are struggling financially and the committee should have a real conversation about telehealth, mental health, and the availability of providers because providers are leaving rural Iowa. That is one part of the conversation that is missing. She shared that when she first ran for office one of her constituents was facing either paying for daily insulin and keeping his foot, or paying rent and keeping his mobile home. Many people at the table are having these same types of conversations with people and it seems insincere to talk about fiscal responsibility when emergency insulin provided at a hospital costs thousands of dollars and these costs could be avoided by covering an individual's insulin on an ongoing basis. It is fiscally responsible for everyone, including the insurance industry, to pay for the cost of prescribed insulin, rather than for the administration of

emergency insulin. Representative James noted she had contacted a colleague in another state who worked on passage of an insurance mandate that the state's insurance industry advocated for because it was fiscally responsible. She disagreed that when a new mandate is enacted insurance costs will automatically increase because there may be other considerations and counterbalancing variables in play. She reiterated that the elephant in the room is the input missing from providers.

Mr. McKinney shared that when talking about insurers "picking up the cost," it is not as if an insurer goes to its savings account to do so. Insurers are in the business of spreading risk across a group and plans are designed to maximize the use of dollars so that individuals insured by a plan can obtain the best outcomes. Insurers spend a lot of time and money trying to design coverage and the benefits included in the coverage. Insurers do not oppose mandates because they impact profit, it is because insurers are concerned mandates ultimately drive up costs. He did concur that not all mandates drive up costs. If certain mandates are imposed, however, the concern is that the insured or the insured's employer may have to pick up the additional cost, and ultimately this affects health care costs in the state.

Ms. Strouse added that even if a mandate is enacted, the cost of the mandate does not disappear. For example, if insulin is mandated to be covered, the drug manufacturer continues to charge the insurance company full price for the insulin, which requires all individuals covered by the plan to bear the cost. She added that she works on federal legislation and is frustrated at times that changes are not being made at the source, such as with the pharmaceutical manufacturers. She stated that rather than hear from providers, she would prefer input from the administrators of those providers. There are providers who are really frustrated because they are not able to manage their own patients' care due to things happening at the administrative level and lack of competition. While insurers began covering telehealth before the pandemic, she is hearing from her customers, especially in the mental health area, that patients, especially children, are having horrible experiences with telehealth. If a child is dealing with issues and is trying to talk over a computer with a therapist, there is zero engagement, and the idea of moving from a long-term therapist to another therapist is not possible. Just mandating certain coverage does not always resolve the issue. She asserted that the General Assembly has to be thoughtful in how certain things are covered and what the expectations are for providers and insurance carriers. With any mandate that is enacted, insurance carriers make money, even if only on the administrative aspects. So, if insurers wanted to make money they would be in favor of every mandate. It is usually insurance carriers that propose coverage of new therapies because the carriers recognize the value of a specific therapy and propose coverage without being required to via a mandate. She stated that she is in favor of having provider input. She noted that there are many direct primary care providers coming into the market who are choosing to skip the insurance coverage process and instead directly charge an individual a fee for health care services. She further noted that many of these direct primary care providers are very successful.

V. Process for Determining Fiscal Impact of Possible Future Mandates

Co-chairperson Lundgren stated that in the past when new mandates have been proposed, she has had conversations about potential costs associated with the mandate. In reviewing the four potential future mandates, for the purposes of collecting data, Co-chairperson Lundgren suggested eliminating continuity of care and nonmedical switching, and focusing on diagnosis and treatment of infertility; PANS and PANDAS; and medically necessary food for individuals with metabolic disorders. She also suggested that existing mandates relating to diabetes, biologically based mental health coverage, and autism spectrum disorders should be included for purposes of collecting data.

She clarified that the committee would focus on the three proposed and three existing mandates and collect data from the health plans to determine how costs either are affected or may be affected. She

also asked that the committee determine if benefits had been eliminated because of either the ACA or state-enacted mandates.

Senator Trone Garriott asked if the committee would also be asking provider groups and constituency groups who might be personally impacted for information on the three proposed and three existing mandates as part of the process for determining the fiscal impact. She suggested that either a committee be established or that the interim committee identify partners to reach out to. Co-chairperson Lundgren suggested the committee move forward and collect the requested data from insurers, and at the next meeting continue the discussion about additional involvement from providers and constituency groups. She stated that data from insurers can be combined with different perspectives such as historic data from providers, but it is important to have the insurance data as a baseline. Senator Trone Garriott said that it seemed the committee was framing the conversation in a very specific way and she did not want the other perspectives to be a mere add-on. Committee members discussed the importance of having providers at the table to understand if a mandate will increase costs and how a mandate impacts access to services, because if one aspect is changed, it may impact many aspects of the health care system.

Mr. Sundstrom offered that coverage for some of the conditions mentioned by Co-chairperson Lundgren had been mandated for some time while coverage for others had been superseded, in some cases by federal law. For example, biologically based mental health coverage began as a state mandate, but subsequent federal mental health parity requirements go well beyond the state mandate. Mr. Sundstrom reiterated that Wellmark does not oppose the policy behind most mandates. He suggested that going forward the ultimate goal of the committee should be ensuring there is a robust process for the General Assembly to understand not only the cost implications, but the benefits, the efficacy, and the impact, including resulting consumer behavioral changes, of mandates. He noted that these types of decisions are difficult in a world of constrained resources that impact how we marshal public policy, make coverage decisions, determine how much consumers and businesses can afford, and provide for the best health care outcomes. He asked how the committee can look at those things in an evidence-based, coherent way that will result in the best outcomes. As to the suggested health conditions to review, Mr. Sundstrom stated that because mandates have been superseded or changed over time, there may not be data available that is useful. Co-chairperson Lundgren responded that the goal of collecting the data is not to eliminate any existing mandate, but to utilize the data collected to inform the process going forward. The data collected could be for the time period prior to the law changing or being superseded. She noted the federal government has a lot of control over what states are allowed to do relative to insurance coverage. She shared that she had a conversation with Congresswoman Hinson prior to the meeting regarding PKU coverage because the same consumers that are advocating for a mandate in Iowa are also advocating at the federal level. She stated that there has to be clarity around what can actually be regulated at the state level. She also stated that while it is not necessarily about money, she had never contemplated that by passing a mandate another benefit provided under a plan would need to be eliminated. Co-chairperson Lundgren suggested that if there are laws in the Iowa Code that had been superseded at the federal level and the state no longer had control over the benefit or coverage, it would be an opportunity to clean up the Iowa Code.

Senator Trone Garriott expressed appreciation for Mr. Sundstrom's comments about the goal being to define a robust process that helps to see all angles, to know all the boxes are being checked, and that the appropriate steps are being taken to fully understand the issue and the impact before changes are made to the Iowa Code. She stated it is important that legislators not make assumptions and that she had learned new things from the perspectives represented at the meeting. However, a number of perspectives had not been heard during the meeting that are part of the broader health care system and those perspectives must be included in the process.

Co-chairperson Schultz stated that he supports collecting the data specified, and while he also supports clean up of the Iowa Code, he does not want to collect information on existing mandates and use the data to eliminate, or choose not to eliminate, a mandate. He also stated that reviewing the impact of existing mandates allows for an emotionless review of the data without the impact of politics that might affect the conversation about a proposed mandate. He noted that it does not matter if the federal government superseded a state mandate, he would still be interested to see if utilization rates increased following enactment of the mandate.

Following a brief recess, Co-chairperson Lundgren announced that the committee would be finishing earlier than initially anticipated and any member of the public present in the room and wishing to, would be allowed to speak during the public comment period. She also announced that the committee would try to accommodate any member of the public who had planned to speak, but was unable to do so due to the early conclusion of the meeting, possibly at the beginning of the next committee meeting.

Co-chairperson Lundgren continued the discussion regarding the process for collecting and submitting data relative to the six mandates, noting that her intent is to protect any proprietary information submitted by insurers. Co-chairperson Schultz asked the Federation to request that its members cooperate in providing data and suggested that its members submit the data through the commissioner. Commissioner Ommen responded that the division would be happy to cooperate and that the division has the authority to collect information from insurance companies admitted in the state. Co-chairperson Schultz emphasized that it is an invitation to insurers to provide data, not a requirement. Mr. McKinney agreed to issue an invitation to Federation members and, cognizant of the sensitivity around some of the data, noted that it may be aggregated or provided in a format everyone is comfortable with. Commissioner Ommen noted that any data or information that comes before the committee is subject to open records laws and asked that Mr. McKinney communicate this to Federation members. Commissioner Ommen stated that if a Federation member asked that certain information be kept confidential, the commissioner would not communicate that information to the committee.

VI. Final Report

Co-chairperson Lundgren was hopeful more information would be available to the committee at the next meeting on December 8, 2021. Following discussion among committee members regarding how quickly data can be collected, Mr. Sundstrom stated that Wellmark had already collected some data on the existing mandates and shared that at least two fiscal notes had already been published during the prior legislative session relative to the proposed mandates. Mr. Sundstrom suggested that if the existing fiscal notes needed to be updated or there were questions about the notes, he would try to provide that information to the committee.

Mr. McKinney asked if there was additional information, besides the information already available in the fiscal notes, the committee would like to see relating to the mandates. Co-chairperson Schultz requested information on utilization rates to determine if need grows after coverage is mandated; whether the cost of coverage increased due to the mandated benefit; data on whether public health improved in general or there was just an improvement in individuals' health; and any downstream benefits.

Co-chairperson Lundgren asked that, if possible, data be provided regarding what other benefits, if any, were eliminated due to a mandate.

Senator Trone Garriott asked Ms. Matney if DHS had any data on mandated benefits and the big picture results or impacts, such as reduced hospitalizations. Ms. Matney responded that DHS has a lot of data, and could look at the impacts of the six specified conditions to determine if there were any lateral effects.

Co-chairperson Lundgren clarified that the Federation should provide the data to the commissioner and the commissioner should aggregate the information and provide a report to the committee.

Mr. Sundstrom added that the data requested by Co-chairperson Schultz might be a bit more difficult to pull together. He noted this is one of the busiest times of year for health insurance companies due to, in part, open enrollment.

The commissioner stated that as long as the data was provided a week in advance of the next committee meeting the division could compile a report for the committee.

Co-chairperson Lundgren reiterated that the plan is for insurers to provide as much information as possible to the commissioner by December 1 so the commissioner can compile a report for the committee to review at its December 8, 2021, meeting. After that meeting the committee may ask for more data or information from specific insurers. The report from the commissioner to be presented on December 8, 2021, will serve as a basis for the committee's continuing work, but is not the committee's final report. Co-chairperson Lundgren added that she is not necessarily opposed to, and will talk with Senator Trone Garriott about, a provider association representative appearing at the committee as a guest. She cautioned, however, that she does not want to discuss specific provider issues, but only be provided an overview of the providers' perspective on mandates.

Ms. Matney added that since the period of time encompassing the pandemic is atypical the data from DHS would include some caveats, especially regarding utilization. Co-chairperson Lundgren asked if 2020 data should be excluded. Mr. Sundstrom responded that Wellmark would try to provide realistic data. Representative James stated that it should be noted for the record that data may be skewed because insurance companies did not have to pay for some services during the pandemic.

VII. Public Comment

Co-chairperson Lundgren reiterated that if members of the public were not able to make comments today, the committee would try to make accommodations at the next meeting, possibly earlier on the agenda.

Mr. Michael Rozenboom, representing the Iowa Bankers Association and Iowa Bankers Insurance and Services, shared the perspective of the 26,000 members of the organization's self-funded multiple employer welfare arrangement. Feedback from its members reflected that members like the current coverage; however, members would like coverage to be provided at a lower cost. Its members have not requested that additional mandates be included in their coverage.