FINAL REPORT

Health Insurance Mandate Review Committee

Wednesday, November 3, and December 8, 2021

MEMBERS

Senator Jason Schultz, Co-chairperson
Senator Sarah Trone Garriott
Mr. Doug Ommen
Ms. Angela Burke Boston/alternate
Ms. Jeanna Gutierrez
Ms. Stacie Maass
Ms. Liz Matney
Mr. Matt McKinney

Representative Shannon Lundgren, Co-chairperson
Representative Lindsay James
Ms. Sonya Sellmeyer
Mr. Dave Schutt
Ms. Marcie Strouse
Mr. Scott Sundstrom
Mr. Jackson Webster

LSA CONTACTS: Report prepared by: Kate O'Connor, Legal Counsel, 515.281.6329, kate.oconnor@legis.iowa.gov and Patty Funaro, Senior Legal Counsel, 515.281.3040, patty.funaro@legis.iowa.gov

CONTENTS

I. Authorization and Appointment

Based on a request in 2021 Iowa Acts, House File 838, section 52, the Legislative Council established the Health Insurance Mandate Review Committee 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, identify and analyze related information, and submit a report to the General Assembly by December 31, 2021.

II. Committee Proceedings

The committee was authorized to conduct two meetings during the 2021 Legislative Interim. The meetings were held on November 3, 2021, and December 8, 2021, in Room 103 of the State Capitol.

III. November 3, 2021, Meeting

A. Preliminary Discussion

Co-chairperson Lundgren explained that each legislative session, the General Assembly receives requests for legislation that creates insurance mandates (mandates) for certain health conditions. Rather than enact additional mandates last session, the General Assembly decided to request an interim committee to review how mandates affect those who are covered by the specific mandate, how each mandate affects premiums, and how each mandate helps Iowans.

Co-chairperson Lundgren stated that through her experiences with mandate legislation, she recognized that it was unclear which health insurance policies (policies) were actually affected by the mandates, and how premiums may be affected. She suggested the committee review both existing mandates and those proposed during the 2021 session to determine which policies the General Assembly can affect and how all insured individuals in a specific insurance pool are affected, and to provide necessary information for legislators to make educated decisions about future mandates. Co-chairperson Schultz

added that his constituents expressed support for the interim committee as an opportunity for legislators to listen and learn.

B. Definition of Mandate

The meeting packet included a working definition developed by the co-chairpersons that defined "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."

Mr. Doug Ommen, Insurance Commissioner, stated that while all requirements applicable to insurance may be considered mandates, the Insurance Division (division) compiled a list, which he reviewed with the committee, of what the division identified as coverage mandates.

Mr. Matt McKinney, Counsel, Federation of Iowa Insurers (federation), agreed that any insurance requirement could be considered a mandate, and that when the members of the federation were asked to define a mandate, they included both coverage and process mandates. Mr. McKinney shared the definition of "mandate" used by the federation in compiling its mandates list and reviewed the federation's list.

Mr. Scott Sundstrom, Vice President, Government Relations and Communications, Wellmark Blue Cross Blue Shield, added that the insurance industry is heavily regulated and while every requirement could be considered a mandate, he suggested the committee focus on mandates that affect coverage of a particular service, provider, treatment, or drug.

Ms. Stacie Maass, Vice President, Legislative and Government Affairs, Iowa Total Care, noted that the mandate lists presented to the committee did not include the Medicaid program for which mandates are largely dictated by federal, or joint federal and state, requirements. Ms. Liz Matney, Iowa Medicaid Director, added that when a mandate is proposed by the General Assembly, the Department of Human

Services (DHS) generally requests an exemption from application of the mandate to the Medicaid program. Instead, 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, and are accompanied by a related appropriation. If a state mandate is in conflict with Medicaid federal guidance or regulation, there may be significant cost to the state. Ms. Maass stated that policy changes in the Medicaid program are generally subject to federal approval.

Senator Trone Garriott suggested that the definition of mandate depends on the priorities and the perspectives of those sitting at the table, and proposed that the committee receive input from consumers and health care providers.

Following committee discussion, Co-chairperson Lundgren stated that while she agreed a mandate may encompass more, she asked that for the purpose of collecting data and the committee's work, the committee's definition of mandate focus on specific coverage for specific conditions.

C. Existing Mandates and Application to Each Type of Insurance

Commissioner Ommen reviewed a division-developed document, "Iowa Total Health Insurance Coverage Chart," the back of which included a breakdown of individual insurance both post-Affordable Care Act (ACA) and pre-ACA. He said the division often receives questions from consumers covered by self-insured plans and the division has to explain that the state is preempted from regulating those plans by the federal Employee Retirement Income Security Act (ERISA).

Mr. Sundstrom stated that individuals who have coverage through a very large employer have employer self-funded coverage. Under that type of coverage, the employer pays claims out of the employer's funds and hires an entity like Wellmark to administer the plan. The employer bears the financial risk and has control over what is included in the plan coverage. Excluding Medicare, Medicaid, or other

government programs, the majority of Iowans who have a Wellmark or United insurance card 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 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 added that Iowa Code section 514C.6 references uniformity of treatment in benefit plans and the intent of the section 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 plans. That is why most mandate statutes begin with "notwithstanding section 514C.6."

Commissioner Ommen added that the division regularly sees confusion regarding ERISA plans during annual rate hearings when the public expresses concern about cost. For ERISA plans, the decision maker is the company offering the coverage. Constituents may complain about not having access to certain coverage under such a plan; however, the decisions are not made by the plan administrator or the General Assembly.

Co-chairperson Lundgren stated that part of the issue with evaluating mandate legislation is educating the public about the complexity of insurance regulation under state and federal law. Ms. Jeanna Gutierrez, Vice President, Client Services, EB/Shareholder, Holmes Murphy, agreed that it comes down to education as consumers are confused about who actually pays their claims. Ms. Marcie Strouse, Partner, Capitol Benefits Group and Government Relations, Iowa Association of Health Underwriters, noted that under the ACA, small group and individual health insurance plans are standardized using platinum, gold, silver, and bronze metallic tiers that must meet specific actuarial values. If a state mandate is added, either out-of-pocket costs may increase or another benefit may be eliminated in order to comply with the actuarial requirements. Within very narrow ranges, the plans within each tier must cover the costs of a certain percentage of an average person's health care costs and the

remainder becomes out-of-pocket costs. Actuaries must develop benefit plans to fit within the ranges. If a mandated benefit is added to the plan, the plan has to change to maintain the actuarial value requirements of the plan, which means either reducing or eliminating coverage for another benefit, or increasing costs.

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 while there are many 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.

D. Process for Determining Fiscal Impact of Existing Mandates

Using phenylketonuria (PKU) as an example, Co-chairperson Lundgren asked the committee to consider what the process would look like for insurers to administer and effectuate the mandate if the General Assembly passed a mandate to cover PKU.

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). The fiscal note indicates the fiscal impact to the state employee health plan which is a self-funded plan administered by Wellmark. LSA sends a fiscal note request to the Wellmark actuarial team which is on call during the legislative session for just this purpose. 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. The state plan is not subject to the metallic tiers because it is self-funded; however, it is roughly equivalent to a platinum-level plan. Mr. Sundstrom briefly described the process the actuarial team utilizes to analyze a proposed mandate. Co-chairperson Lundgren clarified

that when the General Assembly requests a fiscal note for a proposed mandate, the note is based on what is known about the state employee plan. Ms. Matney added that the only exception is if the mandate impacts Medicaid. If Medicaid is impacted, DHS reviews the same type of information to arrive at the additional cost incurred due to the mandate. She noted that in determining the fiscal impact, DHS also evaluates whether there are costs that may be offset downstream by the addition of a mandate for a particular type of coverage. Mr. Sundstrom stated that the actuaries also work through countervailing effects and will continue to do so when appropriate. Mr. Sundstrom cautioned that one limitation inherent in the current process is that the actuaries are doing a static analysis. 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 may occur after the mandate is in effect.

Senator Trone Garriott suggested the fiscal impact should also reflect the long-term impact of individuals lacking or not having any coverage; the impact to individual Iowans' 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. Co-chairperson Lundgren stated that legislators need to make decisions based not only on heartbreaking stories but also on the consequences of what Iowans will lose or gain under a specific mandate.

Ms. Strouse commented that the state is losing providers, including mental health providers, in rural areas. She cautioned that there should also be a focus on identifying the actual true costs of health care, as well as the process for mandating coverage and managing the insurance process.

Representative James stated that Iowans are struggling financially and the committee should have a real conversation about telehealth, mental health, and the availability of providers as providers are leaving rural Iowa. She provided an example of a constituent's struggles with obtaining daily insulin.

Mr. McKinney stated that insurers are in the business of spreading risk across an entire group, and plans are designed to maximize the use of dollars so that individuals insured by a plan can obtain the best outcomes. Insurers do not oppose mandates because they impact profit; they oppose mandates because insurers are concerned they ultimately drive up costs. He agreed 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.

E. Process for Determining Fiscal Impact of Possible Future Mandates

For purposes of collecting data from insurers to determine how costs either are affected or may be affected by mandates, Co-chairperson Lundgren suggested the committee focus on three proposed and three existing mandates: diagnosis and treatment of infertility, Pediatric Acute-onset Neuropsychiatric Syndrome/Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infection (PANS/PANDAS); medically necessary food for individuals with metabolic disorders; diabetes; biologically based mental health coverage; and autism spectrum disorders.

Senator Trone Garriott asked if the committee would also be requesting input from provider groups and constituency groups who might be personally impacted as part of the process for determining the fiscal impact. Co-chairperson Lundgren suggested the committee move forward and collect the requested data from insurers, and continue the discussion about additional involvement from providers and constituency groups at the next meeting. 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. Committee members discussed the importance of having providers at the table to understand if a mandate will increase costs and how it impacts access to services.

Mr. Sundstrom suggested that 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 of a mandate, but the benefits, the efficacy, and the impact, including resulting consumer behavioral changes. Co-chairperson Lundgren noted that the federal government has a lot of control over what states are allowed to do relative to insurance coverage and that there needs to be clarity around what can be regulated at the state level. Co-chairperson Schultz supported collecting the data specified and also expressed interest in collecting data that demonstrates whether utilization rates increase following enactment of a mandate.

Co-chairperson Schultz asked that the federation request that its members cooperate in providing data and suggested its members submit the data to the commissioner. Mr. McKinney agreed to issue an invitation to federation members and noted that the data may be aggregated or provided in a format with which everyone is comfortable. Commissioner Ommen and Mr. McKinney agreed to only communicate nonconfidential data and information to the committee. Mr. Sundstrom stated that Wellmark had already collected some data on the existing mandates and that at least two fiscal notes had been published during the prior legislative session relative to the proposed mandates. Co-chairperson Schultz requested that additional information be collected on utilization rates to determine if need grows after coverage is mandated; whether the cost of coverage increased due to the mandated benefit; whether public health improved in general or there was an improvement in individuals' health; and any downstream benefits. Co-chairperson Lundgren asked that, if possible, data be collected regarding what other benefits, if any, were eliminated due to a mandate. Senator Trone Garriott asked Ms. Matney to include Medicaid data and Ms. Matney agreed to look at the impacts of the six specified conditions to determine if there were any lateral effects on the Medicaid program.

Co-chairperson Lundgren asked that the federation provide the data to the commissioner to aggregate in a report for the next committee meeting. The report will serve as a basis for the committee's continuing work.

F. Public Comment

Members of the public submitted written comments that were provided to committee members. Mr. Michael Rozenboom, representing the Iowa Bankers Association and Iowa Bankers Insurance and Services, shared that the 26,000 members of the organization's self-funded multiple employer welfare arrangement support their current coverage but would like to reduce coverage costs.

IV. December 8, 2021, Meeting

A. Public Comment

Members of the public submitted written comments that were provided to committee members. Members of the public, including a doctor, and parents and grandparents of children who suffer from PANS/PANDAS, spoke about available treatments; the emotional, physical, social, and financial toll that PANS/PANDAS takes on the children and family; misdiagnosis of mental illness and the related costs for treatment; and laws in Arkansas, Delaware, Indiana, Illinois, Minnesota, and New Hampshire that require coverage for PANS/PANDAS treatment.

B. Insurance Overview

Ms. Angela Burke Boston, Senior Policy Advisor, Insurance Division, reviewed the document produced by the division entitled "Iowa Total Health Insurance Coverage Chart for 2020," which provides information about the number and percentage of Iowans covered by type of insurance coverage.

C. Presentation of Data Collected for Existing and Possible Future Mandates

Mr. McKinney provided background on the methodology used in collecting and compiling mandate data from federation members. The committee had asked that data be collected for three existing and three proposed mandates including, respectively, the costs or anticipated costs; increased utilization

or anticipated utilization following implementation of the mandate; and the populations impacted by the mandate. The federation reached out to its members with a template to allow collection of the information on a uniform basis so the resulting federation-prepared document would be in a uniform format.

Mr. McKinney reviewed the existing health insurance mandates for diabetes, autism, and biologically based mental illness, using the diabetes data as an example. He stated that the federation used the legislation from the 2021 Legislative Session for PANS/PANDAS, and medically necessary foods, as the basis for analysis. For infertility, the federation used the state of Iowa plan as a basis because that plan covers infertility benefits. At Senator Trone Garriot's request, Mr. McKinney explained the per member per month (PMPM) cost impact. Co-chairperson Lundgren conjectured that based on the PANS/PANDAS data, there would be a relatively small increase in cost if PANS/PANDAS coverage were mandated by the State. Mr. Sundstrom and Mr. McKinney cautioned that it is difficult to predict how many individuals would utilize the more expensive PANS/PANDAS treatments or utilize the coverage if it was mandated. When a mandate is first implemented, the cost does not immediately increase as it takes time for administrative implementation of the mandated benefit, for members to be aware that the benefit is available, and for implementation by the medical community. If initial utilization is low, the cost impact is not reflected until those benefits are actually utilized by that pool or population, which may take several years. Senator Trone Garriott noted that there might be increased utilization and cost following enactment of a mandate, but asked if there is data to show a decrease in costs long term as a result of people being provided appropriate treatment or preventive measures, or due to cost avoidance from reduced hospitalizations. Mr. McKinney responded that, unfortunately, for some of the existing mandates, such data is not available. Mr. Sundstrom provided an example of the cost avoidance relative to mandated coverage for education and supplies for diabetes.

At Co-chairperson Lundgren's request, Mr. Sundstrom described the process to add drug coverage for certain conditions based on the United States Food and Drug Administration (FDA) approval of a specific drug. Representative James asked about information provided to the committee on other states that mandate coverage for PANS/PANDAS and Mr. McKinney said that the federation would review information from those states.

Senator Trone Garriott stated that the premium is only one way of looking at the cost of a mandate and asked how to explain to a layperson the determination regarding the balance between premiums, copayments, and out-of-pocket costs. Mr. Sundstrom described the metallic tier plans under the ACA. He also described the drug formularies, and the requirements for premiums and out-of-pocket costs for the plans within each tier. Senator Trone Garriott asked, based on the low utilization projected for PANS/PANDAS, if an insurer might restructure out-of-pocket costs rather than increase premiums. Mr. Sundstrom replied that if coverage is expanded to include additional benefits, out-of-pocket costs will increase, premiums will increase, or both will increase as a counterbalance. If premiums increase, the insured could obtain a plan with higher deductibles; however, that makes care more expensive if actually utilized. Mr. Sundstrom stated that a growing concern for Wellmark Blue Cross Blue Shield (BCBS) is affordability and noted that BCBS has formed a national workgroup to address changes in federal policy.

Co-chairperson Lundgren asked if an FDA-approved drug became available to treat PANS/PANDAS, how an insurer would determine whether to include the drug in its formulary, and how the insurer would perform a cost benefit analysis. Mr. Sundstrom described Wellmark's pharmacy and therapeutics (P and T) committee and the process the committee goes through to add a drug to Wellmark's formulary. He stated that he would take the information provided to the committee about intravenous immunoglobulin (IVIG) treatment back to Wellmark's P and T committee for evaluation. Co-chairperson Lundgren asked if Wellmark would provide coverage if the General Assembly mandated coverage for IVIG treatment for PANS/PANDAS, even if Wellmark's P and T committee did not approve coverage under its own

process. Mr. Sundstrom replied in the affirmative. Mr. Sundstrom provided an example of a new class of Hepatitis C drugs approved a few years ago. He also explained the process Wellmark uses to establish proof of efficacy for a treatment, and the process consumers can use to advocate for a treatment to be considered by Wellmark.

D. Closing Comments

Ms. Matney stated that even though Medicaid was largely carved out of the conversation on mandates, Medicaid also has a P and T committee on the pharmaceutical side. Medicaid covers FDA-approved and rebatable drugs, and the P and T committee reviews new drugs and the associated medical science on an ongoing basis. For medical services, Medicaid has a clinical advisory committee to which the public may submit recommendations for new treatments as those treatments are developed.

Representative James stated that legislators need to weigh the human costs in addition to premiums, rates, and bottom lines, and expressed dissatisfaction with how the issues raised by public commenters were addressed.

Co-chairperson Lundgren stated that the system is broken at the federal level, the state is limited in what it can do and what it can force insurance companies to do, and the General Assembly needs to understand the limitations.

Mr. McKinney stated that if an insurance company covered the specific treatments discussed without going through the insurer's standard approval process, other policyholders would ask why the company was using their premium dollars to cover a treatment that is not approved by either the Redbook or other medical sources. Insurers are trying to be good stewards of policyholders' dollars, and manage the dollars that are available so that members get the coverage they need at a premium that is affordable while limiting out-of-pocket costs.

Representative James stated that she would like to learn more about the insurers' process because doctors have told her that IVIG treatment works.

Ms. Strouse said that as an insurance agent, she works for consumers and can help insureds file appeals and work through the process.

Ms. Maass shared that Iowa Total Care relies on FDA approval and utilizes an advisory panel in making decisions about drug coverage. She also noted that as medical science changes and evolves, coverage changes and evolves.

Senator Trone Garriott said that evaluating insurance mandates is complex and other voices need to be included in the process. The committee reviewed the costs to insurers, but the costs to individuals and the community, as well as personal costs, also need to be evaluated. Premiums and out-of-pocket costs as well as other factors like profit should be considered.

Co-chairperson Schultz said that the legislation specified the issues the committee could address and the membership of the committee reflected the expertise necessary to address those issues.

Co-chairperson Lundgren added that the General Assembly passes a lot of bills; however, the General Assembly is not doing its job if legislators do not ask questions and understand how their constituents are going to be affected. She stated the committee will file its final report with the General Assembly and the work will continue.

V. Materials Filed With the Legislative Services Agency

The following materials were distributed at or in connection with the committee's two meetings and are on file with the Legislative Services Agency. The materials may be accessed at the link on the committee's Internet web page: www.legis.iowa.gov/committees/committee?ga=89&session=1&groupID=36638.

1. Memo from Co-chairpersons to Members with Attachments

2. Insurance Mandate Listing — Federation of Iowa Insurers
3. State Health Insurance Mandates, Health Insurance Coverage by Insurer, Iowa Total Health Insurance Coverage Chart, Fiscal Notes for Senate File 165 and House File 656 — Insurance Division
4. MCO Capitation Data and Membership by County — Iowa Medicaid
5. Adopted Committee Rules
6. Existing and Proposed Health Insurance Mandate Compilation — Federation of Iowa Insurers
7. Iowa Total Health Insurance Coverage Chart for 2020 — Insurance Division