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House Committee on Ways and Means Subcommittee on Health Testimony of Glen Mulready Oklahoma Insurance Commissioner Wednesday, May 17, 2023

Good afternoon, Chairman Buchanan, Ranking Member Doggett, and members of the Subcommittee. My name is Glen Mulready and I currently serve as the 13•h elected Insurance Commissioner from the great state of Oklahoma. I have served in this role for the past 4 years having just been reelected for another 4 years this past November. I previously served in the legislature for eight years where I chaired the insurance committee and later served as Majority Floor Leader. This past year, I chaired the Health Insurance Committee for the NAIC.

I have basically been in the insurance business for my whole life. This coming October it will be 40 years since I was first licensed. The 22 years previous to me becoming insurance commissioner were solely focused in the health area.

Like my counterparts in other states, I work to maintain competitive markets for insurance in my state. Competition is strong in Oklahoma's individual market for health insurance, where six insurers offer coverage. However, assuring competition for health insurance can be challenging due to the complex interaction of state and federal regulations- ERISA keeps the benefits of self-funded employer plans outside of state jurisdiction. Adding to the challenge is the complicated health care delivery system with many different sources of coverage, providers of services, and middlemen like pharmacy benefit managers, some of which fall under the authority of state insurance regulation and some of which do not.

Today's topic is one that I have worked on for more than two decades in Oklahoma. There are many facets to the healthcare delivery system. One of those key components is where I have "lived"...that is the financing of healthcare.

Over my years in the business, we have seen the constant pull between hospitals and healthcare systems and the health insurers who continue to try to constrain costs and manage care in order to try to keep premium costs down and affordable to consumers. The consolidation of hospitals and health care systems have made this even more difficult. Our rural communities have specifically been hard hit. I am a strong believer in a competitive free market system. However, the consolidation that has taken place has not helped in this constant struggle.

A specific area of great concern is the rising cost of prescription drugs. Over the past 20 years we have seen this move from an average of mid-teens ofthe health insurance premium to 22% where it stands today. In Oklahoma our legislature has specifically targeted Pharmacy Benefit Managers (PBM) and

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trying to reel in some of the market controls and trade practices that have become commonplace in this area. PBMs are companies that handle the prescription drug services for health insurance companies as well as large, self-insured employers. They handle things like contracting with a network of pharmacies, determining formularies and processing of prescription drug claims.

We have been enforcing this legislation since 9/1/2020. During this time, we have received complaints of over *300,000* violations. We have issued fines of over $3.5 million and have reimbursed back to local pharmacists over *$700,000*. We have found ourselves at the tip of the spear on this nationally hot topic and in *fact,* just yesterday the landmark ERISA case *(PCMA vs Mulready)* was heard in federal appeals court in the 10th Circuit in Denver. This case involves the issue of state laws pertaining to PBMs and ERISA plans. The lower courts in this case have generally decided that there is not an ERISA preemption for our law. In an earlier case that ended up at the Supreme Court, a similar decision was rendered in the *PCMA vs Rutledge* case. The Oklahoma law was mainly focused on allowing consumers to determine where they got their prescriptions. Some of the items it addressed *were,* steerage to any single pharmacy or mail order service, "any willing provider" language to allow all pharmacies that wish to join a network the ability to do *so,* transaction fees and generally the restriction on promoting any one pharmacy over another. Most recently we have run into an issue with the largest PBM restricting all prescriptions to only a 30-day supply. Though our law fully allows for 90-day prescriptions, their previous internal structure and contracting only allowed for this through their own mail order service. This has caused great disruption in the market and substantial inconvenience for consumers. The PBM market is controlled by three very large companies. Between the three of them they have about an 80% market share. These PBMs are VERY large. 2 of the top 3 are Fortune 10 companies. They have also become vertically integrated, meaning that these companies own a health insurance company and the PBM and in some cases a chain of pharmacies. This can lead to a reduction in costs due to leverage with wholesalers or manufacturers but also can lead to some other strategies to maximize profits such as spread pricing and preferred formulary placement in order to gain that profit. In this *area,* as in much of this broader conversation, transparency is critical.

An important aspect of competition among health insurers is in establishing networks of providers. The payment rates and other contract terms that insurers negotiate with the providers who make up their networks go a long way to determining health insurance premiums and the level of competition for health insurance. Providers sometimes seek to include provisions in contracts that help keep their payments high. These might be requirements to include all of a health *system's* facilities in-network or none at all or limits on putting providers into different cost sharing tiers. State insurance regulators can only regulate one side of those negotiations- the insurance side. The practices of health care providers -even if they stifle competition and raise prices- have not traditionally been under the purview of state insurance regulators.

Another practice we've seen in the market is higher prices charged by hospitals for care delivered in outpatient departments. A hospital outpatient department that is located off-site might provide the same service as a physician's office in the same type of clinic but add a large facility fee because of the hospital affiliation. This raises prices with no benefit to patients.

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It also tends to limit competition because it creates a large incentive for hospitals to acquire physician practices so the hospital can start adding its facility fees to the bills. The health system gets bigger and adds leverage in insurance negotiations. Medicare has limited this practice to some degree and state insurance regulators have been exploring their authority to do so, as well.

Pharmacy benefit managers (PBMs) have also often gotten in the way of competitive markets. They have reduced consumers' access to the pharmacies of their choice, hidden the true cost of drugs, and limited the ability to use cost sharing tiers to promote cost effectiveness.

In Oklahoma, we've been working hard to promote competition by protecting consumers' ability to use retail pharmacies when and where they choose. That has required a large effort to license and audit PBMs. Our PBM regulation has come under legal challenge, but we believe it provides important benefits to consumers, promotes competition, and complies with federal law under ERISA and *Rutledge vs. PCMA*. We hope Congress will support states in our efforts to limit anticompetitive practices in health care by PBMs and other entities. It can do that by protecting state authority.

Thank you for the opportunity to be with you today as we work together to protect consumers and ensure access to affordable choices.