

NATIONAL COUNCIL OF INSURANCE LEGISLATORS  
HEALTH, LONG TERM CARE AND HEALTH RETIREMENT ISSUES COMMITTEE  
PHOENIX, ARIZONA  
NOVEMBER 18, 2017  
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health, Long Term Care and Health Retirement Issues Committee met at the Sheraton Grand Phoenix Hotel on Saturday, November 18, 2017 at 9:00 a.m.

Assemblyman Kevin Cahill of New York, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert, AR	Sen. Jerry Klein, ND
Rep. Martin Carbaugh, IN	Asw. Maggie Carlton, NV
Rep. Peggie Mayfield, IN	Asm. Will Barclay, NY
Rep. Joseph Fischer, KY	Asm. Andrew Garbarino, NY
Rep. Jeff Greer, KY	Sen. James Seward, NY
Sen. Dan "Blade" Morrish, LA	Sen. Bob Hackett, OH
Rep. John Wiemann, MO	Rep. Marguerite Quinn, PA
Rep. Lois Delmore, ND	Rep. Bill Botzow, VT
Rep. George Keiser, ND	

Other legislators present were:

Rep. David Livingston, AZ	Sen. Neil Breslin, NY
Rep. Richard Smith, GA	Rep. Phil Jensen, SD
Rep. Doug Gutwein, IN	Rep. Tom Oliverson, TX
Rep. Matt Lehman, IN	Rep. Jim Dunnigan, UT
Sen. Rick Billinger, KS	

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO  
Paul Penna, Executive Director, NCOIL Support Services, LLC  
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

## MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 14, 2017 meeting in Chicago, Illinois, and its October 13, 2017 interim conference call committee minutes.

## DISCUSSION/CONSIDERATION OF NCOIL OUT-OF-NETWORK BALANCE BILLING TRANSPARENCY MODEL ACT

Sen. James Seward (NY), sponsor of the Out-of-Network Balance Billing Transparency Model Act (Model), stated that the Committee has been discussing the Model for several meetings. The Model's purpose is to protect consumers from unexpected medical bills that result from their receiving care from out-of-network physicians. Improved disclosures by health benefit

plans, providers, and facilities, and a procedure for appealing out-of-network referral denials will help consumers better navigate the insurance processes and reduce the incidence of costly, surprise bills. Sen. Seward thanked interested parties for their comments on the Model and noted that the Committee held an interim meeting via conference call to discuss and review said comments.

Sen. Seward noted that since that interim meeting, he has made some changes to the Model:

a.) for purpose of uniformity, the word “physician” has been replaced with “provider” throughout the Model;

b.) the definition of “usual and customary cost” has been changed to “usual, customary, and reasonable rate<sup>1</sup>” (UCR rate) – and that definition has been moved from Section 6 to Section 4, the Definitions section;

c.) in Section 5 – Determination of Network Adequacy – language was added to require that a health benefit plan that contracts with a network of health care providers shall ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers at each in-network health care facility sufficient to render the services covered by the health benefit plan. That added language is meant to address the problem of ensuring network adequacy for facility and hospital-based physicians at in-network hospitals;

d.) in Section 9 – Provider Notice to Enrollees – language was added to clarify that the notice requirements shall not apply to emergent or unforeseen conditions or circumstances discovered during a procedure. That added language is meant to recognize the fact that in emergent or unforeseen circumstances, it is not feasible to provide patients with certain information;

e.) in Section 13 – Balance Billing – language was added to allow for the enrollee, in addition to the insurer and provider, to initiate an independent dispute resolution (IDR) proceeding; and,

f.) in Section 16 – Provider Directories – a change was made from “periodically” to “annually” to standardize a time within which carriers must audit at least a reasonable sample size of its provider directories.

Sen. Seward also noted that he, along with NCOIL at an organizational level, believes that a good piece of Model legislation should be a generalized legislative framework. As States adopt the Model they can then modify it as they wish, as well as further develop it through the promulgation of more specific implementing regulations.

Sen. Seward stated that he views this proposed Model as an effort to expand and improve upon NCOIL’s “Healthcare Balance Billing Disclosure Model Act,” originally adopted in 2011. By way of example, a drafting note in the 2011 Model states that “States may wish to consider using an existing mediation process or establishing a mediation process to manage disputes that may arise regarding balance bills.” Accordingly, the proposed Model proposes the inclusion of a process to resolve disputed out-of-network charges, including balance bills, similar to what some States have implemented, including New York. Such an approach, if set up and executed properly, can be more streamlined and help consumers more than other offered approaches because if each party knows there is a distinct possibility that they can lose outright, a strong incentive is created for the parties to negotiate and settle.

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<sup>1</sup> The Model’s definition of UCR rate is: the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner. The nonprofit organization shall not be financially affiliated with an insurance carrier.

Further, Sen. Seward stated that he believes a strong Model has been drafted, and that his reaction to the comments – generally speaking – falls in favor of the drafted Model with the amendments announced today. That is not to say the Model is perfect; legislation never is. There may be instances where some clarification is warranted, perhaps through the issuance of more specific regulations. But, Sen. Seward strongly believes that this Model provides States with a solid starting point for debate on these issues. And with legislative sessions fast approaching in some States, Sen. Seward urged this Committee to pass this Model so that States can have it to debate in their respective legislatures.

Betsy Imholz from Consumers Union stated that Consumers Union supports the provisions of the Model that protect consumers from balance billing in emergency situations but that the other situation that warrants protection is when the consumer is at an in-network facility but receives a “surprise” bill because someone at the facility, perhaps an anesthesiologist, is out-of-network. Consumers Union appreciates the notice provisions in the Model and the provision that allows for enrollees to initiate an IDR process, but Ms. Imholz noted that in states that allow enrollees to initiate such a process they don’t take advantage of it because it is hard for them to summon the time, money, and confidence to do so. Ms. Imholz stated that premiums are increasing at an alarming rate and the issue of reimbursement is primarily an issue between providers and plans, but consumers have an interest in keeping costs reasonable and urge caution on basing the reimbursement rate on billed charges because there is no ceiling or criteria on which to cap that. Ms. Imholz also urged the Committee to include more consumer stakeholders in future discussions on this Model and others the Committee may consider going forward.

Michele Kimball from Physicians for Fair Coverage (PFC) stated that PFC applauds Sen. Seward for his work on the Model and that she is here today not only on behalf of PFC but on behalf of other multi-specialty physician groups including orthopedics, oral and maxillofacial surgeons, the American college of emergency physicians, the American college of radiology, the society of plastic surgeons, the college of American pathology and the American Medical Association. Ms. Kimball stated that there are three key areas that are essential to ending surprise billing – all of which Sen. Seward’s Model addresses: a.) taking the patient out of the middle – the most important area. Ms. Kimball requested that the expansion of the Model’s provisions in that area apply to non-emergency situations; b.) transparency – Ms. Kimball requested that the audit of a carrier’s provider directory should be biannual, not annual; c.) Ms. Kimball applauded the Model’s definition of the UCR rate. Benchmarking reimbursements to a non-profit, non-conflicted, independent database of billed charges makes sense and doing so ensures that the database is not controlled or influenced by insurers or physicians. Most importantly, it allows for proper reimbursement, especially in rural areas. Ms. Kimball closed by stating that while the Model is not perfect, the Committee should adopt it as it is an excellent framework for States to consider.

Sherif Zaafran, Chair of the Ad Hoc Committee on Out of Network Payment, and on behalf of the American Society of Anesthesiologists and PFC, stated that in the two states that benchmark reimbursements to a non-profit, non-conflicted, independent database of billed charges, New York and Connecticut, it has worked very well. Since implementation in those States, the charges have remained fairly constant, and the idea that physicians would collude to cause an increase in charges has not come to fruition, particularly since it would be in violation of anti-trust rules. In response to Ms. Imholz’ request for the Model to provide protections for consumers against “surprise” billing, Mr. Zaafran noted that Sections 9 D. and E., provide for disclosure when a provider refers a patient to an in-network facility that may potentially contain out-of-network providers. Mr. Zaafran did note, however, that the group of providers listed in those sections of the Model is too narrow since it doesn’t capture surgical assistants or

neuromonitoring services. Accordingly, Mr. Zaafran recommended including the language “any anticipated service or provider.” Mr. Zaafran also voiced support for the Model’s IDR provisions and stated that such systems have worked well in the States that have implemented them.

David Boone, CEO of Alacura, stated that Alacura works directly with several insurance companies in trying to build networks and the costs differences between in and out of network are staggering. Mr. Boone stated that the definition of “emergency services” in legislation like the Model is critical in terms of whether the perspective set forth in the definition is of a prudent layperson’s or a physician since that is a determining factor as to whom the Model’s balance billing protections apply. Mr. Boone also commented on the Model’s definition of UCR rate and stated that using such a benchmark could artificially raise charges and be detrimental to the system, particularly in areas where there is a lot of consolidation. Using a different benchmark such as an amount of Medicare is probably a better indicator of what a true and reasonable cost is.

Asw. Maggie Carlton (NV) stated that Nevada has been working on these issues for over a decade and thanked Sen. Seward for considering some of her suggestions. Asw. Carlton stated that she was concerned with the Model’s definition of UCR rate. The biggest discussion point in Nevada when working on legislation that dealt with these issues was that of dis-incentivizing contracting. Nevada legislators were told that using a FAIR health database as an option for benchmarking would in fact dis-incentivize contracting – why would someone sign a contract at possibly 35% or 40% when they know that if they go out-of-network they are guaranteed 80%? Asw. Carlton stated that there are several provisions in the Model that she supports and would consider introducing in Nevada but because of the Model’s definition of UCR rate she would not be able to support the Model.

Rep. Tom Oliverson (TX) stated that he appreciates the Model and that he thinks it is a better work product than what is currently in place in Texas. In response to Asw. Carlton’s statement about dis-incentivizing contracting, Rep. Oliverson stated that physicians don’t contract with networks based solely on reimbursement – the whole concept of contracting is that you accept a discount in exchange for a guarantee of volume. Rep. Oliverson noted that it is his understanding that the States that have used a benchmarking system similar to what the Model provides have not experienced an increase in physician charges, which seems to indicate that it is a stable model that is fairly reflective of actual market conditions, more so than Medicare.

Rep. Jim Dunnigan (UT) stated that he sponsored balance billing legislation in Utah that passed the House but was never voted on in the Senate. The Utah Medical and Hospital Associations wanted 85% of billed charges as the standard for reimbursement, which Rep. Dunnigan did not support. Rep. Dunnigan supported the Model’s definition of UCR rate and agreed with Sen. Seward’s earlier statement that States could adjust certain provisions of the Model, such as the percentile in the definition of UCR rate. Rep. Dunnigan stated that he is concerned that Section 7 of the Model - the health benefit plan ensuring that the enrollee incurs no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network provider, does not restrain out-of-network facilities at all and that it could drive healthcare costs up – both sides should have “skin in the game.” Rep. Dunnigan also stated that he appreciates the Model’s provisions regarding “surprise” billing but questioned the practicality of Section 9E - requiring the provider or provider’s representative, when scheduling an enrollee to receive services at a health care facility, to give to the enrollee information about any anesthesiologist, laboratory, pathologist, radiologist and/or assistant surgeon who will also be providing services to the enrollee consisting of: (1) name, practice name, mailing address, telephone number and (2) how to determine in which health benefit plan networks each participates.

Sen. Seward responded that, regarding Section 7, the Model's IDR provisions allow the parties to negotiate on what a proper reimbursement should be, and that even though Section 7 says "the health benefit shall ensure that the enrollee incur no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network provider," the intent of the Model is not for the health benefit plan to simply pay such a lump sum to the provider – the plan can initiate an IDR proceeding to negotiate proper payment. And regarding Section 9 and the issue of "surprise" billing, Sen. Seward stated that, in Section 5 – Determination of Network Adequacy – language was added to require that a health benefit plan that contracts with a network of health care providers shall ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers at each in-network health care facility sufficient to render the services covered by the health benefit plan.

Rep. Richard Smith (GA) stated that he appreciates Sen. Seward's Model and that the environment in Georgia has been very contentious when discussing these issues. Rep. Smith stated that he introduced legislation in Georgia last year that stated if a provider had exclusive privileges at a hospital then the provider should be in the same network as that hospital. Such legislation was viewed as a "vicious" attack on providers. Rep. Smith stressed that getting the patient out of the middle is the most important thing in balance billing situations. Transparency must also be improved to ensure that the patient knows which providers are in and out of network.

Rep. Oliverson, a practicing anesthesiologist, stated that it is important to understand how contracting for hospital based providers works. Such providers are fairly unique in that the patient doesn't come to see them and are then taken to the facility, rather, the providers are already at the facility waiting for patients to come to them. Such providers first contract with a hospital to provide services, and then, secondly, they must independently contract with health plans. At the same time, the hospital independently contracts with health plans which is important because you don't want doctors owned or directly employed by the hospitals because financial incentives can become misaligned and the provider may not necessarily always do what is best for the patient and instead do what's best for the hospital. Essentially, Rep. Oliverson wanted to drive home the point that for hospital based providers who are out-of-network at an in-network facility, it's not always their choice – it is the result of a free-market negotiation process that has broken down or has not been resolved. Such providers would prefer to be in-network at in-network facilities so they are not blamed for being the one who has the out-of-network bill, but it is a negotiating tool often used against such providers in order for them to accept lower reimbursement rates.

Sen. Bob Hackett (OH) stated that in Ohio, hospitals used to be responsible for directing a patient to an out-of-network provider, but the law was changed. Also, in his experience, specialists do not like the networks and they will always seek to control the market when they can. Sen. Hackett also stated that the market is constantly changing with regard to hospitals employing providers.

Asm. Cahill noted that the issues being discussed today are very complex and that the Model is not the perfect solution, but, the Model encourages network participation, seeks to protect consumers and is a very strong framework for States to consider. Asm. Cahill then entertained a Motion to adopt the Model with the amendments announced earlier by Sen. Seward. Assemblyman Andrew Garbarino (NY) made said Motion; Representative Bill Botzow (VT) seconded the Motion.

Asw. Carlton noted that what NCOIL does carries a lot of weight and a lot of States look to NCOIL's model legislation for guidance. Asw. Carlton stated that by passing this Model, the Committee will put her in a position of opposing an NCOIL Model in Nevada due to the Model's definition of the UCR rate. Asw. Carlton stated that her opponents in Nevada will use that against her, and it will make it more difficult for her to get balance billing legislation passed in Nevada. Sen. Seward stated that he understands and respects Asw. Carlton's concerns and he fully expects States to make modifications to the Model if they decide to introduce it in their legislatures. State legislators in one State may have an entirely different perspective on these issues than those in another State, but the Model is set forth as a framework and is based on provisions that have worked well in other States. Asw. Carlton stated that she again wanted to make clear that the Model will be another barrier that she will have to go over to get to where she needs to be.

Upon a request for a roll-call vote made by five members of the Committee (pursuant to NCOIL bylaws), the Committee voted to adopt the Model by a vote of 15-3.

#### EXAMINING PRESIDENT TRUMP'S EXECUTIVE ORDER ON HEALTHCARE: WHAT IS CHANGING AND WHAT IS THE IMPACT

Ms. Imholz stated that while Congress and the Administration have not yet repealed the ACA, the Administration has taken other steps that will weaken the ACA's underpinnings in the individual and small group markets. The concern is that the Executive Order (Order) issued on October 12, 2017, is another step in that direction. The American Academy of Actuaries has commented on the Order stating that creating exemptions for the ACA's insurance market rules can have far-reaching and unintended consequences such as tilting the market in favor of entities with weaker benefits or solvency standards and weakening the protections for consumers with pre-existing health conditions. The Order does not change the ACA or its regulations but rather sets in motion a regulatory process within the confines of existing law. The three main parts of the Order deal with association health plans (AHPs), short-term limited duration plans (STLDPs), and health reimbursement arrangements (HRAs). The proposed regulations on AHPs and STLDPs are at OMB but have not been seen publicly yet.

With regard to AHPs, the Order directs the DOL to consider, within 60 days, new rules or guidance to allow more employers to form AHPs under ERISA. Under current law, fully insured AHPs follow rules pertaining to the segment they enroll in, i.e. small group or individual. Those rules contain several consumer protections such as protection against denials for pre-existing conditions and requiring 10 EHBs. Large groups on the other hand are not required to adhere to such rules, and large group premiums can vary based on the expected health costs of the group and with greater allowance for variation of age. Prior to the ACA, AHPs were allowed to underwrite and set premiums based on the healthcare condition of its members. If the Order, as it seems to contemplate, allows AHPs to qualify as large groups, they can then return to their prior practices and eliminate many of the most important ACA's consumer protections. AHPs could then be free of State regulation, sell across State lines, and provide plans with skimpier benefits, making it easier to cherry-pick healthier enrollees and avoid unhealthy enrollees. At the same time, the premiums in the ACA compliant plans would increase because that risk-pool would deteriorate since it would contain less-healthy members. History is shown that the landscape is littered with AHPs that have failed – some were scams that defrauded their members and left millions of dollars in unpaid claims leaving both providers and consumers in the lurch. MEWAs, which provide coverage for employees of two or more unrelated employers or self-employed individuals, have been quoted as “the vehicle of choice for promoters of phony insurance.” In 1982, Congress amended ERISA to give States regulatory authority over

MEWAs and States did a better job than the Federal government in administering them, but the fraud did continue. Between 2000 and 2002, insurance scams through AHPs left more than 200,000 policyholders with unpaid medical bills totaling \$252 million. MEWAs have also been especially prone to insolvency, and just last week the DOL issued a cease and desist order against a MEWA. Ms. Imholz noted that the NAIC's position on AHPs is simply "AHPs are bad for consumers."

With regard to STLDs, the Order directs the Secretary of Labor, Treasury, and HHS within 60 days to consider revising regulations or guidance to expand the availability of STLDs, including increasing the plans time period and allowing them to be renewed by consumers. STLDs have long existed to allow coverage between jobs or for those who missed an open-enrollment period. The ACA excluded STLDs from its protections, so such plans can reject consumer due to pre-existing conditions. STLDs are meant as a stop-gap measure and because they are not ACA-compliant, they do not meet the ACA's individual mandate requirement. State insurance regulators have reported that they have seen fraudulent marketing of STLDs even in advance of the anticipated regulations or guidance. Consumers Union believes that expansion of STLDs will lead to adverse selection, consumer confusion, and de-stabilizing the individual market. Together, Consumers Union believes that the expansion of AHPs and STLDs will lead to more "junk" insurance – something that was prevalent before the ACA.

The Order also directs Treasury, Labor and HHS, to reduce restrictions on HRAs through guidance or regulations within the next 120 days. The primary goal seems to be to try to allow the use of HRAs to pay premiums in the individual market. Current law, however, allows them only in group plans paired with ACA compliant policies and requires them to fund only medical expenses for employees on a pre-tax basis. They must be funded solely from employer contributions. In 2016, the CURES Act created a very narrow exemption for small employers to use HRAs for premium payments. The concern is that employers might try to use HRAs as a way to stop covering higher risk employees and just provide such employees with money that they could use for a premium to shop elsewhere.

Ms. Imholz urged the Committee to stay vigilant as to what the specific proposed regulations say as they are not public yet. For AHPs, State legislators can assess their regulatory framework for in-state and out-of-state MEWAs and if Federal action in this area does not preempt State law, then State legislators can require compliance with small group/individual market rules; if preempted, State legislators can at least require financial solvency standards for those in-state MEWAs. For STLDs, State legislators can assess their regulatory framework and try to prohibit their sale; ban their renewals; require compliance with some or all ACA market reforms, e.g. EHBs; no medical underwriting; place an assessment on STLDs and invest that money in re-insurance; require STLDs to meet minimum medical-loss-ratio standards; and at the very least try to require increased disclosure/notice requirements of STLDs.

Rep. George Keiser (ND) stated that regarding MEWAs, it is North Dakota's interpretation that they are within the Federal government's jurisdiction, like ERISA plans, and will not qualify for the State guaranty funds. Ms. Imholz stated that may be correct and there are several factors that would go into answering ERISA-MEWA jurisdictional questions. Also, Ms. Imholz noted that most of her suggestions for State legislator action dealt with STLDs, and not AHPs/MEWAs, which is an area that States have more jurisdictional flexibility with.

Asm. Cahill asked Ms. Imholz if there was a specific timeframe within which to expect the regulations so that States could plan appropriately. Ms. Imholz said she was not sure but noted

that two of the three sets of regulations are at OMB – it is uncertain as to how quickly OMB will review them but Ms. Imholz expects the regulations to be ready as soon as January, 2018, but whether they can take effect immediately is another topic for discussion. Ms. Imholz noted that in the face of such uncertainty, some States such as Pennsylvania are starting to ramp-up consumer warnings about what is true and what is not relating to the Order and how it relates to current ACA protections.

## DISCUSSION OF MODEL ACT REGARDING AIR AMBULANCE INSURANCE CLAIMS

Rep. Jeff Greer (KY) stated that the Air Ambulance Task Force has worked very hard to make a recommendation to the Committee in the form of the Model Act Regarding Air Ambulance Insurance Claims, sponsored by Asm. Will Barclay (NY). Rep. Greer stated that he believes the Model will protect consumers from exorbitant balance bills after having received service from an air ambulance provider.

Asm. Cahill then provided a brief timeline of the Task Force's work: the Task Force was created in March 2017 and began to gather relevant information; after having several conference call meetings, the Task Force met in July 2017 and heard testimony from several interested parties; in October 2017 the Task Force voted to recommend Asm. Barclay's Model Act to the Committee by way of a voice vote on a joint interim conference call meeting of the Task Force and Committee; on the same joint interim conference call meeting, the Committee voted by way of a voice vote to recommend the Asm. Barclay's to the Executive Committee for adoption; at the request of NCOIL President and Executive Committee Chairman Rep. Steve Riggs (KY), Asm. Barclay's Model was returned to the Health Committee for consideration of two technical amendments.

Asm. Barclay provided a brief summary of the Model and stated that the highlight of the Model is that it calls for a State Department of Insurance (DOI) to set up and Independent Dispute Resolution (IDR) program that takes the patient out of the middle and directs the provider and insurer to negotiate reimbursement. Asm. Barclay noted that it is important to recognize that such a process is possible because by registering and participating in the IDR program, the air ambulance provider waives the provider's ability to challenge the IDR program based on the Federal Airline Deregulation Act (ADA) preempting it. Asm. Barclay further noted that another highlight of the Model is that by registering in the IDR program, air ambulance providers agree to (a) publish air ambulance transport rates charged by it in that State and (b) provide de-identified, itemized billings for each of its transports in that State. Asm. Barclay then offered two technical amendments to the Model. First, in Section 2(C), clarification is needed to state that a "health plan" does not include: (a) Medicaid managed care programs operated [insert applicable State statute]; (b) Medicaid programs operated under [insert applicable state statute]; (c) the state child health plan operated under [insert applicable state statute]; (d) Medicare; or (e) "excepted benefit: products as defined under 42 U.S.C. 300gg-91(c). Additionally, in Section 4(D)(1), language is needed to state that "subject to the provisions of the covered person's health plan contract, a health plan is responsible for payment directly to the air ambulance service provider or denial of a claim for air ambulance services within 30 days after receipt of a proof of loss." There could be constitutional issues if that language was not included when dealing with two independently contracting parties. Asm. Barclay then made a Motion for the Committee to adopt those two technical amendments; Sen. Dan "Blade" Morrish (LA) seconded the Motion. The Committee then voted without objection by way of a voice vote to refer the Model back to the Executive Committee, as amended.



Asw. Carlton asked if the prior Motion was to vote on only the amendments or on the Model, as amended. Asm. Cahill stated that the Model was already adopted by the Health Committee on the Oct. 13 interim conference call meeting. Asw. Carlton stated that it was her understanding that there were not many Committee members on that conference call and that the Committee would be voting on the Model at this meeting. Asm. Cahill stated that the Oct. 13 minutes reflect that it was adopted by the Health Committee during that call and referred to the Executive Committee for adoption and that at the beginning of that call a Motion was made and adopted to waive the quorum requirement. Asw. Carlton stated that it was her mistake then that she had left that call early but that she has concerns with that process. Rep. Keiser stated that in North Dakota, if a bill is brought back to the relevant Committee for amendments, that Committee then has jurisdiction over the bill. Asm. Cahill then entertained another Motion to move the Model, as amended, back to the Executive Committee. Asm. Barclay made the Motion; Sen. Jason Rapert (AR) seconded the Motion. The Committee then voted by way of a voice vote to refer the Model back to the Executive Committee, as amended.

The Committee then recognized the retirement of Dianne Bricker from America's Health Insurance Plans (AHIP). Asm. Cahill stated that Ms. Bricker has been a friend of NCOIL for several years and thanked her for all of her hard work.

#### ADJOURNMENT

There being no further business, the Committee adjourned at 10:45 a.m.