

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS AND INTERNATIONAL INSURANCE ISSUES
COMMITTEE
OKLAHOMA CITY, OKLAHOMA
DECEMBER 7, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) State-Federal Relations and International Insurance Issues Committees met jointly at The Renaissance Oklahoma City Convention Center Hotel in Oklahoma City, Oklahoma on Friday, December 7, 2018 at 3:30 p.m.

Senator Jerry Klein of North Dakota, Chair of the International Insurance Issues Committee, presided.

Other members of the Committees present were:

Rep. Sam Kito (AK)	Rep. Steve Riggs (KY)
Asm. Ken Cooley (CA)	Rep. Lewis Moore (OK)
Sen. Travis Holdman (IN)	Rep. Tom Oliverson, M.D. (TX)
Rep. Matt Lehman (IN)	

Other legislators present were:

Rep. Deborah Ferguson (AR)	Sen. Paul Utke (MN)
Rep. Martin Carbaugh (IN)	Asm. Kevin Cahill (NY)
Sen. Gary Dahms (MN)	Rep. Joe Schmick (WA)

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

After a motion was made by Rep. Matt Lehman (IN) – NCOIL Treasurer - and seconded by Asm. Ken Cooley (CA) – NCOIL Secretary - to waive the quorum requirement, the Committee unanimously approved the minutes of its July 12, 2018 meeting in Salt Lake City, UT upon a separate motion made by Rep. Michael Webber (MI) and seconded by Sen. Jason Rapert (AR) – NCOIL President.

DISCUSSION ON CHANGES TO THE 1332 WAIVER PROGRAM – WILL STATE RELIEF AND EMPOWERMENT WAIVERS (SREW) HELP CONSUMERS?

Randy Pate, Director of the Center for Consumer Information and Insurance Oversight (CCIO) and Deputy Administrator for the Centers for Medicare and Medicaid Services (CMS), stated that CMS is committed to promoting healthcare choice and has been very busy over the past year in trying to make headway in that area, with significant progress being made particularly in the area of state flexibility. Mr. Pate stated that the 1332 waivers have been re-branded with a new direction in calling them SREW's. CMS

issued guidance at the end of October that replaced prior guidance that had been in place since Dec. 25, 2015 that CMS believes will open up more possibilities for states. CMS also just last week released 4 SREW concepts in collaboration with Treasury that aim to spur conversations with state policymakers.

Mr. Pate stated that, as a refresher, under §1332 of the ACA, a state can apply for a waiver from certain ACA requirements, allowing a state to implement innovative ways to improve their health insurance market and provide access to quality care. For a waiver to be approved under the statute, it has to meet 4 guardrails which means that for each year of the waiver, the application must compare measures of coverage, comprehensiveness, affordability, and must also take into account the impact on the federal deficit, absent the waiver, the baseline scenario being “absent the waiver.” Waivers can be granted for a period of up to 5 years under the statute. Mr. Pate stated that the new guidance released in October replaces the prior guidance and outlines 4 principles that are going to be important to the Secretaries in evaluating waivers. Those principles are: empowering states to innovate in ways that will strengthen their markets; expanding coverage choices; targeting public resources to those that are most in need, including low-income and high-cost individuals in order to meet unique circumstances in each state; and lowering barriers to innovation in states seeking to reform their health insurance markets.

Mr. Pate stated that states can use both the guidance released in October and the waiver concepts, but emphasized that CMS welcomes additional ideas and wants states to be thinking of their own directions as CMS views the guidance as concepts as conversations-starters. CMS welcomes comments on the guidance and concepts. Mr. Pate stated that many people at CMS have had multiple conversations with states and regulators and heard a lot of feedback on §1332 waivers, the guidance issued, and what the barriers states were seeing and what they would like to see changed. CMS tried to reflect that feedback in the guidance it issued to address those concerns. With regard to the statutory guardrails, CMS heard from states that the prior guidance had interpreted the guardrails as making anything other than a waiver that provided the exact same ACA subsidy structure out of the question. CMS also heard from states that they wanted to seek innovative ways to stabilize their markets and develop more effective approaches to increase choice. CMS further heard from states that the 2015 guidance imposed additional hurdles on states in terms of meeting the guardrails in terms of microanalysis and simulations that were really difficult.

Mr. Pate stated that in the new guidance, CMS sought to loosen some of those restrictions while still maintaining the requirements of the statute. Under the guidance, the focus is on whether the waiver provides access to coverage that is at least as comprehensive and affordable under the waiver when compared to coverage available without the waiver. CMS believes that is going to enable states to provide access to new health insurance coverage options at different price points and benefit levels so long as people retain access to coverage options that are just as comprehensive and affordable as before. So the idea is that states are free to open up new options that may be more affordable and less comprehensive as long as they are preserving access to the same level of affordable and comprehensive coverage as was there prior to the waiver. The guidance surrounding the coverage guardrail specifically continues to consider the number of state residents who are actually receiving coverage. So as long as a comparable number of residents are projected to be covered as would have been covered absent the waiver the coverage guardrail will be met. Mr. Pate stated that CMS

also expanded the definition of what coverage is under the guardrail; the prior definition was minimum essential coverage but the new definition is minimum essential coverage plus the federal definition of health insurance coverage under the Public Health Service Act. That change allows STLDs to count under the coverage definition for §1332 waivers as well as other types of health insurance coverage.

Mr. Pate further stated that CMS now focuses on the aggregate affects of the waiver rather than requiring that the guardrails be met for specific sub-populations, which CMS had heard was a barrier for states in having their waiver approved. While CMS is looking at the aggregate affect of the waiver, applications should address how the waiver will impact those with low incomes or high healthcare costs in alignment with the guardrail analysis. Mr. Pate stated that another issue that CMS heard a lot of feedback from states on related to operational options. For states that are using the healthcare.gov platform, CMS wants to work with them to accommodate backend support to design a new system with a different eligibility and enrollment regime for example, potentially allowing new data sharing functionality and the ability to leverage state designs with private sector operational assistance. That is something that CMS can talk to states about further as they get further into the details.

Mr. Pate stated that surrounding the state legislative requirement in the statute, CMS had heard that the previous interpretation was challenging for many states especially when many state legislatures meet infrequently. States and other stakeholders requested additional information on how the departments would assess their applications based on the statutory requirements and other review criteria. Accordingly, the new guidance clarifies that states may use their existing state legislation or existing state authority if it provides statutory authority to enforce ACA provisions and the state waiver plan combined with a duly enacted state regulation or executive order in order to satisfy the statutory requirement. Under this new approach, states can use different combinations of legislative authority to meet the state law requirement to pursue a waiver. The guidance does not eliminate the requirement for a state to enact a law or encourage state executives to bypass their legislatures by any means; it simply recognizes that state legislation can come in different forms.

Mr. Pate stated that in discussing the review timeline, CMS heard from states that the timelines can create challenges for states to come up with ideas and have their applications approved in time for them to be implemented. Accordingly, under the new guidance CMS is reiterating encouragement to states to reach out to CMS as early as possible in the process to discuss specific ideas and get feedback along the way so the departments and states can enter into a conversation early on which CMS thinks is very important. The amount of time it would take to develop and review a wavier application and to implement a waiver depends heavily on the specific content of that waiver. CMS received positive feedback from most of the states it currently works with on its current approach in the 7 waivers that have been approved and CMS has been able to be responsive to states under the review timelines. Mr. Pate stated that the departments reviewed all 2019 waiver applications well before the 180 day timeline for federal review. Mr. Pate stated that he and his team are happy to work with states to ensure there is a reasonable timeline implemented for a waiver.

Mr. Pate stated that states also asked CMS for more clarity on how it evaluates the waivers it received. Accordingly, the guidance clarifies that the Secretaries will consider favorably waiver applications that advance some or all of the 5 principles: providing

increased access to affordable private market coverage; encouraging sustainable spending growth; fostering state innovation; supporting and empowering those in need; and promoting consumer-driven healthcare. Mr. Pate noted that states had asked for model waiver ideas that would fit within the framework of §1332 and that is exactly what CMS released last week: 4 waiver concepts to start a discussion with state policymakers. Each of the concepts illustrate ideas that the Administration supports and fit within the framework outlined in §1332.

Mr. Pate noted that the first concept is an account-based subsidy. Under that waiver concept a state can direct public subsidies into a defined contribution consumer-directed account that an individual can use to pay for their health insurance premiums or other healthcare expenses. The account can be funded with pass-through funding made available under §1332 by waiving the premium tax credit under section 36b of the Internal Revenue Code, or the small business healthcare tax credit under section 45r of the IRC. The account could also allow individuals to aggregate funding from additional sources including individual and employer contributions. Mr. Pate stated that an account-based approach could give beneficiaries more choices and could also help them to take more responsibility for managing their healthcare costs. The approach could also allow greater consumer ability to select a plan based on the individual's or family's personal needs including a higher deductible plan with lower premiums.

Mr. Pate stated that the second concept is called state specific premium assistance. Under that concept, states can create a new state administered subsidy program. A state can design a subsidy structure that meets the unique needs of its population in order to provide more affordable coverage options to a wider range of individuals or they can use it to attract younger and healthier consumers into their market, or to address structural issues that create some perverse incentives such as the subsidy cliff. States may receive federal pass-through funding by waiving premium tax credits to help fund the state subsidy program.

The third concept is called adjusted plan options. Under that concept, states would be able to provide financial assistance to different types of health insurance plans including non-qualified health plans, potentially increasing choice in the market and making coverage more affordable for individuals. For example, states could choose to expand the availability of catastrophic plans beyond the current eligibility rules by waiving section 1302(e)(2) of the ACA. Used in conjunction with the account-based subsidy waiver concept, states can provide subsidies in the form of contributions to accounts, allowing individuals to use these funds to purchase coverage that is right for them and use any remaining funds in the account to pay for their out of pocket healthcare expenses. Mr. Pate stated that the final concept is called risk stabilization strategies and is really a bundle of concepts to help states address high cost individuals. That concept gives states more flexibility to implement reinsurance programs or high risk pools. For example, a state can implement a state operated reinsurance program or high risk pool by waiving the single risk pool requirement under section 1312(c)(1) of the ACA. Reinsurance programs have lowered premiums for consumers in many states, improved market stability and increased consumer choice. To date, states have chosen to use a variety of models to operate their state based reinsurance programs, using flexibility available under section 1332. Such models include a claims-based cost model; a conditions based model; and a hybrid conditions and claims cost model. If a state can show an expected reduction in federal spending on premium tax credits, the state can receive federal pass-through funding to help fund the state's high risk pool or

reinsurance program. Mr. Pate stated that states are not required to use those concepts; states can use them in pieces in conjunction with others. CMS is committed to working with states on waiver requests. As with all waiver requests, a state must ensure that the waiver plan meets the 4 statutory guardrails relating to comprehensiveness, affordability, coverage, and deficit neutrality.

Mr. Pate then discussed some things that have not changed in light of the new guidance and model waiver concepts. It is important to note that the new flexibilities do not impact the ACA's protections relating to pre-existing conditions which are not waivable. Also, the requirement for states to provide for a meaningful level of public input and comment prior to submitting an application has not changed. Mr. Pate closed by reiterating that CMS is committed to working with states to stabilize their markets and urged states to reach out as early in the process as possible even if states are not sure if they want to pursue certain options.

Sen. Klein asked if it is fair to say that the concepts issued by CMS enable states to "fill in the blanks" and therefore speed up the waiver process. Mr. Pate stated that he would term the concepts more so as discussion papers, but CMS plans to issue more specific templates and checklists, which is something they did for reinsurance waivers that states found helpful. CMS was focused on getting the concepts initially distributed in advance of upcoming legislative sessions and to start discussions with states. Sen. Klein stated that ND Insurance Commissioner, Jon Godfread, was excited about the concepts because they have some ideas that could do more with less and provide opportunities to certain individuals.

Sen. Gary Dahms (MN) asked for an expected timeline for when CMS would receive and approve an application for reinsurance. Mr. Pate stated that under the statute there is a 180 day review period that the federal government has once a waiver has been submitted. However, with reinsurance waivers in particular since CMS has received several of them now, that timeline can be reduced significantly but the earlier a state beings a dialogue with CMS the better.

Rep. Lewis Moore (OK) asked if the checklists and forms mentioned by Mr. Pate are accessible somewhere. Mr. Pate stated that the only checklists issued thus far have been for reinsurance which is available on the CCIIO website, but CMS plans to issue similar checklists and templates for the waiver concepts. Rep. Moore asked if under a waiver a state could expand Medicaid or have a catastrophic plan introduced. Mr. Pate stated that the waivers do not specifically address expanding Medicaid as a state would not need a waiver to do that. If a state wanted expand tax credits to an expanded population that is something that a state could look to do under a 1332 waiver. In that circumstance, under the deficit neutrality guardrail, a state would have to do something else in its waiver to trigger the pass-through savings to the federal government that would create the amount of money that a state could use to for example provide subsidies for private coverage for those under 100% of the federal poverty line. To draw a clear line of delineation, 1332 waivers do not speak to Medicaid expansion as that can be done outside the waiver process. Rep. Moore asked if the waivers were a return of federal dollars that came from the state. Mr. Pate stated that the way the analysis works is that a state's waiver will do something to alter the rules previously mentioned and in order to receive a pass-through those changes will have to trigger a reduction in the premium tax credits or small business tax credits that would otherwise flow into the state. CMS runs micro-simulations that take all of the assumptions into account and will

forecast what the next year's market will look like without the waiver, and then plug in the waiver's triggers for the premium or small business tax credits to examine if it creates a savings for the federal government. That would be the amount of money the state would get to implement its plan.

Rep. Deborah Ferguson (AR) stated that considering insurance rates across the country have stabilized, is it likely that a state would get approved for a reinsurance waiver at this point. Mr. Pate stated that with the reinsurance waivers that have been approved thus far there is a set of parameters that a state comes up with regarding a reinsurance program such as what they want the attachment point to be, the cap, and coinsurance rate. Those issues are examined in addition to what the anticipated premiums and enrollment will be in that state and the issuers come back with the rates and all of that is plugged into an actuarial analysis which states what will happen to premiums if you take into account the reinsurance program's parameters, which can then trigger the pass-through amount that the state would get if the program lowers premiums. Mr. Pate added that under a reinsurance waiver, a state does have to put in some of their own money. Under the reinsurance waiver there are savings to the federal tax credits but for the reinsurance program to apply across the whole market the state has to plug in some money for the unsubsidized portion of the market that is not getting premium tax credits. Rep. Ferguson stated that Arkansas has looked at reinsurance waivers for the Medicaid population and asked if the reinsurance waivers in states such as Alaska and Minnesota have been for Medicaid. Mr. Pate stated that for AK and MN and for all reinsurance waivers approved, they have all been for the individual health insurance market.

Sen. Dahms stated that MN was the second state to obtain a reinsurance waiver back in 2017 and the original estimate that MN was expected to receive back under the 1332 waiver was approximately \$184 million dollars. In the past 10 days or so MN received notice that the amount would be \$80 million dollars. Accordingly, Sen. Dahms asked what the changes were that led to that disparity. Mr. Pate stated that MN was the third state to obtain a reinsurance waiver so at that time CMS had not done many of them. The way the process operated was that Treasury would run a microsimulation model to figure out how much pass-through the state will get under the waiver. When Treasury sends the letter to the state, it gives a 5 year projection but clearly states that the projections need to be re-examined every year based upon changes in law or changes in the market. The microsimulation is done every year for every state that has a reinsurance waiver. With MN, there had been changes in the market as premiums have decreased and there are many different factors that Treasury looks at in its microsimulations. Sen. Dahms asked Mr. Pate if he is essentially saying that because the reinsurance program was successful and caused premiums to go down, that resulted in MN being penalized. Mr. Pate stated that he would not characterize it that way as he is not a statistician or an actuary but again noted that Treasury takes into account several different factors when running its simulations, not just whether premiums decreased, but other factors such as what enrollment is going to look like. There is no arbitrary decision made by anyone to decrease the amount of money a state receives. Sen. Dahms asked if MN submitted another application for another reinsurance program, or to extend the current program, can it assume that the program would be subject to the same disparity from year to year. Mr. Pate stated that the document a state receives with the 5 year projection clearly states that if the assumptions on which the microsimulations were based upon change, which often do depending on marketplace realities, the projections can then change.

Sen. Paul Utke (MN) asked if the MN Commerce Dept's statement that they are not aware of any state's right to appeal any decisions relating to the aforementioned projection figures is accurate. Mr. Pate stated that there will always be phone calls and meetings and conversations with Treasury and a state to make sure the assumptions are correct although it is not a formal appeal process. Also, there are actually 3 points each year at which Treasury calculates the numbers for the pass-through payment amounts, the first being when the initial rates are filed, the second when the final rates come in, and the third when the final enrollment numbers come in. Each projection of the first two points is an estimate and there is always a dialogue with Treasury after those estimates are received to review everything.

The Honorable Jessica Altman, Pennsylvania Insurance Commissioner, stated that the old saying relating to once you know one state's health insurance market, you know one state's health insurance market, is especially true in individual health insurance markets today which are in very different places and have many different problems and therefore may warrant very different solutions. States believe that they are in the best position to identify what those solutions should be – collectively among state insurance regulators and legislators. Cmsr. Altman stated that she believes state flexibility is needed and most state regulators are pleased to see the new flexibility in the form of new guidance and concepts issued from CMS. The new guidance takes a positive step in allowing state insurance regulators to use the full authority that their state laws already grant them. If a state legislature has already chosen to grant the insurance commissioner the authority to fully implement the ACA or otherwise pursue a state waiver, the commissioner can now use that authority without further action from the state legislature which can help with the timing of a waiver application but does not mean that a Governor or insurance commissioner can act on their own as the state would need an Executive Order or duly enacted regulations to define it waiver plan and if state funds are need, the legislature would most likely need to appropriate such funds in addition those appropriated in the original legislation.

Cmsr. Altman stated that the new interpretation of waiver guardrails will also allow for wider availability of short term plans and other alternative coverage types in fulfilling the law's requirements for states that choose to pursue such a waiver. States very much differ on how much they want such plans to be a part of their market and what their approach to them is and will be but any state that chooses to propose a waiver will have to look closely on the effects on the risk pool because coverage is not the only guardrail. A state's waiver must make available to state residents coverage that is as comprehensive and affordable as ACA plans even if some residents choose a less comprehensive plan. A waiver must also not increase the federal deficit. Cmsr. Altman stated that if the availability of short term or other less comprehensive plans makes coverage more expensive on the exchange due to risk pool effects, the federal gov't's cost for tax credits could potentially increase meaning that the state could have trouble meeting the federal deficit neutrality guardrail. Such a scenario might also not meet the affordability guardrail either since exchange plans would be more expensive than the without-waiver scenario.

In addition to the 5 principles that Mr. Pate reviewed, the Administration released last week a discussion paper outlining 4 concepts that states could pursue under the new waiver guidance which many states are reviewing. One of the concepts is a reinsurance mechanism which a number of states have already chosen to pursue and are well-versed in. Cmsr. Altman stated that, overall, it is good to have some additional direction

in this area and the principles are fairly broad but state insurance regulators would not want to see the Administration use the principles to limit state flexibility and innovation. Waiver proposals should be judged against how they meet the law's requirements and not whether they serve any particular Administration's ideological goals. In particular, sustainable spending growth should not be interpreted more narrowly than it has to date; federal costs under a waiver should be compared to the expected federal costs in the absence of the waiver; anything lower than or equal to the expected without-waiver cost should be allowable. The principle of increased access to affordable private market coverage should not get in the way of a state that wanted to, for instance, develop a Medicare buy-in option or other public option. Such a waiver could certainly fulfill the principles of fostering state innovation, limiting spending growth, and supporting those in need as well.

Cmsr. Altman stated that the revised guidance opens the door a little wider for states to pursue different strategies but it remains to be seen if the additional flexibility is truly useful for states and how many will take advantage of it and what they will do in doing so. A number of states have successfully used waivers under the old guidance to develop reinsurance mechanisms but other types of waivers have not yet come to fruition widely. The Administration acknowledges that the concepts are intended to be the beginning of discussions with states, as they should be since this is a state-specific endeavor. The concepts provide a set of important questions for states to think about in designing and operationalizing waivers but they do not include the detail required to be evaluated as a complete proposal so state insurance regulators look forward to the additional information that Mr. Pate stated is on the way. Cmsr. stated that overall, more flexibility is good but it remains to be seen how states will choose to move forward with that additional flexibility.

The Honorable Gordon Ito, Hawaii Insurance Commissioner and NAIC Vice President, stated that Hawaii was the first state to be granted a 1332 waiver but it was significantly different from the high-risk reinsurance program that many states have created. In 1974, HI passed the Prepaid Healthcare Act which was an employer mandate and therefore HI had a separate system for small and large businesses to purchase insurance on behalf of their employees. HI's waiver was to waive out of the Small Business Health Options Program (SHOP) provisions and not have the middle levels applicable to small businesses that purchase ACA plans. Cmsr. Ito stated that HI is interested in pursuing a second 1332 waiver to create a high-risk reinsurance program. To put things into context, in HI's microsimulations, HI has about 16,000 individuals that effectuated plans through the ACA marketplace, and about 10,000 off the exchange. For those 16,000 individuals, in the microsimulation to effect the 10% reduction in premiums, the state portion would be about \$9.4 million.

DISCUSSION ON FEDERAL INSURANCE OFFICE (FIO) PRIORITIES

The Honorable Tom Considine, NCOIL CEO, stated that it seems to be an interesting at FIO. Steven Dreyer, who had committed to speak at this meeting and whose attendance would have marked the first time a FIO Director spoke at an NCOIL meeting in some time, recently resigned suddenly. Cmsr. Considine stated that the relationship between FIO and NCOIL was never better than it was under Dir. Dreyer's leadership as he had reached out to NCOIL in a way that FIO never had before when it became clear that the U.S. was going to pursue another covered agreement with the UK. NCOIL believes that the UK should not be disadvantaged by not having a covered agreement.

Since the UK would be a beneficiary while they are in the EU, they should have those same benefits when not in the EU. Cmsr. Considine stated that does not change the fact that NCOIL does not favor the elimination of collateral but understands the political realities of the need for a substantially similar covered agreement with the UK. If it were to happen that the UK covered agreement departed substantially from the EU covered agreement, then collateral would be one of the issues that would need to be put back on the table. Cmsr. closed by noting that Steve Seitz is once again Acting FIO Director and we had reached out via e-mail, letter and phone to invite him to this meeting but we did not hear back.

DISCUSSION ON OKLAHOMA INSURANCE BUSINESS TRANSFER (IBT) LAW: IS THIS THE BASIS FOR A MODEL?

Luann Petrellis, Managing Director at PricewaterhouseCoopers, LLP (PWC), stated that in many countries worldwide IBT mechanisms are used to transfer legal liability of a contract or a group of contracts to another carrier without the need for policyholder consent. As a restructuring tool, IBT can allow companies to more effectively respond to changing regulatory environments; can allow companies to balance overall capital between different lines of business to bring finality to business or to release excess capital. For example, in Europe, IBTs were a key restructuring tool that was utilized by carriers to respond to the requirements of Solvency II. In order to create a vibrant and healthy market, insurers need to be able to respond to different challenges and in order to do that they need effective tools to restructure so that they can achieve capital, operational, and administrative efficiencies, as well as develop strategies and plans to deal with non-core or discontinued business.

Ms. Petrellis stated that because of the limited availability of effective restructuring tools in the U.S., U.S. companies are somewhat challenged to achieve these objectives. The most frequently used restructuring options in this country are sale and reinsurance or limited portfolio transfers (LPTs) but those options are limited in their scope and effect. A sale can bring finality but many times run-off is embedded with live business and there is no mechanism to segregate the discontinued business from the active business, making a sale unattractive. Similarly, LPTs and reinsurance provide some economic relief but no legal finality because the ultimate liability remains with the original insurer. Also, LPTs and reinsurance may not be attractive because of counterparty credit risk that can be tied to long duration liabilities. Presently, the only way to transfer blocks of business is by way of a policy novation process but that process in the U.S. is inconsistent among the states and very cumbersome, expensive and time consuming. And in most instances, companies will not be able to obtain positive consent from all policyholders, especially for older books of business.

Ms. Petrellis stated that PWC did a recent survey of the global run-off insurance market and it was estimated that U.S. non-life run-off liabilities are \$335 billion and the life run-off market is estimated to be even larger than that. Companies need tools to be able to manage these liabilities to achieve their objectives as well as to address concerns of regulators. An IBT allows an insurer to transfer some or all of its business underwritten to another insurer. For example, enabling a company to segregate run-off from live business. This can be used within a group or to a third party. The approval process itself is a multi-layered transparent review that includes multiple safeguards to protect policyholders. IBT requires regulatory and judicial review and it is the court order that will implement the novation of the contracts and it will include the attaching reinsurance.

One of the key features of the process is that it does bring complete legal finality to the transferring company for the transferred business. Since it came into effect in 2001, the U.K.'s IBT mechanism, that is commonly called the part VII transfer, has become a core restructuring tool for companies look to restructure their operations or utilize capital more efficiently. Presently, the UK part VII transfer is the most frequently utilized legal mechanism to move blocks of insurance business in the UK. Ms. Petrellis stated that since the part VII transfer was enacted there have been hundreds of successfully completed part VII transfers of life and non-life portfolios, none of which encountered subsequent financial difficulties. Many of the transfers have been to reorganize business within large insurance groups but the process is equally applicable to transfers between third parties and there has been hundreds of billions of dollars in liabilities transferred since the legislation was enacted.

Ms. Petrellis stated that the part VII transfer is part of a broader European landscape that provides for a harmonized and cooperative approach to the supervision of insurance business and the transfer of insurance business between members of the EU. In continental Europe, in addition the aforementioned transfers, there have been about 140 successfully completed transfers. The part VII transfer and its wider equivalents in the EU are the mechanisms most frequently used to move business, especially run-off blocks of business. Unlike most modern jurisdictions, until very recently, the U.S. has not had an IBT mechanism but we are starting to see some states pass IBT legislation. The first state that attempted to pass IBT legislation was Vermont by passing the Legacy Insurance Management Act but that was not a true IBT but rather a regulatory process but it did result in a novation of the business. The first true IBT legislation was enacted in Rhode Island in August 2015 when the Div. of Business Regulation introduced regulation 68 that did provide an IBT mechanism. It allowed the transfer of blocks of commercial P&C run-off business from any insurer into a RI domiciled carrier. In May of this year, Oklahoma passed its IBT law that became effective on Nov. 1. The OK IBT law is currently the most direct reflection of the UK part VII legislation but in both RI and OK, the transfer results in a court-sanctioned novation of policies from one carrier to another carrier without the need for policyholder consent.

Ms. Petrellis stated that the transfer results in complete finality for the transferring company. Because of the non-consensual nature of this process, the process is designed with certain checks and balances that protect the position of policyholders which include: notification to all stakeholders, including policyholders; an independent expert report that evaluates the impact of the transfer on affected policyholders; review and approval from regulators in the transferring and assuming company's state of domicile; a court hearing and an opportunity for stakeholders – including policyholders - to be heard; and judicial review and approval. The court must find that policyholders are not adversely impacted. The process before approval is robust and thorough in requiring both the regulators from the receiving and the transferring company's to be involved and no process is complete without a court order. Policyholder protection is a key driver in any IBT approval process and it is rightly the driver for the approving regulators and the court. The regulators and the court need to be satisfied that the policyholders will be protected in the hands of the new owner. The regulators will only approve a transfer if they are satisfied that the policyholders will be just as protected, if not better protected, after the transfer. It is also up to the acquiring insurer to show its own solvency pre and post transfer.

Ms. Petrellis stated that a key element of the review is the independent expert report. Every IBT process will include an independent expert report that will focus on security provided to policyholders. The independent expert will be approved by the regulator and will be charged with providing assistance to the regulator and the court to ensure that the transfer is sound. The report itself will consider all affected parties in the transfer and is a very important element in the process to determine whether the transfer is sound and it is what is used in the part VII transfer process. Ms. Petrellis noted that the IBT itself has many different applications and its flexibility is what makes it so useful. It can be used for internal restructuring and many times in the UK and continental Europe it was used for just that. A company can consolidate business from one or more subsidiary, putting it all in one company to achieve regulatory, capital, and administrative efficiency. It can also be used by a company to segregate business - to segregate live from run-off business - or to position a company for a future sale. Because you can segregate live from discontinued business, it's more effective than a sale because it can involve just the portion you want to sell. It can also be used to transfer business between third party entities.

Ms. Petrellis stated that the UK part VII transfer, which serves as the model for the OK IBT law, is a successful business model that has been used throughout the world for decades. In continental Europe, 28 countries have worked together to establish guidelines so that all countries recognize the transfers in every other country. The process varies from country to country but each country recognizes the transfers of the other countries. Ms. Petrellis stated that over time as more states pass IBT legislation it is possible that the U.S. could enact a similar recognition process that works within the U.S. regulatory and legal framework.

Buddy Combs, Oklahoma Deputy Commissioner of IBTs, stated that he served as the legislative liaison for the OK Insurance Dep't as it attempted to get the OK IBT law passed and it is also his job now to implement the law in his current position. Mr. Combs stated that the process surrounding enactment of the OK IBT law started at the 2016 NAIC Fall National Meeting via conversations with people in the industry who mentioned that there are several restructuring options overseas that are very successful and some states have dabbled in the area but have not been successful in getting it off the ground. OK Insurance Cmsr. John Doak and others were very intrigued by the IBT concept and therefore in 2017, SB 606 was introduced. SB 606 was very similar to the RI IBT law where there is a commutation plan filed along with the IBT and limited to only P&C commercial business and run-off business. SB 606 was met with strong opposition, mainly due to the commutation provisions, the idea of transferring business and then severing the contractual relationships and buy-off claimants or policyholders. The RAA, AIA, NAMIC and almost every trade association opposed the bill very strongly and a decision was made to go back to the drawing board. Accordingly, an interim study was conducted in the Summer of 2017 to study the issue more.

Mr. Combs stated that a lot of lessons were learned from introducing SB 606, the main one being that the RI IBT law was not necessarily the model for other states to use. Some of that has changed since RI passed a new law this year that pulls back some of the problematic elements of their IBT law, specifically, there was an interpretation that the commutation portion of their law was required and they have since clarified that it is not necessarily required although it is still an optional part of their legislation. Mr. Combs stated that he and others in OK learned that the UK part VII transfer is the model to look at. Policyholder protection is essential and SB 606 did not have enough procedural

safeguards and due process protections for policyholders. After taking time to step back and analyze, it was clear that it needed to be fixed. Also, legal finality was a must because the way SB 606 was drafted, it was a commissioner-only review in that only the cmsr. would receive an IBT application and review and sign-off on it. There was a worry that the legal finality for that was not high enough and therefore courts needed to be involved to make sure there is a court order that novates the policies.

Accordingly, during the 2018 OK legislative session, a revised version of SB 606 was introduced – SB 1101 – which passed that was modeled most more after UK part VII transfer. Mr. Combs noted that they are currently in the early stages of the first IBT transaction at the OK insurance dep't and insurance cmsr. has selected the independent expert for the first transaction. Everyone is confident in the expert's qualifications and will be review not only the actuarial and financial information, but how the new company will be able to handle claims and administer the policies, and opine on whether there is a material adverse impact on policyholders after the transfer. The OK IBT Law allows for all lines of business to be transferred while the RI IBT law is only commercial P&C. The OK IBT law is also not limited to run-off business while the RI IBT law only allows transfer of policies that have no new premiums within the last 60 months. The OK IBT law also requires insurance commissioner and court approval, and there is no commutation provisions.

Mr. Combs stated that the OK IBT law allows for the transfer and novation of the policies. A novation is a legal term for exchanging one party to a contract with another party. Under the OK IBT law, the assuming insurer must be domiciled in OK and the hope is that such a provision brings business to the state. Also, in addition to the OK insurance cmsr. signing off on the IBT, the chief insurance regulator of the domiciliary state of the transferring company has to either approve or not object to it in a letter. Lastly, after that review, the insurance cmsr. then permits the parties to go to court and obtain a court order, representing the legal finality that those involved were looking for. Mr. Combs stated that policyholder protection is the most important thing to consider when discussing the OK IBT law because novation is very serious since you are switching parties to a contract, against the policyholder's consent in some instances. Therefore it is important to ensure that policyholders have their day in court and can appear to explain why they object to the novation. In the OK IBT law, when the commissioner signs off on transfer to go to court, that triggers a hearing date to be set which triggers a 60 day comment period. That comment period occurs after all policyholders are notified in writing. Also, the guaranty funds in any state the companies have ever done business in are notified, as are reinsurers, claimants, and the insurance regulators in the states where the companies have ever been licensed. Any policyholder or interested party has the ability to not only object in writing but to appear in court and explain why. The other policyholder protections in place include the two step approval process involving the insurance regulators and the court; and the role of the independent expert, who also have a duty to the court to advise as to whether it is a good transaction or not.

Mr. Combs stated that those involved with the OK IBT law believe that it is not only good for OK, but also good for the industry. To make an analogy, OK can serve as a regulatory sandbox for IBTs, and while the RI IBT law is currently in place, those involved with the OK IBT law are very excited and believe that they can be the first state to get a full-fledged deal done.

Adam Kerns, Vice President – State Relations of the Reinsurance Assoc. of America (RAA), stated that RAA believes adoption of a Model IBT Law using the OK IBT law as the basis is premature given that only a few states have adopted laws like the OK IBT law or a similar law that is called a domestic stock insured division law, and also because it is RAA's understanding that there have not been any deals completed under any such laws so, at least in the U.S., there has not been an opportunity to examine any deals. There are also many unanswered procedural questions as to how an IBT would occur. The mechanism of transferring assets and obligations is untested and requires more debate and discussion before moving towards an IBT model law. One question is what happens if the new entity fails? If the new entity fails, the guaranty fund in the solvent insurer's state would be held responsible for the resulting obligations of the new entity if that new entity didn't have sufficient assets to cover its obligations and its liabilities. It is also not clear which state law would provide the best framework for development of an IBT law as they all have slightly different variations.

Mr. Kerns stated that another issue is that the IBT laws are potentially suspect as violative of U.S. constitutional protections against the alteration of contracts. The fundamental terms of the insurance contract are changed along with the original promise to the consumer and other third parties such as reinsurers; no consumer or reinsurer consent is required under any of these laws. Certain state laws specifically dealing with contracts would not apply even though the decision is being made by another state. Mr. Kerns stated that the NAIC is just starting to discuss IBTs and during the most recent discussion, CA Insurance Cmsr. Dave Jones questioned the constitutionality of IBT laws, based on a legal opinion given to him from the general counsel of the CA insurance dep't. Mr. Kerns noted that said opinion has not yet been publicly released.

The RAA supports state-based regulation and IBT laws bring that concept into question as a single state would make decisions that would affect consumers in other states, thereby creating similarities to a federal regulator. The consumers and the reinsurers in the other states would have no mechanism to challenge the divisions and are essentially forced to accept the decision that is made by another state. Overall, given the many unanswered questions, Mr. Kerns stated that RAA urges NCOIL to continue the dialogue on IBTs before moving towards an IBT model law as this is the first time it has been on a meeting agenda, and since other states are likely to introduce IBT bills in the near future.

Sen. Klein asked Mr. Kerns what the biggest concern was during negotiations surrounding the OK IBT law. Mr. Kerns stated that RAA's position on IBTs has evolved, mainly due to political realities, both internally with members who want to use IBTs as a business opportunity, and externally. RAA became more comfortable with the OK IBT bill towards the end of the process and RAA does not necessarily oppose it. Rather, RAA believes that more discussion is warranted before moving towards development of an IBT model law.

BALANCE BILLING: IS A FEDERAL SOLUTION IN SIGHT AND IS IT RIGHT?

Erin Trish, PhD., Assoc. Dir. of Health Policy at the USC Schaeffer Center for Health Policy and Economics, stated that in a standard, functioning healthcare market, healthcare providers are negotiating with private health insurers over the terms of essentially constructing contracted rates and forming provider networks. What that means is that those providers are willing to accept lower than their billed charges as payment in full in exchange for being included in those health insurer's networks.

Providers do so because they ultimately believe that it will drive a bigger volume of patients to those providers because insurers are able to use their benefit design to incentivize and steer patients to in-network physicians. However, the insurers contract separately with healthcare facilities such as hospitals or emergency rooms so there is no guarantee that the facilities are going to be in the same insurer's networks as the physicians that work in those facilities. That means that the patient can be caught in the scenario where, with an elective in-patient procedure, the patient dutifully sought out an insurer that the hospital in which the procedure is going to occur is in their insurer's network, that the primary surgeon is in the network, but they largely have no control over the ancillary physicians that might see them throughout the course of that operation such as the anesthesiologist, pathologist, radiologist, or emergency medicine physician. The patient isn't choosing or shopping for those types of physicians and sometimes they can be out-of-network (OON).

Dr. Trish stated that in such a scenario, the patient can be liable, so for example, the anesthesiologist can send the patient a bill for their full billed charges since there is no contracted rate in such a scenario. The health plan may pay a portion of that bill if there is an OON benefit but ultimately, there typically is a big gap between the provider's full billed charges and what, if anything, the plan will pay. That gap, or balance, is something that the provider can send directly to the patient and in instances where it results from the patient being treated by an ancillary, OON provider that the patient did not choose and was unaware of, it is called a surprise balance bill (SBB). Dr. Trish stated that in the healthcare setting we have today, SBB's are common. Depending on the type of healthcare episode being discussed – an emergency setting or in-patient admission, either electively or through the ED – it ranges from a 1 in 5 to 1 in 10 chance that the patient will be treated by an OON physician and receive a SBB.

Dr. Trish stated that there has been a lot of national attention surrounding SBBs since they can be potentially financially ruinous for those that receive them, ultimately because there is no cap on what OON providers can bill or charge the patients. This represents a market failure because in standard, well-functioning healthcare markets, providers face a trade-off of being willing to accept a contracted rate less than billed charges in exchange for a larger volume of patients, but for some types of ancillary providers that the patient has no role in choosing, they have no incentive to be in-network since what drives the volume is the main providers such as surgeons and hospitals being in-network. Therefore, since traditional contracting dynamics are not at play, this represents a market failure since the ancillary physicians have an incentive to stay OON. Such a market failure cries out for a policy intervention.

Dr. Trish stated that a comprehensive policy solution for surprise medical bills requires a multi-faceted approach to truly protect patients across the board. First, it is important to take the patient out of the middle, which can be done by limiting patient cost-sharing to the amount they would owe to an in-network provider and prohibiting OON providers from balance billing patients. However, that leaves a discussion point regarding what the provider can charge the insurer who is now on the hook since the patient is out of the middle. If there is no guidance on an appropriate payment rate a scenario is created where providers have a huge amount of market power where they can essentially bill the insurer whatever they want and the insurer must pay that amount, thereby ultimately raising healthcare costs for everyone involved, including consumers. Therefore, a policy solution must involve setting a payment standard regarding what insurers owe providers in these situations.

Dr. Trish noted that many states have taken action to protect consumers that include the aforementioned policy measures, especially in recent years, but current laws do not apply to the self-insured market due to ERISA preemption which has put pressure on federal policymakers to craft a broad solution. This Fall, there were two proposals on balance billing introduced, one being a bi-partisan discussion draft titled the "Protecting Patients from Surprise Medical Bills Act" and the second titled the "No More Surprise Medical Bills Act of 2018." Both proposals take the patient out of the middle by prohibiting balance billing and limiting patient cost-sharing to in-network rates for OON care and OON care delivered at an in-network facility. That applies to all OON emergency care, both the physician side and the facility side, as well as to all OON care delivered at in-network facilities. Dr. Trish noted, however, that the proposals differ in their approach to determining the OON provider payment rate. The bi-partisan draft follows an approach similar to what has been enacted in CA and CT which essentially calls on the policymakers or regulators to determine what are reasonable or fair payments. The bi-partisan draft gives states or localities the authority to determine at the local market level what the appropriate payment rate is that an insurer must be required to pay a provider in these types of scenarios. But if a state or locality does not come up with a payment methodology, then it defaults to the federal schedule which is currently the greater of the median in-network contracted rate, or 125% of the average allowed amount. It is not clear why both of those figures are included because the latter will essentially always be higher than the former and that is a big concern because it begs the question of why a provider would go in-network if they know they are guaranteed 125% of the average allowed amount.

Dr. Trish stated that the alternative approach in the other proposal sets up binding arbitration process to determine appropriate payment rates. The goal is to have the parties settle beforehand as to what an appropriate amount of payment should be and if they cannot agree, they go to baseball style arbitration which means that each party submits an offer and the arbiter must choose one or the other. Dr. Trish stated that in some ways it allows for more flexibility and more understanding of fair rates in particular situations but ultimately it is more complex even though the goal is that, as the arbiter's decisions are made public, both sides will come to learn what amount the arbiter will choose and they will settle before entering arbitration. Dr. Trish stated that such a system can be complex and administratively costly and the arbiter must still be provided guidance as to what to consider in making a decision. The federal proposal instructs the arbiter to consider Medicare and negotiated network rates (but not charges) when making their determination. The proposal also permits states to establish own arbitration process or elect a defined payment standard (capped at 125% Medicare) instead.

Dr. Trish believes that this is an issue where many can coalesce around taking the patient out of the middle. Determining the rate at which the providers should be paid is the challenging part which is where the two federal proposals differ and is where it will be difficult to see the proposals advance. Arbitration arguably provides more flexibility but determining a payment rate, particularly one that is tied to the Medicare rate, provides more certainty and is attractive to insurers who have actuaries who are setting premiums. Dr. Trish also noted an alternative policy approach is to require the hospital to contract with insurers for all ancillary physician services and, in turn, pay physicians as that would be more market-oriented, but it is a considerable change from the status quo. That policy may be attractive from a state perspective because since the providers are being regulated rather than the insurers, the self-insured market might be able to be

regulated. Dr. Trish closed by stating that in large part the two federal proposals are positive developments and would provide strong consumer protections. Some small tweaks need to be made but the big issue is going to be the determination of appropriate provider payment rates. Additionally, in terms of federal intervention, Dr. Trish stated that federal law is needed to protect the self-insured under current common billing policies. This is also an example of a targeted market-correction effort from the federal level and is not representative of a federal takeover of insurance regulation. There is precedent for Congress to step into insurance regulation when it sees the need and state flexibility is likely with any federal proposals on these issues.

Rep. Tom Oliverson, M.D. (TX) stated that he agreed with most of Dr. Trish's statements but the vast majority of hospital-based physicians in America would prefer to be in-network rather than OON. There are reasons besides having a larger book of business as to why a hospital-based physician would want to be in the same network as the hospital and the surgeon, most notably the fact that you don't want to be the only person in that healthcare transaction who is OON. There is tremendous pressure that is put on hospital-based physicians to be in-network and rightly so. Insurers also exploit that by trying to entice such physicians to take a lower reimbursement to be in-network by suddenly terminating a contract and then calling the CEO of chief-of-staff and stating that their anesthesia is OON and you may want to think about replacing them or convincing them to take their best offer. Hospital-based physicians would prefer to be in-network primarily center around prompt-pay issues and if someone has the ability to get paid within 30 days as opposed to going through a difficult process of billing the insurer and getting paid 15% of what they would get paid as an in-network physician, and then bill the patient for the remainder, they would choose the former. Rep. Oliverson stated that these issues arise primarily because of gaps in coverage and inadequate networks. It is no surprise that the majority of inadequate network issues, at least in Texas, relate to hospital-based physicians. Rep. Oliverson stated that is not necessarily or exclusively the provider's fault. There is definitely financial incentives for keeping hospital-based providers out-of-networks if you can dump that cost onto the backs of the patients and then let them fight with providers. The solution is to get the patient out of the middle and it is unfortunate that putting the patient in the cross-hairs as become somewhat of a business practice.

Rep. Oliverson further stated that the issue with trying to lump everyone together under a standard payment and then deal only with the hospital and let them figure it out is that the job of the physician is to speak for the interest of the patient and when there are dollars and cents attached to tests and procedures and things that get ordered on the patient, if the doctor and the hospital's incentives are in alignment, who speaks for the best interest of the patient? It is conceivable that a patient may get an MRI when a chest x-ray would suffice if that doctor is in danger of not meeting his quota from the hospital in terms of making his bonus payment for that quarter. Dr. Trish noted that there are a lot of issues surrounding state corporate practice of medicine laws that create issues for certain type of payment structures.

Rep. Ferguson asked if any states have passed a law that deals with balance billing arbitration. Dr. Trish stated that NY, NJ, and IL have but it is her understanding that it has not been used yet in IL. Rep. Ferguson then asked whether those states use the in-network rate or a lower rate. Dr. Trish stated that in NY does not make its decisions public but the recently passed NJ law requires the decisions to be made public so there will be an opportunity to examine the specific numbers in the decisions.

Debra Judy, Policy Director at the Colorado Consumer Health Initiative (CCHI), stated that CCHI recently launched a consumer assistance program to help individuals navigate their claims and billing issues one of the issues CCHI hears from consumers about the most relates to surprise balance bills. Ms. Judy stated that CO has a hold harmless provision in current law relating to such bills but it has been determined that such a law alone does not do enough for consumers. After more than 5 years in trying to get balance billing legislation passed, it is everyone's hope that 2019 will be the year that something is enacted that will help consumers. Ms. Judy noted the results from a Kaiser Family Foundation poll in 2018 which stated that almost 70% of respondents stated that they were concerned about being able to pay for an unexpected medical bill, which ranked above the polled concerns of paying for a mortgage, insurance premiums, and prescription drugs. The poll also stated that almost 40% of respondents stated that they had received an unexpected medical bill in the past 12 months, 10% of which said the bill was from an OON provider.

Ms. Judy further stated that several studies have shown that almost 20% of emergency room visits have resulted involved surprise bills. Additionally, a Kaiser study focused on large employer health plans noted that about 18% of hospital stays included an OON claim. A recent study involving ambulance transports found that ambulances were OON about 50% of the time. Ms. Judy agreed that the main goal is to get the patient out of the middle because a 2016 survey on medical debt stated that among consumers with OON bills that they could not afford, almost 70% did not know that the provider was OON at the time of service which relates to issues relating to notice. Moreover, the average balance bill in that study was over \$622 but nearly half of Americans do not have the means to pay an unexpected \$400 charge without incurring debt.

Ms. Judy stated that from a consumer perspective, they do not want to get balance billed from providers when they had no choice and they want to be the ping pong ball between the provider and the carrier when trying to resolve the dispute. At the same time, consumers want their coverage to be affordable and as a consumer advocacy organization, CCHI wants to ensure that carriers are paying fair and reasonable rates but not exorbitant amounts as one example in CO has shown that there was a payment of almost 1,200% of Medicare. The NJ Policy Perspective conducted an analysis of the impact of involuntary OON billing in NJ and found that as a result of the billing practice, NJ citizens pay higher premiums to the tune of about \$957 million statewide.

Ms. Judy stated that CCHI believes that it is vitally important that consumers are held harmless by the carriers and that the providers are prohibited from balance billing. It is important to have both of those protections in place because in CO it has become clear that it does not work to just have one. Such protections also need to apply to both emergency room services and in-network facilities. CCHI has recognized that there are some situations where consumers intentionally go OON and CCHI is deliberating on how to craft legislation to respect that choice. Ms. Judy also stated that notice protections are particularly important in states where only partial balance billing protections exist. Past legislative attempts in CO have all required, at a minimum, notice by carriers, facilities and providers that there are existing consumer protections in CO already. It is also important for each of those entities to coordinate because it is important that the consumer receive consistent information. CCHI also supports transparency and notice about a provider's OON status and possible charges in planned, non-emergency situations, which is particularly helpful to those who have self-funded plans or if a state is

unable to adopt any other protections. To be clear, however, notice alone is not enough to solve the balance billing problem.

With regard to the benchmark rate which providers should be paid at, Ms. Judy stated that is the biggest stumbling block and suggestions such as a multiple of Medicare; a percentile of billed charges; the average in-network rate; a usual and customary rate; a reasonable rate; or some combination. Ms. Judy stated that CCHI is opposed to billed charges as being the rate and Medicare makes more sense as a starting point for a transparent reference point, although CCHI is open to looking at other suggestions such as using data on in-network rates and allowed amounts from the CO APCD. With regard to the federal proposals discussed by Dr. Trish, Ms. Judy stated that CCHI sees value in them since they regulate self-funded plans since about 1/3 of covered lives in CO are in self-funded plans and CCHI has been unsuccessful in crafting legislation to regulate self-funded plans. Additionally, the federal proposals take the patient out of the middle, apply to emergency settings, and address the in-network OON provider situation. Ms. Judy stated that she prefers the bi-partisan proposal since it limits the cost-sharing and has a prohibition on balance billing. Ms. Judy is more concerned about the other proposal since it has an opt-out provision if notice is provided at least 24 hours before the procedure as that is problematic for a consumer who has planned for a procedure well in-advance only to be informed of that information the day prior to the procedure. Ms. Judy stated that CCHI prefers having a benchmark rate amount as opposed to arbitration because the arbitration system could be costly administratively and for consumers through higher premiums. Ms. Judy noted that some of the conversations on the state level when discussing arbitration dealt with what type of fiscal note that would require depending on how it is set up.

Ms. Judy closed by stating that some other issues that have been discussed in CO relate to who will enforce the requirements at the end of the day; the insurance dep't; the medical service board; or another agency. Additionally, what should happen if a consumer erroneously pays a balance bill; should there be an obligation of provider repayment? Lastly, with regard to ambulances, they are almost never in-network and that issued needs to be resolved to protect consumers.

ADJOURNMENT

There being no further business, the Committee adjourned at 5:00 p.m.