

NATIONAL COUNCIL OF INSURANCE LEGISLATORS  
HEALTH INSURANCE AND LONG TERM CARE ISSUES COMMITTEE  
CHARLOTTE, NORTH CAROLINA  
MARCH 7, 2020  
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance and Long Term Care Issues Committee met at the Charlotte Marriott City Center Hotel in Charlotte, North Carolina on Saturday, March 7, 2020 at 9:00 a.m.

Assemblywoman Pam Hunter of New York, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Deborah Ferguson (AR)	Sen. Vickie Sawyer (NC)
Asm. Ken Cooley (CA)	Sen. Jerry Klein (ND)
Sen. Jack Tate (CO)	Sen. Shawn Vedaa (ND)
Rep. Martin Carbaugh (IN)	Asw. Maggie Carlton (NV)
Rep. Matt Lehman (IN)	Asw. Connie Munk (NV)
Rep. Joe Fischer (KY)	Asm. Kevin Cahill (NY)
Rep. Bart Rowland (KY)	Asm. Andrew Garbarino (NY)
Rep. Michael Webber (MI)	Sen. Bob Hackett (OH)
Sen. Paul Utke (MN)	Rep. Tom Oliverson, M.D. (TX)
Sen. Paul Wieland (MO)	

Other legislators present were:

Rep. Joe Cloud (AR)	Sen. Bob Peterson (OH)
Rep. Stephen Ross (NC)	Sen. Roger Picard (RI)

Also in attendance were:

Commissioner Tom Considine, NCOL CEO  
Will Melofchik, NCOIL General Counsel  
Cara Zimmermann, Assistant Director of Administration, NCOIL Support Services, LLC

## QUORUM

Upon a motion made by Rep. Martin Carbaugh (IN), and seconded by Sen. Vickie Sawyer (NC), the Committee waived the quorum requirement without objection by way of a voice vote.

## MINUTES

Upon a motion made by Sen. Paul Utke (MN), and seconded by Sen. Bob Hackett (OH), the Committee approved the minutes of its December 11, 2019 meeting in Austin, TX without objection by way of a voice vote.

**MAKING THE SWITCH FROM FEE-FOR-SERVICE TO MANAGED CARE: AN UPDATE ON NORTH CAROLINA'S MEDICAID TRANSFORMATION**

Jean Holliday, Sr. Program Manager, Division of Health Benefits at the North Carolina Department of Health and Human Services (DHHS), stated that the NC General Assembly passed session law 2015-245 in 2015 which basically directs DHHS to transition to managed care. From 2015 to 2018, DHHS engaged in extensive collaboration with getting feedback from a variety of stakeholders. In August of 2018, DHHS released a request for proposals. In October of 2018, DHHS received responses to those proposals and in February of 2019, the pre-paid health plans were selected. The vision for the Medicaid transformation is “To improve the health and well-being of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses both medical and non-medical drivers of health.” That is very critical and important that there is a whole-person approach in the division’s opinion as up to this point there was some bifurcation with benefits and who paid for them and what kind of system those benefits were received. DHHS wanted to provide its beneficiaries with one place where they would get all of their care and incorporate and integrate behavioral health benefits into the managed care products so that managed care products will include a certain amount of behavioral health benefits.

Ms. Holliday stated that the transformation goals included: Ensure budget predictability through shared risk and accountability; Ensure balanced quality, patient satisfaction, and financial measures; Ensure efficient and cost-effective administrative systems and structures; and Ensure a sustainable delivery system. DHHS has certainly kept those goals in mind as it has tried to build the program with its partners and taking stakeholder input throughout the past four years. The authorizing legislation also defined the role of the General Assembly, DHHS, PHPs and DOI; Defined a timeline for transformation; Defined which beneficiaries would be transitioned to managed care and when; Defined which benefits would be covered under managed care and which would remain as part of FFS; and Defined that the capitated contracts with PHPs would be awarded as a result of a competitive proposal process. That process was not competitive in terms of a price competition but was rather about who met the standards the best in terms of showing DHHS it understood the goals. They are capitated contracts and the state defines the capitated rate that the plans are paid so there was no money per se in the bids that came to DHHS.

Ms. Holliday stated that since the authorizing legislation, DHHS has collaborated extensively with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates, and other stakeholders to shape the program, and is committed to ensuring Medicaid managed care plans. This has not stopped since the issuance of the RFP – efforts are consistent to make sure everyone is ready. Goals within DHHS include: Deliver whole-person care through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models; Address the full set of factors that impact health, uniting communities and health care systems; Perform localized care management at the site of care, in the home or community; and Maintain broad provider participation by mitigating provider administrative burden. NC has enjoyed very broad participation in its fee-for-service program and the hope is that will continue with managed care.

1.6 of 2.2 million Medicaid beneficiaries will enroll in Standard Plans. Tailored plans will be offered later. Beneficiaries will be able to choose from Prepaid Health Plans (PHPs). Some beneficiaries will stay in fee-for-service until tailored plans are launched or because it provides services that meet specific needs, or they have limited benefits. This will be called NC Medicaid Direct. The authorizing legislation set up two types of PHPs,

the first being a commercial plan which is “Any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and holds a PHP license issued by the Department of Insurance.” The other type is a provider-led entity (PLE) which is an entity that meets all of the following criteria: A majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts for the delivery of Medicaid and NC Health Choice services or Medicaid and NC Health Choice providers; A majority of the entity's governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and (ii) have experience treating beneficiaries of the North Carolina Medicaid program; and Holds a PHP license issued by the Department of Insurance.

Ms. Holliday stated that the standard plan RFP stated that the commercial plans would have to be statewide if they chose to bid. The PLE's on the other hand could be a state wide regional or they could bid for both. That was done so that if there were regions that were begin bid on by PLEs, DHHS wanted to be sure there was appropriate coverage under the PLE provisions. The RFP was set up such that: Total of 4 statewide contracts (CP or PLE); Up to 12 regional contracts (PLE only); PLEs encouraged to propose for more than 1 region (contiguous); Only 1 regional contract for Regions 1 and 6 (far west and far east which are predominantly rural); and Up to 2 regional contracts for Regions 2, 3, 4 and 5.

The RFP was issued Aug. 9, 2018 and responses opened Oct. 12, 2018. The Department of Procurement & Contracts section reviewed proposals for completeness per RFP requirements. Over several months, the Evaluation Committee of Department professionals: Screened proposals for minimum qualifications outlined in RFP; Reviewed proposals and developed consensus scoring; and Used scoring to develop award selections. Four statewide PHP contracts were selected: AmeriHealth Caritas North Carolina, Inc.; Blue Cross and Blue Shield of North Carolina, Inc.; UnitedHealthcare of North Carolina, Inc.; and WellCare of North Carolina, Inc. One regional provider-led entity was selected: Carolina Complete Health, Inc. for Regions 3, 4 and 5 – a joint venture between the NC medical society and Centene. The regions have actually been in effect for a long time – six regions were set up in total.

Ms. Holliday stated that all Standard Plan PHPs will be subject to rigorous oversight by DHHS to ensure a successful managed care program. DHHS is leading intensive onboarding through the end of February, including introducing key staff, reviewing contract requirements and aligning on key milestones and deadlines. Unlike other states, DHHS essentially takes on all oversight of PHPs other than licensing and solvency which is done by the DOI. DHHS reviews network adequacy, contracting, benefit standards, and other aspects. DHHS has onboarding with the plans in February 2019 and since then DHHS has been working with them across all aspects of the PHP contract. The plans will need to pass a Readiness Review before Medicaid Managed Care launch. Most of that review was completed before the launch was suspended last fall. It is expected that when things pick back up, some minimal readiness review will have to be done. An inability to fulfill contract provisions can result in corrective action plans, financial penalties and other sanctions.

Integration is necessary for improved health. The three products that will be available once all plans are launched are: Standard Plans for most Medicaid and NC Health Choice beneficiaries; BH I/DD Tailored Plans for qualifying high-need populations with a serious mental illness, serious emotional disturbance, substance use disorder, I/DD, or traumatic brain injury - tentatively scheduled to launch about 1 year after SPs; and Statewide Foster Care Plan for children in foster care - tentatively scheduled to launch shortly after the launch of BH I/DD Tailored Plans. All three types of products will offer a robust set of behavioral health benefits; however, certain more intensive behavioral health benefits will only be available through BH I/DD Tailored Plans. There will be a continued focus on high-quality, local care management in all three types of products.

Improving provider engagement and support is very important because going from one payor to five payors is going to increase some of the administrative burden that the providers will be experiencing. That is sought to be achieved by actions such as: Incorporating a centralized, streamlined enrollment and credentialing process; Standardizing and simplifying processes and standards across Health Plans; Ensuring transparent payments for Health Plans and fair contracting and payments for clinicians; and Standardizing quality measures across Health Plans. These actions were important to address concerns from the providers who are very needed in the program and they are obviously encouraged to participate. Accordingly, training and outreach to them was conducted.

Ms. Holliday stated that the Medicaid transformation opportunities include: Focus on Population Health; Focus on Quality; Address Unmet Social Needs; and Pilot new initiatives i.e. Telemedicine, access to SUD and behavioral health treatment through IMD, in-lieu and value-added services. Ms. Holliday stated that the current status of the transformation is that it is suspended. Managed Care cannot go-live under a Continuing Resolution Budget. A new budget must include: Authority to pay capitation payments and claims run-out; Authority to utilize Transformation dollars; PHP tax authorization which is already included in the capitation rates; and Authority for the appropriate Hospital assessments. There is no specific launch date yet and DHHS is continuing to work with the PHPs to prepare them and test them for things such as network adequacy and IT issues. Ms. Holliday noted that there was significant progress made in anticipation of the February 2020 launch data but that has been put on hold without a budget.

Ms. Holliday noted that there have been significant suspension activities such as: Open Enrollment cancelled - Notified 1.6 million beneficiaries about the suspension; Held webinars, all-state calls and other engagement activities with provider and members explaining what was happening and what to expect; Continue to meet regularly with the health plans to move forward; Reduced vendor contracts with specialized skillsets; Engage with counties and other stakeholders to continue to facilitate the transition to managed care, including non-emergency medical transportation, ambulance, behavioral health crisis, health care systems; Moving forward with managed care related procurements including Member Ombudsman, External Quality Review Organization (EQRO), Healthy Opportunities Pilots.

Restarting wont be easy and there will have to be significant work in areas such as: CMS Readiness Review - Assess ability/capacity to operationalize Managed Care; Inbound Deliverables - Review and/or approve contractual deliverables as part of DHHS

oversight (e.g., clinical coverage policies, annual compliance plans, etc.); System Testing - Assess ability to ingest, process and transmit data and information with DHHS and vendors; Network Adequacy - Ensure we have sufficient providers contracted to provide services to Medicaid beneficiaries; and Technology Operations - Monitor call center/website issues and technology-related defects/issues (e.g., daily file exchanges, file defects).

Asw. Hunter asked if there is any idea as to when the suspension will end. Ms. Holliday stated that DHHS doesn't have a date in mind but knows that the NC General Assembly will return in April for short session. There is hope that a budget will be taken up but it is not clear.

#### CONTINUED DISCUSSION ON NCOIL SHORT TERM LIMITED DURATION INSURANCE (STLDI) MODEL ACT

Rep. Martin Carbaugh (IN), sponsor of the NCOIL STLDI Model Act (Model), thanked everyone that has worked on this Model thus far and noted that the Committee has been discussing the Model since last July and it is almost ready to put the Model forward for a vote. Since the Committee's last meeting in December, one change has been made to the Model. A drafting note has been added to the "Purpose" Section to make clear that States are not required to offer short term limited duration insurance plans. Rather, for states that choose to offer such plans, this Model is intended to serve as a framework that can be adjusted accordingly to meet each state's needs.

Rep. Carbaugh stated that he believes the drafting note is important because he knows opinions differ as to the value of short term insurance plans, and some states have in fact prohibited their sale. Rep. Carbaugh disagrees with those states as he is a strong believer in the product, but stated that nonetheless it's important for the Model to be clear that states are not required to offer these plans and the Model is meant to be a framework for states that do offer such plans. Rep. Carbaugh stated that he is open to making some further changes to the Model but would like to have the Model ready for a vote at the Summer Meeting in July. Accordingly, Rep. Carbaugh encouraged anyone seeking changes to the Model to submit those changes to him and NCOIL staff by May so that the Committee is ready to roll in July.

#### DISCUSSION ON NCOIL PATIENT DENTAL CARE BILL OF RIGHTS MODEL ACT (MODEL)

Asw. Hunter noted that the sponsor of the Model, Rep. George Keiser (ND), was unable to make it to the meeting and then turned it over to Rep. Deborah Ferguson (AR), Vice Chair of the Committee and co-sponsor of the Model. Rep. Ferguson stated that in the interest of full disclosure, she is a dentist but sold her practice so she will not financially benefit from anything in the Model. Rep. Ferguson stated that the Model is really about clarifying coverage when patients come into the office. Transparency is wanted from insurance companies so that providers accurately tell the patient what to expect. If you get a prior authorization you want to make sure that if they approve it, they pay for it, and it does not end up being a surprise bill for the patient. All of the Model's provisions have been adopted in some states and it really is about protecting the consumer and making sure there is transparency for dental insurers and providers so that coverage is understood and information is conveyed correctly.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA), stated that ADA is here today because there is a problem. Dental coverage in America is going in the wrong direction and needs correction in order to begin working for people again. In a paradox, dental coverage is expanding, meaning the number of people covered is expanding, but it is becoming less meaningful. For example, annual maximums on a typical dental insurance haven't gone up since the 1960s but the cost to purchase dental insurance has certainly risen. Couple that with the inflation of the dollar and you can see how the coverage that Americans are getting just doesn't add up to what it once did. To put this simply, patients deserve coverage that protects them, removes financial uncertainties rather than creating them, and is clear about what is covered and how to properly use the coverage. With those goals in mind, Mr. Olson stated that he is here today to speak about the Model which would collectively work to establish clear, simple, and transparent processes for dental coverage plans. These reforms set up protections for consumers and providers to ensure more reliability and predictability in the coverage. The Model focuses on five reforms: Network Leasing, Medical Loss Ratio, Retroactive Denial, Virtual Credit Cards and Prior Authorization. The five reforms have been passed in various states across the country.

Mr. Olson stated that he will focus today on three of the reforms but all five will help patients understand the coverage that they have. The first is network leasing. Dental carriers occasionally lease or rent the in-network relationship they have established with a provider to another entity such as another carrier or a TPA. Right now this can happen in many states without the provider's consent or knowledge. This hidden approach to building networks erodes patient-provider trust which can lead to incorrect assumptions about treatment plans and costs when the provider has no idea a patient is moving in or out of network. Network leasing laws, such as the one proposed in the Model, would expand transparency before networks are leased and provide an opportunity for providers to accept or refuse these contracts. This reform would reduce occurrences for unexpected bills for example following a procedure.

The second issue is retroactive denial. Currently, dental plans can require providers to repay claims payments when the dental plans discover they paid a claim erroneously even if the claim was processed years ago. This often results in a surprise bill for the patient. In the Model, dental plans would be limited to a reasonable time period such as 12 or 18 months where they can request refunds from providers where they have paid the claim in error.

The third issue is medical loss ratio (MLR). Currently, most major medical plans must abide by standards of how much the premiums paid must be applied to the medical care received versus the administrative cost. Dental plans are not currently held to this standard. However, two states – WA and CA – have already acted to require that dental plans report the vital information for those purchasing the benefits. This reporting-only requirement, which is in the Model, would allow purchases, whether employers or consumers, to know whether their plan is going to meet their needs in one easily accessible spot. One easily accessible spot is key – not hunting inside the DOI reporting on one individual carrier – to ensure that the dental plans are more transparent to the people they serve. The other two issues, prior authorization and virtual payment through credits cards, would meet the same goals of increasing transparency and removing barriers to accessing benefits.

Before concluding, Mr. Olson stated that he would like to address some comments submitted regarding leasing asking for an exemption in the Model for self-funded plans. 75% of dental benefits in this country, and growing, are now provided in self-funded arrangements. Putting that exemption in the Model would pull the teeth out. NCOIL currently has a Resolution adopted criticizing the reach of ERISA preemption in allowing carriers to avoid state law. There is no reason to provide an exception in this Model, particularly when it undercuts the role of state legislators in providing protection to the citizens in their states. Mr. Olson thanked the Committee for listening and stated that ADA believes that the reforms in the Model will work together to enable patients to feel more confident in their ability to receive and pay for care, enable dentists to more reliably plan for and provide care that fits their patient's needs because. That is a key point as dentists are often the ones explaining the coverage to the patient so they should know as much about it as possible. The reforms will also encourage a more stable and satisfied customer base for patients and providers to reliably participate in their dental coverage plans.

Eme Augustini, Executive Director of the National Association of Dental Plans (NADP), stated that she is here today with a coalition of trade associations that also includes America's Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI). The coalition is opposing the Model because it conflates several very complex issues and would impose burdensome regulations on carriers without a benefit to consumers. However, the coalition is not just here to oppose – it has an alternative. As background, NADP's members provide dental HMO, PPO, indemnity, and discount dental products to 90% of Americans that have dental benefits. At the end of 2018 there were approximately 260 million Americans, or about 80% of the population, that have dental benefits. Two thirds of that group have benefits through a private sources, most getting coverage through an employer or another group plan or program.

Ms. Augustini stated that in the majority of cases, employees pay some portion or all of the premium of their benefit. We know that consumers are twice as likely to go to the dentist when they have coverage and as prices increase on what is effectively a voluntary benefit, consumers are more likely to drop their benefits and lose the financial protection that affords access to their dentist and ultimately not get the dental care that they need – care that helps to prevent dental disease, helps to stave off pain and help manage some chronic medical conditions. Given this, and the voluntary nature of the benefit, it is good that premiums have remained low and stable with negative growth in some years. This is some important context to consider when looking at new regulations for dental plans. There should be balance in looking at consumer protections and provider protections with the cost to administer and ultimately any impact to premiums.

The Model has been presented as a transparency measure but the issues are much more complicated than that. The Model has five different unrelated subject areas some of which are problematic and have not been vetted. Others have appeared as legislation in a handful of states and have required a very lengthy and complete analysis. The Model contains extensive provisions on dental network leasing for example. A network leasing bill was introduced in NJ in April 2018 and wasn't enacted until more than a year later in August 2019 after a long and deliberative process that included many stakeholders. The model also has a section on prior authorization. Similar language was introduced in Arizona earlier this year. After the bill was vetted in meetings with providers and the insurance industry, the sponsor decided to pull the bill and instead

form a study committee that will meet for the remainder of this year to more fully vet and explore the issues.

The Model also has a section on MLR. The Affordable Care Act (ACA) did not apply loss ratio requirements to HIPAA excepted benefits including dental. While some of the other topics in the Model have at least appeared in a number of states, legislation implementing ACA-like MLR for dental plans have hardly been considered with only one state enacting a law in reporting. Most of the topics in the Model are disparate, complex, and don't belong in the same Model. While the Model is framed as a pro-patient measure, most of its provisions are really focused on regulating how dentists interact with their insurance carriers. With that being said, the coalition is not here to just oppose. Of all the issues in the Model, network leasing is one that has recently received quite a bit of attention. Over the last few years, several state dental associations have expressed concerns about leasing practices. Dentists have told NADP that they want more transparency in network leasing as well as the opportunity to opt out of leasing entirely. NADP worked with dental associations in those states to create compromise legislation that resolves the issues while also protecting network leasing as a practice which is beneficial to everyone including employers, consumers, and dentists. The collaborations have been productive and since 2018, six states have enacted similar laws.

While not all of those laws are necessarily the same, the ones in NJ and CA are considered the gold standard. Those laws are more extensive than those in any other state and represent the most aggressive regulation of dental network leasing in the U.S. the laws include stringent transparency requirements and opt out provisions that allow dentists to not participate in leasing at all if they so choose. That is why the coalition drafted alternative model text based on those laws which were the result of very lengthy discussions and contributions from many stakeholders including carriers and dentists. If the Committee wants or chooses to adopt a dental network leasing model, the coalition strongly encourages it to consider the alternative language. The coalition remains committed to working with the Committee to address the needs of providers while also protecting patients and dental consumers.

Karen Melchert, Regional VP of State Relations at the ACLI, stated that ACLI looks forward to continuing to work with NADP and AHIP to develop a Model that will actually help patients and also protect the dental insurance that ACLI's members provide.

Brendan Peppard, Regional Director of State Affairs at AHIP, stated that the fact that the issues in the Model are disparate and complex does not mean that they are not important. The coalition is not stating that it does not want to work on the issues, it's just that each issue is controversial. A lot of time has been spent on just the dental network leasing issue. Mr. Peppard stated that he worked on the NJ law when it was passed and he can assure the Committee that it required a lot of in depth work and compromise and it did not happen quickly. So, taking that issue first – as there are some legitimate issues that need to be addressed – and tackling that in a rationale way makes sense but it is going to take a lot of work. MLR is pretty well understood on the medical side but if you try to apply that to a benefit like a dental benefit, it is not straightforward and that will take a lot of time and work by itself. If you try and tackle all of these issues in one Model, the Committee may be biting off more than it can chew and the coalition believes that it is best to first deal with the leasing issue. That issue has received a lot of



attention and there are legitimate issues to be worked on to see if a compromise can be reached.

Andy Guggenheim, VP and Senior Counsel at the American Bankers Association (ABA), stated that he is here today to discuss Section E of the Model – Virtual Credit Card – Claim Payment/Transaction Fees Options. ABA fully supports the idea that dentists and other providers should have full transparency as to the methods of payments available to them and any fees related to those methods. ABA also believes that providers are best served when they have choices between payment methods and the ability to freely choose the method that best fits their needs. The marketplace is effective in determining payment options on commercial transactions. All payers are not alike. All providers are not alike. Payer must be able to address and utilize a variety of electronic funds transfers to address the cost and providers should be free to select the payment method that best serves their needs after considering relevant factors including the cost of acceptance.

The payment method a healthcare provider selects may depend on a variety of considerations, including the type of payer whether it's a health plan, a TPA or government entity, how often the provider gets paid by the payer, the type of provider, whether it's a hospital or solo practitioner, the amount of the claim, the process by which the healthcare provider reconciles the payment, and the practice management system utilized by the healthcare provider. In many cases, healthcare providers may determine a blend of electronic funds transfers, ACH and virtual credit cards across the spectrum of payers is the best course of action for them. Mr. Guggenheim stated that every payment method has a cost of acceptance. Healthcare providers pay banks lockbox services and revenue cycle management companies to process their check and ACH payments. There are holds on funds when depositing checks and internal staff time to re-associate remittance advice with ACH. If healthcare providers accept a virtual card, merchant fees, also referred to as interchange, will be assessed on the transaction. The amount of the interchange is dependent in large measure on the agreement the healthcare provider has with the business that provides them the card terminal. The rates for these merchant services are also negotiable.

With respect to Section E of the Model, Mr. Guggenheim stated that he would suggest the following amendments. Delete the requirement in section 3 for the following reasons: the provisions could require the disclosure of confidential information in violation of contractual covenants and/or trade secrets and proprietary information of the payor otherwise protected under state law. What a provider may change is unique to that provider. It's not one credit card company involved in the transaction. The card network is one participate but there also might be an issuing bank, a merchant acquirer, and perhaps others involved in every single card transaction. Also, the provision is not in any federal or state law pertaining to healthcare claim payments. If the goal of the Model is to create uniformity across all jurisdictions, the provision is inconsistent with nine jurisdictions that have enacted statutes regulating virtual credit card payments for healthcare claims.

The ABA also suggests removing the statement that lists offering by a dentist's agent for the following reason. Many parties that assess a fee pursuant to an agreement with a provider may not be an agent as that term is generally understood applicable law. In order to reflect the intent of the Model the section should guarantee that any party that has made an agreement with a provider to provide any services with a payment should

be required to disclose what fees may apply. This broader guarantee in the first sentence of the section requiring a provider to consent to the fee. To sum up, ABA agrees with the transparency provisions that are in the Model but they are not consistent with jurisdictions that have taken up the issue of virtual card payments and transactions that are associated with them.

Asw. Hunter asked how the Model specifically helps advance the rights of patients. Mr. Olson stated that it is important to understand that dental care and the transaction of dental care is an environment – it is not happening in isolation. It is correct to say that it appears that this is all related to transactions but those are so critical to patients to understanding what care they are receiving. The dentist is often the explainer of the care because dental insurance like medical insurance is often opaque to the people that are receiving the care. So, all of the Model's provisions are about shining as much light as possible on what is occurring in the background of the dental care being received and how the patients are paying for it.

For example, on prior authorization, a patient and a dentist will get a notice as to how much they are expected to pay for the care. If the insurance company walks back on that both the patient and provider are in a situation where what they expected to pay and what they expected to receive in the form of payment does not occur. In the case of retroactive denial, it is an error by the insurance company on a payment. The provider is then notified about the error and that they are going to have to go after the patient if they want the money. So again, that becomes a patient issue because downstream, there is the impact of whether the provider perhaps sours the relationship with the patient by going after the payment. Another example is with MLR. If you are a consumer who is maybe purchasing an individual plan and you have no idea that only 30% of what you are paying in premium is actually going towards you receiving care, that is information a patient should have and should know before they purchase a plan. Again, it is an environment and everything is interrelated so that is how it would impact patients as well.

Rep. Tom Oliverson, M.D. (TX), stated that he fundamentally doesn't understand the objection to a situation where a provider simply asking for clarification and the ability to opt out in terms of if I sign a contract with you to lease out your condo, that doesn't give me the right to sublease that condo to someone else without your permission. This is very similar and it is also essentially settled law on the medical side as the silent PPO issue has been dealt with and NCOIL has a model law on it which was recently readopted in 2017 settling the issue of whether providers should have certain rights and certain abilities to opt out and certain protections as far as notification with regard to leasing agreements.

Rep. Oliverson stated that to his way of thinking, these contracts are instruments that have been created between two parties, voluntarily, and as such those contracts have, in his opinion, ownership for both parties – it was a mutual agreement. And yet we're talking about leasing which means one party is taking that contract and financially benefitting from it without the permission or sometimes even the knowledge of the other party – that is egregious and incredibly unethical. The issue is not about the dental issue per se as much as it is parity. There is already law on this for the medical side in several states and what is being presented here with respect to dental leasing is more so parity between dental and medical issues. With respect to the virtual credit card issue, Rep. Oliverson stated that issue has been looked at in Texas and there are

significant cost differences for a provider in terms of an ACH payment which transaction may cost pennies versus a virtual credit card payment which may cost 3-5% in some circumstances. When its an ACH payment, you're talking about a charge that is paid for by the party that is initiating the payment but a virtual credit card payment always seems to fall on the shoulders of the person receiving the payment. That is a way to chip away at reimbursements for providers unnecessarily. Rep. Oliverson stated that he takes issue with the ABA's proposed deletion in Section E of the Model as it would be important to know of an additional source of revenue if that is the reason why the virtual credit card payment might be preferred since it does result in a significantly higher fee or reduction in payment to the provider on the backend which is completely different than the way an ACH transaction is handled.

Ms. Augustini stated that dental plans want participation in dental PPOs to be a positive experience for dentists and to be beneficial for their practices. There are several industry best practices carriers and network companies do employ to ensure transparency in the process of leasing. Original contracts do and should disclose that the network unless the provider agreement and the fee schedule can or will be leased. There are also usually ways for a provides to find out what third parties have access to the network. Carriers also disclose the source of the discount on remittance advice and much of this is reflected in the alternative language that the coalition has provided to the Committee. These types of provisions can ensure transparency in the process that is consistent with industry practice and doesn't necessarily challenge or diminish all the benefits that can come from leasing in terms of broadened access to dental benefits and dental care. Ms. Augustini stated that hopefully the alternative language provided can be useful when exploring this issue.

Rep. Matt Lehman (IN), NCOIL President, asked the panel to touch upon the issue referenced earlier regarding self-funded plans and how that relates to ERISA-preemption. Ms. Augustini stated that she is not aware of any provision in the Model or the alternative language relating to ERISA plans. Mr. Peppard stated that he is not aware of any provisions either.

Mr. Olson stated that he was referring earlier to a drafting note in the coalition's alternative language regarding self-funded plans and that is how the coalition is trying to capture that. Ms. Augustini stated that may be something that the coalition will want to look at because that is not the intent of the drafting note. The intent is to clarify the difference between carriers and leasing companies. Leasing companies are not carriers and they don't write insurance. Those companies recruit and develop dental networks which are leased to third parties like insurance carriers, TPAs, and self funded groups. Providers contract with leasing companies with the explicit understanding that and expectation that they will be leased. These companies are not under the alternative language exempt from the entirety of the Model but rather the one specific piece on opt outs which was established in the CA and NJ legislation. Applying opt out requirements to those entities would impair their central purpose as understood by all parties so they need to be specifically excluded from that specific provision. Ms. Augustini stated that she would be happy to return to the language to examine it to determine if it needs clarification.

Mr. Olson stated that the companies most impacted by that are self-funded – those that take advantage of the leases. Also, what the companies attempt to do when they don't have an opt out is get a network established in the blink of an eye without any

notification to the providers. Why should providers be treated two different ways depending on how the recruiting mechanism occurs? That is why ADA would oppose the exclusion being sought in that drafting note.

Rep. Carbaugh asked with regard to MLR, if it is the long term view that an ACA-like MLR should be imposed on the dental side and if so, how would that lower costs as we have seen MLR actually increase costs under the ACA. Rep. Carbaugh stated that in his conversations with insurance companies in IN, MLR has actually created a required spending that otherwise could have been lower but the companies have been forced to spend more and many studies have shown that it has actually contributed to the increase in healthcare costs. Accordingly, Rep. Carbaugh stated that he wants to be careful when discussing MLR that a cost increaser is not created when trying to make sure people just know what is going on. Mr. Olson stated that the experience in CA was that the dentists were initially on board with establishing something similar. However, something that everyone on the panel understands is that dental benefits are not dental insurance – it is a different animal in many regards and that is why MLR reporting is what was landed on. The ADA would find it a benefit just to have the transparency and have no inclination at this time to look for an imposition of an actual MLR requirement.

J.P. Wieske of the Health Benefits Institute stated that on the issue of opting out and self-funded plans, the institute has very serious concerns that the drafting note mentioned earlier will destroy pieces of that self-funded market. If you look at self-funding you are seeing groups that are getting down to five and six lives for a level funded premium. In the institute's interpretation, the alternative language would require approved permission for every single time an insurer is offering those programs to get new permissions in new networks for each one of those clients which makes it virtually impossible for the insured to maintain a good network and the administrative burden will be significant.

#### DISCUSSION ON NCOIL VISION CARE SERVICES MODEL ACT (Model)

Sen. Bob Hackett (OH), sponsor of the Model, stated that several years ago NCOIL adopted the Model Act Banning Fee Schedules for Uncovered Dental Services in an effort to prevent discounts from being forced on dentists. Forty states have adopted that Model but not Ohio as it has been very difficult to get it adopted. Accordingly, Sen. Hackett stated that he tried to enact legislation in Ohio using the same concept but on the vision side. The best bills that he has worked on have been when you get the interested parties in a room and see if they can work out a solution. That worked in Ohio because the optometrists and the vision plans got together to work things out. Sen. Hackett stated that this Model is still a work in progress as both sides are still discussing the issues. Sen. Hackett noted to the American Optometric Association (AOA) that if you get benefits you have to realize that it is a give and take world. The Model is similar to what passed in Ohio and it is also important to remember that the vision and dental industries are totally different. Vision deals more with materials where with dental you are talking more about services.

Robert Holden, State Gov't Affairs Director for the National Association of Vision Care Plans (NAVCP), stated that he is happy to work on this Model and noted that he worked on the Ohio legislation referenced by Sen. Hackett. NAVCP represents the 17 largest national vision care plans; they provide coverage to 178 million Americans; the networks include Optometrists and Ophthalmologists providing routine vision care – the routine

care being eye examinations and the purchase of eyewear, not medical illness to the eye; NAVCP does not represent retailers, eyewear manufacturers, or discount plan organizations. Mr. Holden noted that the dental Model referenced by Sen. Hackett has indeed been very successful and after it was adopted a number of folks looked at its application to the vision industry. There were some unintended consequences when that happened and that was due to the very different way that the vision industry has set up its benefits. The dental model was intended to prohibit services that were not covered from having a specific reimbursement. Since the success in Ohio, there has also been some success in other states with regard to negotiating language such as Arizona where a bill has passed the House and is expected to pass the Senate soon.

Mr. Holden stated that vision coverage addresses routine coverage and preventative care. Vision is frequently sold as a voluntary benefit. An employer may have vision coverage but the individual employee will decide whether they want to pay an additional premium to have that coverage. There is some self selection there. Folks that need eye wear or have some known corrective vision issues are very likely to purchase it. 74% of all vision benefits are done through standalone plans so it is not embedded in a medical plan, it is a separate document. The average premium is very low in comparison to medical – typically one-tenth of medical.

Unique to vision care, there are typically two transactions that occur. One is the annual eye examination and the other is the purchase of a retail item eye wear. That is very different from the dental environment. Vision benefits as plans reflect that so there is coverage for the annual examination, there is an allowance for choosing your frame for your glasses and then there is covered spectacle or contact lens additionally. One of the issues that the model attempts to address and has been addressed in other states is that there are options available to the enrollee to purchase on that covered lens. Typically, the enrollee pays out of pocket for those options. There is a covered lens but those options are something that they choose to pay for in addition to that. Vision plans are trying to limit that out of pocket cost because enrollees are coming in with a benefit to purchase a covered lens and they want to make sure that the overall cost is still within certain parameters. The other discount that vision plans will frequently negotiate with optometrists and ophthalmologists in their network is the ability to come in later once they have used their benefit to buy a second pair of frames and that is usually a discount on the usual and customary rate that the optometrist or ophthalmologist has in their office and they can choose how to offer that to the patient.

Mr. Holden stated that the advantage to this model is that as a preventative care vehicle, folks are four times more likely to get their eye exam compared to a physical. Eye exams detect a lot of changes in vision but diseases can also be identified like diabetes and hypertension ahead of time. The advantage of the benefit is that Americans are much more likely to get that eye examination if they have coverage and also to purchase eyewear if they have that coverage. The networks are structured to make sure that benefit is available. Providers are credentialed to make sure they can operate under their scope of practice. Access to certain materials and eyewear is also guaranteed to enrollees and it is made sure that they meet quality standards. The benefits to providers are also significant. Patients are being directed to network providers and those patients are visiting more frequently and they are also purchasing eye wear more often. They are more likely to buy eyewear from their provider in-network and they are also much more loyal.

Mr. Holden stated that the Model defines critical terms that are unique to vision which are not in the dental model and it provides providers the flexibility to choose not to offer these discounts and yet join the network. That is the fundamental compromise that was made – to make it optional. If providers want to provide discounts and correspond to plan pricing they may and if they don't they don't have to. The requirements on plans is that they can't discriminate against those providers and can inform enrollees that there is a different pricing model for the providers that choose not to participate. But that, as well as a notification at the point of service, are minimum consumer protections that need to be there so that they know what their options are and they know what the pricing might be instead of plan pricing.

Mr. Peppard stated that AHIP agrees with the points made by Mr. Holden and noted that part of the value of what plans provide to its members is the network itself. The ability for plans to communicate information about the network to members is essential in allowing members to get the full value of the benefit. To that point, the Model goes with the aim of consumer protection and interest first and foremost. A lot of what is in the Model does get at providing consumers the appropriate information. AHIP supports the Model but has just one clarifying amendments that it offered with regard to striking the last sentence in Section E as it is not necessary and the Section would read more simply if that sentence was deleted.

Dr. Rebecca Wartman and Dr. Steve Eiss, practicing optometrists, then spoke on behalf of the AOA. There are over 44,000 optometrists in the U.S. providing primary eye health and vision care that people need. Doctors of optometry are located in more than 10,000 communities and in counties covering 99% of the U.S. population. Many optometrists run independent, small businesses typically serving thousands of local patients unlike the consolidation you see in hospitals and medical doctors. Some optometrists are employed in chain stores and in big box settings controlled by large, vertically integrated corporations. Overall, optometrists serve millions of Americans families. Vision plan companies are billion dollar companies, some of which are foreign-owned who cover, administer or control vision benefits for nearly 200 million Americans. They typically do not spread the risk of catastrophic medical costs like health insurance does but instead act more like pre-paid benefit and discount plans. Like dental plans, they are typically not held to the same rules as group health plans or health insurance companies. In fact, the two largest vision plans alone claim to serve 145 million people and are arguably even more dominant in the market for materials such as frames and lenses – they have extraordinary market power.

Dr. Wartman stated that 40 states have adopted the aforementioned NCOIL dental Model and about 23 states have enacted similar laws to corral the self-serving tactics of vision plans with non-covered vision services and materials. If NCOIL did nothing else but repeat the same law for eye doctors and vision plans as NCOIL did for dentists and dental plans and applied it to the services and prescription of eye glasses and contact lenses then you would be helping patients and doctors.

Dr. Eiss stated that a vision plan is mainly a prepaid benefit discount plan. Patients pay for discounts the vision plans negotiate with doctors. However, vision plan companies have gone a step further and set prices for services and materials that are not covered. In other words, vision plans – as dental plans once did – aggressively used their market power to set prices for additional services and items and neither patients nor the plans provide any additional considerations to the doctors. But the vision plan companies will

try to tell you that this lowers the prices for patients but it actually does the opposite. More often, doctors have to raise their prices for all patients just to make up the artificial discounts the vision plans require. Just like employees in other small businesses ask for cost of living pay increases every year, discounting these extra services all across the board has the negative effect of having to raise prices in order to cover the cost of your employees and your business.

Dr. Eiss stated that all these increased costs tend to fall on patients that are not covered by the plans and that tends to fall on the elderly and the low income patients who don't have the vision plans to give them the extra discounts. A few moments ago, it was mentioned that vision plans are part of large corporations who also control the market for frames and lenses and that some optometrists work for chains and big box stores. Those same companies that control benefits for 145 million Americans also own those chains and as a result also employ optometrists. These large companies surely have the freedom to set their prices in retail stores but by way of these discounts for noncovered services they are also setting prices for their competitors – the independent eye doctor. They use these anti-competitive contract provisions to make sure that tens of thousands of independent eye doctors can't lower their prices. In other words, vision plans set the discounts. These discounts prevent doctors from setting their own prices which in some cases may actually be less than the contractual discounts. The result is vision plans setting prices for both optometrists both outside and inside the store chains. You can't really charge less or more because of the plan-made discounts for the noncovered services.

Another disadvantage for the private family eye doctors is that the same vision plan companies control much of the supply chain including the frame manufacturers, lens manufacturers and the labs where they are assembled. In the Model before the Committee, the vision plan companies want to create loopholes – loopholes that don't appear in the NCOIL dental model – so these large companies can continue to steer patients to the most profitable company owned sites. Vision plans will also try to tell you that they want to add provisions that allow doctors to choose to give discounts. If you put an end to these corporations controlling the prices then doctors will actually have the freedom to compete and to lower prices sometimes below what the vision plans dictate you to pay.

Dr. Eiss then spoke to issues of enforcement. The AOA has submitted comments as to how to improve the Model to better meet the goal of protecting patients. The vision plan companies oppose these laws in every state so the fact that they support the Model as written should tell you something. Even when they have agreed to language they don't want to actually abide by it. Vision plans have objected to legislation in every state, have resisted compliance and sought to write loopholes and poison pills into bills. Ohio optometrists are struggling to have their state law enforced even though the vision plans hailed it as a compromise. In Ohio and nearly every other state that enacted a prohibition on setting prices for noncovered services, optometrists have struggled to get the vision plan companies to follow the intent and letter of the law. The AOA recommends an amendment to the Model regarding enforcement so that state regulators can force the vision plans to comply. This is important because vision plans are typically exempted from many of the rules that apply to health insurance. Even better, allow a private right of action so independent family optometrists can go to court if need be to stop the vision plans from trying to control what the doctor charges for services and material that the vision plans don't cover.

Dr. Wartman stated that the vision plan companies will try to tell you that their schemes are good for doctors but the AOA represents the doctors they are here to say they disagree. The AOA is also here to say that the gigantic vision plan companies use their market power to demand so called discounts for services and items they don't cover is actually harmful to independent doctors, patients, consumers, legislators and the families and constituents they represent. The Model should closely follow the dental Model for noncovered services but include prescription contacts and eyeglass lenses and include an enforcement provision.

Asw. Hunter stated that going forward perhaps more discussion should be spent on online services because it seems that is now a large part of the market and consumers are taking advantage of the lower costs in that space.

Sen. Hackett stated that in Ohio there was not much pushback from the optometrists and asked the AOA why that was the case. Dr. Eiss stated that may be because the Ohio law addressed the noncovered services in that they were able to be part of the panel and not have to offer the noncovered services. The concern with some of the language in the Model is that there is some grey area and some loopholes where the doctors may not necessarily be able to opt out of those noncovered services the way they could in Ohio and a lot of other states without it either affecting their network status or affecting how they are reported. Sen. Hackett stated that he does not want any unintended consequences and he thinks NAVCP doesn't – if they choose not to offer the noncovered services they should still be able to be part of the network.

Dr. Wartman stated that one of the reasons that optometry will participate in networks is because of access to patients because we all know that if there is a difference in a \$5 copay, a patient is going to pick a different provider. But as a consumer, if I look in a provider manual and see provider A offers a discount and provider B doesn't, that is like putting a scarlet letter on the one that doesn't offer a discount when indeed they may not abide by the contracted discount or accept the contracted discount and provide higher discounts or other ways of getting materials that are actually better for the consumer and more cost effective for the consumer.

Asm. Andrew Garbarino (NY) asked what has happened with reimbursement rates over the past several years. Dr. Eiss stated that he has been in practice for awhile and has a multi-location practice and participate in quite a few networks. The majority of vision plans in that timeframe have not increased any reimbursement and there is one that has gone down since starting practice in 1995. A couple have gone up percentage points but you're talking minimal increases occasionally and nothing consistent. Dr. Wartman stated that overall there has been downward pressure or at least certainly no increase in medical reimbursement across the board during that time while cost of living certainly goes up.

Rep. Ferguson asked if she is understanding correctly that even if you wanted to sell services at less than the vision plan fee you could not tell the patient that; almost like a gag clause in the PBM-pharmacy context. Dr. Wartman replied yes – if I have a contract that says I am going to give you a 20% discount on a noncovered service then I have to give you a 20% discount when normally I might give a bigger discount. Also if I am not forced to give discounts on noncovered services then the cost of those services may



indeed be priced less to begin with because I don't have that pressure to make sure that I can stay in business to be able to serve those patients.

Mr. Holdman stated that the Model as proposed would allow for all providers to opt out of any discounts that they did not want to give on a noncovered service. The concern of NAVCP is that such information be made available to the enrollees because in a dental context, if I go in for a teeth cleaning or something else and there is another service that the dentist provides to me that is not covered, that is its own transaction/service. Here, an enrollee is walking into their optometrist's office and purchasing a covered lens and there are upsell options that can be delivered on that lens to the enrollee. Plans have negotiated prices on those options to limit the overall cost and they would like to continue to do that but that is only with the permission of the optometrist. Plans are not making participation in the network contingent on them agreeing to that so they can have their own discounts and set their pricing at whatever they want. Plans just want the ability to notify their enrollees of that. Also, with regard to lowering fees in response to Dr. Wartman's comment, that would be fine under the Model, and there is also language in the Model that states that no gag clauses are permitted in any agreements.

Dr. Eiss stated that what is a little different with the noncovered services for glasses is that when the patient comes in and orders the glasses they are given the cost and the fees upfront before they even order the glasses. So, there is not a situation of surprise billing where they will get a bill afterwards that says "this wasn't discounted or covered the way you expected" – they'll have all of that information upfront and can make that decision before they order the glasses.

#### CONTINUED DISCUSSION ON NCOIL HEALTH CARE SHARING MINISTRY (HCSM) REGISTRATION MODEL ACT (Model)

Rep. Carbaugh, sponsor of the Model, stated that the Committee has had two very productive discussions on this issue at its past two meetings. Rep. Carbaugh stated he wanted to make clear that in no way shape or form is this Model seeking to legitimize or authorize the bad actors that we have unfortunately read about in the news the past several months. The Model instead is intended to do the exact opposite – build a legislative and regulatory framework applicable to HCSMs so that public policymakers are better informed of how they operate. Indeed, the Committee may hear from some members of the industry suggesting ways to add to the Model. The Model is a good starting point for what that framework can be, and some states have actually already introduced a version of this draft Model. That is a good sign that the work of this Committee on this issue is very important and is being received well across the country. Rep. Carbaugh stated that he hopes this Committee can continue to make progress with the Model and he looks forward to hearing from the panel today.

Scott Reddig, CEO of Christian Care Ministries (CCM), stated that CCM operates the health care sharing program, Medishare. Mr. Reddig thanked Rep. Carbaugh, Asw. Hunter, and the Committee for allowing him to speak on this panel pertaining to health care sharing and possible model legislation. Mr. Reddig stated that fundamentally, health care sharing ministries are communities of members who have come together to share in each other's medical expense burdens. The members typically agree with and confirm a particular set of religious beliefs; and the type of medical expenses they share are influenced by and/or are an expression of those religious beliefs. Medi-Share is a health care sharing ministry administered by CCM, based in Melbourne, FL. It has over

400,000 members throughout the United States. As a Christian faith community, Medi-Share has been facilitating the voluntary sharing of medical expenses among its members since 1993 as an exercise and expression of the members' beliefs. Since its inception, MediShare's members have shared over three billion dollars of medical expenses incurred by its members. Indeed, during that time Medi-Share members have fully shared every incurred medical expense eligible for sharing in accordance with guidelines adopted by the members, which CCM believes reflects God's faithfulness to the ministry.

Though different than insurance, CCM believes Medi-Share, as well as other ministries, offer a health care financing solution that serves at least a couple public policy goals. One, it provides another choice for some US residents to meet their medical expense burdens, and two, it provides people of faith a mechanism that meets their health care needs that is more consistent with their religious beliefs. It is a different solution than health insurance, particularly in that the members of health care sharing ministries are not legally obligated to pay other members' burdens. But, member to member sharing and/or belonging to a community that very visibly and tangibly supports one another, and the sincere belief that these ministries provide a vehicle for God to provide support for the members in need. All this gives members a very positive experience and confidence that their needs will be met.

Mr. Reddig stated that he might add a couple facts about Medishare that will underscore this point. The program consistently receives A+ ratings with the BBB; and the satisfaction scores that we receive from members, using a scoring system similar to how many businesses monitor customer experience, is very high. Also, if you were able to listen to calls into the member service center, you would hear member representatives praying and offering care and encouragement to members all day long every day. It have a chaplain who came on board last year who observed that those member reps do more ministry in a week than a church pastor does in a year. Mr. Reddig stated that his message in sharing this background is to say CCM wants to help address concerns, but also wants everyone to appreciate these ministry programs are a very positive option in the marketplace, particularly for people of faith.

There is a history of legal and regulatory discussions surrounding HCSMs such as how to have oversight over them and what is different about them compared to insurance. There are safe harbor laws in about 30 states and the ACA provided an exemption for HCSMs from the individual mandate and provided a useful definition of a HCSM. But in the last year, several state regulators have investigated complaints about the Alera companies and Trinity Healthcare and expressed frustration over consumer confusion and even possible unlawful conduct committed by Alera or Trinity.

Mr. Reddig stated that with that background, CCM would like to respectfully submit a proposal to address the questions that have arisen, partly those from the last year, but even some that have lingered from prior years. Before the details, few aspects of the thinking behind this proposal is that CCM is positioned well to offer a proposal for crafting model legislation regarding Health Care Sharing, partly because it holds a leadership position within this small "market space", partly because it has participated in numerous conversations about current issues with other health care ministries through different forums in the last year and feels it has a pretty good handle on the various perspectives, and partly because it has begun to gain a greater appreciation for what is on the minds of regulators or legislators that have given some attention to these issues.

The proposed model legislation, which builds from what NCOIL discussed at its December meeting, offers a form of so-called “registration” as an alternative form of regulating this small part of the overall market of health financing alternatives. There are several ministries who will argue that registration, or any form of regulating health care sharing, is unnecessary. They note, in particular, that existing laws already empower Attorneys General to take action when there is true fraud and deceptive practices committed by a HCSM, and Insurance Commissioners have similar authority over producers like Alieria, and over insurance products that merely purport to be sharing programs. CCM is very sympathetic to this argument. And, if a state deems this additional legislation unnecessary, CCM would understand and support that conclusion. However, CCM also recognizes that this idea of registration offers a means to make the health care sharing space a bit less mysterious. If, by offering some information through this registration mechanism, we can increase transparency for how the ministry programs work, what medical expenses they share, etc...and just simply set some ground rules so that state officials can understand who is operating such programs, that is a good thing. On behalf of Medi-Share, CCM is happy to provide such information and can support a mechanism for extra transparency.

However, CCM notes that it doesn't think it's wise or necessary to make this legislation overly detailed and prescriptive. CCM has seen or heard proposals that, for example, propose to ban HCSMs from using insurance agents. CCM thinks that's an over-reaction and mis-reading of the lessons learned from Alieria. In fact, CCM thinks the use of properly trained agents (or as CCM calls them, new member representatives) could be a positive force in clearing up consumer confusion. In CCM's case, it finds that equipping an insurance agent (who, by definition, is an expert about the insurance product) with knowledge of its Medishare health sharing program provides the consumer with a well informed comparison of Medishare to insurance, allowing them to make a much more informed decision. Bottom line, CCM thinks it have crafted an update to the model legislation that provides a balanced way to address a whole host of questions that have accumulated in recent years, and especially in the last year because of the Alieria/Trinity situation.

Stuart Lark, Sherman & Howard, L.L.C. and General Counsel to CCM, stated that CCM's draft proposal was recently submitted to Rep. Carbaugh and NCOIL staff. Generally, the draft requires that sharing programs provide information to members and to state officials that are relevant to the ministry, prohibits sharing programs from engaging in deceptive practices, provides enforcement authority to state officials to enforce the operation and registration requirements. Mr. Lark stated that CCM looks forward to working on the draft with the Committee going forward.

Robert Baldwin, COO of Sharable, stated that his perspective on these issues is a little different from the HCSMs that the Committee has heard from today and in previous meetings. Mr. Baldwin stated that he and a colleague used to run CCM from 2004-2016 so he has had a lot of experience in the industry and have interfaced extensively with regulators and legislators. Sharable is a consulting and software company that was formed to help existing and new health care sharing organizations to practice health care sharing in a way that complies with the state safe harbor provisions. Mr. Baldwin stated that he is here today to thank Rep. Carbaugh for introducing the Model, support it, and suggest a few changes. Mr. Baldwin thanked Rep. Carbaugh for addressing some misconceptions about the industry. There are legitimate HCSMs out there and everyone

in the industry wants to see the good actors promoted and not the bad actors. Sharable exists to advocate for responsible growth in the industry and to help guard against bad actors.

Mr. Baldwin then suggested a few changes to the Model. First would be to remove the reference to U.S.C. 26 § 5000 which is the ACA's individual mandate exemption section and the 1999 date-stamp. That is a provision that requires HHS to recognize only those organization that existed prior to 1999 that met certain definitions. That code in particular is facing stiff legal headwinds today and therefore Sharable believes the Model would benefit from having its own definition of what constitutes health care sharing. To that point, Sharable also recognizes that the safe harbor state statutes probably are going to be usurped by the Model so there is value in looking at those safe harbors and integrating as the new definition of health care sharing the majority of provisions that are contained in them such as: having a common set of ethical and religious beliefs; an annual audit; being a 501(c)3 not for profit organization; where the HCSM acts as a facilitator of matching members who have needs with those who have financial resources to satisfy those needs; and no assumption of risk or promise to pay. Those are all provisions that are present in the majority of safe harbor statutes.

With regard to the Model's anti-fraud provisions, Sharable agrees with the language and also supports the inclusion of anti-fraud provisions that protect the organizations themselves such as those relating to consumer-fraud against the HCSM and/or providers committing fraud against the HCSM. Finally, the inclusion of a member's bill of rights would be a great addition to the Model. That kind of consumer protection and transparency could take the form of points of transparency in pricing – when a member receives their monthly share notice, they should be told how much they pay each month goes directly towards the payment of medical bills of other members as well as to the administrative and program expenses and those are easy things to do. Including the provision for consumers to have binding legal arbitration would also be beneficial which is present today in the typical insurance space. Mr. Baldwin noted that many ministries have multiple steps that benefit the consumer member even before they get to the point of wanting binding legal arbitration.

Disclosing medical bill payments and to whom those payments are going to support would also be beneficial. That is one of the differentiators between health care sharing and health insurance – it really is a community of people coming together to share each other's bills. Next would be a provision that states members can keep their membership even if they get sick. That is also a provision that is in many safe harbor statutes. Also, things that would be considered abuses in the insurance world such as two-tier rating structures could be included in the Model. Also, Mr. Baldwin stated that regulators have often asked him if the ministry denies a bill for sharing and deems it not eligible for sharing pursuant to the ministry's guidelines, does anyone in the organization benefit from that being denied. Mr. Baldwin stated that as far as he knows that is not a practice in any ministry but if that is a concern then perhaps that could be included in a member's bill of rights.

Matthew Smith, Executive Director of the Coalition Against Insurance Fraud (Coalition), stated that the Coalition and its member organizations do not take any position in favor or opposed to HCSMs. That is not the Coalition's role – it is a consumer advocacy organization fighting all forms of insurance fraud across the nation. One of the largest areas, especially after Alera, that the Coalition and as a consumer representative to the

NAIC that Mr. Smith has seen is consumer complaints and fraudulent practices surrounding HCSMs. That is not an indictment to anyone here but a reality that fraud needs to be addressed. Mr. Smith stated that this cannot be left to the State Attorneys Generals. Because when you talk to players in this space and ask for their anti-fraud plan, no one has one and no AG has the power to mandate that. When you talk to players in this space, and you use the term special investigative unit (SIU), no one knows what you are talking about. No AG has the power to impose a duty to have special investigations conducted both to preserve providers and to protect consumers. When you ask providers in this space to show an anti-fraud plan – where are your written efforts to show that you are undertaking to protect your members and your company, no one can produce a plan. No AG has the power to order that.

Mr. Smith stated that in working with leadership behind this effort, language has been crafted that was provided by the Coalition that if adopted, would be groundbreaking. The language recognizes that HCSMs are not insurance carriers and not regulated insurers but voluntarily submits them to 100% of the state's laws and regulations protecting consumers from fraudulent practices. Mr. Smith stated that absent that language, the Coalition would be opposed to any type of provision moving forward that does not contain anti-fraud protections. The language reads: Each health care sharing ministry registered in [state], even though not an insurance company, shall be subject to, and comply fully with, the same anti-fraud provisions and requirements that otherwise apply to insurance companies in [state]. Each member of a registered health care sharing ministry shall covenant not to engage in or assist others in commission of fraudulent practices, including but not limited to the processes of enrollment, seeking medical treatment and reimbursement for medical care.

Mr. Smith also noted that it is important to have on every state DOI website language which states that HCSMs are not insurance programs. Such language does not indict those programs but simply and fairly informs the consumers that if they go with an alternative plan that the DOI may not be able to help them.

Asw. Hunter noted that the Committee was running past its allotted time and accordingly encouraged all Committee members to reach out to the panelists if they have questions and to ask NCOIL staff for their contact information if they need it.

Rep. Joe Fischer (KY), NCOIL Secretary, stated that when we talk about things like anti-fraud and a bill of rights, what promises do the HCSMs make that could be the basis for a claim of fraud or a claim of misrepresentation. What rights do the members have in the HCSMs to make those claims; is there a legal basis for making the claims? Mr. Baldwin stated that while health care sharing is not insurance and not a promise to pay, there is an implied commitment by the organization to process medical bills fairly, consistently, and according to the organization's guidelines. If an organization decided to process a medical bill pursuant to those guidelines for one member but not another, then that could be fraud. Rep. Fischer asked if that means that the guidelines are sort of a quasi contractual obligation. Mr. Baldwin stated that the guidelines are the rules for how medical bills are shared among the members so that is what the organization uses to determine if a bill is eligible or not to be shared.

Asw. Maggie Carlton (NV), stated that hearing this reminds her of having to unwind confusion surrounding medical discount plans. Because that information was on the DOI website, everyone thought that a medical discount plan was insurance so it ended

having to be moved to consumer protection so people didn't automatically conflate it with insurance. Accordingly, full disclosure is great but once it is on the DOI website people automatically think that is where they should go to file a complaint. Asw. Carlton stated that she has concerns with this being with the department of insurance and thinks that the consumer protection division would handle any complaints appropriately.

Rep. Carbaugh asked Mr. Smith if the Coalition has a position regarding the request referenced earlier to strike the 1999 timestamp in the U.S. Code. Mr. Smith replied no. Rep. Carbaugh stated that he looks forward to continuing to work on the Model and encouraged anyone with comments on the Model to direct them to him and NCOIL staff.

#### ADJOURNMENT

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