NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
ALEXANDRIA, VIRGINIA
SEPTEMBER 26, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health insurance & Long Term Care Issues Committee met at the Hilton Alexandria Old Town Hotel on Saturday, September 26, 2020 at 11:30 A.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Rep. Deborah Ferguson (AR)*
Asm. Ken Cooley (CA)*
Rep. Martin Carbaugh (IN)*
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)*
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Rep. Dean Schamore (KY)
Rep. Brenda Carter (MI)
Rep. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)
Asm. Kevin Cahill (NY)
Sen. Jim Seward (NY)*
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)

Other legislators present were:

Rep. Edmond Jordan (LA)*
Sen. Kirk Talbot (LA)
Rep. Kevin Coleman (MI)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

Upon a motion made by Asm. Kevin Cahill (NY), NCOIL Treasurer, and seconded by Sen. Paul Utke (MN) the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Sen. Jim Seward (NY) and seconded by Rep. Joe Fischer, NCOIL Secretary, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's March 7, 2020 and August 21, 2020 meetings.

CONSIDERATION OF NCOIL SHORT TERM LIMITED DURATION INSURANCE (STLDI) MODEL ACT

Rep. Martin Carbaugh (IN), sponsor of the NCOIL STLDI Model (Model), thanked everyone that has worked on this Model and noted that he greatly appreciates everyone's input. The Committee has been discussing the Model since last July and it seems that the Committee is finally ready to put the Model forward for a vote. The Model can be viewed in the binders starting on page 258. Rep. Carbaugh stated that he believes very strongly that STLDI plans are products that can really help people. This Model is based on the bill that he sponsored in Indiana and upon that bill being signed into law, many uninsured people in Indiana have been helped by these plans, and many businesses have come into the state to provide more competition and therefore lower prices. Rep. Carbaugh stated that he has seen in Indiana that plans have offered the minimum coverages required by the law and then some due to competition so that is exciting.

Rep. Carbaugh noted that as he has stated previously, it is important to note that States are free to oversee, regulate, and even ban short-term plans – that is why he included the drafting note in Section 2 of the Model stating: "States are not required to offer short term limited duration insurance plans. 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." The drafting note is important because opinions differ as to the value of short-term insurance plans, and some states have in fact prohibited their sale. Rep. Carbaugh stated that he disagrees with those states but that doesn't mean that every state has to function the same and offer these plans. Rep. Carbaugh stated that he hopes that the states that have looked down on STLDI plans in the past could perhaps look to the Model and what has happened in Indiana to reconsider their position.

Rep. Carbaugh stated that the Committee had a great Zoom meeting about a month ago during which a final discussion was held on the Model. Rep. Carbaugh stated again that he greatly appreciates everyone's input.

Upon a Motion made by Rep. Dean Schamore (KY) and seconded by Rep. Matt Lehman (IN), NCOIL President, the Committee voted to adopt the Model by way of a voice vote. Asm. Kevin Cahill (NY), NCOIL Treasurer, was the only vote against adoption.

INTRODUCTION AND DISCUSSION ON NCOIL TELEMEDICINE AUTHORIZATION AND REIMBURSEMENT MODEL ACT (MODEL)

Asw. Pam Hunter, sponsor of the Model, stated that many of those here today, whether in-person or virtually, were most likely on the interim Zoom meeting this Committee had about a month ago during which this topic was introduced and it was indicated that the first draft of a Model would be forthcoming. The first draft of the Model is in the binders on page 265 and it is a good starting point for this Committee. This issue is a perfect opportunity for NCOIL to step in and provide guidance to states. The expansion of telemedicine has undoubtedly been one of the most significant issues the industry and consumers have faced throughout the past several months. New York faced issues surrounding in-person medical visits and reimbursement levels and people not having broadband internet to be able to be on a telemedicine visit with their provider.

It is clear that action is needed on the state level to make sure that the proper legislative framework is in place such that consumers are best protected. NCOIL is a perfect forum for us lawmakers to debate what should or should not be in model legislation for states to consider adopting. Asw. Hunter stated that she is proud to sponsor the Model and looks forward to discussing and developing it throughout the next several months. The Model is a good starting

point but it is indeed a first draft and there is certainly much work to do. Asw. Hunter appreciates all of the comments already submitted.

The Hon. Dean Cameron, Director of the Idaho Department of Insurance (DOI) and National Association of Insurance Commissioners (NAIC) Vice President, applauded NCOIL for discussing this important issue. Idaho, like many other states and the federal government, moved to loosen restrictions and remove barriers for telemedicine during the pandemic. That causes us all to evaluate and reconsider those barriers that were there in the past. Idaho went from an average of 200 telemedicine visits per month to over 28,000 in April and it has dramatically moved forward. Idaho has five carriers and the ID DOI worked very closely with them to remove any barriers to allow them to expand networks and have the discussion and be able to use any provider who was willing to use the telemedicine platform. That has worked pretty successfully – all of the carriers even though they were not required to by law did pay providers at parity or at the same rate as if they were visiting in person. Dir. Cameron stated he does not know if that will stand that way forever but at least that is the way it is for the foreseeable future as they are trying to benefit consumers and give consumers choices.

Idaho has also seen where telemedicine has helped those with a mental illness and needed a mental health provider – it turned out to be in some cases a preferred methodology to receive treatment and have that discussion. Dir. Cameron then shared some data from what the NAIC has collected and noted that the NAIC is certainly willing to work with NCOIL as these discussions are had. There are some considerations at the federal level whether to continue to relax some privacy concerns and other concerns with telemedicine. Nearly 45 states have taken action since March to expand telehealth. 25 states issued orders to state regulated insurers. Nineteen states publicized requests to insurers and 10 ten states provided notice of relaxed enforcement. Idaho is not big on issuing orders but the DOI did remove barriers and probably would fall into the relaxed enforcement category. Idaho wanted to make sure consumers were protected. Many states provided state regulated insurers with similar flexibilities in Medicare providers including those related to other platforms and sites.

In addition to the 10 states with preexisting state laws on parity, about 11 states issued bulletins or emergency regulations on payment parity. Idaho worked with its carries to encourage payment parity during the pandemic but it also recognized that there is a potential unintended consequence of payment parity of carries moving to more out of state providers in the event that they are forced to do payment parity. Idaho has chosen to not get in the middle of those negotiated contracts between providers and the carriers.

Ann Mond Johnson, CEO of the American Telemedicine Association (ATA), stated that she is delighted to speak to the Committee about what ATA has seen in telehealth across the country and about ATA as well. The ATA is the longest standing organization focused exclusively on the expansion, dissemination, and adoption of telehealth. The vision of ATA is to ensure that Americans get care where and when they need it and when they do they know its safe, effective and appropriate while enabling clinicians to do more good for more people. ATA's membership includes a very wide range of organizations including delivery systems, payers, academic medical centers, pediatric facilities, and a range of solution providers including organizations like American Well and Teledoc Health as well as organizations like Zipnosis and BrightMD both of whom were at the forefront of providing support to delivery systems as they scaled their response during the pandemic.

ATA also includes in its memberships organizations like Babylon Health and Conversa that provide artificial intelligence (AI) driven solutions for consumers. ATA also has organizations

that provide lifestyle and direct to consumer asynchronous support. And ATA also has members who provide remote monitoring to many of the hospitals in communities. ATA also includes in its membership a number of organizations like Microsoft, Sony, Verizon, HPintel which are organizations that are really enabling telehealth and believe in the idea that high water floats all boats.

Ms. Johnson stated that she would be remiss if she did not acknowledge that many of the statistics in terms of the incredible growth of the number of telehealth visits. Telehealth is very broadly defined in our lexicon and includes synchronous communication like we are having now where we can see each other and go back and forth in real time. It includes asynchronous communication which could be text based and a delay in providing communication and it also includes remote monitoring which has been a lifeline for many Americans during the pandemic. The amount of activity that took place shows an incredible surge leading up to week 15 of this year in early April and now we are seeing it drop off. What we have seen is that the decline in telehealth visits has not been to the same levels as it was previously before the pandemic so it is safe to say that ATA is committed to ensuring that telehealth remains in place as long as it provides a safe and affordable and effective option for Americans.

The idea is that the ATA wants to serve as a resource to NCOIL as it examines the Model. ATA has a number of items on its website that Ms. Johnson urged the Committee to look at including terminology defining telehealth and terminology for states on medical practices and standardized terminology for states in terms of policy language on coverage and reimbursement. All of that emanates from the policy principles that were driven by the ATA and that is very much consistent with the idea that people should be able to get care where and when they need it.

Ms. Johnson noted that what has been relatively new to many of us is the growth of asynchronous communications in telehealth and it is important for us to remember that even if it is new to us it doesn't meant its unsafe. Asynchronous services are provided by companies who are committed to the good health and wellbeing of Americans just like our doctors and their offices. The topics the Committee will be dealing with will surely include reimbursement which ATA addresses in its policies. As stated by Dir. Cameron, it is very important that we really acknowledge that there is payment that needs to be made for these services. Another big issue relates to originating site. There were a number of barriers that were in place previously as it relates to originating site which were relieved with waivers and it is hoped that is continued going forward because it is very often the best way for people to get care. So, to have someone drive two or three hours from their home to see a clinician when in fact that service can be rendered virtually using technology is very important and should be maintained.

We also have seen that technology can be used to help people stay in nursing homes instead of getting transferred to a hospital and risks disruption of medication and disorientation. The ATA is very much supportive of using technology and encouraging laws to be adopted that acknowledge that technology has prompted safe and effective use of services by all Americans. One area that ATA is interested in working on deals with Medicaid. Only 4% of the Medicaid populations across the country have access to telehealth services and yet we all know that we can get services on our phones and 95% of Medicaid population have smartphones or access to them so ATA supports the idea that Medicaid adopt telehealth in a more expansive fashion recognizing that states are going to be under severe economic pressure and telehealth can be a very cost effective and affordable way to provide service in greater numbers. Lastly, Ms. Johnson stated that ATA does not believe it necessary to require an in-person visit in order to establish a physician-patient relationship. ATA encourages the Committee to consult its website

and reach out throughout this process. Ms. Johnson thanked the Committee for the opportunity to speak on these issues.

Brendan Peppard, Regional Director of State Affairs at America's Health Insurance Plans (AHIP), thanked the Committee for the opportunity to speak today and during the Committee's interim meeting in August. Since the interim meeting, AHIP has submitted a detailed comment letter and a red-lined version of the Model. Mr. Peppard stated that he would like to reiterate that insurance providers are and have been supportive of the use of telehealth to provide access and reduce costs. That is a good thing and AHIP is pleased to see the increase in use as noted in earlier testimony today. In order to move forward following the pandemic, there are a number of things that can cement the positive changes that we have seen. Mr. Peppard commended Asw. Hunter as sponsor of the Model for including a number of those things in the Model.

First, during the crisis, many states lifted restrictions on practicing across state lines. Physician's ability to work across state lines is determined by the state licensure boards under normal circumstances. Section 5 of the Model appears to address that situation and AHIP believes that is positive. Next, there have also been inconsistent state restrictions or mandates relating to types of technologies, services or specialties and originating sites that limit the ability of health insurers to design benefits that meet consumer's needs. The Model has several provisions allowing for flexibility including broad acceptance of various technologies and types of providers who can offer telehealth services – at least that is how AHIP reads the Model. However, there are some provisions that raise concerns. AHIP believes that health insurance providers should have the flexibility to design benefits and there is language in the Model that limits flexibility – mostly in Section 4 (A), (B), (C), and (E).

AHIP is concerned about requiring equivalent telehealth and in-person payment rates. That eliminates the cost saving potential of telehealth and can create inadvertent disincentives. While payment parity made sense during the pandemic as doctor's offices were closed and people could not go to their doctor and telehealth was the only way for them to receive care it made sense to provide a revenue stream for the providers and to allow access to networks. Even now, as has been stated, many individuals are still reluctant to go to their doctor in-person and some of those people have good reason not to if they are immunocompromised or have some other concern. However, post-pandemic it is important to look at what we are setting up as a structure going forward. Telehealth visits do not require the same level of intensity and same amount of time or the same amount of equipment as in-person visits and should not be required to be reimbursed equally. We have heard that providers cannot provide telehealth unless there is equivalent payment. However, it is important to point out that providers are not required to provide telehealth. They are encouraged to but they are not required to and there are providers that insurers have negotiated with who are willing and able to offer the services at negotiated rates. That is a benefit to AHIP's members.

AHIP also agrees that telehealth should not become a replacement for needed in-person visits. We don't want to create inappropriate incentives to substitute a telehealth visit for a necessary in person visit. There has been a drop in vaccination rates and that is a tremendous concern to the industry and to the provider community as well. We want to encourage people to go in and get their vaccines. That is just one example but we don't want to create any disincentives to have people go visit their doctor when they should. AHIP recommends to allow flexibility in negotiating appropriate payment rates for telehealth services – this is post-pandemic. The savings from negotiations can and do benefit consumers.

The explosion of telehealth under CVOID has provided opportunities and has raised new questions. Ultimately, the growth is good and health insurance providers have been providing telehealth coverage for a long time and they are pleased to see the growth. Mr. Peppard thanked the Committee again for the opportunity to speak.

Sen. Bob Hackett (OH) stated that when telehealth was brought to Ohio several years ago they were able to sell the business community by saying there would be a lower reimbursement rate. Sen. Hackett complemented the plans during this crisis in their efforts regarding reimbursement levels. Sen. Hackett stated that there has been a huge increase in the use of telehealth but there also has been a huge decrease in people going to the emergency room so there has been tremendous savings to the plans as they are not paying for those emergency room visits as they normally would. Sen. Hackett stated that he has supported telehealth but only at a lower reimbursement rate but noted that maybe he might change. What bothers him is that the providers say telehealth can be delivered at a cheaper price so what about the consumer – why don't they share in the savings? If they can do it at a lower price why should there be payment parity? During the pandemic is one thing and Sen. Hackett agrees with parity during the crisis but afterwards when we know the cost of telehealth is lower it raises interesting questions. Sen. Hackett stated that he has had numerous telehealth visits during the pandemic using his iPhone and it has worked tremendously.

Kim Horvath, Senior Legislative Attorney at the American Medical Association (AMA), thanked the Committee for the opportunity to speak and stated that this is an exceptionally important and timely issue and the AMA appreciates the Committee for introducing the Model which includes many of the key provisions to ensure expanded access to and coverage of telemedicine. Regarding coverage, the AMA supports the language in the Model expanding coverage of telemedicine. The AMA believes telemedicine can and should be integrated seamlessly into the delivery of healthcare and when clinically appropriate telemedicine is just one of the ways in which care can be provided to patients. Therefore, coverage of services provided via telemedicine should be on the same basis as comparable services provided in-person. The AMA has learned over the past six months that telemedicine cannot and should not be viewed as a separate and distinct service but rather a way in which physicians can provide care to their patients.

Likewise, the AMA believes patients should be able to access services via telemedicine from the same physicians who provide that care in-person and they should be able to do so without barriers or different cost sharing structures as other telemedicine providers. The AMA strongly encourages the Committee to include language in the Model to protect that construct. The AMA's letter to the Committee describes some specific parameters for consideration and the AMA believes they are important to ensure both protecting the patient-physician relationship and also continuity of care. Regarding payment, physician practices across the country have made and are continuing to make significant investments both in terms of time and money to adopt and promote access to telehealth service and telemedicine services for their patients particularly during the pandemic. Providers have ramped up in a very short period of time a number of physician practices that are providing telemedicine to their patients.

The AMA recognizes that it is not going away and many patients and providers alike don't want it to go away. The AMA will take efforts to make sure that does not happen but those practices should have certainty going forward that their investments are sustainable. We know that telemedicine has been instrumental in making sure patients have access to care during the pandemic and it has been vital for many patients during the pandemic including vulnerable populations. The AMA supports fair payments to further the advancement of telemedicine and

believes services provided via two way audio visual telemedicine are commensurate with in-person services and the payment should be the same. With the increased use in telemedicine over the past six months we know that we have the ability and opportunity to collect data that will help inform potential savings associated with the appropriate use of telemedicine but also fair payment. So, there is a lot more to come and a lot more to discuss on this and the AMA hopes that conversations with the Committee will continue.

Asw. Hunter asked if Mr. Peppard or Ms. Horvath could respond directly to Sen. Hackett's question as to why there should be payment parity if the costs are not the same. Ms. Horvath stated that when we are talking about audio visual telemedicine that is commensurate with what you would have with an in-person service. The AMA is working on collecting data to help inform those potential cost savings. The data is not ready yet but the AMA is working on it and will share it with the Committee when ready. The past six months have shown a huge increase in telemedicine and we have a unique opportunity now to gather that information and utilize it going forward.

Mr. Peppard stated that most carriers who design these benefits do in fact provide a reduced cost share for telemedicine use and so there is already a savings for the consumer immediately built in. Regarding decreased emergency room use, we always want to see that when it is not an appropriate emergency room visit and if this is a way to prevent that it is terrific. Providers are willing and able to negotiate with plans to provide these services so it is a benefit that is going to be available for AHIP members. Regarding data collection mentioned by AMA, Mr. Peppard stated that if you get more of something and pay more for it at the same time it is difficult to see how it reduces costs. Mr. Peppard challenged the AMA on that point.

Ms. Johnson stated that the ATA works closely with AHIP and AMA on many of these issues and the ATA in representing its broad, diverse membership supports fair payment that is commensurate with the investment required by telehealth providers recognizing that telehealth can be audio-only, and audio-visual but also provided remotely and there is a fair amount of costs and investment associated with that.

Rep. Deborah Ferguson (AR), Vice Chair of the Committee, stated that if you talk to your physician they will tell you that telemedicine actually takes them a little bit longer because of the video aspect taking longer to negotiate the visit so that supports payment parity. It is important to understand that telemedicine has evolved into sort of three separate things. You have your doctor to specialist which is like doctor to stroke specialist and which are great but in terms of the doctor to doctor of telemedicine that is also evolved into two separate things. You have your big-time telemedicine providers like Teledoc that contract with primarily ERISA's or big companies to provide telemedicine services to employees.

Then you have a separate telemedicine that has evolved during the pandemic which is setting up doctor's offices to do telemedicine with their own patients. Rep. Ferguson stated that she has a real concern that the big telemedicine companies who are contracting with ERISA's or insurance companies or employers are actually going to circumvent the patient's own provider and require the telemedicine visit to be with the big telemedicine company and not with the patient's own provider who may have telemedicine services available.

Rep. Ferguson stated that Arkansas looked at some problems where telemedicine was actually going to reduce access to rural healthcare because a telemedicine provider from a hospital was going to come into an area and provide services where the only doctor in the county was right across the street. That is a real concern. You should not circumvent the patient's own provider

and it might actually reduce access to rural care if you driving patients to telemedicine away from the only rural provider.

Ms. Johnson stated that the ATA understands the concerns about telemedicine and believes that it is health - telehealth is health and telemedicine is medicine and the ATA views it as another modality of care. In rural communities where organizations operate in the Dakota's and other states, what they have done is really support rural physicians who have not been able to sustain their practices otherwise without this technology so the ATA believes that when it is deployed in a reasonable fashion it really ends up supporting physician-patient relationships.

Mr. Peppard stated that AHIP believes that telehealth should not become a replacement for in-person visits when they are needed so that is a concern if telehealth was developed in a way described by Rep. Ferguson.

Ms. Horvath stated that often with telemedicine you don't always know, physicians or patients, at the beginning of the telemedicine visit whether that visit will necessitate an in-person care following that service. Not everything can or should be provided via telemedicine and not every patient should or can receive services telemedicine.

Asw. Hunter stated that everything is not created equal and not having some reliable access to broadband and Wifi has really hindered some people being able to have access to telehealth. While many people do have smartphones that have the capacity to do so that isn't always there. We see that with education now with remote learning in that its just not always available even though we think its so simple and everyone has a phone. Asw. Hunter stated that she has a concern about the requirement for an in-person meeting. You can see someone over the phone but you can't feel their heartbeat and feel their glands if they are swollen so it is important to make sure that care really is being given and recognize that everything is not equal and access isn't the same.

Dir. Cameron stated that the NAIC is also studying these issues and they don't have a firm position yet. Dir. Cameron stated that he has received telehealth services and it was quite the experience. Regarding parity, certainly there are additional costs associated with setting up telehealth services but there are savings that are also occurring when a physician is able to provide telehealth services. All of Idaho's carriers prior to the pandemic had telehealth services but they were with many of the companies such as WebMd and others mentioned earlier. Dir. Cameron stated that he does not believe we want to necessarily encourage to go back to just those options. We need to have a balance between encouraging the use of local doctors and helping local doctors set up their services but at the same time if there is not some commensurate savings for doing so it will naturally force the carriers to contract with those that are out of state and not with the across the street physician. Accordingly, Rep. Ferguson's concern is very valid and one that should be discussed going forward.

Asw. Hunter thanked everyone for their comments and stated that she looks forward to working with everyone on the Model going forward.

CONTINUED DISCUSSION ON NCOIL PATIENT DENTAL CARE BILL OF RIGHTS

Rep. Ferguson, sponsor of the NCOIL Patient Dental Care Bill of Rights Model Act (Model), stated that discussion on this Model started in December of last year and we have had a very productive dialogue since then. Since the last meeting in March, some changes to the Model have been made, which is in the binders starting on page 270. First, the title has changed from

"Patient Dental Care Bill of Rights" to "Transparency in Dental Benefits Contracting Model Act." The main reason for that change is that the first draft of the Model started out with five separate substantive sections – each addressing a separate issue – but Rep. Ferguson stated that she decided to remove the sections dealing with retroactive denial and medical loss ratio as she believes those issues are complex enough such that they warrant their own separate discussions and perhaps separate Model Laws. Accordingly, given the removal of those sections, the new title is more appropriate. The medical loss ratio and retroactive denial sections were not necessarily removed because of their substance, but rather in an effort to make the Model more concise and make it easier for the Committee to dedicate sufficient time to each topic. Three topics is already a lot to understand and digest, let alone five.

Rep. Ferguson stated that it is important to note the Sponsor's note that appears in the latest version of the Model at the top of page 1– it states that "this Model remains a significant working draft. Specific language for modification needs to be resolved and will continue to be discussed." That note is important because while Rep. Ferguson appreciates everyone's work and input on the Model thus far, there is still a lot of work do. Rep. Ferguson stated that she is confident that we will get there. Rep. Ferguson stated that she is proud to sponsor the Model and looks forward to working on it further with the Committee.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA), stated that it is no secret that health insurance is confusing and dental insurance is no different. The ADA's feeling is that patients deserve a dental plan that protects them, removes rather than creates financial uncertainties, and is clear about what is covered and how to properly use that coverage. The ADA appreciates the changes made by Rep. Ferguson and noted that the ADA is working to develop further language that represents more of a cohesive stakeholder input version and looks forward to continuing that work.

The issues that remain in the Model are network leasing, prior authorization and virtual credit card payment, all under the umbrella of transparency. The first issue is to develop model language to establish fair and transparent network contracts. Insurance carriers occasionally lease or rent in network relationships that they have established with a provider to another entity such as another carrier or third party payer or administrator. This can be problematic when both the patients and providers don't know what's going on. If this approach is not done in a fair and transparent manner it can erode patient provider trust which can lead to wrong assumptions about the treatment plans and costs.

For example, the ADA had a New Jersey dentist who had signed into a network in the 1980s and reported that perhaps one or two subscribers had actually come through his office under that network umbrella. About five years ago that network relationship was rented to a very large carrier in the area and he found out about this because a patient said "thanks for joining the network." There was no notice given to the doctor and he found out later that a large portion of his patient base was now in network without his knowledge. He was not able to get out of the contract relationship for 90 days so he had to accept that discount for 90 days and then had to, because he chose not to be a part of it, inform all of his patients that he was removing himself the network. You can see that it ended up costing him almost $100,000 when all was said and done. That is a situation that a doctor and patient should not be put into and that is what the Model language does and tries to address.

Network leasing legislation like what is in the Model would expand transparency before networks are leased and provide an opportunity for providers to review the contracts and accept or refuse them. To that end, Mr. Olson stated that he would like to address some of the

comments that were submitted stating that provider dentists should not have the right to opt out of rental networks if their carrier contracts indicate that the network relationship can be sold – similar to the 1980s scenario described earlier. The opt-out right of the dentists is an essential part of the Model and preserves an appropriate balance of power between the providers and carriers maintaining their networks. Without the ability to opt out, dentists will be at risk of signing into pretty much every network when they sign onto one network, particularly because carries frequently operate from a take it or leave it situation when they present the contracts – there is not the ability to cross out some lines when signing a network contract with a dental carrier and say "I would like to sign into the network but not the leasing portion."

As written, the Model makes a clear distinction between dental insurers and dental network leasing companies. If a dentist agrees to sign up with a dental network leasing company the dentist should reasonably expect that he or she is going to be leased. That said, a dental benefit insurer or carrier is a different kind of entity often wielding significant market strength in most states. To allow dental insurers to use a take it or leave it approach when they lease their networks they make it very difficult for a dentist to opt out particularly in areas when the carriers network strength is very strong because the provider would lose their in network status and perhaps put a significant portion of their patient base at risk.

With regard to prior authorization, as early as possible, patients and dentists should have a clear understanding of what coverage a patient has and what a patient will be financially responsible for as a result of healthcare services. Insurance carrier documentation issued prior to a service being provided, and often its called prior authorization, should accurately communicate the amount the carrier will pay. Doing so leads to a transparency for the patient and allowing better treatment planning for all involved. If an insurance carrier has issued a prior authorization the ADA's view, which the Model reflects, is that state law should require the carrier to stand by its commitment to pay. Prior authorization is essentially a pre-submitted claim for treatment usually with diagnostic notes, x-rays or specific procedure codes reflecting prescribed care. State laws requiring carriers to honor prior authorization will prevent surprise billing which can lead to devastating effects on families and patients.

The third issue is virtual credit card payments. When reimbursing dentists on the claims they pay, some carriers send a series of numbers to the practice when entered into a credit card terminal or designated website it releases funds to the dentist as a payment for claim. Like any other credit card transaction, there is of course a processing fee associated with virtual credit card payments. They can range from 2.5% of the payment amount. This means that if you have a dentist's office that is accepting $500,000 per year and virtual credit card is the only type of payment they are accepting the dentist office ends up paying $12,500 to $25,000 in fees for accepting that money. The Model says that can't be the only option that the insurance carrier gives to the dentist to accept payment – there needs to be others such as direct reimbursement or a paper check. The Model would also ensure that a dentist is informed if there is a profit-sharing arrangement that has been set up between the virtual credit card company and the carrier. If the carrier is receiving a little percentage of the fee the credit card company is charging for cashing the payment this is information that would help the dentist decide whether or not to accept that form of payment. The Model is prescribing a simple notice of the arrangement - not a detailed accounting of what percentage the insurance company is collecting.

Mr. Olson thanked the Committee for the opportunity to speak. Having the Committee support these issues would be very beneficial as they have already passed in certain states.

Artur Bagyants, Associate Director of Gov't Relations at the National Association of Dental Plans (NADP), stated that NADP continues to have concerns with the Model but appreciates the willingness of the Committee to be receptive of NADP's feedback. NADP's main point today is that the three issues should not be combined in one Model. Bills at the state level generally don't do that for good reason. The three issues are very distinct with distinct characteristics and they do not have much in common. Each issue is complicated enough to allow for individual treatment. NADP has worked on the issues in multiple states and knows this from experience. For example, the network leasing issue in New Jersey was enacted in 2019 and it took over a year of work. Earlier this year in Arizona there was a prior authorization bill similar to the Model and it had to be withdrawn and assigned to a study committee because of issues raised during the process. NADP believes that combining all of the issues into one piece of work product could cause problems.

That being said, network leasing is probably the primary issue so NADP would recommend that the Committee narrow the Model to only that issue which would be cleaner and more concise. NADP and AHIP and the American Council of Life Insurers (ACLI) submitted legislative language to the Committee that does that and it is based on recent laws passed in NJ and CA. Those laws are some of the most strict leasing laws in the country so it is believed that they should be looked at as a starting point. That does not mean the Model has to mirror that language but it could be used as a starting point. Mr. Bagyants stated that the other reason the NJ and CA laws were looked to is because those laws were very well-vetted and came about after a lot of deliberation and input from stakeholders. NADP was involved in that process and it came down to considering individual words and commas and that level of detail. For that reason, it is better to follow those laws as a base rather than something new. If the Committee does decide to move forward with the Model, NADP is committed to working with the Committee and helping it to make it a good final product. NADP routinely works with dental associations and legislators in states when these issues arise and there is usually a good dialogue.

Karen Melchert, Regional VP of State Relations at the ACLI, stated that the ACLI concurs with the NADP's comments on the need to break the Model up into three separate Models and work on them individually going forward. ACLI will continue to work with Rep. Ferguson, the ADA, and the Committee on perfecting the Model if that is the will of Rep. Ferguson. Ms. Melchert thanked Rep. Ferguson for the changes made thus far and looks forward to working on the Model going forward.

Mr. Peppard thanked Rep. Ferguson for the changes already made to the Model and echoed the comments made by Mr. Bagyants and Ms. Melchert with regard to there still being some concern over the remaining language. Focusing on the leasing component which seems to be getting the most attention is appropriate at this point. AHIP appreciates Rep. Ferguson's willingness to work on the Model going forward.

Rep. Ferguson stated that reducing the Model down to three issues has made it less contentious and with any Model legislation, states are going to take whatever part they want. Many of these issues have already been passed in Arkansas and other states so states can separate the issues themselves if they have already passed certain components. Regarding the virtual credit card issue, that was passed in Arkansas because most payers pay electronic fund transfers as it is really the smaller companies that send the credit card reimbursements and then they receive part of it and the provider has to take the percentage out just like running any other credit card. The Model doesn't prohibit that but makes clear that the dentist has the option to opt out. Regarding the leasing issue, Arkansas passed Medicaid expansion with private insurance particularly with BCBS as the biggest provider in the state. They were

requiring dentists to participate in all products in other words Medicaid expansion under private insurance paid significantly less but you were required to participate in all products so it is a similar problem with leasing. You don't want to require a provider to accept low reimbursement if they are not contracted to do that. Rep. Ferguson believes that provision of the Model is reasonable and legislators can always take the Model and sperate however they would like.

Asw. Hunter thanked everyone for speaking and stated that hopefully the Model will be ready for a vote in December.

CONTINUED DISCUSSION ON NCOIL VISION CARE SERVICES MODEL ACT

Sen. Hackett, sponsor of the NCOIL Vision Care Services Model Act (Model), stated that Ohio is one of the few states that could not get the non-covered dental legislation passed no matter how hard the dentists pushed. Sen. Hackett stated that the Ohio optometrists saw this and they worked with the vision plans to get legislation similar to this Model passed in Ohio. Both sides gave and they met in the middle. NCOIL has not been able to get the support of the national optometrist association even though vision plans have agreed to allow the optometrists to stay in the network even though they did not offer discounts on non-covered items.

The national optometrist association will not support the Model and it really is because of one issue: when plans list on their website who is in the network they also want to list which providers will offer discounts on non-covered items. The question is should consumers know who is offering a discount and who is not? That is what the issue has come down to.

Robert Holden, State Gov't Relations Director at the National Association of Vision Care Plans (NAVCP), stated that the Model is based on consensus legislation was passed in Ohio and subsequently NAVCP has worked in Utah to pass similar language and is currently working in Arizona to do so as well as that bill passed the House but was not taken up in the Senate due to COVID. It is important that NCOIL consider the Model because there has been some confusion based on a previous Model that has passed at NCOIL referenced by Sen. Hackett – the Model Act Banning Fee Schedules for Uncovered Dental Services – and its application to the vision industry.

There are a number of differences between how vision benefits and dental benefits are offered. Unlike a dental plan, vision plans offer really only one healthcare service and that is an annual eye examination. It is routine and preventative care and is valuable care but there is really only one major health care service provided and it has many component parts but it is a relatively simple benefit from that perspective. The complexity comes in when we talk about coverage for the purchase of eyewear and in that way it really shows the difference between dental plan benefits and vision plan benefits. When a patient receives an annual eye examination, vision plans are based on the model of encouraging them to purchase eyewear from their provider as they get much better service from that perspective and it deepens the relationship.

However, there are complexities to that one of which is that there are a whole host of options available to the patient. One is from a non-medical side they have a number of frame options available to them to suit their preferences but also with respect to the actual lens there are a number of different medical options some of which are important for purposes of improving their vision and others are simply preferences as to the lens. For example, lens materials can be selected while vision plans typically cover single-vision bifocals or trifocals they may prefer progressive lenses and may want tinting or anti-reflective coating. Patients also have the option to not purchase from their provider as they can go elsewhere to other retailers.

Mr. Holden stated that the Model reflects some of those critical differences. One is that the Model defines vision care materials to distinguish materials from services. Also different in vision plans as opposed to dental plans there are two different provider types – one being optometrists and others ophthalmologists, medical doctors. Those are both equally treated in the Model as vision care providers. The Model also places requirements on plans. One which was a big compromise in Ohio is that vision plans will be prohibited from setting prices on non-covered services and materials as a condition of joining the network. This represents a compromise because essentially it made participation in any kind of plan pricing optional to the individual provider but allowed them to be a preferred provider within the network in every other sense. While vision plans would have preferred to have a consistent benefit, a compromise was able to be reached. What that made critical is some of the patient protection provisions in the Model.

The Model also provides and guarantees that providers can prescribe all options to the patient with regard to services or eyewear so even if a particular eyewear type is not covered or is differentially priced there is no restriction on their ability to offer that through their own dispensary. The patient protection components of the Model are very critical because the patient needs to know that the pricing can differ if that provider has opted out of plan pricing and that comes up in two ways. One of the things that vision plans do is negotiate a discount on a second pair of frames. Once enrollees use up their benefit for the year they really have no reasons to continue to shop with a provider on price. Plans want to encourage them to continue to go to their doctor and purchase eyewear from them as a second touchpoint during the year or just to make sure that the second pair of frames properly suits their medical needs so they have negotiated discounts on that. Under the Model those discounts would be optional but the pans want to be able to tell the patient whether or not those standard price discounts are available.

The other component of this is something that is related to the lens options. All NAVCP plans cover a basic lens whether it's a single lens or bifocal lens and there are different options that can be provided on top of that. If a patient chooses any of those options, that is usually paid through a copay and that copay is offset by the cost of the lens but the remainder of that goes to the provider in addition to a dispensing fee. NAVCP is considered because during some discussions some providers considered that non-covered and then do not put a limit on that pricing. The concern there is that a patient thinks they are getting a covered lens and a covered option and before they know it there is a large increase in the out of pocket cost for them with their provider. Plans want to have the ability to provide them with information on that before they go to that provider and it needs to be reiterated at the point of service.

Mr. Holden stated that there is no doubt in the studies that NAVCP has run and with other studies that there is a tremendous value to patients going to see their optometrists or ophthalmologists and purchasing eyewear form them. They are far more likely to get that examination every year if they are going to purchase eyewear and even if they go specifically for the eye examination they are more likely to purchase that eyewear than if they don't have that benefit. So, NAVCP believes that combining those benefits provides a great deal of value to the patient and also to the provider and the Model is a great compromise in providing not only great flexibility to providers that are on the plan but also providing transparency to the individual consumer.

Mr. Peppard stated that AHIP agrees with the points made by Mr. Holden. Plans need to be able to provide information to their customers so they know what their benefit is and what they are looking at. This is a consumer protection and consumer interest Model. AHIP did submit

one requested clarifying amendment as it believes the additional sentence at the end of Section (E) is not necessary and the provision reads more simply if that sentence is struck.

Daniel Carey, Senior Director of State Gov't Relations at the American Optometric Association (AOA), stated that the AOA appreciates the opportunity to be a part of this dialogue as it is a very important issue they have dealt with in almost 23 states. The AOA agrees that clear communication and notification to patients is critical to the care that they receive, to the benefits that they have and to the payments they may potentially make. The way that the Model is written and the way the AOA has seen it play out in states across the country is because ultimately when plans list out AOA's members, the result is a scarlet letter. Whether AOA's doctors are providing a full breadth of discounts or if they are offering singular discounts as it relates to the plan they are held separately and problematically to the doctors who fully subscribe to the plans discounts that are being offered and those who fully sign onto the plan's contract.

The AOA has seen that happen in Ohio. In practical application, the AOA has seen its doctors held out and are not readily available to be viewed by patients when they do log into those portals. That is the concern. By no means does the AOA want to be disingenuous with what the protection or what the plan is offering. Ultimately, the AOA wants to make sure that patients are able to find the doctors that are most accessible and can provide the most comprehensive care to.

Another issue the AOA has relates to Section (D) and the non-covered services themselves. The non-covered services are discounts that the plans are marketing where they ultimately have no skin in the game because they are not fulfilling the costs as it relates to non-covered service materials. AOA is saying that as it relates to non-covered services it is important to make sure that the doctors are not being dictated to by the market power the plans have in place. NAVCP plans have roughly 180 million individuals across the country who are part of the plans. The issue is that they yield incredible market power within the states. One doctor Mr. Carey spoke to said that upwards of 70% of her patients come from the vision plan in her state. So, either she is in with the plan or not but she is not really able to opt out of the plan because 70% of her patient base comes from that. So, if she can't be found on the website as it relates to notification or if she weren't to take the discounts as outlined in the Model then she would essentially not be able to practice within her state.

Mr. Carey thanked the Committee for the opportunity to speak and stated that he looks forward to seeing a version of the Model ready by December that benefits providers, plans and most importantly consumers.

On behalf of the AOA, Dr. Rebecca Wartman, a practicing optometrist, stated that regarding the issue of informing patients of discounts the plans had a concern that providers were going to increase prices and charge a lot more to any plan member for anything that was not covered. There is a principle in usual and customary fees that is standard across everybody and is in most of the state laws already in place and is certainly a requirement in all federal programs that you charge what you charge across the board to everybody. There was a bit of scoffing when that was mentioned in a previous conversation. AOA's providers are doctors and they are not going to overcharge patients – their fees are what they are. That is a number one principle and should be sufficient to go by.

Plans as well should not be allowed to add covered items at nominal fees just to say that something is covered and pay a dollar or two dollars. That is not fair. Plans should be very

clear on what is covered and what is not covered with patients. As a practicing provider, one of the common reasons is that a patient comes in assuming that they can get a free eye-exam and a free pair of glasses and then when they opt with education to go above what is standardly covered they get upset because the plans haven't informed them that there is going to be some things not covered.

Further, the AOA feels like if plans feel the need to educate their customers on what is covered and not covered and what fees exist for non covered services they should simply say there may or may not be discounts offered on non-covered services. That informs the patients that is a conversation they may need to have with their provider. Patients always have the choice on what they get. Patients are always educated on what their options are and why they may or may not want those options. Providers do a really good job because they are also businesspeople and as such they want their patients to be happy. They want them to know exactly what to expect and the transparency when they come in. With plans leading patients to believe that their glasses are free or they are going to pay $10 or whatever their copay happens to be, that is as misleading as what the plans seem to think is misleading as the providers not being willing to have it published whether or not they are going to offer extra discounts on non-covered services. That needs to be an individual provider choice. As providers and businesspeople they know their markets and know what they need to do to make customers and patients happy. The AOA is hoping that it can move forward with the Model and fix this major issue.

Rep. Matt Lehman (IN), NCOIL President, stated that he is hearing multiple examples of where consensus was reached on this issue with state optometric associations but now there seems to be opposition to the Model. Rep. Lehman asked Sen. Hackett if that is correct. Sen. Hackett replied yes and stated that the issue also seems to come down to that Ohio was not able to pass the non-covered dental services legislation. Most states do not allow dental companies to do that.

Mr. Carey stated that optometric associations did support the legislation referenced earlier in AZ, UT and OH. Ultimately the bills were not what the AOA wanted and in OH for example the practical aspect of the bill has been problematic with the plans with not only listing out of doctors as they are listed on the websites but also lab choice in the ability of providers to be able to prescribe out to specific labs and that is ultimately what is best for the patient. Generally, the AOA tries its best to support its state associations and as the Committee knows legislation varies from state to state. The AOA is looking to have a national model on this issue be something that is the most comprehensive and best suits not only the plans and providers but the consumers. That is why AOA sent over to Sen. Hackett and NAVCP and NCOIL staff state legislation that was thought to not be completely one-sided such as that enacted in CO and AR. Perhaps if the Committee used those laws as a starting point that would be the better approach in developing a national Model. Mr. Carey stated that the AOA would enjoy the opportunity to have those conversations going forward.

Asw. Hunter stated that hopefully the Model can be ready for a vote in December.

Sen. Hackett stated that it is important to realize that getting in the network is a plus for the providers. With dental, if you don't offer the discounts you can't get in the network. NCOIL outlawed that but not all the states adopted that Model. Providers are getting a benefit of getting in the network so why can't consumers be protected to know which providers offer discounts and which don't. You can't blame the optometrists as some in Ohio don't like it

because they don’t want their patients to know that they don’t give the discount. This is not an easy Model but work will continue to be conducted.

ADJOURNMENT

Upon a Motion made by Rep. Lehman and seconded by Rep. Carl Anderson (SC), the Committee adjourned at 1:00 p.m.