

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
SAN DIEGO, CALIFORNIA
MARCH 10, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Westin San Diego Gaslamp Hotel on Friday, March 10, 2023 at 9:45 a.m.

Representative Jim Dunnigan of Utah, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)	Rep. Brenda Carter (MI)
Sen. Mark Johnson (AR)	Sen. Paul Utke (MN)
Sen. Travis Holdman (IN)	Sen. Bob Hackett (OH)
Rep. Rita Mayfield (IL)	
Rep. Michael Sarge Pollock (KY)	

Other legislators present were:

Sen. Jesse Bjorkman (AK)	Sen. Lana Theis (MI)
Sen. Justin Boyd (AR)	Sen. Michael Webber (MI)
Rep. Denise Ennett (AR)	Rep. Cameron Parker (MO)
Sen. Ricky Hill (AR)	Sen. Nellie Pou (NJ)
Asm. Tim Grayson (CA)	Asm. Ken Blankenbush (NY)
Rep. Rod Furniss (ID)	Sen. Jeremy Cooney (NY)
Sen. Win Stoller (IL)	Asm. Jarett Gandolfo (NY)
Sen. Robert Mills (LA)	Asw. Pam Hunter (NY)
Rep. Kelly Breen (MI)	Rep. Tim Barhorst (OH)
Rep. Kevin Coleman (MI)	Rep. Brian Lampton (OH)
Rep. Kristian Grant (MI)	Rep. Mark Tedford (OK)
Sen. Mark Huizenga (MI)	Rep. Ryan Mackenzie (PA)
Rep. Mike McFall (MI)	Rep. Carl Anderson (SC)
Rep. Julie Rogers (MI)	Rep. Kirk White (VT)
Rep. Lori Stone (MI)	
Rep. Helena Scott (MI)	

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Manager, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Sen. Bob Hackett (OH) and seconded by Sen. Paul Utke (MN), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Jerry Klein (ND) and seconded by Asm. Kevin Cahill (NY), NCOIL Vice President, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 19, 2022 meeting in New Orleans, LA.

PRESENTATION ON FEDERAL AND STATE DATA FROM BALANCE BILLING INDEPENDENT DISPUTE RESOLUTION PROGRAMS

Tom Naughton, Division President, Federal Services at Maximus thanked the Committee for the opportunity to speak and stated that in January, 2022 the federal surprise billing arbitration program was instituted. Cases started to be received and distributed to federal arbitrators in April of 2022 and this morning I'm going to talk to you for a few minutes about preliminary data out of the program and some of the challenges and opportunities within that program and how that existing program has impact on the existing state programs and states that do not have existing programs currently. So, the volume in that program has been more significant than initially expected. I've been involved in dispute resolution programs for 25 years and have a very good understanding of expected volumes when these programs are instituted and we were projecting the federal program to have somewhere probably between 20,000 to 30,000 cases in the first year and it had received over 100,000 cases in the first six months. And although the preliminary data is not out for calendar year Q4 of 2023, we're putting that at probably about 150,000 cases for the first calendar year of the program. So that's a large number and I think what's most important associated with that number is only about 30% of those cases have been accepted for full arbitration. There's a number of reasons why 77% of the cases aren't accepted for arbitration. I'm going to talk about that a little bit and some of the challenges in the states there and I think even more importantly as you break that down to date of that 30% probably only 10% have been fully decided cases wherein an arbitrator says the award goes to the provider or the award goes to the payer. And to underscore what we believe is the primary pain generator or confusion is right now there are 22 states that have their own surprise billing arbitration program and 28 states plus territories that do not. And within the 22 states that have existing programs they are labeled as bifurcated states by the Center for Consumer Information and Insurance Oversight (CCIO) and the Centers for Medicare & Medicaid Services (CMS). That means a provider depending on a specific claim may go to a state program in the state of Georgia or he or she may need to send that claim to the federal program and I think the outreach and education to provider groups across the states has not been overly effective. So many providers are submitting cases to the federal program that actually should be going to the state program. That creates a significant amount of delay and stakeholder frustration and other hurdles to getting the job done and making sure the program is effective.

One issue that I think states could take on to assist their providers of the 22 states that are bifurcated is that I believe only six of them allow Employee Retirement Income Security Act of 1974 (ERISA) opt-in. So that's the bifurcation. If you're not a state regulated plan you have to go to the federal program. States such as New Jersey and Virginia allow ERISA plans to opt in to the state arbitration program therefore providers do not have to go the federal pathway. I think states with existing programs would benefit from considering an ERISA opt in into that program because it would give the providers one pathway, one door to deal with and one set of rules. And more importantly existing state programs, how they're managed and the rules of those arbitrations are different than the federal program so the bifurcated states right now have providers sort of being treated differently for the same problem. So a provider could go to the New Jersey state arbitration program and get one answer and then go to the federal program for the exact same claim just an ERISA plan and get a different answer. So you have a similarly situated problem which has strong potential for getting two different answers. That's mostly

because there is and I'll put in quotes, "default" arbitrator answer on the federal side to go with the average in network rate of the payor and that is not included in many of the state programs.

So a provider going to the state of New Jersey is going to get a much different arbitration through the state program than they do at the federal level - same with the state of Georgia and all the bifurcated states. For the remaining states that don't have programs, I think considering instituting their own program, which is a zero budget program because the payers pay the cost of the arbitrations and can also pay the cost of setting up the program for the state, would also do a lot to help provide for confusion and give them an easier access to resolve their disputes with the payers. It would also be very helpful to the payors to really have one program to utilize as opposed to two pathways. Another issue that I think is impacting is provider education. CCIO does not have a formal outreach education program to providers in the specific states and I think if they engaged with any of the national independent dispute resolution entities (IDRE's) to provide outreach and education or if the states, particularly the bifurcated states, asked an arbitrator that knows all the programs to come in and provide education to their hospital associations, to their medical associations, to their specialty groups, and really show them how the nuances of the two different programs and their rights and responsibilities under both sets of programs - I think that would go a long way to ease provider confusion and help them in the process. Those are the two main pain generators that I really wanted to bring up here. As I said the data right now is still very preliminary because so few cases have been decided and I think probably six to nine months from now we will have a better idea of why cases are decided for providers or payers and the reasons for that, etc.

One other thing I wanted to underscore as this is an important nuance between state programs and the federal program - the federal program has recently decided that if an arbitration case includes an encounter and that encounter includes half a dozen claims or codes, each of those codes becomes a separate arbitration. That leads to much more significant expense for providers to engage in the program. It leads for much more significant expense for arbitrators to complete and it in my opinion will only lead to confusion and frustration within the program. Historically, in an arbitration program you get one encounter and you go through the codes and you make determinations based on the rules of the arbitration program and it's one arbitration. To take a seven code or 12 code encounter and turn that into a 12 code arbitration is going to exponentially increase the cost and time to get work done and will only I think further increase frustration and confusion on the part of providers and payers. So that is the update of significance on this program and again, I would just underscore that I think States that have existing programs considering allowing opt-in of ERISA plans into the state program would be very helpful and I think states that don't have programs should now consider setting up their own program to be helpful to their providers and payers within that state. And again further outreach and education to the provider and payor associations within specific states will only help the program.

Rep. Dunnigan asked if he heard correctly that only 30% of the cases are accepted? Mr. Naughton replied yes. Rep. Dunnigan asked what happens to the other 70%? Is the initial resolution just what ends up happening? Mr. Naughton stated that the other 70% may be rejected because they should have gone through an existing state program. They may be put on hold because CMS is not sure how to handle that specific type of case or there is information that is required to complete the arbitration that has not been submitted. Those are the main reasons for rejecting cases. Rep. Dunnigan stated that I think you said 70% of the cases are going to the feds and should go to the states? Mr. Naughton stated we don't have that data yet but I would say it's at least 40% to 50%. Rep. Dunnigan asked when that happens is it just sent back to the States or just rejected? Mr. Naughton stated that it's rejected and the provider now

has to go through the process again of going through the state. Rep. Dunnigan asked if there is an additional fee associated with that. Mr. Naughton stated that there could be depending on the state.

Rep. Dunnigan asked if there is enough data to see by either providers or the insurance plans if the states or the feds are considered to be more friendly to their cause? Mr. Naughton stated that we don't have enough data from the federal program yet to do a good comparison right now. I would say anecdotally the federal program likely leans towards payers at this point but there's a very good example from the state of New Jersey which has had arbitration programs since 2007. And in 2007 the payers were here and the providers were here and we actually did about 5,000 cases that year and providers were winning a significant amount of the time. And so in 2008 we did 10,000 cases. In 2009 we did 12,000 and then we did 15,000 in 2010 which for the state of New Jersey is a significant number of arbitrations. And what happened after that was the payers and providers started coming together so that in 2011 we were down to 8,000 cases and winding down to the point where starting in 2015 and going forward you're really seeing cases where folks just always are going to arbitrate every case no matter what or it's a new code or case of first impression but the volume has gone down significantly in the New Jersey programs and has stayed right around south of 5,000 cases since 2015. So a year from now we should have data and you should actually start to see middle ground starting to be achieved and based on our experience it usually takes about three to five years to get to the middle ground of what we would call success where the arbitrations are again people that always want to arbitrate or it's cases of first impression. Rep. Dunnigan stated that if you were to look through your crystal ball, if you had 150,000 cases this year in the first year, what will we have the second year? Mr. Naughton stated that our projections for the next year are over 200,000 cases.

Sen. Bob Hackett (OH) state that Ohio got a real good solution but how we got that solution is both the plans and the providers got together with the Department of Insurance almost being a referee. I think we all got involved saying that we did not want too many cases arbitrated and I agree with you there but I don't know if I agree with some of your statements of trying to get everything together because you're going to have certain states that are going to be extremely more liberal than conservative states and it's a difficult scenario of how to do that. But my question to you though is how is Ohio doing? Is it too early to tell? Because we didn't want too many cases, but we wanted to be fair. The providers and the plans played a major role and you had both sides working towards that solution. Mr. Naughton replied yes, they did, and we were definitely involved in some of those negotiations and discussions. For Ohio, it's too early to tell but I would also say you achieved your goal of not getting too many arbitrations.

WHAT QUALIFIES AS "PREVENTIVE SERVICES?" A POLICY DISCUSSION, AND BRIEFING ON *BRAIDWOOD MANAGEMENT, INC. V. BECERRA*

Justin Giovannelli, Associate Professor, Center on Health Insurance Reforms, Health Policy Institute, McCourt School of Public Policy, Georgetown University, thanked the Committee for the opportunity to speak and stated that much of our work is understanding state and federal regulation of private health insurance. Certainly a significant chunk of that is trying to understand the implementation of the Affordable Care Act (ACA) and how states have responded to that federal law. So what I hoped to talk to you about today is the federal preventive services protection which was enacted with the ACA back in 2010 and give you an overview of that protection from a legal standpoint and talk about a recent lawsuit that is challenging that protection and talk about an option or two that you all as state legislators may have depending on the outcome of this case. I think you're going to hear a bit more about some of the particular services that have been classified as preventive under the statute and perhaps

about other aspects of the litigation but I'll try to provide an overview of all of that. So federal preventive services protection requires coverage of many preventive services without cost sharing. And that last part is really important. There's a lot of evidence to suggest that if there is imposition of cost sharing on even these high value services that are covered now by health insurance companies that individuals don't get those services if they have to pay out of pocket often. So this protection provides access to those services without cost sharing. It applies very broadly to almost all private health insurance so all of the fully insured markets that you all regulate as well as ERISA regulated employer benefit group health plans. So it's important to get an understanding of the litigation that I'm going to talk about in a second and to get a sense of what kind of services we're talking about.

So instead of listing all of the preventive services that seemed to be a good idea in 2010, what the statute did instead was identify three different expert bodies, the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA), and indicate with respect to each of them that certain types of services recommended by these expert bodies would need to be covered without cost sharing. So for example plans must cover all items and services with an "A" or "B" rating from the USPSTF. There actually is more language there with respect to it needing to be evidence-based items and services but you get the general idea. So this has been the framework that everyone's operated under for the past dozen or so years and I'll talk a little bit about how many folks are covered by plans that have this protection in a little bit. What we have more recently is this litigation challenging aspects of that or really the entire protection that I've described - that's the *Braidwood Management* case. This is a lawsuit in the Northern District of Texas. There are a couple of elements to it. One involves a comparatively more narrow claim under federal law under the Religious Freedom Restoration Act (RFRA). That challenge at this point is primarily about coverage of anti-human immunodeficiency virus (HIV) medication. I'm not going to really get into that element of the case today. I'm happy to answer questions about it if you'd like. Then I'm going to focus more on the broader constitutional challenges to the provision and this is really important. We have here a challenge based on the U.S. constitution to the power of the U.S. Congress. This is really a federal lawsuit without implications for the authority of all of you to regulate health insurance under state law. It's obviously a very significant piece of litigation but it's really all about Federal power under the U.S. Constitution.

There are two main elements of the constitutional challenge that I'll outline briefly here and I'm happy to talk about them in more detail if you'd like. So, the first is grounded in the Appointments Clause of the Constitution. The second has to do with something called the Nondelegation Doctrine. The plaintiffs in this case are a couple of businesses, a couple of individuals, who objects to this provision of the law, the Appointments Clause. The argument here is that the individuals who sit on these expert bodies are in a legal sense officers of the United States and because they are officers they've got to be appointed in a certain way that complies with the Constitution and the argument is that they have not been. The second argument surrounds the nondelegation doctrine. This is a doctrine that has not gotten much use or attention in recent years. The Supreme Court last used it to strike down a law back in the early New Deal years in the 1930s but there is certainly an indication from the current Supreme Court that there is an interest in perhaps revitalizing this doctrine. And the gist of it is that while Congress can certainly delegate authority in certain circumstances, when they do that they have to provide an intelligible principle for how that authority should be exercised and the argument here from the plaintiffs is that when Congress said that these expert bodies will identify recommendations that have to be covered they were delegating authority to the bodies without any sort of guidance for how that should be done.

So that's the legal challenge. We have an opinion on the merits in the District Court issued back in September of last year. It's a merits decision it's not a decision on the remedy which is really important. So, on the merits what we have is in some fashion a split decision but I will emphasize here this is really round one to use my boxing metaphors here. The decision from the District Court was to agree with the plaintiffs on their Appointments Clause challenge as to the USPSTF recommendations. So, the court concluded that there was a violation there. Really it concluded that all of these experts should count as officers of the United States and were not properly appointed, but for two of the three bodies their decisions are in effect ratified by the U.S. Department of Health and Human Services (HHS) and so that cures any constitutional problem. The USPSTF is different. Its decisions cannot be ratified so the court said we have a violation there. The court also agreed with the plaintiffs on the RFRA challenge. Again, I'm not going to really touch on that at the moment but there's that there as well. The non-delegation claim, the court rejected it primarily because of existing precedent on this issue. So, as I indicated this is a type of approach to federal administrative law that we haven't seen much of in many years and there is binding U.S. Fifth Circuit Court of Appeals precedent where the Texas Court sits that easily disposed of that sort of challenge. But the court recognized, which is absolutely correct, that the current Supreme Court might think differently.

And so while the government prevailed on this claim in the District Court we may see more of it as the case goes up on appeal and his case will definitely go up on appeal. It will definitely go to the Fifth Circuit. It very well may wind up in the Supreme Court in years to come. A word on the remedy - the court decided on the merits but it didn't decide about what should happen because of this appointment's clause violation. That's been briefed by the parties. The court could issue a decision any time. The plaintiffs have asked for a universal remedy. Basically, they want the requirement to cover the USPSTF recommendations to be struck down nationwide so that a requirement that would no longer be in effect in any state. We don't know if the District Court will agree with that approach but there's some reason to believe in the merits opinion that it might. So, what is currently at issue is more than 50 preventive services that are recommended by the USPSTF and they must be covered. Things such as: screenings for a range of cancers, for depression, for high blood pressure, preeclampsia screening, folic acid for pregnant women. These are services that are currently required to be covered. Plaintiffs assert that they should not be required to be covered and have asked the District Court to issue a nationwide ruling. So that's where we stand in the District Court on appeal. Again, everything is really on the table. I think there's certainly reason to believe that the higher courts could actually issue a broader ruling in favor of the plaintiffs and so really at that point you're talking about more than 100 preventive services potentially at issue affecting a lot of Americans. And I tried to provide some state specific estimates of folks who might be impacted by this and if you can't see it on the screen I'm happy to give you that data if you'd like to see it.

But these are the numbers of people in states that would be affected by a ruling making this coverage no longer required. We're talking a lot of people. So, what might states do if they are so inclined? Well, step one is to take a look at current law and see what is required under current law. So of course as you know there are a fair number in virtually all states certain state required benefits. They are certainly not as comprehensive as the coverage framework we've worked with the last dozen or so years under the federal protection. Also some of these state laws do not speak to cost sharing and do not require preventive services to be covered without cost sharing unlike the current federal framework. So depending on what the status of your laws are and your interest one thing that states can do is require the fully insured markets to cover the services that are currently required to be covered under federal law. As I indicated at the outset, the lawsuit's all about federal law, it's not about state law, it's not about state power to regulate. States certainly have authority to enact laws that look just like the federal provision if you're so

inclined. There are more than a dozen states that have something like that on the books already for their individual markets and certainly this could be done in other places. As I wrap up here, I would say of course there's a major drawback to this particular solution and that's simply of course that while you all have regulatory authority over fully insured plans you do not over ERISA federally regulated plans and so the large numbers of people affected by a decision here, many are folks you can't actually help if you're inclined. But for fully insured markets there is state authority and certainly you can act in this way if you would like.

Emily Carroll, Senior Legislative Attorney at the American Medical Association (AMA) thanked the Committee for the opportunity to speak and stated that the AMA is the largest professional association of physician residents and medical students in the U.S. We have members practicing in every state in every specialty. We very much appreciate the opportunity to be here to discuss the importance of preventive healthcare and our concerns about an overly broad remedy in the *Braidwood* case that could jeopardize the access of coverage of preventive services to millions of Americans. Physicians certainly know the value of preventive care when it comes to helping their patients live long healthy lives. Ensuring that patients can receive services without financial barriers is of the utmost importance to our members. Preventive care can mean the difference between kicking a smoking habit or living with a heightened risk of dozens of illnesses. It's the difference between taking a statin or suffering a heart attack. It's the difference between catching a patient's cancer early or catching it after it's too late. Identifying and treating conditions before they worsen or before they present at all yields better outcomes for patients and saves money for the overall healthcare system. Physicians recognize they have an obligation to ensure that their patients and the public as a whole receive medically indicated preventive services. Principle seven of the AMA's principles of medical ethics state a physician recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health. And opinion 8-11 of the code specifies that while a physician's role tends to focus on diagnosing and treating illness once it occurs physicians also have professional commitment to prevent disease and promote health and well-being for the patients and the communities.

This is because preventive care first and foremost saves and improves the quality of lives. There's an extensive body of evidence demonstrating how preventive care can help patients live long healthy lives. Such services aimed at this include prevention, early detection and treatment of potentially fatal medical conditions and chronic diseases, as well as services aimed at encouraging people to live healthy lifestyles. These services can identify or these services can help identify diseases at earlier stages when they are more treatable or may reduce a person's risk for developing a disease. For example according to the American Cancer Society cervical cancer incidence and mortality rates have decreased by almost 50% in the past three decades and this is attributed to screening which can detect both cervical cancers at an early stage and precancerous lesions. Screening can identify people at risk for developing type 1 diabetes before they even become symptomatic and screening in pediatric populations has shown to lower hba1c's and shorten hospital stays at diagnosis. Smoking cessation reduces the risk of 12 different cancers and can help improve health outcomes after a cancer diagnosis. It also reduces risk and improves health outcomes after a diagnosis as to cardiovascular diseases, stroke, aneurysms, respiratory diseases, asthma, pregnancy and reproductive health. And late entry into prenatal care or no prenatal care at all is known to contribute to poorer birth outcomes especially in increases in low birth weight and preterm babies. Ensuring access to preventive care also saves money within the healthcare system. By reducing the amount of undiagnosed or untreated conditions preventive care reduces cost through less invasive or complex treatments. Put simply cancer is easier and cheaper to treat at the outset than after it has metastasized.

HIV is less costly to prevent than treat. Prediabetes screening is cheaper than treating diabetes. A flu shot is cheaper than caring for a patient in the hospital with the flu. But despite all the benefits it's often difficult for physicians to get patients to access preventive services and this can be particularly true for minoritized and marginalized communities. For example, an estimated 1.2 million Americans at risk of HIV infection should be taking pre-exposure prophylaxis (PrEP) according to the Centers for Disease Control and Prevention (CDC) but only 25% are doing so and use among Black and Hispanic patients is especially low. Studies have shown that out-of-pocket payments can be a barrier to use of recommended preventive services and reductions and cost sharing were found to be associated with an increased use. Congress recognized this when it passed the ACA and it recognized the role of health plans and payers in improving access to preventive care. In enacting the ACA, Congress sought to guarantee access to services like these regardless of financial constraints and I want to stress how important this access is to the AMA and our physician members. Congress was really careful to make sure that insurers would be required to cover only effective high value services through evidence-based recommendation. And just to be clear one more time as to the types of services we are talking about. We're talking about screenings, genetic assessments, risk reducing medications and behavioral counseling for various cancers including breast, colorectal, lung, skin and various forms of cancers of the female reproductive system.

We're talking about preventive services for pregnant people and those who have recently given birth including screening for aspirin use in those with high risk for preeclampsia. Interventions to support breastfeeding. Screenings for sexually transmitted diseases. Folic acid supplements for neural tube defects. Gestational diabetes screening. Preventative medications for newborns and blood testing. We're also talking about services for populations at high risk for certain conditions including aneurysm screenings for older men who have a history of smoking. Cardiovascular disease screening including among at-risk populations. Tuberculosis screening. Screening for osteoporosis in older women. Screening for diabetes and type 2 diabetes in adults who are overweight. And statin use in adults with cardiovascular risk factors. And we're also talking about preventive mental health screenings including anxiety, depression and suicide risk screenings in children and adults. Removal of guaranteed access to these services could have devastating effects. As mentioned, currently 151.6 million people have private health care coverage that covers preventive services with zero cost sharing. A literature review in 2022 found that 35 separate studies determine the majority of findings conclude that cost-sharing elimination led to an increase in utilization for select preventative services. Literature also suggests that this is particularly true for low socioeconomic groups and those who experience the greatest financial barriers to care. Additionally, the availability of no cost preventive care has improved utilization and health outcomes among populations that have been historically subject to discrimination. If the court were to apply a broad remedy in the *Braidwood* case, we fear a return to pre-ACA regulatory regimes where insurers could charge patients for preventive care at their will.

It's likely health plans and employers would impose deductibles and copays for some or all the services recommended by the task force. Imposing a co-pay or high deductible to access preventive care for patients will deter some and in particular those of limited means from scheduling such care. And gutting this requirement will significantly set us back as a society in terms of improving health outcomes in marginalized communities. Moreover we'll all be affected by the confusion that emerges. For the first time in ten years we will have to scrutinize insurance plans to determine what preventive care they cover and at what out-of-pocket costs and we will likely see a race to the bottom in terms of insurance. Insurers and payers will alter their plans in ways to distort the functioning of the system and many insurers will likely design their preventive benefits to attract healthier customers forcing other insurers to follow suit to compete. Ultimately

if the court invalidates the task force recommendations nationwide physicians will be left in a really tough situation. They'll struggle to encourage their patients to accept services they know will save their lives but they'll see many other patients, some of their most vulnerable patients, turn down medically indicated care because of financial barriers. As we wait to see what the court decides in terms of the remedy we are reminded that remedies are about equities and those equities here include the ability of patients to continue receiving no cost preventive care as they have for over a decade. The past ten years have shown the benefits of no cost preventive coverage and that's why the AMA and a number of other medical societies have asked the court to consider this before ordering a remedy that could upset this process.

Greg Baylor, Esq., Senior Counsel, Director of Center for Religious Schools at the Alliance Defending Freedom (ADF) thanked the Committee for the opportunity to speak and stated that ADF is involved in many religious liberty cases including this one. ADF has been and continues to be involved in many disputes involving the application of insurance coverage mandates that violate the religious freedom of our clients, including the *Hobby Lobby* case that made it to the Supreme Court. And the *Zubik* case which subsequently made it to the Supreme Court. Given that involvement and experience it'll be no surprise to you that I wanted to focus on the RFRA aspect of the case and I think it's helpful perhaps to put RFRA into a little bit of context. Religious liberty in general we lawyers like to think that there's two categories of legal rules that violate religious liberty or at least infringe upon religious exercise. There are those rules which are thankfully pretty rare that target religious exercise for particularly adverse treatment. And then there's the other kind that's more complicated, it's a rule that sort of applies to everybody but happens to sort of incidentally impose a burden even a serious substantial burden upon a religious claimant. And that division matters because judges want to know what test they should apply and how much scrutiny should they apply to the government's action in a particular case. And there's been a debate about this, about what do you do with a law that wasn't intended to go after religious exercise but nonetheless imposes a burden as significant as if the law were targeted at religious exercise exclusively.

And for a time the U.S. Supreme Court when it was interpreting the First Amendment's free exercise clause said "look we don't care where the burden comes from the burden is the burden and therefore in order to uphold the spirit and the letter of the First Amendment we need to apply what's called strict scrutiny to this burden." So under strict scrutiny the Court will ask the claimant "tell us how bad this is for you - how substantial is the burden on the exercise of your religion?" And if the claimant is able to prove to the court that that burden is significant enough the Court will turn to the government and say "look what are you trying to accomplish here - how important is your interest - is it compelling?" And then they'll ask "is there any other way you can do this - is the means that you've chosen to pursue your objective the least restrictive one?" Eventually the Supreme Court changed its mind about this and said "you know what if it's not targeting, if it's a generally applicable facially neutral rule we're going to no longer apply strict scrutiny." There was great uproar on all sides of the spectrums political, ideological, and religious and that resulted in the passage of RFRA which restored strict scrutiny, this test is hard for the government to win with, to cases not just involving targeting of religious exercise but to incidental burdens on religious exercise of generally applicable and facially neutral laws. So that statute passed in 1993 and resulted in a number of victories for religious claimants. Unfortunately, at least from my perspective, about four years later the Supreme Court said "Congress you had the authority to restrain the federal government with RFRA but you do not have the authority to restrain state and local governments." So I think this goes to the point about the impact of this case on the state system. A RFRA conclusion in favor of the plaintiffs in this case doesn't necessarily control the power of state legislatures and state administrative agencies to enforce insurance coverage mandates against religious claimants.

So that's the backdrop - let's move to litigation over mandates in general. I think the debate in this area started when states themselves started adopting contraceptive coverage mandates well in advance of the ACA. And some of the states had robust religious exemptions for those religious entities that didn't want to include that in their employee health plans for religious reasons of conscience. But some states had very narrow exemptions and that necessitated litigation in New York and California by Catholic charities that did not want to cover contraceptives and sterilization and they lost those cases because the tests the courts were using was not strong enough. But then fast forward to when the federal government adopts a contraceptive mandate via the ACA. Again an insufficient religious exemption was there which prompted literally hundreds of lawsuits challenging the contraceptive mandate. Many of the plaintiffs challenged only the abortifacient contraceptives, the ones that can and do sometimes interfere with implantation of the young human being in the uterine wall. Many of the Roman Catholic challengers challenge the whole thing - they didn't want to be sort of complicit in the provision of any contraceptives and their legal claim to challenge this was RFRA which as you will recall requires the claimant to say "this is really bad for my religion, it's making me do something that's against my religion, I'm offending God by engaging in the behavior that this statute or administrative regulation forces me to do."

So the courts in these cases turned to the government and said, "okay what are you trying to accomplish here and is there some other way you can do it?" And Hobby Lobby prevailed in its case because there was some other way to do it. HHS had set up a mechanism by which non religious non profits could comply but they didn't offer that alternative mechanism to Hobby Lobby and other for-profit entities owned by people of faith. So they prevailed. And then the nonprofits prevailed as well on sort of a complicated reasoning and eventually because the rules were changed when President Trump came into office in 2017. So that's the background to *Braidwood*, let's talk a little bit about the case. What is it that they objected to on religious grounds? Well, when the case got to the stage that we're talking about right now the remaining objection was to the PrEP medication and the plaintiffs argued that they believe that homosexual behavior is contrary to their religion and then they said "look if we include that medication in our employee health plans we're going to be facilitating behavior that we think is inappropriate, immoral or sinful." And the court agreed that this requirement imposed the substantial burden on their religious exercise for purposes of RFRA. And this was not hard and not controversial at least as a legal matter because *Hobby Lobby* had already paved the road for this. I mean *Hobby Lobby* if it stands for anything it stands for the proposition that if you make someone include in their health plan an item that violates their conscience that's a substantial burden.

So the court turned to HHS and the other defendants and said "okay what is it that you're trying to achieve here? What's your interest? How compelling is it?" And of course the interest is reducing the incidence of HIV and the spread of HIV and the resultant health problems and deaths that occur when that happens. And the plaintiff said, "hey we don't disagree that that's a compelling interest but you're asking the question at the wrong level of specificity - the question is not whether the interest is compelling sort of in the abstract - the question is whether it's compelling and necessary with respect to this plaintiff." So you don't ask the question "what would it be like if this mandate didn't exist?" The real question is "what would it be like if this mandate didn't apply to this particular claimant?" And obviously the consequences are much lower when you're talking about one employer as I understand that the employer making this claim had about 80 employees. So the court concluded that this violates RFRA. There's no other way to comply. There's no other mechanism that they've offered to *Braidwood* to comply with this and there are less restrictive means by which they could accomplish this purpose. Throughout the HHS mandate litigation one of the things that the plaintiffs argued was "you know

what there's another way you guys can do this - you can actually pay for it yourself." And interestingly enough the Biden Administration and its proposed rule about the contraceptive mandate in which they're proposing to replace the Trump rules has proposed precisely that. So that women who work for employers who have objected, who have opted out, who'd been given exemption under the law, they have an opportunity to get the coverage cost free to them through the federal government paying for it, not through the mechanism of the objecting employers health plan and at the health plan expense.

So what does this mean in *Braidwood*? Who won? What's the remedy going to look like? Well, they haven't said yet exactly what the remedy for the RFRA violation will be but I have no doubt in my mind that the only entity that will be exempted because of this decision from the PrEP coverage mandate is the company itself. Now certainly other employers can file their own lawsuits and use that decision as a precedent but the *Braidwood* case itself does not confer on anyone else the right to opt out of this requirement. So what are the implications for the states? As mentioned, this means that if this stands up on appeal there will be a certain number of women and others given the scope of the preventive services that are required to be covered that won't have that protection or that mandate of federal law. And presumably the role for the states can be to step in and provide that themselves. One issue about that and that's the last thing that I'm going to say is just because a state level mandate can't be attacked based on RFRA, because it doesn't apply to state and local governments, it doesn't mean that it can't be challenged under comparable statutes and constitutional provisions in state law. So if a state were to adopt a sort of PrEP coverage mandate there's a significant possibility that some employers would turn around and file litigation not under RFRA but under state statutes that provide for strict scrutiny and under state constitutional provisions that provide for strict scrutiny.

Rep. Mike McFall (MI) stated that his question is for Mr. Giovannelli: you had mentioned that there were states that had done this - which states were those? Mr. Giovannelli stated that by our count there are something like 15 or so states that have provisions actually that they had enacted before this litigation frankly in response to other federal challenges to the ACA that take slightly different forms but in some fashion basically mirrors the language of the federal statute and so state lawyers should always take a look at everything you're considering and acting on but to our mind these are provisions that don't in any way rely on the federal protection continuing and do not implicate any of the federal constitutional or statutory issues that are raised in *Braidwood*. Rep. McFall asked for some of those states. Mr. Giovannelli stated that off the top of my head, and I'm happy to provide you this afterwards, I believe New York has such a statute and Oregon is making slight changes to theirs and I believe Washington state and New Mexico.

Rep. Lori Stone (MI) stated that I'm directing this to Mr. Baylor but anyone on the panel is open to it - has anyone approached this issue from the position that they're having an individual's religious beliefs imposed upon them and that their individual rights are being violated because someone is stripping them of access? Mr. Baylor stated that I think that argument has been made kind of in the court of public opinion but it's not been made in the course of a legal case and it's not a case that would succeed because RFRA and the Free Exercise Clause and state analogs to those things don't restrain non-governmental individuals. There are some exceptions but for the most part you can't sue someone else who's a non-governmental entity for violating RFRA with a free exercise clause. But in a kind a conversational sense or in discussions in the media and in other public forums people have said, "Yes, you're imposing your religion on me." So you're right about that but it's not a valid legal argument.

Rep. Rita Mayfield (IL) directed her questions to Mr. Giovannelli. I also wanted to get that list of states that are already doing this. I know that Illinois has something like this because we do offer the PrEP and other preventive services but I would like a comprehensive list. And then for your recommendation asking that there be parity between group market carriers and individual market carriers you're saying that they need to add the same required benefits without cost sharing? Mr. Giovannelli stated that what I was suggesting is that under the current framework the federal protection applies to all fully insured plans, individual and group market plans and it also applies to ERISA regulated plans over which you all lack authority. But over the fully insured plans that you can regulate you would have authority to pass this requirement in the individual market but then also for coverage that is offered to small and large businesses too. Rep. Mayfield stated that and these states that have already implemented this is that what they've done or did they implement something different? Mr. Giovannelli stated that our investigation looked at the individual market specifically and the 15 or so states that I'm throwing around is with respect to the individual market. I know that some of those states the protection is broader into the group markets. I can't say for sure how many that's the case for.

Rep. Mayfield stated that my next question is how does offering preventive maintenance impede somebody's religious rights? Mr. Baylor stated that in most states they have a moral assessment about what's religiously permissible and not permissible and a lot of the times you're talking about an action that the person themselves believes that they may not do but there's another doctrine both in religious and non-religious philosophy about being complicit in somebody else's behavior and I think that is what we're talking about when we're talking about a contraceptive mandate and when we're talking about a PrEP mandate. It's not so much that the person is being compelled to do the thing ultimately that they object to but they're being required to facilitate it and to play an indispensable role in the causal chain and I think it's a kind of a well settled principle of ethical philosophy that's a legitimate kind of thinking about what's morally permissible and what's not. It's not limited to the things that you do but it includes the things that you're sort of complicit in by the things that you add to the process and as a legal matter it's been accepted by courts that you can have a valid religious freedom claim because you're being compelled to be complicit in something that you believe to be against your religion.

Rep. Mayfield asked if this claim is about the health insurance carrier being mandated to offer the preventive maintenance having a religious objection as opposed to an individual that is receiving the health care? Mr. Baylor stated that the plan sponsors are typically the plaintiffs in cases challenging these so it's the employer or the University that has a student health plan, they are the challenger because at least in the ACA case the mandate applies both to carriers and to third party administrators (TPAs) and to the plan sponsor. Most TPAs don't have a religious objection to providing any of this but there are some. Guidestone which works with the Southern Baptist Convention, they were a plaintiff in the HHS mandate litigation not because they were a plan sponsor and objected because of that but they were actually the plan provider or the TPA so both kinds of plaintiffs can assert these claims. Rep. Mayfield asked if the plan sponsors are corporations? Mr. Baylor replied yes. Rep. Mayfield stated that corporations are not exactly people. They're comprised of people but they're not people. Mr. Baylor stated that of course there's a distinction between corporations and natural persons but this was actually an important part of the *Hobby Lobby* case. RFRA confers religious freedom protection on persons and of course the definition of person in federal statutory law does include non-natural entities like corporations, partnerships and all the rest and the federal government in defending these challenges to the HHS contraceptive mandate, its first argument was Hobby Lobby doesn't have a right to claim the protection of RFRA and some of those arguments were sort of legal and more rooted in the text and some of them were more like how does a company have a religious belief? And companies have positions on questions even if they're not natural people and the conclusion

was the owners of the company, the Green family in the case of *Hobby Lobby*, they were the leaders of the organization and could decide for it what the entity's religious views are so it's a question that got asked in the Supreme Court but it's been settled.

Rep. Julie Rogers (MI) stated to Mr. Baylor that you just mentioned the ethical philosophy and the complicit behavior and so my question is what about infants - what about situations where the person being affected potentially by HIV had no decision making in that? So going down the road of the argument saying that the religious institutions don't want to cover HIV medications because of this complicit behavior, what about the infant that had no choice in the matter that contracts HIV from his or her mother in the womb? Mr. Baylor stated that almost every religious liberty claim involves a balancing of competing interests and the strict scrutiny test that I laid out that is applicable under RFRA and many state analogs takes account for all the interests involved in the case. So the first interest they focus on is whether this imposes a burden on the religious exercise of the entity that doesn't want to include something in its health plan and suppose that they satisfy that you move on. And then the government identifies its interest and in the analysis of that interest you do consider the impact on third parties. That's just part of the analysis, how much will giving this at any exemption undermine the goal that the government is trying to pursue and you can certainly raise evidence about what kind of impact it would have on third-parties. That's why we argued in the contraceptive mandate cases not that individuals should never get this coverage but that the company itself or the individual wouldn't be complicit in providing it and we recommended that the government itself pay for that so that the ultimate beneficiaries of the plan would get what they want but just leave us out of it. And again, the Biden Administration has belatedly embraced that view in the current notice of proposed rulemaking on the HHS contraceptive mandate so it's a valid consideration. It's taking into account in the test and the Biden Administration is doing probably at least from their perspective the right thing to make sure that people get the coverage they want.

Rep. Rogers stated that I have a quick follow-up - I just want to thank Ms. Carroll for her comments as covering preventive care is not only the moral and right thing to do but it's oftentimes the fiscally conservative thing to do as pointed out. So for the insurers in the room if this case does go in a different direction I implore you to do the right thing and step up and do preventative coverage.

UPDATE ON PREPARATIONS FOR/IMPLICATIONS OF END OF PUBLIC HEALTH EMERGENCY (PHE)

Miranda Motter, Senior VP, State Affairs and Policy at America's Health Insurance Plans (AHIP), thanked the Committee for the opportunity to speak and stated that I want to spend just a couple of minutes revisiting a couple of issues that we have previously spoken about. The first is Medicaid redeterminations and some legislation that was passed at the end of the year which has now decoupled one of the major requirements as part of Medicaid redeterminations from the end of the PHE. And since that time we also now have an announcement from the Administration about when the COVID national emergency and the public health emergency will end so I really just wanted to provide a couple of updates relative to those announcements and some key dates and then certainly a series of resources that you will find hopeful and some links included in this presentation. With that I will start with the Medicaid redeterminations and a piece of legislation that Congress passed at the end of the year called the Consolidation Appropriations Act of 2023. Many of you are very aware of the work that sits in front of the states with the decoupling of the Medicaid redetermination processes from the maintenance of eligibility requirements. The most recent numbers I think I saw this week out of CMS indicate that individuals that are currently receiving health insurance coverage under Medicaid has reached

about 93 million individuals all across this country. I know many of your Medicaid directors and staffs and Governor's office health policy staff and many of you and your staff and insurance Commissioners in this room have been very focused on this issue. There is a number of individuals that will now with this decoupling be sitting in a situation where they will need to go through an annual redetermination process that had paused during the PHE.

Originally, the Medicaid redetermination maintenance of eligibility requirement which essentially was in the Family's First Act that Congress passed, Congress provided states an additional Federal Medicaid Assistance Percentages (FMAP) percentage, a 6.2 percentage, if they did not terminate anybody's Medicaid eligibility throughout the PHE. Prior to the passage of this Consolidation Appropriations Act that was all going to be tied to the end of the PHE. This legislation now gives us a date certain. I think the last time we talked there was a lot of uncertainty about when the PHE was going to end and so while a lot of work was being done in the states it wasn't quite clear when all of that needed to start. We now have a date, March 31st. As a result, and is laid out in that statute that additional 6.2% which sits on top of the FMAP that each one of your states have as it relates to your Medicaid agencies will begin to decrease. So that decreasing will be 6.2% through the 31st of March. So beginning on April 1st states may begin to terminate individuals who no longer are eligible for Medicaid and you'll see there the additional leveling down of the FMAP as we get to December 31st of 2023. The other two things that passed as part of that federal legislation are there are state requirements as it relates to how states will conduct their redetermination. They must comply with eligibility requirements. They need to use a national change of address database. That's the one thing I know that many states are very concerned about is having updated contact information to actually do the outreach to individuals who may need to be redetermined and then certainly for those individuals that are no longer deemed eligible for Medicaid. States must also provide a report to the federal government to provide information about what is happening and how that is going. And then certainly there are enforcement and corrective action provisions included in that legislation.

So with that I just wanted to provide a visual of actually what that looks like relative to the key dates and policies. So you'll see here states could begin their unwinding or their redetermination processes to internally determine who may or may not be eligible beginning as early as February 1st. They cannot terminate coverage until April 1st but they could start on February 1st to do that internal analysis about who is and who is not eligible. If they started on February 1st those states needed to provide a report to CMS on February 1st about what that plan is. If a state started after that their deadline for providing that report is February 15th. So there should be some good visibility in terms of state work as it relates to this. The other dates up there were ones that I just mentioned as it relates to leveling down of the FMAP and then I would also just note a couple of the links there at the bottom that do provide some good resources from CMS that talk about the different dates and what that looks like and what states should be aware of and understanding the impact. One of the things that we have been spending a lot of time focusing on is certainly during this unwinding process there will be a number of individuals that are no longer deemed eligible for Medicaid and so trying to understand where those individuals can find access to health insurance coverage. This is a high level number that came from the Urban Institute that really shows that in most instances most of the individuals that will be transitioning off of Medicaid have the opportunity to transition into employer sponsored coverage. I will tell you at least from my personal perspective this was a little bit of a surprise to me but we knew that individuals would have access to employer sponsor coverage. The numbers then after that you will see that there's still anticipation of a pretty high number of uninsured individuals going to the Children's Health Insurance Program (CHIP) and then individuals being able to purchase in the individual market whether that's in the marketplaces and the subsidized marketplace or just in the individual market.

AHIP released just yesterday and there's a link there at the bottom - we thought it was really important not just to understand this from a national perspective but to understand with some visibility what may be taking place in your individual states, again for a source of support as you are working with your Medicaid agencies and with your Governor's offices and with your insurance Commissioners and quite frankly all of the provider stakeholders on the ground and patient advocacy groups on the ground and employers on the ground to really understand where they may have access to coverage. The modeling that you just saw there once it winds up it indicates that most individuals will be able to transition to employer sponsored insurance coverage and you'll see there it's really slightly under 50% to slightly over 50% depending upon the state. Let's move now to the end of the National Emergency and the PHE. So while we are focusing certainly on the decoupling that's happening and the date of April 1st and Medicaid redeterminations we do now have a date certain for the end of the National Emergency and the PHE. The Administration has announced that will end on May 11th. They have formally made that announcement and has also recorded it in the Federal Register.

So essentially what does that mean as the federal government and as we all across the states are moving back to a return to normal? There will be a number of impacts. I know a number of these impacts we talked about I think at one of the very initial conversations that we had about Medicaid redeterminations because that was one of many changes that took place during COVID. But you will have things because of waivers that states took advantage of, waivers that the federal government provided across different markets and you'll also have things that took place in individual state Medicaid agencies whether they did that by state plan amendments or other kind of waivers and flexibility that they took advantage of. Again really the purpose is to understand that there are likely changes in front relative to COVID vaccinations and tests and treatments and telehealth services. The emergency use authorization which many of you know gave the federal government and the Food and Drug Administration (FDA) the ability to quickly move through products that were needed during COVID. There are also elements of this that won't change and this emergency use authorization is one of those areas that will remain the same. The Prep Authority which really provided immunity from legal liability was another change that took place and then as many of you know there were many changes and flexibilities given to healthcare professionals during COVID. So again the resources are listed there in my slides if you need them.

Asw. Pam Hunter (NY), NCOIL Treasurer, stated that when we had this conversation last year it was concern about the amount of people who are going to be dropped off the Medicaid rolls because municipalities weren't prepared and there was supposed to be an end date and then they moved the date again so I'm just trying to get some clarity as to the numbers that we expect will be dropped from the Medicaid rolls. And I know some people aren't eligible anymore because maybe they're working now and they're not eligible but a lot of people are transient too especially low income people that have had a lot of movement during COVID. So what has been the expected number of people to drop off? But also what has been the directive from I guess the feds to states as far as getting themselves together in order to make sure that they are identifying all of the people to make sure that if they need insurance that they're getting insurance? Because they can't have back coverage for people if they get dropped off and isn't there a certain waiting period before they get on again? That's concerning.

Ms. Motter stated that as you indicated the number of individuals that will have to go through this process is significant because they haven't done this in over three years. The estimates that we've seen in terms of individuals that will lose Medicaid eligibility is really anywhere between five million to 17 million and those numbers obviously have adjusted and as I said just last week we saw the new 93 million total number so absolutely it's a significant number. States have been

planning to your point of how do they get in front of this? How do they make sure that they are reaching out? How do they make sure they've got the right contact information? Because that is really going to be the key - being able to contact the person at the right address and really getting that person to do what they need to do to maintain their eligibility. So there are many different things happening all across the country in a variety of ways using best practices from one state to another in making sure that those plans are very thorough and that they look at making sure that they are moving through the population in a certain number per month so not doing too many too soon. Also, another way that states are looking at this is maybe doing their redeterminations by population so maybe taking the individuals that they think are going to be ineligible first and then moving through to other populations. I will tell you there is a workforce concern present across this country in many different businesses and in state government and it is very true in Medicaid agencies and many states this actually happens at the county level. So, in Ohio for example there's 88 different counties that may be doing this so it doesn't always wind up to one agency. As a result I would say it is incredibly important to one make sure that you're working across agencies. This I think originally surfaced and there was a lot of thought that this was just a Medicaid issue but when you look at these numbers and when you understand that a number of the individuals actually could move to employer sponsored coverage, this is an insurance issue, this is an employer issue, this is a provider issue to make sure that providers have a reimbursement resource going forward and so there is a lot of work. There's a lot of sharing across levels the best practices that are there. As health plans we are really standing ready and trying to help states to try to fill some of that workforce gap that is existing in state agencies and health plans in many instances know where the members are better than the states. Our data is more up to date and so to the extent that you can work with your health plans in the state it's really helpful but a lot of planning is underway.

Sen. Bob Hackett (OH) stated that remember we all know about the cliff effect where people can come off Medicaid and phenomenal coverage and then have less even though they're getting higher incomes which came through COVID because of the demand for workforce, etc. The question I have though is we see in almost all the states we're having a huge increase in the number of Medicaid state employees. We're really seeing that huge in Ohio. In your mind is that temporary? And why can't our managed care plans handle it? Ms. Motter stated that does not surprise me. The workforce that's going to be needed to help with this volume I think is absolutely true and then to your second question I would say health plans stand ready and are working very aggressively and deeply with the state agencies where they can and where they're given permission to do that direct outreach to enrollees.

Rep. Rogers stated that I think there's some challenges and I spoke with some of my health plans in my state that because of Health Insurance Portability and Accountability Act (HIPAA) laws they're prohibited from trying to reach out proactively. So I do think that the states have a big role in trying to help push this information out and we should have been doing this in my opinion late last year. In our state alone we have 400,000 people that this could affect. The other thing I wanted to note and I did not know this until I started diving into it a couple months ago is that the marketplace is significantly subsidized by the federal Inflation Reduction Act (IRA) so in my opinion the other thing that is needed is navigators to handhold some of these Medicaid patients that are no longer eligible because there are products and they may be very cost effective they may be \$10 a month whereas before the products were just so cost prohibitive that they wouldn't look at them. So I think getting the word out with digital tool kits as well as having some hand holding to have a soft landing for these folks to go I think is critically important.

Rep. Deborah Ferguson, DDS (AR), NCOIL President, asked if there is anything in place from the health insurance plans to help smooth this transition? I worry about patients that may have a

prior authorization for immunotherapy or medication and all those kind of things. Is there some process to sort of smooth those people from Medicaid to an insured plan where they don't have to immediately change providers or get a new prior authorization and have a gap in their care? Ms. Motter stated that is a great question and as you probably know in many states the Medicaid managed care plans also have a product on the exchange marketplace and so that is a place where if there is an opportunity to move somebody who is ineligible in Medicaid over to the exchange marketplace where they might have the ability to receive subsidies, where there can be that continuity of coverage to really help with that.

Rep. Brenda Carter (MI), Vice Chair of the Committee, state that you mentioned that 50% of the people will go into some employer base insurance. I'd like to know how would they be able to get that insurance if they are not employed? Many Medicaid people are on Medicaid because they can't get the job. Ms. Motter stated that's a great question, and many of the individuals that I'm speaking to are those that have remained on Medicaid throughout COVID and they may have obtained a job. They may have got a promotion in a job or obtained a different kind of job and as a result of that change in employment that is taking place during COVID it would provide them access to that employer coverage. Rep. Carter then asked what about the recipients who didn't get a job, what is their recourse? Ms. Motter stated that so certainly the individuals that don't hopefully there is an opportunity for them to purchase affordable health insurance coverage through the marketplace and through the additional subsidies that have been extended through the IRA so that certainly is another strong opportunity for them. What we hope is that individuals won't become uninsured. We know that has a significant impact not only on that own person's life to not have access to healthcare but it certainly has an impact across the healthcare market for employers, for providers, where you have a higher percentage of uninsured.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Rep. Carter, the Committee adjourned at 11:15 a.m.