

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OHIO
NOVEMBER 18, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Saturday, November 18, 2023 at 9:30 a.m.

Representative Jim Dunnigan (UT), Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)	Sen. Paul Utke (MN)
Rep. Matt Lehman (IN)	Sen. Jerry Klein (ND)
Rep. Michael Sarge Pollock (KY)	Sen. Bob Hackett (OH)
Rep. Rachel Roberts (KY)	Rep. Ellyn Hefner (OK)
Rep. Brenda Carter (MI)	

Other legislators present were:

Rep. Chad Aull (KY)	Rep. Bob Titus (MO)
Rep. Michael Meredith (KY)	Sen. Walter Michel (MS)
Rep. Cherlynn Stevenson (KY)	Asm. Erik Dilan (NY)
Rep. Edmond Jordan (LA)	Asm. Jarett Gandolfo (NY)
Rep. Jane Pringle (ME)	Rep. Brian Lampton (OH)
Rep. Helena Scott (MI)	Rep. Forrest Bennett (OK)
Sen. Lana Theis (MI)	
Rep. Stephanie Young (MI)	

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Jerry Klein (ND) 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. Klein and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 20, 2023 meeting.

CHECKING IN ON THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) – WHERE DO STATES STAND IN SELF-FUNDED REGULATION?

Rep. Dunnigan stated that first on our agenda is a presentation on ERISA. As many of you know, NCOIL has been on record advocating for ERISA reforms in an effort to provide states with more ability to regulate the state healthcare marketplace. Starting on page 360 in your binders, you can find in ERISA waiver concept that NCOIL has endorsed followed by a resolution that NCOIL has adopted advocating for amendments to ERISA.

Bill Copley, Parter at Weisbrod, Matteis & Copley, PLLC, thanked the Committee for the opportunity to speak and stated that I'm here today to talk about ERISA preemption, and I think when a lot of people think about ERISA they think of a highly technical statute with complex requirements. But I'm really here today to talk about a simple and fundamental issue which is to what extent can states continue to exercise their traditional authority to legislate and enforce laws in the areas of insurance and healthcare. And it's an important issue. There is a prevailing understanding out there that I think is not quite right that any state law in those areas cannot be applied to a self-funded ERISA plan and I think that comes from a fundamental misunderstanding of a risk of preemption, particularly as it's been interpreted recently by the Supreme Court of the United States in a case called Rutledge v. PCMA. I expect you to know a fair amount about ERISA but I'd like to start out with just discussing some basic principles so that we're all on the same page. So, what is ERISA? ERISA is the Employee Retirement Income Security Act of 1974 and it's a federal statute that creates a uniform set of rules for the administration of employee benefit plans sponsored by companies and unions. Congress's goal when it enacted the statute was to protect employers from having to comply with 50 different States and 50 different sets of requirements in setting up benefit plans for their employees. ERISA set standards in a couple of areas. It requires sponsors to act in the best interest of the plan beneficiaries, also known as fiduciary duties. It requires the administrators that the sponsors hire to run the plans to also act as fiduciaries. It requires reporting requirements, information that the plans have to give both to the federal government and to beneficiaries. It sets standards for who is eligible to participate in the plan. And it establishes funding levels to make sure that whatever benefits the plan promises it actually has the resources to deliver. What ERISA does not do, however, is dictate that a plan provide any particular benefit.

So, what is the risk of preemption? Again, Congress's goal when it set up ERISA was to protect plans from having to comply with the patchwork of 50 different state laws when setting up the plans. I've got the actual language from the statute in the PowerPoint but essentially what the statute says is that ERISA preempts state laws that relate to any employment benefit plan. And courts have really struggled with this language. They've noted that it's unhelpful and the reason is because the phrase "relates to" is subject to interpretation. At a certain level of abstraction everything in the universe relates to everything else. So, they've tried to come up with formulations to understand and give substance to that and they've said that a state law relates to an employment benefit plan in two different ways. One, it can refer to an ERISA plan, which means that a state law singles out ERISA plans for different treatment. It also can have a connection with an ERISA plan. A connection with focuses not only on what the state law says but on what it does. And the courts have ruled that a state law has a connection with a plan if it regulates a central matter of plan administration which it notes are things like dictating what benefits a plan must provide or dictating who can be a benefit. Or dictating different or duplicative reporting requirements to states in addition to what the federal government requires. Those have been examples of what courts have said and the Supreme Court has said ERISA preemption prohibits. Now the preemption clause also contains an exception for state laws that regulate insurance and I think this is where some of the misconception about insurance laws not being able to apply to self funded plans come from. So, what does the insurance exception preserve? The insurance exception applies only if the law would be preempted under the statutes relates to test. And there are two parts to the insurance exception. One is the general

exception which says that a state law that regulates insurance won't be preempted. And the other is called the deemer clause which says that a self-funded plan will not be deemed to be an insurance company for purposes of this exception.

So, what does it mean? What is a state law that regulates insurance? There's two parts to that. One is that it must target insurance companies and the second is the law substantially affect the risk pooling arrangement between the insurer and the insured. The insurance exception saves the state law of regulating insurance under ERISA. But importantly, that's only if the law is preempted in the first instance. That is that the Court finds that it relates to an ERISA plan. And so I think this is where we get into some of the misconceptions because ERISA preemption impacts insurance laws in a number of ways. Because you've got organizations that will work with legislators to pass laws that are good for patients and providers. Laws like regulating assignment of benefits. Laws requiring insurers to honor prior authorizations. And laws limiting retroactive denials of benefits. And the insurance companies that manage self-funded plans will simply ignore these statutes under the assumption that they cannot apply to self-funded plans. And so, I think it's important to understand sort of what is the state of the law, because in many cases, that's not correct. And it's not correct under the Supreme Court's recent decision, Rutledge v. PCMA. So, why is this decision so important? It's important because the Supreme Court clarified the types of laws that ERISA preempts and it rejected some of the broad interpretations of ERISA preemption. And this is important because as I've said before, the insurance exception where it matters whether or not a plan is self-funded, that only applies if ERISA preempts the statute in the first instance and Rutledge is a case about whether or not a statute is preempted in that first instance.

And in that case, the Court rejected several broad interpretations of ERISA preemption that had been percolating in some of the Courts of Appeals. One of them was an argument that if a statute applies generally to benefit plans, that inherently is a reference to ERISA plans. And they rejected that saying, "No, that refers to will only trigger preemption if you're singling out an ERISA plan for different treatment." It also clarified, though, that ERISA preemption under the connection with part should focus on whether state laws interfere with plan administration itself by dictating benefits, by determining who can or must be a beneficiary, or by regulating in an area that ERISA already regulates itself. A state law that passes this Rutledge test means that it doesn't matter whether or not it's a law regulating insurance and it doesn't matter whether or not the law is being applied to a self-funded plan because the law is not regulated in the first instance. So, what was at issue at Rutledge? It's helpful to understand what the Supreme Court was actually looking at and the issue there was whether ERISA preempted Act 900 which was an Arkansas law that basically did two things. It said that pharmacy benefit managers (PBMs) must pay pharmacies their wholesale cost when they dispense generic drugs. The problem was one called negative reimbursements where PBMs were paying pharmacies less than what the pharmacy had to pay to get the drug in the first place. The law also importantly created enforcement mechanisms including requiring PBMs to set up an appeal process where pharmacists could challenge the reimbursement rates they were being paid. The Court ruled 8-0, a unanimous decision, that ERISA did not preempt the Arkansas statute. It held that ERISA only preempts state laws that dictate benefits or eligibility determinations or that regulate an area that ERISA already regulates. A state law that regulates third party service providers generally does not refer to ERISA plans. ERISA also doesn't preempt cost regulations or regulations that only have a de minimis impact on plan administration.

So, what are the key takeaways? Well, Rutledge addressed whether or not the state law relates to an ERISA plan and that's the first step in the analysis. So again, the Rutledge analysis doesn't depend on whether or not a plan is self-funded and it made clear that a state law that

regulates benefits plans generally without treating employee plans differently does not refer to an ERISA plan, and that ERISA does not preempt laws that merely have a change of plans costs or incentives or the way that it participates as a market participant. And it specifically does not preempt regulations that only impact costs or what a plan pays. So how have courts applied Rutledge? It's important now that Supreme Court has spoken to know how are the lower courts interpreting it and there's been two decisions. One with PCMA V. Wehbi in the Eighth Circuit and that case involved some similar restrictions on pharmacies and how PBMs interacted with them and it ruled very closely to Rutledge. It said generally that these regulations are regulations of healthcare and insurance about how PBM's pay pharmacists and that they do not relate to central matters of plan administration. The second case that has come out has been from the Tenth Circuit in PCMA v. Mulready and Mulready took a very different approach. Mulready said that ERISA, despite Rutledge, does not only preempt state laws regarding plan administration but it goes much further and preempts state laws that govern benefit design. And the problem with that analysis is it's very broad. What that means is that if ERISA preempts how benefits are provided, it essentially preempts the entire field of insurance healthcare regulation as it applies to self-funded plans. And so, these decisions conflict, and the Tenth Circuit specifically said that it was disagreeing with the Eighth Circuit which creates a circuit split in the United States and so it's created the situation where ERISA preemption actually applies differently in the states within the Tenth Circuit which are Oklahoma, Kansas, New Mexico, Colorado, Wyoming and Utah, than it applies in the rest of the country.

So, what's going to happen going forward? The ability of states to regulate and to exercise their traditional authority in the field of insurance and healthcare is going to be impacted by how this circuit split is resolved. I expect the resolution is going to come in the next one to two years. The Tenth Circuit is currently considering a request by the state of Oklahoma to rehear the case what's called en banc. The way the Courts of Appeals work is that generally a case is decided by a three-judge panel and then the losing party can request that all of the judges that sit on the court hear the case and decide as a full court. And the Tenth Circuit has actually requested that PCMA respond to that petition. So, I think that shows that there is some serious consideration of that but if the Tenth Circuit doesn't reverse its decision I expect this is going to be a significant issue that the Supreme Court is going to take up again. Because again, you've got ERISA and ERISA preemption being applied very differently in different parts of the country. So how does Rutledge impact state insurance regulation? Assuming that my reading of Rutledge is correct, and that the Eighth Circuit's reading of Rutledge is correct, it means that states have a lot more authority to enact laws and enforce them, including against self-funded plans, than has traditionally been thought. When you're dealing with matters that don't go to central plan administration but are just about how benefits are being provided, those laws should be enforceable generally because they don't rely on the insurance exception. And so that means it doesn't matter whether or not a plan is self-funded or not. And examples of state laws that have been enacted by many of the states here but that aren't currently being enforced potentially against self-funded plans are laws that require insurers to allow assignment of benefits out of network, laws that regulate retroactive denials of claims after they've been paid, and laws that require insurers to honor pre-authorizations. So, those are just a few examples of laws where those laws are not currently being enforced consistently throughout the states and we think the states actually are well within their authority to apply those laws to all benefit plans whether or not they're self-funded.

Rep. Deborah Ferguson, DDS (AR), NCOIL President, stated that in Arkansas we actually had a bill before Rutledge that didn't hold up in court and we came back and wrote a new bill for PBMs and that's what ended up in the Rutledge decision. I guess my question is, looking at the Oklahoma bill in Mulready, is there something they could do to alter that law so that it might be

upheld? It's my understanding in the bill there are things like network adequacy and contracting, and any willing provider. Mr. Copley stated that the Oklahoma bill that was at issue at Mulready primarily dealt with pharmacy density requirements. Requirements that when the PBM's for the plans put together a network of pharmacists that certain thresholds like 90% of the beneficiaries in an urban area had to be within two miles of an in-network pharmacy and in suburban areas they had to be within five miles and in rural areas, they had to be within 15 miles. So that was sort of a simplification of sort of the general thrust of the statute. As far as could it have been rewritten, under the Tenth Circuit's analysis I don't think so because the Tenth Circuit analysis basically took a very broad view that any statute impacting how benefits are provided by plans is preempted so I don't think there's anything that you could have done given the breadth of the Tenth Circuit. I think if that same statute had come up in the Eighth Circuit post-Rutledge the case would come out the other way and I think that's true in most other circuits as well. So when I look at Mulready, it's not necessarily that I look at how the statute was drafted and I say there was some flaw there that triggered ERISA preemption. It's more that I think the Tenth Circuit's analysis on how broad ERISA preemption is, is viewed far too broadly and I think it's out of step with the Rutledge decision but we're going to find out whether or not I'm right or wrong in the next couple of years.

Sen. Bob Hackett (OH) stated that I'm really concerned in Ohio on the two to 50 book of business. I've been in business a long time and it used to be people wouldn't move to self-insured ERISA plans unless they had 500, then 250, then 100. We're seeing a lot of groups that are moving between two and 50 to ERISA groups, self-insured groups. And the reason is in the old days if they had a bad problem with the ERISA group and they try to get back in the public insured plans they would get hammered because of the claims they hit a bad year. But now, and you know this is community rated two to 50 so they can play both sides. So my concern is that that book of business from two to 50, the regular fully insured that we oversee, a lot of it's going to multiple employer welfare associations (MEWAs) and association plans. How do we protect it? And I understand what preemption does, but it still doesn't block companies because you can come right back in. They don't ask health questions. So, they don't know that somebody went to an ERISA plan and had a bad claim experience and they came right back in and get better rates than probably they should get. And so that book of business from two to 50 it's going to get worse and worse. Will you comment on that because that's what worries me in Ohio. Mr. Copley stated that I'm not sure that I'm in a position to comment on sort of the movement back and forth between the plans but one thing I would say is that the more consistently the law is applied between self-funded plans and insured plans, that removes a lot of the incentive for those plans to operate differently and I think that sort of uniform enforcement law can only help improve that situation. Sen. Hackett stated that our authority in Ohio used to be in the mid to upper teens but now it's 12%. The rest of the people are under ERISA plans which we have some authority because of preemption and that will get resolved but you can see the problem that we're losing a lot and the ones that are staying is not a good book of business.

Rep. Dunnigan asked whether in your opinion, could a state say these ERISA plans or these level funded plans are not allowed in a state's marketplace between two and 50 or that they are allowed but that they have to do community rating? Mr. Copley stated that I don't think that's an ERISA preemption issue. I don't think ERISA preemption has anything to say about that topic. Rep. Dunnigan stated so a state in your opinion could say a group plan between two and 50 employees needs to use community rating? Mr. Copley stated that I'm not sufficiently versed in that particular law to give an opinion on whether or not that would pass ERISA preemption. I'd need to look at the law. Sen. Hackett stated that how they get out now is they go to a MEWA as an association which puts them in a much larger group and then that larger group goes to the ERISA plans so they can ask health questions under that scenario and so they'll know they're a

very healthy group. But how can you stop access to somebody telling a MEWA or an association plan even though there are companies under 50 - I don't know.

Rep. Dunnigan stated to Mr. Copley that you listed three things that a state could not regulate - the benefits if it's regulated by ERISA. But how do you determine what's regulated by ERISA? Because to me it kind of says you can't regulate that if it's regulated by ERISA. What's defined as what's regulated by ERISA? Mr. Copley stated that I think that would be the statute itself, the implementing regulations by the Department of Labor (DOL) and what topics do those specifically cover? If ERISA specifically covers that topic then I think there's a good argument that those are matters of central plan administration that the states cannot regulate. An example would be there was a case from 2006 to the Supreme Court called the Gobeille decision and in that case, the state of Vermont tried to enact its own reporting requirements that were similar, but different from the types of information that ERISA plans were required to report to the federal government. And the Court there said because ERISA itself has reporting requirements, that any attempt by the states to impose similar or different requirements is preempted. And that was a 7-2 decision I believe with Justices Sotomayor and Ginsburg dissenting. And justices Sotomayor and Ginsburg would have even allowed that. They wanted even narrower ERISA preemption but the Court did rule that that was sort of a paradigmatic example of states trying to do something where ERISA's already operating in that space.

Rep. Dunnigan thanked Mr. Copley and stated that this has been informative. I think one of my challenges for decades now is we've been told ERISA prevents all this state regulation. You can't do it. And we've just kind of accepted that. And now the Supreme Court ruling has pierced that to some degree and we're trying to figure out what that degree is but thank you very much.

Miranda Motter, Senior Vice President, State Affairs and Policy at American's Health Insurance Plans (AHIP) thanked the Committee for the opportunity to speak and stated that I appreciate the focus and opportunity to spend a few minutes on preemption. And certainly, from our perspective the importance of preemption for employers in all of your communities has been said. Many of the employers in many of your states all across this country are desperately continuing to look for affordable healthcare coverage and the protections under ERISA preemption give them uniformity. It gives them stability. It gives them an opportunity to continue to provide affordable healthcare to all the employees in your states. And so, from a policy perspective, I would just continue to caution certain ERISA reforms by extending state laws that in our perspective are really overextending states authority. We want to make sure that we're not continuing to put additional pressure on employers so that they end up in a situation where they're unable to provide their employees' affordable healthcare.

PRESENTATION ON RECENT FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) AND NATIONAL FLOOD INSURANCE PROGRAM (NFIP) INITIATIVES

David Maurstad, Ass't Administrator, Federal Insurance Directorate at FEMA, and Senior Executive at the NFIP thanked the Committee for the opportunity to speak especially after the 27th short term reauthorization of the NFIP this week. I truly appreciate the opportunity to be here at NCOIL's Annual Meeting especially as a former state senator from Nebraska. NCOIL is valued partner to FEMA and the NFIP in helping to get the word out to Americans about their flood risk and the importance of purchasing a flood insurance policy and I truly consider all of you a part of the NFIP's movement to close the flood insurance gap and reduce disaster suffering. I especially want to recognize and appreciate the concrete actions you are taking including your recent fly-in to D.C. where you advocated for a multi-year reauthorization of the NFIP to Members of Congress. We know these short-term extensions and the uncertainty they bring are

not good for the program and not good for our policyholders. Especially right now, given the climate crisis that is making storms more frequent and more severe. From where we sit in Ohio, it might be easy to think this is just about something for coastal areas to worry about. But inland flooding is real, and the Midwest is no exception. This July, a storm dumped nearly nine inches of rain within 12 hours over Chicago while the Chicago River rose by six feet, damaging over 2,000 homes and resulting in a presidential major disaster declaration. And in August heavy rains pounded the Mid-Ohio Valley, causing flooding and damaging multiple homes and apartments. It's a good reminder for the Midwest, where it can rain, it can flood. And when these kinds of disasters hit far too few survivors have the peace of mind and the financial protection provided by flood insurance. And we know the flood protection gap is felt most by folks in disadvantaged communities who have often been pushed into high-risk areas because of years of discriminatory land use planning and systemic inequity. And to underline that point, the U.S. Census Bureau estimates that 30 million black Americans were displaced due to a natural disaster last year. Folks, this is the kind of disaster suffering we need to confront. And that's why FEMA is so determined to break the rinse and repeat cycle of disaster recovery in this country and replace it with more insured survivors and more resilient individuals and communities against the perils of flooding.

So, with that in mind, today I want to share what we're doing under our own authority to transform the NFIP and close the flood insurance gap. Some of you may be familiar with the NFIP through your work. But for those who aren't I have a brief overview. We like to think of the NFIP as a four-legged stool. The first leg is mitigation grants, which can be used by communities to fund eligible mitigation measures that reduce disaster losses by targeting repetitive loss properties. The second leg is flood hazard mapping and risk identification which can be used by communities to determine which areas have the highest risk of flooding. Now I want to be clear, these maps are not predictive. They cannot tell us where or when or how much it will rain. This is sometimes misinformation you may read in the press. Rather, they help communities make informed decisions about how to best protect lives and property, plan development and make infrastructure improvements to manage or reduce flood risk. The third leg is flood management. It's used by communities to manage risk in this special flood hazard area. This can include zoning, building codes, education and other efforts to help communities adopt and enforce higher standards to both minimize harm and preserve the natural and beneficial function and value of floodplains. And finally, we have the fourth leg, flood insurance, which is used to protect against the financial impacts from flood disasters. As you know, a flood insurance policy is required for homes that have government backed mortgages in designated high-risk areas. But the reality is, and this surprises many, that a lot of our claims, almost 30% a year, come from outside the special flood hazard area. And from where I sit as the head of the NFIP, despite the growing threat, flooding remains a woefully underappreciated risk.

Let's take a look at this map of penetration rates here. Where we sit in FEMA region five. They're far, far lower than what they need to be given our new normal. And it's not just the Midwest. I know you all know this, it's starting to feel like a broken record, but nationwide only about 4% of homeowners inside and outside the special flood hazard area have flood insurance. Nearly all U.S. counties have experienced some level of a flood event which makes sense because according to the Insurance Information Institute (III), 90% of U.S. catastrophes involve flooding. Thankfully, it's not all gloom and doom. Even as some insurance companies have made the decision to pull out of areas of the country with the highest impact from climate change, the private flood insurance market overall now accounts for a bigger piece of the growing pie to quote a recent report from the III. As you can see on the screen in 2016, 12.6% of flood coverage was written by 18 private companies. Fast forward to 2022 and 32.1% of flood coverage was written by 77 private companies. An overall increase of 24%. For whatever

reason, we're glad to see it. We've encouraged for years private insurers to share in the nation's flood risk. And there's plenty of room in the market for options. After all, the goal is to close the flood insurance gap so we have more insured survivors and less disaster suffering. So, I won't quibble how we get there.

That in mind let me pivot to some of the work we're doing to transform the NFIP. I'll start with our modern rating approach. As of April 1st of this year, our full book of business, that's roughly 4.7 million policies in force across 22,600 participating communities is now being rated under Risk Rating 2.0. Under this approach every policyholder now pays for their own flood risk. Not someone else's. And as a reminder, a significant aspect that doesn't seem to generate much attention is reduced premiums for some policyholders. Under legacy rating, 23%, nearly one million policyholders, were paying more than their full risk rate. Low value property owners were subsidizing high value property owners. The current pricing approach charges these policyholders only their fair share of risk resulting in significant savings for these policyholders. For policyholders who are experiencing increases under the modern rating approach, these increases are distributed gradually, not suddenly, as most premium increases are capped by Congress at 18%. Meaning, these policyholders will be on a glide path to reach their full risk rate. We estimate that 95% of policyholders will reach their full risk rate by 2037 or longer for those policies who were previously mispriced and discounted the most. The next initiative I'll highlight is something our stakeholders have been requesting for a while. Not only has Risk Rating simplified the process for insurance agents to generate quotes for potential customers and renew policies for current customers, but we're also researching other options to reduce barriers to purchasing flood insurance. And that includes how we can make installment plans work so that our policyholders have the option to make manageable monthly payments. I'm sure many of you are familiar with the community rating system or CRS. But for those who aren't, CRS is a voluntary incentive program that rewards communities who participate in mitigation activities that reduce flooding. Those rewards show up in the form of discounted flood insurance premiums for policyholders in CRS communities. We're currently looking at how we can improve the program through our CRS Next initiative, focusing on making access and participation in the program simpler, more equitable and feasible for all communities. And of course, we're working with our stakeholders every step of the way. These are a sample of some of the things the NFIP is doing to meet the urgency of the moment under our own authority.

So now on to what we need Congress to act on to keep the transformation train moving forward. First and foremost is a long-term reauthorization of the NFIP. If we are to build an enduring NFIP that lasts for generations we need Congress to pass a ten year reauthorization of the NFIP, something we've proposed with the support of the Biden administration. Now, along with the longer multiyear reauthorization, we've proposed a set of 17 legislative reforms as part of our strategy to set the NFIP up for long term success. They're spelled out in detail on [fema.gov](https://www.fema.gov), which I encourage you to visit. But I'll highlight a few here. The first is affordability, which is the most significant barrier to accessing flood insurance and one of FEMA's recommendations addresses this critical factor. We know from the research that too many families are being forced to prioritize putting food on the table over purchasing a policy which is why FEMA engaged the broader policy community, including academia and other government agencies, and developed an affordability framework that was delivered to Congress in 2018. Moreover, NFIP's flood insurance means tested assistance legislative proposal has been included in the administration's 22-23 and FY24 budgets. But let me be clear, absent legislative authority FEMA is constrained in its ability to offer more affordable premium rates to those who need it. As they say, the ball is in Congress court. To achieve our affordability goal, the NFIP must have a sound financial framework. As you probably know, when disasters exceed the NFIP's capacity to pay, Congress

has repeatedly raised the NFIP's borrowing authority rather than address this structural flaw of the program.

The NFIP is currently saddled with \$20.525 billion in debt at an average interest rate of 3.02% every day. The NFIP accrues \$1.7 million in interest on its debt. As future notes mature and are refinanced at higher interest rates, the NFIP's debt service will only grow and become an ever-increasing drain on the program. This is why debt cancellation is integral to getting the NFIP's financial house in order. So clearly there's a lot riding on Congress. And so, as I wrap up, my goal today was to give you a snapshot of some of the work we're doing to transform the NFIP. And while we're making important progress, there's still a long road ahead of us to close the flood insurance gap and this is where the power of relationships really matter. We continue to build those relationships with realtors, lenders, private insurance companies, local elected officials, community advocates and various associations like NCOIL. These are the trusted voices in communities that can share, that can change the hearts, relative to the importance of having a flood insurance policy because we can't do it alone. There's so much more at stake. So, I would just ask you to use your spheres of influence so that you can persuade your individuals in your communities, your constituents, of the importance and the need of flood insurance protection and mitigation and continue to help us build momentum to our movement to build a resilient nation and reduce disaster suffering.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that I want to preface what I'm about to say with noting that this is not insulting to you or to the NFIP, but it is getting extremely frustrating to have the NFIP come every year and all I hear is "we've accumulated more debt." In 2017 you were \$25 billion in debt and Congress canceled \$16 billion of that so you could pay claims. Are we on the path of Congress cancelling more debt as you said that needs to happen? You have paid claims right? You used the term "long term solution." I don't know if Congress's definition of long term is anything more than 60 days or six months but long-term solution has to be a long term solution. And we've argued for some time that the private market needs to engage in this. And as you pointed out, the private market in percentages have increased. But I think you're still going to have a segment that will never engage in the private market. The private market will never engage in it. We've asked Congress why would you not look at this similar to how you handled the government handled the Terrorism Risk Insurance Act (TRIA) where you said we know you can't handle a Hurricane Katrina but you can handle a flood in Ohio and Indiana. But you don't want to take that risk because you'd be on the hook for a Katrina. So, we'll be your backstop but we're not going to be that first dollar. Do you think the carriers would engage in filling that gap if they knew what their stop loss would be? Then you're not going to be \$20 billion in debt. TRIA's funded. Now we haven't had any terrorist activity, but the bottom line is policyholders are paying for TRIA. It's works. To me it seems like a logical example of where government can work with the private market. But there doesn't seem to want to be any discussions on that. We go to Congress every year on our fly-in and we bring this up and it's like, "hey, that's a that's a darn good idea." But nobody does anything other than we've got to reauthorize NFIP. We'll do it for another three months. Another six months. In the meantime, what is the long-term solution? What can we do at our end to have you come back and say, "you know what things are getting better" instead of it's the same old same old and actually financially it's getting worse." So my challenge is what can we do to make this better?

Mr. Maurstad stated first of all, you're absolutely right. The NFIP is essentially a residential flood insurance program and the program still writes about 96% of all residential flood insurance coverage that's provided currently in the country. On the debt, your figures are spot on. We were successful in 2016 of being able to have \$16 billion of the debt cancelled so that wouldn't saddle current policyholders to pay interest on a debt that was accumulated by federally backed

claims that were paid in the past. It violates actuarial principles for one. I think it's morally reprehensible, number two. Congress decided back after Katrina that unlike every other disaster program across the federal government space for when there's an event that exceeds the amount of dollars appropriated for that year, they pass a supplemental appropriation for that amount. The NFIP is unfortunately a distinction from that practice. The big problem with why the program continues to have its challenges is because people don't understand how it's funded. The policyholders cannot fund the entire cost of the program because in addition to the insurance that they receive, there's also a mitigation grant program, a flood hazard mapping program, and as I indicated in my comments floodplain management program that benefit all the citizens of the country. Policyholders themselves can't fund the program themselves because our program violates a key principle of insurance and that's concentration of risk. Private sector companies can spread the risk throughout a state, country and underwrite to the standards that they set. The NFIP on the other hand, regardless of where a property is, regardless of the loss experience of that property, if that property is in one of our 22,600 communities, we provide a policy.

So, we have a concentrated risk that the policyholders themselves cannot have the full burden on. So, our proposal for developing a sound financial framework is to address this and transparently show that the taxpayers need to participate in part of this program. And here's how they can do it. There's three things that we propose. First is that we cancel the debt, so the current roughly \$600 million of interest could be used for the benefit of the program and the current policyholders. Second, we say hold the program accountable for losses exceeding an annual level of a one in 20 year loss exceedance event. Roughly now that's about \$11 billion. If an event exceeds that amount, the administrator of FEMA would be required to request the additional amount over and above that from Congress in a supplemental appropriation. The third key part is what we're calling an equalization payment. The actuaries say we're supposed to collect \$10 dollars. Because of the limitations that Congress has placed on the program relative to our rating structure and our cap on increasing premiums only 18% of the year, we're only able to collect about \$7.50. So, the program is recommending with the support of the administration that if you want to provide this level of benefit that's great. Just fund it. And so, we request an annual appropriation for that difference on an annual basis. What can you do? You can do the same thing that you've been doing and that's expressing the need for a sound financial structure that is transparent. That shows what the policyholders can pay. What the taxpayers need to be paid for, and to do it for, we say at least a ten-year period, so the program can have the stability to put in place the transformative recommendations that the subject matter experts have brought forward.

Rep. Brenda Carter (MI) stated that you mentioned climate change and you also mentioned the Midwest. I'm from Michigan and last year we had substantial flooding. My concern is, according to what I've read and you can correct me if I'm wrong, you have to participate in the NFIP. Have you evaluated these new areas that may have been affected by climate change to see whether or not they can participate? I'd be particularly interested if any area in Michigan is considered. Mr. Maurtad stated first of all, since the program started in 1968 one of the primary functions was to try to have every community that had land use authority to be a part of the program and participate in the program. We're now at roughly 22,600 communities. So there's a small percentage of communities, generally low in population in rural areas with limited resources, that are not a part of the NFIP. So, we continue to work through our regional offices with the states in identifying those communities and seeing what we can do to assist them in becoming a part of the of the NFIP. Rep. Carter stated thank you for that, but I'm specifically interested in finding out whether or not areas affected by climate change like you mentioned in the Midwest and particularly Southeast Michigan that was hit very hard, whether or not they are participating in the

NFIP. And if not, what could we do? Mr. Maurstad stated I would suggest that climate change impacts every part of our count as for example, 98% of counties have had a significant flood event. And so, I think it's across the nation. I can certainly take back and I don't have right in front of me what the participation rate is in your area. We certainly could find it, but I know the regional office in Chicago has a good idea of where those areas are and have a strategy for trying to address bringing them into the program.

Rep. Edmond Jordan (LA) stated I'm really just trying to get some understanding because I've heard you say several times that we need to get more taxpayers into the program and as you're aware in my state, Louisiana, we've had some issues with those Risk Rating 2.0 maps and we're challenging those maps because it's led to a 234% increase in the rates. So, I guess in a state like Louisiana and Mississippi and others where we have some of the largest percentage of people living in poverty, you're giving us a 234% increase, but yet you're saying you want more people to participate in the program. I can't reconcile that, especially in a state where we have limited access to carriers and homeowners insurance has risen by over 63% as well. And so we have a lot of people on Citizens who is the issuer of last resort. Make me understand how you're making that request to somebody like me who has to go home and say, "Okay, we want you to participate although the rate has increased by over 200%"

Mr. Maurstad stated first of all there needs to be a distinction between our new pricing methodology and the community flood insurance studies that determine where and how that community needs to be regulated. So, our pricing methodology utilizes those maps, but also utilizes a whole lot of other information. So, there aren't any Risk Rating 2.0. maps. Secondly, part of the benefit that we believe of the new pricing methodology is we for the first time have been able to show people what the full risk rate is for their specific property. Not somebody else's, but theirs. And that information we believe is helpful for them to understand what their risk is. If you're a current policyholder, you don't get a 234% increase. If you're a current policyholder your policy can only increase 18% a year, not 63% or any other number. And unlike previously, that 18% glide path ends when your property reaches its full risk rate. So right now, roughly 30% of our policyholders are paying full risk rate. And so, the risk premium stays level. We'll have by year five about 50% of our policyholders will be at that full risk rate. Year ten about 90%. So unlike in the past where premiums were going up every year and would have continued to go up every year the new program sets a limit or sets a cap. So, I want to make two distinctions. One, if you're a new policyholder, you pay full risk rate. No longer do you come into the program discounted or subsidized. If you're a current policy holder, your policy can only increase 18% a year.

Rep. Jordan stated that I get that and I understand for the current people but you're asking new taxpayers to come in and so for the ones who are currently there, I get the 18%. But if you're asking me to go back and say that we want new taxpayers to come in and participate in the program and they're paying that full rate then that's difficult. Mr. Maurstad stated first of all, my taxpayer comment was to try to illustrate that the revenue that we received from the policyholders can't alone support the program. So, we need federal taxpayer supports as it's a federally backed program. Relative to the new policyholders having to pay their full risk rate, we believe more information is better. But most importantly, that's why it's critical that we have support for the affordability plan that we've put in place. That is a means tested premium assistance program and our proposal is to start at a 120% of average mean income. As your income goes down, your percentage of your support would go up. It's been in the President's budget the last three years and a key to the issue that you're talking about is having that affordability plan adopted.

MENTAL HEALTH PARTIY AND THE AFFORDABLE CARE ACT (ACA) – WHY IS THERE STILL A GAP?

Rep. Rachel Roberts (KY) stated that I'm very proud to sponsor this model law dealing with mental health parity. It contains a number of provisions that I believe are very important and worthy of our discussion time here. We had a great session focusing on mental healthcare at our last meeting in July and since that time, a lot of you reached out to me and gave feedback on that hearing and we really want to keep this conversation moving ahead and work towards NCOIL adopting some model policy around these issues. The conversation initially started with a bill that I've been sponsoring in Kentucky which requires insurance coverage for an annual mental health wellness exam performed by a mental health professional. While I'm very passionate about that specific issue, this also seems to be an opportunity to broaden the conversation and to focus on other mental healthcare and behavioral issues. As a reminder, that conversation we had in July was really the first behavioral health conversation NCOIL's had in quite some time, or perhaps ever, so I want to stress that this bill that's in your book today is really a starting point. The cake is not baked here. We have just opened the pantry to figure out what the ingredients are that we have to work with. And I'm very open to conversations around this and additions to this and co-sponsorship for this. So, as you can see on the first draft of the Model on page 352 of your binders, the annual mental health examination provision is on page 359. That's the original starting point of this. The other provisions are based on existing state law and deal with issues such as medical necessity determinations and substance use disorder benefits. Specifically, establishing standards of care for substance use disorder care, coverage parity, access to medications and treatments and removing some of the preauthorization step barriers to those methods of care and emergency care benefits. The conversation today is meant to be a brief introduction and to frame some of these issues and hopefully we can further develop this model throughout the year. I encourage anyone with interest to please reach out to me as we continue these conversations.

Jim Broyles, Ph.D., Director of Professional Affairs at the Ohio Psychological Association (OPA), thanked the Committee for the opportunity to speak and stated that my role is to work with our member psychologists primarily focusing on insurance issues. So, part of what I do is I hear from our member psychologists about any kind of concerns or issues they have in working with the insurance companies which is the vast majority of our members. I also interact with my colleagues at the American Psychological Association (APA) who have a very similar role. And I interact with other behavioral health professionals here in Ohio, The Social Workers Association, the Counselors Association and the Psychiatrist's Association. I guess most importantly, what I'm saying is I hope that you will hear my comments as being pretty representative of behavioral health professionals. I was, by the way, very encouraged to hear this conversation about the ERISA issue which I also think is a really important issue that we're facing too in a similar way. So, in general, we have a very favorable reaction to this model legislation. We feel like it is a very much needed next step in creating parity requirements for the insurance industry. What I want to do is I just want to go through some of the legislation and highlight some of the areas that we feel can be very helpful for us in facing and dealing with some of the problems that we encounter. But in general, I guess what I ask you to do is just be mindful of the idea that there is some very important access to care issues at stake in providing behavioral health coverage to our population. And in some cases, the access to care barriers can be there as a result of policies made by insurance organizations. More and more, behavioral health providers are leaving panels, and when I talk to them and ask them about their reason for that, we do regular surveys, they state that it's due to administrative burden, poor coverage frustration and just general hassles associated with policies that come from the insurance organizations. And we feel like this piece of legislation addresses many of those.

So, I'll go through and just sort of highlight some of the areas that we feel like are very helpful pieces of this legislation. So, in section one, under the definition of "generally accepted standards of mental health and substance use disorder care" - a nice definition but finding the generally accepted standards is easier said than done. But I will say that in many cases, those standards of care many providers feel like their perspective and their understanding of what is the right standard of care is not always heard. And so, the ending of this definition includes valid evidence based sources reflecting generally accepted standards of mental health and substance use disorder care include peer reviewed scientific studies and medical literature recommendations from nonprofit healthcare provider professional associations and specialty societies. So, that you can see there in that piece of the legislation that actually requires our voice to be heard in creating these standards of care. And we think that could be very helpful. Under the definitions again the "medically necessary treatment of mental health or substance use disorder" - the topic of medical necessity is a very much hot topic among behavioral health providers. I think probably among all even physical health providers too. The definition of medical necessity is far away from being clear to us about how insurance organizations define that and how they apply that. And most of us are feeling like some of that is not always right up front for us. Requiring the use of standards, criteria and guidelines created by nonprofit professional organizations such as the APA, a very respected association, allows us again to have a very much needed voice in the creation of these definitions or the standards that are used.

Section two, "ensuring mental health and substance use disorder medical necessity determinations follow generally accepted standards of care" - in that section there under (b) it states an insurer shall not limit benefits or coverage for chronic or pervasive mental health substance use disorders to short term or acute treatment at any level of placement. So, what we find sometimes is that insurance coverage for a condition can be limited if acute symptoms are not currently present and what we know to be true is that many chronic conditions or pervasive conditions can often still be present, encouraging the reemergence of more difficulties later on. But if those acute symptoms are not present then access to insurance coverage can be denied. Section 2(d), that ends with all denials and appeals shall be reviewed by a professional with the same level of education and experience of the provider requesting the authorization. I can tell you that in many cases, denials can occur and we have no idea about this decision making process or the level of training or experience for the individual who's making that decision so that can be a very helpful portion. Section 2(f), conducting the utilization review of all covered healthcare services and benefits for the diagnosis, prevention and treatment of mental health and substance use disorders in children, adolescents and adults, an insurer shall apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. Again, the very same reasoning there. It seems very important to us. So, in other words, this gives us a voice in creating or defining the standards that are being used by the insurance company.

Section 2(h) addresses a really important problem that many behavioral health practices are having right now. It talks about forbidding of rescinding or modifying authorizations for services rendered for any reason, particularly if it is later determined after the services are provided the insurer makes a subsequent determination that it did not make an accurate determination of the insurance or policyholder's eligibility. So, I want to describe to you a circumstance that is not uncommonly faced by behavioral health practices. So behavioral health services can be rendered to an individual and treatment can be successful. And then a year later or two years later depending on the circumstance, an insurance organization can say, "Hey, we found out that we weren't really covering that person or we shouldn't give you that authorization." And at that point funds can be reclaimed from the individual provider and that can amount to hundreds or

even thousands of dollars. And the important point in all of this to consider is this - most behavioral health practitioners right now are operating from their own private practice. These are small businesses. They cannot withstand what we call a claw back. They cannot withstand a claw back that amounts to hundreds or even thousands of dollars. It imposes a really important financial burden on them. Section 2(j) talks about actually applying real penalties for violations of the law and we find that in some cases there is not always the consequence that is needed for violations of the law so that's really important for us too.

In Section 3, ensuring coverage of mental health and substance use disorder benefits are at parity with medical and surgical benefits - under (a)(2) it talks about evaluating each complaint to determine whether a parity violation occurred. So, I'm asking you to keep in mind that provider complaints or their client complaints, their patient complaints are very often the only avenue that we have that allows us to bring an important issue to the attention of an enforcement agency. So, having that enforcement agency be required to look at not only what's going on with this individual complaint but also whether or not this is a parity violation can be hugely helpful. Section 5, mental health or substance use disorder emergency care benefits - we're just very much in favor of that. That just seems very clear to us. Section 6, coverage of mental health wellness examinations. The one question that I that about this, and Rep. Roberts and I had talked about this very briefly, is that we have a little bit of concern about that 45 minute time frame. And Rep. Roberts said that it's a parallel to a law in Colorado. And so, we're understanding that. Our concern with that is that it feels a little bit more like a practice guideline. We don't usually see those kinds of time limits happening in the law. So, we're just bringing that up. And I suggested that maybe we have it up to 45 minutes to make sure that that's not being misinterpreted by an insurance organization. So, I hope you're hearing that in general, we are in favor of this legislation and I'm open to questions.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Rep. Lehman, the Committee adjourned at 11:00 a.m.