NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2024 NCOIL SPRING MEETING – NASHVILLE, TENNESSEE
APRIL 12, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Friday, April 12, 2024 at 11:15 a.m.

Senator Jerry Klein of North Dakota, NCOIL Chair at Large, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Deborah Ferguson, DDS (AR)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Rep. Bob Titus (MO)
Rep. Nelly Nicol (MT)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Rep. Ellyn Hefner (OK)
Rep. Lacey Hull (TX)
Rep. Tom Oliverson, M.D. (TX)
Rep. Dennis Paul (TX)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Sen. Reginald Murdock (AR)
Asm. Tim Grayson (CA)
Sen. Aaron Freeman (IN)
Sen. Mike Gaskill (IN)
Rep. Peggy Mayfield (IN)
Sen. Beverly Gossage (KS)
Rep. Patrick Penn (KS)
Rep. Sean Tarwater (KS)
Rep. Bull Sutton (KS)
Del. Nicholas Kipke (MD)
Rep. Mike Harris (MI)
Rep. Mike McFall (MI)
Rep. Jerry Neyer (MI)
Rep. Julie Rogers (MI)
Sen. Natasha Marcus (NC)
Sen. Vickie Sawyer (NC)
Sen. Bill Gannon (NH)
Asm. Roy Freiman (NJ)
Asw. Ellen Park (NJ)
Asm. Jake Blumencranz (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Mark Tedford (OK)
Rep. Carl Anderson (SC)
Rep. Barbara Dittrich (WI)
Sen. Mary Felzkowski (WI)

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 Rep. Nelly Nicol (MT), and seconded by Rep. Jim Dunnigan (UT), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Brenda Carter (MI) and seconded by Sen. Paul Utke (MN), NCOIL Treasurer, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 18, 2023 meeting.

BASEL III ENDGAME – DISRUPTIVE TO THE U.S.?

Kevin McKechnie, Executive Director of the Health Savings Accounts Council at the American Bankers Association (ABA), thanked the Committee for the opportunity to speak and stated that the topic today has been named, rather ironically, appropriately. Too much capital regulation means credit is at endgame and I don't know if they meant to name it that way. But that's been the net effect. The federal banking regulators, Federal Reserve Board, Federal Deposit Insurance Corporation, Office of the Comptroller Currency proposed last summer a broad capital rule that has so far drawn three Congressional hearings. Two in the Senate last November and December. One in the House Financial Services Committee just about a month ago. And in those hearings, the question under study and you can see perhaps some of the bias in the name of the hearing especially in the House which is why are we importing international rules when we should be defending the sovereignty of the United States federal system? That has drawn some interesting criticism. What are they talking about? If you could in your mind think about the desk in front of you and on that desk you had ten dimes. If you took one of those dimes and moved it up. That would, roughly speaking, be the capital reserve strategy we currently employ. What's being proposed instead of that one dime is putting another dime forward and taking that capital out in circulation and holding it against risks that other commenters have said remain undefined. Meaning the principal criticism of the Basel III proposal is there has been no robust study of the economy and the harms the proposal seeks to remedy. And until such time as there is, there likely will not be a lot of support for it. There's not a lot of political support for it now in the wake of the Senate Banking Committee hearing in December. All Republican United States Senators signed a letter to the Federal Reserve Board and the other banking agencies asking the question I just asked. Exactly what kind of harms is this proposal trying to solve?

Well, it will affect every bank over $100 billion. And that sounds big. It's not. The largest banks in the country, JP Morgan Chase, has 34 times more assets than that. The next largest bank, Bank of America, has 25 times more assets than that. Which is to say that these new capital rules are going to affect the overwhelming majority of capital being held in financial institutions in this country. And what they mean by that is they're going to idle money and money idle is money you can't use. What can't you use it for? It will affect mortgages. It will affect credit cards. It will affect car loans. It will affect consumer loans. It will mean that if you wanted to have bonds for new schools and new sewer systems for new capital projects in your states and localities the cost of that credit is going to go up. How much up we don't know. But if you take two dimes out of that ten dime line the worth of those other eight dimes goes up. That's how economics works. It's been criticized rather extensively. And if you need to find a short form way to explain it to others, I recommend the comments of Jamie Dimon in December. To paraphrase, in 2008 there was a financial crisis, and since then the financial institutions in this in this country are holding triple the common equity tier one capital that they used to, 300% more. Well, how much is that? It's seven times more capital than federal financial institutions need to accommodate the anticipated losses from the stress tests the Federal Reserve imposed. That's a lot of capital. And remember that's capital that's not moving. And that's the definition of the problem. I promised I would keep this brief. This is not a simple subject. But that's the summary. And we're waiting to see if there's going to be a modification to the proposed regulation. And of

course, this is an election year. And so one side of the political system has said they disagree profoundly with the regulation. The other side has not. Elections matter. We shall see.

Sen. Klein stated that we certainly are constantly bombarded by outside the country influence and my constituents would suggest where we going with this? And is it being suggested that we have to go to this new ratio by some country out of dominance? Mr. McKechnie stated that that's what's being suggested. This is an effort to harmonize capital standards across the globe. And we've seen this in other places. And you have meetings for the rest of this conference on things like data. Data standards are trying to be harmonized across the globe and climate as well but I am not sure that word means anything anymore. No one seems to define it, but that's trying to be harmonized around the globe.

OVERVIEW OF NEW PRIOR AUTHORIZATION RULES FROM THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Randy Pate, Former Deputy Administrator & Director at the Center for Consumer Information and Insurance Oversight (CCIIO) at CMS, and founder of Randolph Pate Advisors, LLC, thanked the Committee for the opportunity to speak and stated that I'm currently in private consulting practice and I'm also the President of States Work which is an educational nonprofit that provides free technical assistance to states pursuing market based health reforms. But more apropos for this meeting, I'm the former director of CCIIO at CMS. I served in that capacity in the previous administration. I just want to be clear, I did not draft the rules that we're going to be talking about today and I'm not necessarily an advocate of them. I just want to provide background and answer any questions to the best of my ability. So, the U.S. Department of Health and Human Services (HHS) issued this final rule back in January. The rule applies across a wide range of payers and providers. It defines impacted providers as plans, issuers and state programs who are subject to the earlier CMS interoperability of patient access rule. This includes Medicare Advantage organizations, state Medicaid, and Children's Health Insurance Program (CHIP) be for service programs. Medicaid managed care programs, CHIP managed care programs and qualified health plan issuers on the federally facilitated exchange. It does not include self-funded Employee Retirement Income Security Act of 1974 (ERISA) plans, large group, fully insured plans, off exchange individual market health plans, whether they're in federally facilitated exchange states or state based exchanges states, qualified health plans in states with their own exchanges, or alternative plans like short term limited duration. A major feature of the final rule there's a requirement for impacted payers to implement and maintain a series of application program interfaces or APIs aimed at improving and streamlining the exchange of certain health information as well as prior authorization processes. The final rule also includes provider incentives under the merit-based incentive payment system (MIPS) to encourage adoption of the APIs. It contains certain other requirements related to prior authorization that I'll talk about, they are applicable January 1st of 2026. However, the payer compliance with the API requirements I'm going to talk about was delayed until January 1, 2027. HHS delayed this compliance date in response to feedback from the stakeholders and payers where they expressed the need to have sufficient time to plan, develop, test and implement the required API changes. They also cited feedback relating to the need to further standardize and mature the implementation guidelines for these APIs.

So, the final rule includes requirements for four APIs. The Patient Access API, Provider Access API, Payer to Payer API, and the Prior Authorization API. I'm going to briefly walk through these so you have an idea of what they include. For the Patient Access API, the rule requires impacted payers to include information on prior authorization. All of these APIs exclude any prior authorization data for prescription drugs. I Just want to make that clear. But the data under this

API has to be available to patients and it includes individual claims and encounter data, data classes and elements in the U.S. core data for interoperability data set, and specified prior authorization data. The prior authorization data includes the date the prior authorization request was approved or denied, circumstances under which prior authorization would end, items and services approved, the denial reason if any, and provider clinical documentation if it was submitted. The information has to be made available to patients no later than one business day after receipt of the request. It must be updated no later than one business day after any status change. And it has to be available for at least one year after the latest status change.
The second API is called the Provider Access API. It's intended to facilitate core care coordination and support, the shift to value based payment arrangements. It's not really focused on prior authorization so I'll just gloss over that one. And the same with the Payer to Payer API which is the third one. It's intended to support continuity of care and has to include claims encounter data but it's not relevant to prior authorization. And then finally the fourth one is called the Prior Authorization API and it will also go into effect on January 1, 2027. It applies to all impacted payers. Under this API payers must populate a list of covered items and services as well as provide documentation of prior authorization requirements for those services. Payers have to include support for prior authorization requests and responses within that API and they must also communicate whether the prior authorization request was approved or denied and the approval circumstances, denial reason or duration. For all of these APIs, HHS says it will exercise enforcement discretion on payer use of a certain prior authorization transaction standard as long as the payer does use this API. And then finally the rule also includes some improvements to overall prior authorization processes. It requires payers to send prior authorization decisions within 72 hours for urgent or expedited requests and within seven calendar days for non-urgent or standard requests. It also requires a provider notice. All impacted payers must provide specific reason for denial, regardless of method used to send the prior authorization request so that includes facts, e-mail and so on. And it also finally includes some rules around collection and publication of prior authorization metrics so the payers must start publicly reporting on their websites these metrics beginning of 2026.

Sen. Beverly Gossage (KS) asked where is all of the information on the rules available, and did you say that goes into effect in 2026? Mr. Pate replied the data interchange part is not really in effect until January of 2027 but these earlier changes will start early 2026. So, say March of 2026, you'll see the insurance companies having to start posting metrics on approvals and denials, for example, of prior authorization request beginning at that time.

Rep. Bill Sutton (KS) stated that when they give those breakdowns of approval and disapproval of prior authorizations, is that going to be broken out by subject matter or is that just a gross number that really you couldn't do anything with? Mr. Pate stated that I think there's going to be future guidance issued that really provides the details on that. I don't recall at this time if that information has been provided yet.

CONTINUED DISCUSSION ON NCOIL MENTAL HEALTH PARITY MODEL ACT

Sen. Klein stated that next on our agenda is a continued discussion on NCOIL Mental Health Parity Model Act (Model) and it's in your binders on page 63 and on the website and the app. The sponsor of the Model and Chair of this Committee is Rep. Rachel Roberts (KY) but unfortunately, she's not here today. But this is a model that I know she's very passionate about and looks forward to developing throughout the year. We're not going to be voting on it today as we're still in the information gathering and comment phase and hope we have something ready for consideration by November.

Jess Kirchner, Senior Policy Analyst for the Children and Families team at The National Governors Association (NGA), thanked the Committee for the opportunity to speak and stated that first, on behalf of the NGA and on behalf of Governor Phil Murphy I want to thank you for inviting us here. I think the world is always better when we're all in contact. And the second thing I want to do before I jump into my slides is share that I am absolutely not an insurance expert. I tried this joke earlier, but you're going to get better results if you asked me for medical advice before you ask me for insurance advice. So, I do want to give that caveat here. But I'm very excited to be here. Today, I'm going to talk a little bit about our 2022-2023 Chair's initiative on Youth Mental Health and the development of the Governor's Playbook which was under the stewardship of New Jersey Governor Phil Murphy. Quickly, for those of you that don't know the NGA, we exist to serve the initiatives and priorities of all 55 Governors in the States and territories. It is bipartisan and always has and always will be. I think we beat NCOIL by 60 years or so. We were created in 1908. And we have two primary arms. We have the Center for Best Practices, which is where I sit which is a research and consulting organization that supports the priorities of Governors through technical assistance, long term projects, ad hoc support, peer sharing, and in person convenings. We have 14 different policy areas. So, for those of you that specialize in transportation, I can connect you with my infrastructure team. I sit on the Children Family team, so we touch everything human services. Think childcare, youth mental health, hunger abatement programs, economic mobility, etc. Which is why I'm not an insurance expert. I have a million other things to think about and we also have our government affairs arm which consolidates and collects the feedback from all 55 Governors and works with the federal government to design solutions that meet state's needs from the top down. So, we are governed in a chaired structure. We have a Republican and a Democrat chair that swaps every year. So, this year our chair is Governor Spencer Cox from Utah and our vice chair is Governor Jared Polis from Colorado. Next year, Governor Polis will be the chair of the NGA.

But the reason that I am here to talk today is because each year the chair of the NGA gets the full power of the NGA to focus on an initiative that's close to their heart. So, they choose an initiative. This year, Governor Cox focused on "Disagree Better" - reducing the political tension divide without reducing disagreement across parties. But last year, Governor Phil Murphy from New Jersey focused on strengthening youth mental health. So, Governor Murphy, who's been a leader on this issue since the beginning of his administration wanted to take it to a national level and involve Governors from both sides of the aisle. Oftentimes we find that youth mental health policy recommendations are viewed or presented in a silo so this initiative was to identify solutions that worked across juvenile justice and child welfare and health human services and schools and then community organizations as well. One of the goals of the initiative was that we didn't want to be too prescriptive with it. We didn't want to be too limited in the scope. We wanted to collect as many recommendations as we possibly could across a number of spaces. And the goal of the initiative was to develop a resource that was immediately useful to new administrations. Something that could be dropped on the desk of a new Governor and set the stage for an agenda for youth mental health in their state. And so, what we did is we developed the NGA Playbook for Governors on youth mental health. I have plenty of copies that I will leave at a desk and I believe it's online as well. And we focused within this playbook across four pillars. We have prevention resilience which is focusing on upstream supports and services. Reducing stigma and increasing awareness of services. Ensuring access and affordability of quality treatment and care. All of those words were very deliberately chosen when we designed our pillars. And then training and supporting caregivers and educators. And so, across those four pillars we worked to identify common pressure points, tension points and state solutions. Because we wanted to collect like I said, things that were actually working and actually happening in the states to help drive change in this space.

So this playbook has 13 policy priorities across the four pillars and across those 13 policy priorities, there are 34 opportunities and under that there's 100a stat examples. What we did create was basically a 50-state scan of what's working in youth mental health across states. Rural, Republican, Democrat, urban, we really tried to come up with a slate of solutions that worked for everybody. So, to do this we hosted a series of four round tables across the country with Governors from both sides of the aisle and hundreds of attendees. And we also hosted conversations with all 55 Governors at our summer and winter meetings and leveraged the expertise of almost 100 thought leader organizations and state leaders themselves some of which will speak after me on this panel providing a lot more context on the insurance piece. But we've been grateful for their partnership and the partnership of several organizations in this room as well. And way that Governor Murphy wanted to approach it was bringing folks to the table as a Governor and I don't have to tell you this as elected officials, you are accountable to every constituent, business and community organization that exists in your state and designing solutions that work in youth mental health requires deliberate and delicate balance. That includes the voices and interests of everybody relevant to the conversation. And so, what we did is we hosted these roundtables and it was a very similar setup to what is happening here today. But we had Governors and state advisors, we had nonprofit and philanthropic thought leaders, we had private sector stakeholders, service providers, insurers and consultants. And we had federal agencies and youth. And all of their feedback went into development of this playbook.

And so, I'm here mostly to share a little bit about that resource and offer our assistance to you. But before I close for questions, I'll share a little bit about what we learned. Governor Murphy has been a champion of parity since the beginning of his administration but he also recognizes the role that private insurers play in supporting and maintaining this ecosystem of care and the role that they play as major employers in states as well. And I think that's a consideration that's reflected across Governors. In terms of what we're seeing movement on, we're seeing a lot of focus on Medicaid reform. I'm sure the folks after me will talk a little bit more there. Personally, I've seen a big push in drawing down Medicaid and to schools and providing those services. And one thing that's been interesting from our position is that we recognize that states where Medicaid expansion is not a topic on the table or an option or a viable or desirable solution, some of the states that are not or have not expanded Medicaid in that way are some of the most ambitious in drawing down Medicaid into schools. And so, we're seeing a big shift in the messaging on initiatives that are happening in that space and are excited about it. We're also seeing a shift to move upstream as is everything these days, considering how to fund that through public and private insurance. We're seeing Governors in Pennsylvania, Massachusetts and Connecticut also thinking about how to cut through red tape that they have deemed unnecessary to the delivery of service. We're also seeing Governors lean with the power of the regulator. I know Governor Hochul in New York is really leaning into school-based services and leveraging the power of the Insurance Commissioner there as well.

David Lloyd, Chief Policy Officer at Inseparable thanked the Committee for the opportunity to speak and stated that Inseparable is a national mental health policy organization that works on a nonpartisan basis across states and federally to improve access to mental healthcare. And as our name suggests we believe that mental health is inseparable from physical health and well-being. So, today I will be discussing an important aspect of the draft model that Rep. Roberts has put forward and I'll be discussing essentially how we can improve mental health and addiction care by aligning providers and payers around generally accepted standards of care. And I'll discuss more about this concept as we go along. So currently, unfortunately, Inseparable believes that too often for Americans, mental health and addiction coverage and really the system more broadly, not just insurance coverage, is failing to meet Americans needs. We've seen a dramatic increase in needs, particularly among the youth in recent years and this must be

addressed by a wide range of stakeholders. But certainly, insurance is a critical piece of the broader puzzle given the important role that health insurance plays in financing healthcare services. So, I wanted to provide just a few examples. So, one in five American adults had a mental health condition in the past year, yet about more than two thirds did not receive any treatment. And additionally, nearly three in four insured adults who received mental health treatment in the past year said they had some problems with their insurance which frankly is too high. So, we want to help address this and make sure that the people can get access to the services they need. We often find in our experience and hearing from patients and families it's that oftentimes our coverage decisions are made in a manner that frankly aren't consistent with what are generally accepted standards of mental health and addiction care. And that frequently conditions are chronic in nature and require treatment of the underlying condition. And mental health has for a long time been marginalized in our system and we've tended to treat just kind of short-term symptoms and not actually address the underlying condition.

So, recent polling actually demonstrates that these issues are a widespread concern among the American public and that they support increasing access to care. In surveys more than 90% of adults believe that there is a growing mental health crisis in the country. They also believe that expanding access to mental health care should be an important priority through elected officials with more than 60% saying it should be a very important priority. And more than 90% of adults also say that insurance companies should be covering ongoing treatment for what are often chronic conditions rather than imposing arbitrary limits on care. And while Federal parity law has addressed some of these issues, we still think that there are ways that we can improve coverage and ultimately improve health but also reduce costs overall to the health insurance system. So, I wanted to talk just briefly about the alignment of standards that really protects patients, providers and it actually protects payers by aligning around standards of care. We often hear that care is not medically necessary and sometimes, indeed, it's not medically necessary and services shouldn't be covered that are being recommended by the provider. But here I list what are generally accepted standards of mental health and addiction care and I won't read through all these, but I wanted to include them so people got a flavor of what we're talking about that effective treatment requires treatment of the underlying condition, treatment of co-occurring mental health and substance use disorders as well as with co-morbid medical conditions and doing that in a coordinated manner. People should be in the least restrictive and the least intensive setting that is safe for them but also, effective. And that part is often lost in the conversation. We don't want to put people in inpatient care who don't need to be there but sometimes that is necessary. There are also some other really common sense standards of care that we need to consider like the unique needs of children and adolescents and that when we're making decisions on what is the most appropriate level of care and for what duration, it shouldn't be based on arbitrary, predetermined notions of how long it should be for. We shouldn't do 28 days of treatment. It should be based on the individual's needs which again, we think is really common sense.

Mental health and addiction treatment is underutilized and it does lead to higher physical healthcare costs and social costs. McKinsey and Company has done some good research on this and roughly 15% of the total disease burden overall is associated with mental health and substance use disorder, so mental health and addition. Milliman has done some good research and found that mental health and substance use disorder reimbursement is only, at least based on their data, about 5% of the total. So, there does seem to be a little bit of mismatch between the disease burden and the amount we're spending on mental health. Milliman also found that people with behavioral health conditions had between 2.8 and 6.2 higher physical healthcare costs. Yet these people, roughly half of them based on claims data received, had less than $95 worth of mental health and substance abuse treatment a year. So, what's driving the costs are

the physical healthcare costs when we don't treat these diseases effectively. Moody's Investors Service has found that healthcare costs for patients with these conditions are over $12,000 annually on average but only about 8% of the spending for those individuals are for these conditions. And they recommend that in order for insurers to reduce total healthcare costs and improve their competitiveness that they need to invest and honestly spend a little bit more on treating mental health in order to reduce the physical healthcare costs. So, one way of doing this is if states have increasingly aligned providers and payers around high-quality standards from nonprofit clinical specialty associations and the example on the screen is the criteria from the American Society of Addiction Medicine. The ASAM criteria. More than half of states have some requirements now that either commercial insurance or Medicaid use the ASAM criteria for substance use disorder determinations. If followed, it ensures patients get the appropriate treatment at the appropriate level of care for the correct duration of time and it improves quality and really puts providers and payers on the same page to make sure that people are getting appropriate treatment and they're importantly not getting inappropriate treatment. And for mental health conditions there's something called The Level of Care Utilization System (LOCUS) family of criteria from the American Academy of Child and Adolescent Psychiatry, and the American Association of Community Psychiatry. And I should note, United Healthcare, the nation's largest insurer has voluntarily switched to all of these criteria across all of their business across the country in recognition that it creates a common single standard that can align and improve the quality of care. So, essentially, these are elements that are contained in the draft model legislation. I put resources here that link to some of the underlying studies that I referenced.

Tim Clement, Vice President of Federal Government Affairs for Mental Health America (MHA) thanked the Committee for the opportunity to speak and stated that MHA is the country's oldest mental health advocacy organization. We've been around since 1909. We have affiliates in over 40 states and most of your states have at least one of our affiliates in them. I'm going to be brief and I think Mr. Lloyd covered a lot of the points about the model law and what's in it and why that's important. I think one thing that's the most important thing to remember that we all should keep in mind is that every day in this country over 440 people die from an overdose or a suicide. When I first started using those daily figures back in 2017 the number was 245. So, it's gotten almost 200 deaths worse in the last seven years. So, we definitely have a huge mental health crisis and the opioid epidemic which you're all aware of. So, what's important when you have a crisis of that scale is that generally speaking when you're gravely ill and at risk of dying in our country, your insurance covers the treatment you need to survive and then recover. So, it's very important that's also the case for mental health and substance use disorder care that you have insurance coverage and when you have a mental health condition, you're ill, you need treatment and you get that treatment and you survive. But also as Mr. Lloyd mentioned, you need to get the ongoing treatment you need to recover and thrive. So, that's a very important component of why insurance coverage for mental health and addiction treatment is very important and critical. We're not going to solve the opioid epidemic or the mental health crisis if people can't get adequate coverage of their mental health treatment and substance use disorder treatment. And of course, that's only one piece of the puzzle. There's lots of different ways that we need to address both crises and not to imply that it's just about insurance coverage but insurance coverage is important. When you think about it that's how we generally pay for things if you have insurance. That's the bargain we make with you, pay your premiums and you get the treatment you need when you're ill and you're at risk of dying and being disabled. Another thing that's important to note is that when people don't get coverage for the treatment they need through their insurance it's incredibly expensive for states and municipalities. So, for instance, it's no secret that a substantial portion of jail and prison populations have a mental health condition or substance abuse disorder or often both. Now, of course, that's not to say that's the only reason that contributes to incarceration but when people can't get treatment, oftentimes through their

insurance coverage, they'll get treatment through taxpayer funded programs. Or, sadly, they'll end up in jail or prison, which is incredibly expensive. So, making sure that people have the coverage they need is important in saving lives but it's also very important to avoiding I mean, we have the two largest mental health facilities in America – it goes back and forth depending on what kind of survey you look at, it's either the Cook County Jail or the Los Angeles County Jail.

So, that's not how we should be providing mental health treatment, through jails. So, instead of having people with mental health conditions ending up incarcerated, making sure that they can get the coverage they need for the treatment that they need is incredibly important for both keeping them well and also keeping them potentially out of jail and incurring very high costs. And just one other thing I just want to note is that I know one thing that's very important for Rep. Roberts is making sure that people can get annual mental health wellness checks, sort of a checkup from the neck up. And so, that's something that I think is an important feature of the model and something that a number of states have been doing on a bipartisan basis. Making sure that people have a pre-deductible, no cost sharing form of seeking an annual wellness check from a mental health provider, something that generally you can't get right now and it's very important. It's very important to be able to, even if you don't have a diagnosed condition, to make sure you can get that check up to make sure that you don't have a condition and if you do you get routed with the appropriate treatment. So that's a very important component. It's ahead of the curve, it's upstream. As was mentioned before, making sure that you catch the potential illness before it turns into a crisis and spirals out of control. So that's a very important component of any consideration of insurance for mental health conditions is making sure that you can get that annual wellness check which I know is so important to Rep. Roberts.

James Gelfand, President and CEO of the ERISA Industry Committee (ERIC), thanked the Committee for the opportunity to speak and stated that ERIC is a trade association representing large employers on employee benefits issues. Thank you for the opportunity to participate in today's conversation. ERIC has had the opportunity to review the draft NCOIL model. While we support efforts to expand behavioral health access and enhancement parity compliance and in fact agree with many of the points that have been made today, we do have significant concerns about the draft. ERIC's member companies are dedicated to ensuring access to quality affordable mental health and substance use disorder treatment. Since passage of the federal mental health parity legislation employers have worked tirelessly to implement parity for behavioral health services including innovating new approaches and benefits, working to address systemic access issues and driving quality to improve patient outcomes. This has been especially challenging because the federal agencies have defied and ignored Congress. The administration has refused to issue sufficient guidance, illustrative examples, lists of non-quantitative treatment limitations, parity analysis templates and the like. Now, this may soon change. The federal government is expected, perhaps in the coming weeks, to finalize a new regulation that significantly changes federal parity requirements. To avoid creating disparate requirements between state and federal law, NCOIL should defer any approval of a model act until that rule is finalized and any subsequent litigation is concluded. At that time we hope that NCOIL will ensure any model act approved is consistent with the application of relevant federal law, guidance and sub regulatory guidance. The Model should not go beyond the scope of the Mental Health Parity and Addiction Equity Act (MHPAEA) including by establishing mandates to cover behavioral health services because remember, parity is not a mandate. It is voluntary although every ERIC member company voluntarily does implement parity.

We hope that NCOIL will also acknowledge that systemic issues remain challenging in the behavioral health space due to factors entirely out of the control of employers or insurance plans such as: the national shortage of physicians, including psychiatrists and other behavioral health

providers, and a shortage of available, culturally appropriate care; refusal of many behavioral health providers to participate in insurance networks, or to accept insurance at all; concentration of providers in specific urban areas; significant gaps in quality, safety and effectiveness data with respect to behavioral health providers, facilities and treatments; and a national mental health crisis that continues to get worse even as unprecedented funds are invested in behavioral health. All of that being said, we have some specific recommendations on the language of the Model Act. For instance, the Model Act gives too much authority to the lobbying groups that represent providers. I'm sure some NCOIL members object to many of the recommendations that provider societies routinely make. For example, when the American Academy of Pediatrics recommended asking children if their parents had any guns at home, or when the American College of Obstetricians and Gynecologists recommended that COVID vaccines be pushed on pregnant women. Or perhaps some of you may take issue with the guidelines from behavioral health provider groups related to gender dysphoria or puberty blockers. Or the intersection of mental health and abortion. I bet all of you on both sides of the aisle can identify examples where the guidelines put out by some of these groups are objectionable to many of your constituents. These groups should not have so much say in the definition of generally accepted standards of care, utilization review criteria or the like. But there are other authorities with expertise that can be relied upon so the draft should be less prescriptive in terms of defining that and the act should tighten the definition of providers as well. While we do applaud the drafters for not including equine therapy, wilderness therapy or retail therapy professionals we don't think that art therapy should be included here either.

The utilization management requirements are unduly burdensome. The draft requires review of denial and appeals by a professional with the same education and experience as the provider requesting the authorization. We believe that this language would either create a provider credentialing arms race or would simply make it unfeasible for a plan to conduct responsible utilization management. As plan fiduciaries we object to that. The draft's language on medications mirrors failed federal legislation drafted by big-phrma. The draft bans medical management, such as prior auth, step therapy, mandates all products being the lowest tier of a drug formulary and disallows requirements to engage in counseling or other services. We believe this section will create a financial windfall for branded phrma companies, crushing generic and biosimilar competition in these therapeutic areas and will jack up health insurance premiums for working families. We also oppose inclusion of civil monetary penalties for parity violations. This is a highly partisan, failed policy that was proposed as part of President Biden's Build Back Better legislation but ultimately deemed too radical, even for a bill intended to pass with only the votes of one party in Congress. Simple monetary penalties will not solve any of the problems listed above but they will create perverse incentives for regulators and the plaintiffs' bar and rather than encouraging cooperation and compliance assistance we have numerous other recommendations related to certain minutiae but these are our big picture recommendations in order to create a successful state level parity regime that properly aligns with federal law. Remember that the more complicated, prescriptive and onerous the requirements the more it will raise costs for plans and ultimately price some small businesses and families out of coverage. So, it is in the best interest of legislators, regulators, employers, plans and patients and providers to pursue a parity framework that is reasonable, that promotes compliance over punishment, that strikes a balance between access and affordability, and drives quality not just quantity of care.

Sen. Lana Theis (MI) stated that I actually have a few statements and then a question. Nowhere else in medicine has the increased focus and increased application of the medicinal treatment created such an expansion of the problem as opposed to an expansion of the solution and I have major concerns with the lack of transparency with respect to the androgenic harm and the lack of psychotherapist expressing that in advance. It should be required as with all medical treatments,

that should be a mandate. The idea that it should go on ad infinitum is not evidence based. You should definitively have a plan for what good looks like upon the first meeting and then be able to reach that and it sounds like that's not something that you're aiming at. You want an indefinite amount of care. There's no place else in psychotherapy where, up until ten minutes ago, where you would expect there to be a relationship between the psychotherapist and the patient. And now we're putting it into the schools, where it's not only between the therapist and the patient, it's also with respect to their educator. If you want to know how to add stress to a child, to an interaction what you do during the test is you add observation. And that stresses and creates anxiety to the person who's being observed. And now we're going to do that in our educational system where our children already can't read. So, I have major issues with this particular approach. I understand and agree that there is a mental health crisis. I will agree with that. I am fundamentally disagreeing with the solutions that are being proposed at this point in time and I would ask that you come back with some answers. And so this is where I'm asking you, do you require of your providers that they define the iatrogenic harm upon the first meeting? Whether it's to the child or to the parent of the child or to the patient if an adult. Do you require that they provide that and that they provide what good looks like upon the first meeting? Is that part of your plan of care?

Mr. Clement asked do you mean the provider should list any potential harms with medications? Sen. Theis replied yes. Mr. Clement replied absolutely, that's part of the medical standard. That's part of the Hippocratic oath. Sen. Theis stated I have yet to find one that does so if that's a standard I'd certainly love to see it. Mr. Clement stated that I think that if you're a psychiatrist prescribing medications they can have side effects or increase suicidal ideation potentially, you have to disclose that to the patient. Sen. Theis replied not medications, treatment. The psychological treatment itself. Not the medications, the treatment itself provides iatrogenic harm to a certain number of people and they're not informed in advance of what that looks like in order to be prepared for it and to respond to it and to tell their provider this is causing more harm than good, can we go a different direction? Mr. Clement stated I'm not a provider but I would agree. I think that any harms that could potentially result should be disclosed right away up front to the parent and the child in question and I think that without disclosing potential harms, I think that's a harm in and of itself. So, I do agree that any harms should absolutely be disclosed. I don't think anyone would suggest the provider should be hiding what could be a potential harm to the child, to the parent, to the family unit. So, I do think it is important that any harms are disclosed, potential harms. And yes, the idea that there should be a plan, that's a big component of a lot of insurance utilization review. You have to have a treatment plan. You have to have a road map for what's going to work and if it's not working, you have to change it and that's something called measurement based care as well. So that's something we highly support. We don't want people just to give treatment and say well I hope it works. We want them to give treatment with specific goals and then also if those goals aren't being met, adjust and adapt the treatment.

Sen. Theis stated can you speak to the problem of there not being a wall of separation where now the child has a relationship with their therapist, a relationship with their teacher who's talking to their therapist and that's never actually happened before and how that actually adds to the anxiety potentially of a child. What do you plan on doing to overcome that? Mr. Clement stated that I don't work for a provider organization but I don't think that you should have inappropriate relationships between the parent and the therapist and withholding information from the child. But I do think parents have a right to know about the treatment their child is receiving, though. I think that is important. I think it's always important that parents be kept in the loop about the treatment of their child. Sen. Theis stated that I wasn't speaking to the parent and the therapist. I'm speaking to the child and the therapist. The child at school being observed by their therapist and their teacher and then interacting at school with the therapist, we're talking about paying

schools to help provide therapy. Mr. Clement stated this model act doesn't address anything that's school based. It's just about insurance coverage. Sen. Theis stated that Ms. Kirchner spoke to providing funding to schools in order to provide this care so that's where I was going with this. Mr. Clement stated that I think that might be Governor Murphy's initiative. That's not related to this model act.

Sen. Gossage stated that I just want to follow up from what Sen. Theis said. Since we passed in most states mental parity laws years ago, has any data been produced on how much premiums have gone up because of that? Mr. Lloyd stated that under the federal parity law, plan sponsors do have the ability to get an exemption from complying with the law if they can show that premiums increased as a result of compliance. To my knowledge, no plan sponsor has ever received such an exemption or applied for such an exemption. And there's no evidence to my knowledge that mental health parity has increased costs and I think this is in part because as the data that I presented suggests that when you're actually investing in mental health and addiction treatment, you're often decreasing other physical healthcare costs.

Sen. Gossage stated that I happen to be one of the Senators that doesn't like the word invest. It's because that usually means pay a lot of state dollars and a lot of taxpayer dollars. Let's invest in this or that. However, here's why I'm concerned. I've been a health insurance and life insurance agent for 20 years in nearly half the states. And I can remember when mental health parity started being added in the states and in our state one could have chosen that as a rider. You would pay between 15% and 20% more on your policy if you wanted to add mental health to your plan. But we now know that the expense of the premium has gone up so much due to that. And it's partially because of what was just said here and that is so oftentimes the care never ends. When it comes to physical therapy or any other physical health insurance plan, you must continue to show improvement, otherwise they will stop whatever the services are. I'm sorry we can no longer do physical therapy because we cannot continue to show that you are improving. So, I share the same concerns. Of course, we want folks to have mental health that need mental health. Absolutely. But the medications have become so expensive. The therapies have become so expensive. But what we usually see from the providers is well then the state should pay for it or somebody should pay for it because these people need that. But every time you raise premiums, then you cause people to become uninsured or not being able to insure their families, especially on private insurance. And I agree we have seen more folks now that are needing mental health and all of this has been helping. Why are we seeing the problem grow? And that's a bit of a rhetorical question. I know that was already answered here. But we find that as legislators in our states that it's we need to invest more. But if we don't see a return on that investment, that's when there is an issue.

Mr. Clement stated that we definitely don't want you to invest any state dollars on this. This involves no state spending. We want insurance coverage. And to address your point about the ongoing treatment, you're right - there shouldn't just be indefinite treatment that goes on forever where you see a psychologist once a week for the rest of your life. That's definitely not something we support. We don't support people getting treatment for the rest of their lives because they have just regular life issues that are coming up. We do think, as was said, that there should be clear goals for treatment. These are the outcomes you have to receive to continue getting that treatment. We don't want some blank check to providers. That's not what we want. We want accountability.

Rep. Forrest Bennett (OK) stated that I appreciate all the presenters and this is a complicated issue. To respond to Mr. Clement, I see a therapist because I'm in the legislature and I think we should all do that and I will until I'm not in the legislature anymore. And I don't necessarily think

that it's a terrible idea for some folks to see somebody once a week and just talk through their problems. I'm dealing with an Alzheimer's diagnosis in my family and I always ask my therapist for silver bullets to fix my problems. And he says, unfortunately, sometimes all you can do is talk about it and he connects me with a support group. And that has been helpful. In some cases mental health solutions are just being able to talk to somebody who can be helpful to you. In other cases, the mental health treatment needs to be tailored to the individual based on what they've gone through and what their body chemistry is. To Mr. Gelfand's comments I would say politicians love to point at things we've invested in and say we haven't received that ROI that some expect. The problem being that politics is so fraught with folks who think they know about how to address issues like this but they have no subject matter expertise. They just have talking points based on kind of what their echo chamber is. You went through a diatribe of different treatments that based on your comments, seem like you don't necessarily believe in them. I remember you saying, for example, wilderness therapy, and I think that that was a bit tongue in cheek. But the reality is for some folks, that does help. And when we talk about investment and this sort of black and white, we put X number of dollars in and why aren't we getting these results? I think sometimes the problem is and I know I'm saying this at a national place where we put model legislation together, but there needs to be some flexibility. There needs to be an ability for the provider to create a plan that works specifically for that individual. We do this in education with individualized educational plans (IEP's). Why don't look at mental health treatment the same way? I don't understand. Equestrian therapy may work for some folks. We have a former President of the United States who famously seems to be doing well because of art therapy. So, my question to you and to all the panelists is how do we strike a balance between finding something that can be relatively easily adopted from state to state, but also provides the flexibility for providers and their patients to work together without guardrails that politicians who like myself, frankly do not have the subject matter knowledge outside of talking to the very intelligent people in this room about how these things work. And I say that with all respect to myself and my colleagues. I think that sometimes we need to let our egos take a back seat to experts. We have politicized the hell out of mental health especially as a result of COVID and all that. How do we strike that balance? Ms. Kirchner, you work with Governors, Republican and Democrat, and they have to strike a balance between what Democrats think. And I'm a Democrat in Oklahoma. So, I know very much how it is to try to craft a message that works for my colleagues. Do you Mr. Gelfand believe that there is room for innovation in mental health treatment? And to all of the panelists, how do we strike that balance between bringing stuff back to our state that's relatively easy to implement and, providing that balance and that flexibility for the patient and the provider to craft a plan that works for them?

Mr. Gelfand stated that I think we're largely in agreement here. The point of my comments were that there may someday be data that shows that glamping in the woods is an effective treatment. Or that equine therapy is an effective treatment and is valuable. That data is not there today and it's not there today for art therapy either even though we may have specific examples of individuals who are helped. And as such, our view is that the draft is overly prescriptive in saying this kind of provider must be covered. So, what we were saying is that there should be flexibility rather than having the government say this is who the plans must pay to do this.

Ms. Kirchner stated that I will just quickly clarify the NGA when we talk about these policies we endorse state flexibility and the power of the Governor to determine the best pathway for their state. We can highlight best practices based on state testimony but we don't want to come up here and say that one policy is the silver bullet or anything like that. We endorse the power of the Governors to identify a pathway that works for their unique environment. I'm actually working with the Oklahoma team on a policy academy youth mental health project as well so I understand the dynamics here. I would say just speaking to the balance piece, at least at the

gubernatorial level the one thing that we did learn is that there is a lot of alignment between Republicans and Democrats. It's about identifying a shared problem and similar approaches to solutions. I think the thing about this issue is that there's always going to be some burden somewhere and so it's about bringing voices to the table to determine what is a reasonable amount of burden, financial, administrative, etc. And so we've seen Governors do that through like what Governor Murphy did through task forces, commissions, etc. Which I know can be a little bit of a well trodden thing, the idea of another commission, another task force, another working group. But I will say, at the gubernatorial level we're seeing a lot of alignment on agreements of issues and differences and problems in messaging. So, I would say that messaging been particularly resonant across our level and so as it pertains to your work identifying at least a shared problem to start is important.

Mr. Lloyd stated that I think we have to be guided by the evidence and research and ensure that that it is peer reviewed. And I would agree with Mr. Gelfand about being guided by data. I think that's critical. There is a lot of data that shows mental health and addiction treatment does work. It is often effective. Is it always effective? No, but for few healthcare conditions is treatment always effective. So, I think we have to be insisting on good data and guided by evidence and peer reviewed research that really illustrates what's effective. Because that will change over time. And I think the provisions in the model are really designed to capture that evolution of what is evidence-based care over time? Because that will change as we learn more. Mr. Clement stated that my heart goes out to you as my mother died from Alzheimer's three years ago. It's very tough. But yes, I think flexibility is the name of the game and following what the research says. And in some instances, seeing a therapist every week is appropriate. I have a friend in the Philadelphia area in his 70s. Schizophrenia was first diagnosed in his 70s. He sees a therapist every week because if he doesn't he ends up in the hospital. And so that's of course in addition to the medication he takes. But for some people, yes that is going to be necessary and the proof of that is that if he doesn't do it, it's a worse outcome. I think echoing Mr. Lloyd, we ought to follow what the research says. Things are going to change. Maybe one day, as Mr. Gelfand said there will be very strong therapy evidence for wilderness therapy and equine therapy. But I think that something that we want to make sure is in place is there is that flexibility and you want to follow things to make sure what we're doing works.

Rep. Bennett stated that I've tried different medications for different things but therapy ends up working better for me. For some folks, you're diagnosed with depression and anxiety but it ends up being attention-deficit/hyperactivity disorder (ADHD) and so these proven methods that we know are proven and have therefore been deemed eligible to be paid for by government money for folks who can't afford it themselves it turns out that individual may have been misguided in going down that path. And so I guess the point of this is we have these tried and true treatments, so to speak but now we're learning that for some folks it's actually the wrong way. And they may have gone years down the wrong path. My father-in-law took the wrong kind of medication for a long time and is now dealing with those consequences. And it was a treatment that for someone else who had been properly diagnosed was the right treatment. On the other end of this we have these treatments that some people consider to be ridiculous but other people would swear by. And so I guess my question is how do we get to acknowledging that all of the above approaches are right? And getting policymakers to be willing to and I hate to use the word invest again, but put money towards these treatments so that they can be established as tried and true methods for some and not others. And to answer my own question a little bit I know that we need to educate ourselves. But anyone who wants to respond to that I'd love to hear it.

Mr. Clement stated that I think you're right, some treatments that will work for one person don't work for another. And then the treatment that doesn't work for somebody like your father-in-law,

that is the right treatment for others. And I think one thing we need to be careful of here is we don't want to get too prescriptive as we're not prescribing treatment methods, we're talking about insurance coverage. Which is about treatment, of course. But, I think that's something that we need to leave room for the treatment community to make sure that there are those best practices here and even they learn from their mistakes. And I think that's the biggest thing to do when you have behavioral health treatment is make sure we learn from what didn't work and why it didn't work and see if we can get better in the future.

Rep. Ellyn Hefner (OK) stated that this is a discussion that I I'd like to look at in a different way of sort of turning it about not the treatment here it is and this is for you, but what supports do you need? And that's where we get into that individualized piece which is definitely hard to make a model law about when some of these things don't work for everybody. My comment and something that I'd like to talk about and hopefully maybe get a response to is something that I see in my world, I've been an advocate for adults and kids with disability for 20 years. And dual diagnosis in our world is intellectual developmental disability and mental health and I didn't hear the playbook including the voices and interests of them. I'd like to start talking about disability if we could include those people that know about disability and those needs so we cannot leave it as an afterthought. Because the afterthought now is if a parent has a child with a disability and mental health because you have behavior, they end up in an emergency room which puts on stress and also goes against the Americans with Disabilities Act (ADA). What are your thoughts about maybe some of what you do in your work to include people that have that dual diagnosis so that we don't always have to be in the outside in the emergency room putting the burden on parents? Or maybe out of state because we don't treat it in state? Mr. Clement stated that I think you're speaking to a very important and overlooked fact is that individuals, particular individual's with intellectual disabilities, have a higher prevalence of mental health conditions. And yet, that's almost swept away, as if those individuals don't get mental health conditions, it's just a symptom of their intellectual disability. And that's not true. And also, substance use disorder too, there is a much higher prevalence and that's something that is often overlooked in the mental health advocacy world. And I think you're right to bring attention to that because individuals with intellectual disabilities and other disability developmental delays, they have mental health conditions. They can have anxiety. They can have depression. It's something that you can't ignore and forget about so I thank you for bringing that up.

Sen. George Lang (OH) stated that as you heard from some of my colleagues some concerns, I also share some very serious concerns with this legislation. Like Sen. Gossage, I also have my life and health license for over three decades. I believe between the four legislators here from Ohio, we probably have over 100 years of experience in the industry. I also have a very unique experience that I actually own a captive insurance company that we recently relocated from the Bahamas to Tennessee. And the reason we picked Tennessee is we looked at every state that was friendly to captives and they were far and away the most friendly and we were able to come here and maximize what we can do for our insureds at a greater rate than we could at any other state. My concern with this legislation is we're putting the cart in front of the horse. I think we would be mistaken if we had standards more onerous or more extreme than the federal government. Because keep in mind the standards we put in only affect the little guys. The large self funded companies, they can discriminate any way they want as long as they don't discriminate in favor of the highly compensated. So, my concern is we're going to be putting an undue burden on the little guys. And I saw in one of the presentations some of the folks that said this is actually going to lower the cost. I would love to see an actuary from one of the plan providers come in and provide us with that information. I believe that if it would lower the cost, plans would already be doing that. And we've all been around for a long time and we have all been told put this in and we're going to see costs go down in health insurance, in Medicare, and

Medicaid. And it's never once happened. Now there may be reasons why that's happened that aren't germane to the plans we put in but costs just continue to rise. So my question is, if we have a cost that the little guy has to bear that the self funded guys don't have to bear we are putting those big companies at an extreme competitive advantage when it comes to recruiting and at least in the state of Ohio right now the number one issue with every company, every category, every sector, is workforce development and now we're going to force the small guy to pay more potentially than the big guys are paying. How do we tell the guys, hey, our regulations are more difficult than the federal government and it's going to cost you more money?

Mr. Gelfand stated that I was going to share in a later presentation today that in a recent poll by the Small Business Majority that represents those small guys, they found that 25% of their members are considering dropping coverage today because they already can't afford to provide the coverage based on the prices and that's before a new parity act would be imposed upon them. I also agree with you that as employers, we're always told by every kind of vendor, legislator, activist, whatever it is that what we want to do in the long run it saves money. So, we should definitely do it. And it never actually does save money. In this case, we don't offer mental health coverage with the intention of it saving money. We know that it's costlier. It's an investment that we're making. We do so because it's the right thing to do. I don't have stats on quantifying what that cost is but I'd be happy to follow up with NCOIL staff and share some actuarial stats with you.

Mr. Clement stated that I'll follow-up with actuarial data because Milliman has done a number of studies that show that if behavioral health coverage was increased you would see costs savings. But I do think part of the issue here though is we've never seen mental health treatment covered to the way it should be so we've never had the opportunity.

Sen. Lang stated that I appreciate that and please do follow up with that information. And as part of that follow up, I'd like to know how many of the insurance providers that Milliman represents as well. That would be very helpful. Mr. Clement stated that they do parity compliance work for a lot of the insurers.

Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, stated that I really just have more of a comment maybe to bring a little balance from the healthcare side to this conversation. I'm certainly for evidence-based medicine but I do think there's still a lot of discrimination in the mental health and substance abuse space that we don't look at it like we look at physical health which it is a part of total health. We look at people who have high blood pressure, they're diabetic, they have high cholesterol, they have chronic conditions. And we don't expect that they're not eventually probably going to have a heart attack or a stroke but we treat them chronically hoping to delay that. Or to delay a crisis episode. I think we have to look at mental health the same way. I'm not sure that it will save money. I'm not sure that treating people for diabetes saves money in the long run. But I think we make a real mistake when we try to separate it from physical health because it is part of mental health. And when you treat these people chronically you're going to have to treat people with mental health and substance abuse as chronic patients. You are going to save money by keeping them out of the emergency room and from having a crisis. But I think that's a real mistake that I see a lot of people try to look at it as a separate issue than total health.

DISCUSSION AND CONSIDERATION OF RESOLUTION REAFFIRMING SUPPORT FOR THE U.S. STATE-BASED SYSTEM OF INSURANCE REGULATION IN RESPONSE TO GROWING FEDERAL ENCROACHMENT (Resolution)

Sen. Klein stated that we are going to then move right along to a discussion and consideration of a resolution reaffirming support for the U.S. state based system of insurance regulation in response to growing federal encroachment. And you can review that in your binders on page 71. And I'll turn things over to NCOIL President, Rep. Tom Oliverson, M.D. (TX) who is sponsoring the Resolution alongside NCOIL Vice President, Asw. Pam Hunter (NY).

Rep. Oliverson stated that this is a pretty straightforward resolution, but very important to us and the work that we do. If you're new to NCOIL, you probably don't know that one of the organization's primary missions is to preserve the state based system of insurance regulation as established by the McCarran Ferguson Act of over 70 years ago, and confirmed by the Dodd Frank Act of the early 2000s. From time to time, however, federal and international authorities attempt to encroach on the system despite the fact that it has produced the largest and most successful insurance market in the world. And that is why NCOIL always needs to be on the lookout for actions that intrude upon the state-based system of insurance. And unfortunately, we've seen a rash of those pop up in the last few years and they are set forth in the resolution as listed on page 71 to 72 of your book. And there are frankly more that could have been listed. So, this bipartisan resolution will be delivered to all the relevant members of our federal system just to remind them of what federal law actually says with regards to the state-based system of insurance regulation and that we and our friends at the National Association of Insurance Commissioners (NAIC) are charged with maintaining and preserving and protecting that system and that they should let us do our job.

Hearing no questions or comments, upon a Motion made by Rep. Oliverson and seconded by Sen. Gossage, the Committee voted without objection by way of a voice vote to adopt the resolution.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Gossage and seconded by Sen. Lang, the Committee adjourned at 12:45 p.m.