NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
INTERIM COMMITTEE MEETING – MARCH 14, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee held an interim meeting via Zoom on Friday, March 14, 2025 at 1:00 P.M. (EST)

Representative Michael Sarge Pollock of Kentucky, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Asm. Jarett Gandolfo (NY)
Sen. Pam Helming (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Sen. Eric Pratt (MN)
Sen. Gale Adcock (NC)
Rep. Mark Tedford (OK)
Rep. Greg Scott (PA)

Also in attendance were:

Will Melofchik, NCOIL CEO
Anne Kennedy, NCOIL General Counsel
Pat Gilbert, Director of Policy, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Sen. Paul Utke (MN), NCOIL Vice President, (IN) and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

INTRODUCTORY REMARKS: CHAIR POLLOCK

Rep. Pollock thanked everyone for joining and stated that the purpose of this meeting is to conduct some business before our April meeting in Charleston. This will help ensure we can efficiently address all the issues on that agenda in Charleston. We have a few Models to discuss today, but we won't be taking any votes. We'll be continuing discussion on the NCOIL Improving Affordability for Patients Model Act and taking any comments on the Models scheduled for re-adoption in Charleston.

CONTINUED DISCUSSION OF NCOIL IMPROVING AFFORDABILITY FOR PATIENTS MODEL ACT

Rep. Pollock stated that we'll begin with a continued discussion on the NCOIL Improving Affordability for Patients Model Act. We first started discussing this issue last April and a lot of work has gone into developing this Model. You can view the Model on the website with all the other materials for this meeting. Before we go any further, I'll turn things over to the sponsor of the Model and NCOIL Immediate Past President, Rep. Tom Oliverson, M.D. (TX).

Rep. Oliverson stated that I'm honored to be able to pick up the work that our former colleague and former NCOIL President, Rep. Deborah Ferguson (AR), DDS, started on this Model before she left the legislature. I'm very excited about it and I'm anxious to hear any comments that you have. I will tell you that from my perspective, both as a lawmaker and as somebody who sees the application of facility fees and what that's doing to our health care as a provider from the inside, I am very concerned about the rise of facility fee charges, particularly as it relates to physician practices that are acquired by hospital systems as part of a vertical integration strategy. Those are my primary issues. I don't have any other specific comments now but I'm happy to take questions when appropriate. I'm looking forward to the discussion as we move forward.

Lucy Culp, VP of State Gov't Affairs at the Leukemia & Lymphoma Society (LLS) thanked the Committee for the opportunity to speak and stated that in addition to my role at LLS, I'm also a consumer representative to the National Association of Insurance Commissioners (NAIC). At LLS, our mission is to cure blood cancer and improve the lives of patients and their families. We really exist to ensure that access to treatments are available for all blood cancer patients. We fund research to advance those treatments. We provide patients and families with one on one guidance and support, really from a whole team of social workers and nurse navigators and support groups. And then we also advocate for policies that protect and improve patient access to treatment. Having that kind of one on one patient connection is just so important to making sure that the policies that we pursue are in the best interest of the folks we serve. And it's with that mission in mind that we're really pleased to support this Model and I want to offer a couple of suggestions for you to consider as you consider adoption.

I know we use the term "consumers" a lot when we talk about insurance, but I'm going to use the term "patients" here because I think it's important to remember that that's who health insurance consumers are. They're patients, many of whom are dealing with really complex and chronic diseases. So I wanted to talk a little bit about why this is so important to us. Blood cancers are extraordinarily expensive to treat. As an example, the average cost to treat acute leukemia in the first year is about $500,000. And these diseases are also incredibly complex to treat. They vary wildly in their intensity and the pace of symptom onset and the length of treatment. And even patients who achieve long-term remission are often in need of heightened surveillance and monitoring throughout their lives. And what that means is lots of doctor's visits of all kinds. Hospitals, clinics, primary care, labs, you name it. And that's over years and years. So, in short, blood cancer patients are very high utilizers of healthcare services and their health insurance plans and are therefore, really highly impacted as those markets change and shift. And we know the price of cancer care and ultimately the consumer cost of care is rising at a really alarming rate. We've all felt it in our personal lives and I think that's why you would be looking at a Model like this. Patient out-of-pocket costs are increasing through higher deductibles, co-pays, and co-insurance and patients are less able to afford the care they need, and it compels them to delay care or even forego treatment. And higher prices and extra fees become medical debt. We know that one in

three Americans currently have medical debt. About half of cancer patients report having to take on debt due to their treatment, and about 42% say that they deplete their life savings in their first two years. A driver of those increased costs, and Rep. Oliverson mentioned it but of course it's not the only driver but certainly a contributing factor, is hospital consolidation. In recent years, significant consolidation has taken place in the healthcare sector, and the research is really clear that hospital mergers lead to larger entities with more market power that can then negotiate increases in their prices which then translates to higher costs for patients.

Unfortunately, what the research doesn't show us is a correlating increase in quality so we can't say that as prices go up, the care is getting better. And in fact, while there's some variation in the research, many studies are showing a reduction in quality, lower payment satisfaction, and a reduction in access to services, especially in rural communities as hospitals continue to consolidate. And the research also indicates that facility fees are one of those cost drivers. I think you all probably already know, because you've been talking about this Model for a little while now, but you know that a facility fees is a charge assessed by a healthcare provider that is separate from and in addition to charges for professional services. For an example, a person who visits a provider for, say, a routine blood draw may be charged for the blood draw itself, but then also receive a separate additional fee. And we acknowledge that there are some cases where a facility fee might make sense and we're not advocating for their full elimination. Historically, most facility fees were assessed by large standalone hospitals to cover costs associated with running the facility because that may not have been fully reimbursed through negotiated rates. So, for instance, the cost of maintaining a 24-7 emergency department, that's a frequently cited example of what facility fees may help finance. But now, patients are increasingly billed for these fees in settings where they really wouldn't have traditionally seen them. And again, that's happening because large systems are able to add fees onto bills for services provided in the outpatient settings that they own, even when they're separate and apart from the main hospital campus.

I'll throw out another example - a person who visits a primary care doctor for that routine physical every year, they could be assessed a hospital facility fee if their doctor's practice is owned by that hospital, even though they never set foot on the actual campus, which was, ostensibly the need for the fee. And this can be particularly surprising for patients whose doctors are newly acquired. You can kind of just imagine the surprise of a fee wouldn't have been assessed and then could suddenly be assessed because your doctor's office was purchased and you may not have even realized. One more example - we were recently contacted by a blood cancer patient who went to her doctor for a fairly routine visit. She wasn't surprised to receive the bill for her portion of what was due, her co-pay, but she was very surprised when she received a facility fee for almost the same amount. So, it essentially doubled what she owed out of pocket. And it came as two separate bills.

Moving to the Model, all of that's to say that's really why we're pleased to support the Model. We would just urge the Committee to consider just a couple of modifications to ensure that it offers even stronger protections to patients. First, we'd suggest that the Model include a prohibition on those services provided through telehealth, just as it does with off-campus locations. So rather than just those outpatient services billed using evaluation management (E&M) codes, we see no reason that services provided in a virtual setting where there's no facility would be treated any differently than those provided in an off-campus setting. Second, we'd really urge you to consider whether it is

ever appropriate for a facility fee to be charged directly to a patient rather than to their health insurance provider. As we've discussed, there might be places where a facility fee is allowed and appropriate and necessary, but patients and consumers pay an increasing amount in premiums each year and in return, they expect a level of reasonable cost protection when they need to access their health care along with the understanding that what they're paying will contribute to their deductibles and their out-of-pocket maxes. So when we think about this from a patient's perspective, getting billed for a facility fee outside of their health plan really feels like a surprise bill by a different name and Congress, along with numerous states, have already acted in a bipartisan manner to really rein in surprise bills. And we think this Committee could continue that progress by ensuring that allowable facility fees be included in charges sent to insurers rather than ever going directly to a consumer as an added bill. Additionally, we think health plans are probably much better positioned to evaluate and negotiate these plans than consumers are on their own. Finally, we're very supportive of the language that ensures that the provider identification number (national provider identifier/NPI) on submitted claims accurately reflect that specific site of where the person receives their care. And we would encourage the Committee to consider amending this section to require that claims provide sufficient information so that you can identify the specific site of service and the larger hospital system or organization. And our thought here is being able to identify and track those linkages between individual sites and their ownership structure will help fill the knowledge gaps of how consolidation impacts patients.

Terrance Cunningham, Director of Administrative Simplification Policy at the American Hospital Association (AHA), thanked the Committee for the opportunity to speak and stated that today, I'll quickly go through some of the overview of facility fees and what they pay for and what the purpose is. I'll talk about some of the specifics of hospital care that differentiate hospital care from other settings. I'll talk about the concept of physician acquisition and what the drivers of some of the physician acquisitions might be. I'll also talk about the NPI issue and the honest billing provisions of the Model and the need for off-campus facilities to have unique NPIs from larger facilities. And then I'll just offer some general takeaways. So, whenever you're discussing legislation like this, on the surface, I get it. Why would a specific bill for a service in one setting and a specific bill for service in another setting differ - if it's the same billed service, shouldn't they be the same? What I would offer is, I think there's a little more nuance and hopefully I'm able to convey some of the nuance that might differentiate and explain why there are different charges in these settings. First, I want to talk about what facility fees cover, specifically as they compare to professional fees. Obviously, professional fees cover physician services. This is the general concept, you bill a specific Current Procedural Terminology (CPT) code, you've got a rate associated with that CPT, and this is what the physician is reimbursed for. Facility fees, as they are unique to hospitals, cover a lot of additional things that might not be something that is necessary in these other settings - things that hospitals need to cover in order to be a successful hospital for patients. And this includes things such as nursing and supporting medical staff, pharmacists, medical equipment and supplies, clinician training, significantly enhanced regulatory compliance. Things that are unique to the hospital setting and are one of the justifications we would offer as to why facility fees are essential parts of the care delivery system and the payment system that we have today.

I talked about how you've got two different settings and the same billed service. I would note that hospital care is inherently different than other settings of care. In terms of patient type, hospitals care for enhanced security of patients. They care for sicker

patients. This is consistently supported by research and larger numbers of uninsured patients are visiting hospitals as opposed to some of these other settings. And so, with that, it causes increased costs of caring for these particular patients. Additionally, the costs for delivering care at a hospital are not equivalent to some of these other settings. For one, hospitals generally are keeping at least portions of their facility open 24-7 for care. They, as I mentioned before, have a significantly enhanced amount of comprehensive licensing, accreditation, and other regulatory requirements that they must meet in order to be a successful hospital. Another thing that hospitals provide, and I don't know if this is often talked about enough, is hospitals have settings that don't produce revenue but are essential public services. And in order to do that, one of the necessary parts of hospital financial settings is there is a certain amount of cost shift that's just inherently necessary in order to provide some of these public services. What do I mean by that? Well, there's certain things such as behavioral health, nephrology, burn units, infectious disease units where consistently the margin is below zero. They are not revenue generating. In fact, they cost more than they actually bring in for delivering that care. And in order to continue to provide these settings, hospitals often need to have higher margins in other settings such as an outpatient department that offset the losses that they're just inherently going to have with some of these settings. And so if you eliminate a lot of those margins that might exist in a hospital outpatient department or other setting that might be where revenue might be generated, it threatens the viability of the hospital to deliver these other settings.

One thing that's not on here that I do think is also worth noting is in certain settings like with maternity care, you have to deliver somewhere between 250 and 300 children a year for a hospital to kind of break even. And so in a lot of the rural settings in particular, if you've got a maternity center that's not delivering that amount of infants each year, they're going to be in the negative as well and there's going to need to be margins and cost shifting that's involved in order to keep those essential facilities open. And so one of the concerns I have when we look at these bills is not seeing the whole picture as to where some of that financial might need to be cost shifted in order to cover some of these other services. One of the things that we often hear is that the increased outpatient rates or the increased hospital facility rates are what's driving the physician acquisition of hospitals and physicians being gobbled up by hospitals in order to charge these higher rates. And the data just doesn't support that. While there is an issue with independent physicians being acquired, it's most often private equity and health insurers, and that seems consistent. Optum is the largest employer of physicians in the country. And the data shows that while physician acquisition is an issue, it's not hospitals that are the ones who are consistently driving this. Why is this happening? I would say oftentimes it's physicians are not being reimbursed sufficiently by the health insurers in terms of their total cost for their services and the administrative complexities and needs in order to jump through the hoops necessary to receive reimbursement from health insurers, things such as prior authorization or prompt pay issues or the documentation requirements and stuff such as that, make the administrative costs continue to rise, and then you don't have a sufficient amount of reimbursement to cover those. And so what a lot of physicians are doing is employment becomes a more practical solution because that takes off that administrative headache. It is occurring, and I think there's a need to potentially address some of those issues. I just don't think this is the way to do it.

The other concern I wanted to talk about is the honest billing provisions of the Model and specifically the need for new NPIs for off-campus outpatient departments. One of the things that I've heard in discussions of this issue in other forums is there's an inability to

know from a hospital's outpatient bill whether or not that was an off-campus facility or an on-campus facility. And I think a lot of this is driven because there's inherent differences between the professional claim and the institutional claim. The professional claim is what a physician will submit for their services and on that, it's going to have what's known as a place of service code and that's going to be used to clearly indicate this is an off-campus hospital, that this is an off-campus outpatient department. The institutional claim doesn't have that. So I think frequently people say, "well, there's no code to be able to identify this as an off-campus outpatient department" but that's not necessarily the case. It's just the differences in terms of how these bills are processed that might make it different to know. But there is a clear way in which a health plan or anyone else looking at these bills can tell whether or not this was care delivered at an off-campus facility or otherwise. Specifically, in order to be processed by a health plan, you're going to need to have a type of bill, which is FL-04. It's a specific segment in an institutional claim, and that's going to indicate whether it's outpatient or inpatient. There's a whole bunch of types of bills, but for the purpose of this discussion, there's an outpatient claim, so there's going to be a specific type of bill that's used. And when you put an address on a claim it has to be the service location, it's not the parent company. It's got to be the service location. In order to have an alternate from the main campus service location, those need to be registered with health plans typically and so the health plan will know right away, "oh, this is the address I have on file for that off-campus facility - this is not on-campus." And so, yes, there's a different way of determining whether or not this is on-campus versus off-campus, but that's not to say that there's not a way of determining. And health plans can clearly determine whether or not care is taking place at an on-campus facility and off-campus facility by looking at these two specific segments of the claim.

I want to leave with a couple of key takeaways of what I spoke on. Facility fees are essential to providing the unique type of care that are provided by hospitals. Specifically, eliminating facility fees jeopardizes the financial viability of certain areas of hospitals, and it could threaten the ability to provide these non-revenue-generating services, particularly in rural settings where there might be a less in-patient population. I also will note the reduction in independent physicians is certainly something that might be concerning, but hospitals aren't the driving factor. And again, I would note that I think the driving factor on this are health insurers and other payers not paying a sufficient rate for physicians to remain financially viable and creating more complex coverage such as high deductible health plans that are shifting cost responsibility onto the patient. And again, in those situations, when you shift more onto the patient, you've got more bad debt that's inherently going to occur because you don't collect at the same rate. And so there's a lot of financial pressure on independent physicians that might be leading to them no longer being independent physicians and instead turning to employment. But the concept of hospitals driving this is not backed up by the actual data. And then finally, the NPI for off-campus departments, it doesn't seem like it's necessary because you can already determine this by looking at an institutional bill and so really requiring this is only going to add to that administrative cost that's uncompensated by the professional fees and things that providers are going to have to address and it'll make the care and the billing even less efficient than it might be today

Eric Waskowicz, Senior Policy Manager for United States of Care (USofCare) thanked the Committee for the opportunity to speak and stated that USofCare is a nonpartisan, nonprofit organization that works in the states to ensure that everyone has access to quality, affordable health care. We are new to the NCOIL world but are very interested in the work that you're all doing to address facility fees and I'm looking forward to

meeting all of you in Charleston. For the most part, I'm going to align myself 100% with what Ms. Culp had mentioned related to the problem that facility fees pose to patients. First and foremost, this hits close to home for me. I received a $180 facility fee at my primary care doctor's office for a strep test – it was a bit of a shock to me. I'm certainly part of the group that really is supportive of action to address facility fees. Looking at this draft Model, we are supportive of the facility fee prohibitions and transparency requirements and we believe that this Model really does align with the approximately 18 states that have passed some sort of protections related to facility fees.

In addition to the consumer protections found in the Model, there are a couple areas of focus that I think we feel could be addressed to strengthen the Model even further. The first is something that Ms. Culp mentioned earlier regarding NPIs. We are supportive of language in the Model to require these unique NPIs for off-campus providers and I would say, on top of that, some sort of mechanism to really establish a connection between parent hospital and affiliated off-campus providers to make sure that we know where these fees are being charged. USofCare has spoken with state all-player claims databases, and they've told us it's very difficult to identify where these fees are being charged even with unique NPI language so we feel some sort of clarification is needed. And then the second item relates to data collection. USofCare has been very supportive of language in this Model requiring hospitals to submit a publicly accessible report on facility fees, at the same time, we would encourage the Committee, if possible, to think through a requirement that states complete some sort of analysis or evaluation to understand the impacts of facility fees on people's access to care, as well as the health care system more generally so looking at providers, hospitals, consumers and the like. This has been done in several states so far that we thought has been pretty successful. And then one final thing, we want to encourage NCOIL to think through solutions beyond facility fee prohibitions, things like site neutral policy or fair billing policy, policies that address the commercial market in states. We feel like doing so would secure even more savings for people, employers and others, while also making sure to lower the cost curve for the health care system more generally.

Randi Chapman, Managing Director of State Affairs at the Blue Cross Blue Shield Association (BCBSA), thanked the Committee for the opportunity to speak and thanked Rep. Oliverson for sponsoring the Model. The policy solutions that are included in this Model can really go a long way to help consumers, patients, our members, achieve more affordability in their health care. I'm not going to reiterate all of the great information that has been shared today. I will say that I am thrilled that BCBSA is aligned with patients on this issue and we think it's essential to address what's going on in terms of helping make health care more affordable for patients. There are a lot of levers that contribute to high costs, and this is just one of them.

Sen. George Lang (OH) thanked Rep. Oliverson for bringing this Model forward. Last year in Ohio, we enacted a hospital transparency bill and included in that we wanted to include some facility fee language but it was only aspirational and at the last minute, we decided to pull it all together. This is something that we want to work on. The concern I have and a potential amendment to fix it would be when these hospitals purchase a physician's practice, I'm assuming as most business models, they use a multiple of something such as interest, taxes, depreciation, and amortization (EBITDA) to purchase that practice and this gives them the opportunity to realize they're going to have additional gains from the facilities, the tools, if you will, at the doctor's office that they currently don't enjoy. So my concern is that a hospital offers a higher multiple based on

the fact that they're going to enjoy higher revenues on the facilities at that firm than the practice otherwise would have received. One potential amendment, and don't hold me to the details because I really don't know but my assumption is when a hospital buys a practice, they like to have it all paid off in five to seven years. That's just an assumption based on my businesses I operate in and when I buy a practice, I have a five-year model. When I buy a building, a seven-year model. I truly don't know what hospitals do. But if that assumption is correct, in order to give hospitals a longer runway and a softer landing, I would recommend we consider grandfathering all existing facilities in for a period of time. My opinion, that should be about three and a half years. That way, if a hospital bought a practice six years ago and they have one year to go, they're going to enjoy fees that they should not otherwise have enjoyed once that building is paid off and so they'll take advantage of it in that scenario. But a hospital that just bought a practice a year ago, they're not going to have the full seven years. They're just going to have an additional three and a half years. So that is an amendment I would like for the sponsor to consider and I'll be happy to help with some language and we're actually working on something similar to that in Ohio.

And some concerns about the testimony that we heard. I heard Ms. Culp say that we should direct the bills to the insurers, not the individuals. And if that means the responsibility of paying those is to the insurers, we will just continue to drive up costs on the small business markets and continue to drive more of those small business markets out of the umbrella of state regulations. I know in Ohio, about 10 years ago, 20% of everybody insured was insured in a small market plan but today, that number is only 10% because these small businesses have figured out how to pool their resources, how to get to a self-funded world where they don't have to follow our directions. And for the AHA, I appreciate the fact that you have items that you lose money on. I don't understand why a hospital would do that, but I don't understand your model. I understand why a retailer would do that. I don't think it should be our responsibility to help you make up for those items that you have priced at a loss or at a lower margin. That would be my pushback there.

Rep. Brenda Carter (MI) stated that last year we were looking at introducing similar legislation in Michigan where we had substantial opposition from the hospitals. It was great to hear some of the feedback that I heard from both sides today and we're going to revisit it again. But I want to ask, how does this Model address the out-of-pocket cost for the patient? That's the primary concern that we have - the facility fees are costing the patients and the cost of health care is already rising to the point that we're increasing our pool of underinsured and uninsured people.

In response to Sen. Lang, Ms. Culp stated I think our concern in part is that, oftentimes facility fees are actually billed directly to the patient, rather than going through their insurance so it's like a separate bill entirely. They'll get their explanation of benefits. They'll get the information from their insurer. They'll pay their copay or their part of the service. And then they'll get this other separate fee. And that I think maybe in part addresses your question, Rep. Carter. But we'd be really interested to talk more about if there are additional ways to provide additional consumer protections and make sure that as facility fees go away, it's not just passed on to patients in another way. But ultimately, what these are is charging more for the same service because it's being provided in a space that's owned by a hospital versus one that isn't. And we just don't think that's fair.

Mr. Cunningham stated that I think in terms of things being not covered by a health insurer and having to go directly to patients, I think we would agree we would like things to be paid for by the health insurer. And I think that, again, might be a cause of a lot of these issues is we want facility fees and everything else to be something that's comprehensively part of your benefits package. And the fact that these benefits packages have been consistently eroding and you've got coverage that doesn't pay for what it maybe should might lead to some of these things. And in terms of services that do not generate margins, especially for specific hospitals to a specific community, they provide public health services that are essential. And I think hospitals take that seriously. And there is a certain amount of cost shift and there are non-revenue generating services because that's what hospitals are supposed to do - you generally expect a hospital to be somewhere where someone can have a baby and they don't have to drive crazy amounts of time or have an issue to access. And so I think it's just inherent to how things are handled so that you can provide the comprehensive health care which is expected of hospitals. In order to do that, there's cost shifting and there might be some services that generate revenue and some that don't, but we think both are essential to what it means to actually provide hospital level care.

Rep. Oliverson thanked everyone for their comments and stated that I really appreciate the good discussion, especially the comments by my colleagues. I'm happy to visit with you after. Just a couple of observations. Number one, to Rep. Carter's concern, I think it's important to understand that what we're talking about here is a facility fee that is levied when a patient goes to see a doctor in the doctor's office. And historically, when a physician contracts with a health plan, there is a certain amount of attention in that global fee that is paid to that physician for reimbursement of the cost of overhead. And so, what we have here is a scenario where essentially the cost to the patient has been doubled or tripled vis-a-vis something that 10 years ago was just included as part of the professional fee. So, it is a true doubling or tripling of the patient cost so by prohibiting these fees, which didn't exist until relatively recently I would point out, you are actually returning us to a state of normalcy. As far as the comments about hospitals and under or uncompensated care, I would just simply point out that in my experience, especially for my lawmaker friends who serve on appropriations committees in your state, our states already, and the federal government, subsidize hospitals across the board for services that they render and provide in under or uncompensated care. There are multiple buckets from both the state and federal government that are designed to account for these shortfalls. And to Sen. Lang's comments, I would say that it's not as bad in the hospital world as you think it is, because unlike a regular business as they're making these decisions, they have literally tranches of both state and federal dollars that they are entitled to. The only thing they have to do is prove that they're doing a certain amount of under or uncompensated care in certain particular areas like emergency rooms, outpatient settings, and labor and delivery specifically.

And the last thing I'm going to say is that with regard to the AHA's comments, I would just say that I don't believe in my experience and my research on this issue that the reason why hospitals acquire physician practices has much of anything to do with the actual facility fee itself, nor is that the main business model mechanism by which reimbursement is gathered. It has more to do with controlling the patient's chart and the continuity of care and the referral patterns. And you see this very clearly when you look at the types of practices that hospitals like to acquire. These are oncology practices, surgical practices, primary care practices, and OBGYN practices. And the reason they do that is because if your primary care doctor is working for the hospital and you need a

stress test, guess where that stress test is going to be done? If you need a referral to see a cardiologist, guess whose cardiologist you're going to see? If you're an orthopedic surgeon and your practice is owned by the hospital or a general surgeon, guess where your surgery is going to be done? It is going to be done at the hospital. So I think one of the main driving factors and benefits for a hospital or hospital system in terms of acquiring physician practices is actually controlling the patient's chart and controlling referral patterns and making sure that the hospital is benefiting from services that may or may not be competitively priced with respect to what's available in the market. Because now it's a closed shop and a closed system, and there is no competition because essentially the referring doctor is obligated to send the patient to a practice, a facility, or a treatment that exists underneath the hospital site license. So I just want to make sure you all have that context and all of that's being considered. I'm looking forward to working with all of you on this. I think we have a big opportunity here in terms of a meaningful Model for NCOIL that we can take back to our states and really help consumers have better affordability in health care.

Rep. Pollock thanked everyone for their comments and stated that if there are any further questions or comments, please reach out to Rep. Oliverson, myself, or NCOIL staff.

OPPORTUNITY FOR COMMENT/DISCUSSION ON MODEL LAWS SCHEDULED FOR RE-ADOPTION BY THE COMMITTEE AT UPCOMING SPRING MEETING IN APRIL

Rep. Pollock stated next on the agenda is an opportunity for comment and discussion on the two Model Laws scheduled for consideration of readoption at the Spring Meeting in April. The Models are the Transparency in Dental Benefits Contracting Model Act, originally adopted in December of 2020, and the Short-term Limited Duration Insurance Model Act, originally adopted in the September of 2020. As a reminder, per the NCOIL bylaws, all NCOIL Models are scheduled to be considered for readoption every five years. If a Model is not readopted, it sunsets. These Models will not be voted on here for readoption today. Rather, this is an opportunity for any comments or discussions in advance of the April meeting where the actual vote will take place.

Sen. Justin Boyd (AR), Vice Chair of the Committee, stated that he and Asm. Jarett Gandolfo (NY) have been in discussion with the American Dental Association (ADA) about some amendments to the Transparency in Dental Benefits Contracting Model Act. Asm. Gandolfo and I would like to sponsor amendments to existing provisions of the Model and also have the Committee consider including adding two new issues to the Model regarding assignment of benefits and limitations on recovery of insurers' erroneous payments. The specific language can be discussed further during the Committee's meeting in April.

Asm. Gandolfo stated that I appreciate Sen. Boyd taking the lead on this, and I'm happy to join him and co-sponsor the amendments. I think the amendments that we are going to be discussing will go a long way in improving the dental experience for the patient.

Chad Olson, Director of State Gov't Affairs at the ADA thanked the Committee for the opportunity to speak and thanked Sen. Boyd and Asm. Gandolfo for sponsoring the amendments. We're looking forward to working through them in the future.

Bianca Belloli, Director of Gov't Relations for the National Association of Dental Plans (NADP) thanked the Committee for the opportunity to speak and stated that I have a few comments on the potential reopening of this Model on behalf of NADP as well as Delta Dental Plans Association (DDPA). At this point, we would recommend that the Committee does not reopen this Model. The current Model was discussed and debated at length in 2020, which I know many of you are very aware of, and it contains important policies that bring a lot of legal clarity and consumer protections to the dental contracting space, including increasing transparency for providers, ensuring access to quality dental care and network specifically for consumers, as well as providing a lot of opportunity to providers to elect participation whether that be in the virtual credit card provisions or in the network leasing provisions. And I do want to note there has been broad adoption of the current Model which to us indicates that it contains strong policies that were the right outcome five years ago when adopted. Specifically, in regards to the virtual credit card portion of this, there are 11 states that have adopted the Model or something substantially similar to it with six states following it exactly and five adopting a very similar approach. And then an additional 15 states have adopted the network leasing provisions in this Model, with six aligning exactly and nine following it very substantially. And I want to note the substantial impact that would occur from amending this Model for some of those states that have already considered it. And with that being said, we just want to note that if the Committee ultimately does decide to reopen the Model, we would respectfully request the publication of any proposed amendments, as we've not seen any to date, and allow for ample time to respond and review that text. As you're aware, NADP as well as DDPA are both member organizations, and we would want to make sure our members have the opportunity to review the potential impact of any amendments to the Model.

Rep. Pollock thanked everyone for their comments and stated that it sounds like we have a lot of discussion on this Mode that will occur between now and at the Spring Meeting. I look forward to working with everyone on this and determining what the best path forward is. Based on how the discussions are going, the Committee could readopt the Model as-is for another five years, or we can readopt it on a meeting-to-meeting basis so that interested parties can work with Sen. Boyd on the concepts that he's discussed. If anyone has any questions or comments on this, please reach out to myself, Sen, Boyd, or to the NCOIL staff.

Will Melofchik, NCOIL CEO, stated that in response to Bianca's comments, any potential amendments to the Model will be included in the Spring Meeting 30-day materials which will be distributed a couple of weeks from now. So there will be ample time for review and comments.

J.P. Wieske, on behalf of the Health Benefits Institute, thanked the Committee for the opportunity to speak and stated that we would recommend that the Short Term Limited Duration Insurance Model sunset. There's nothing substantively wrong with the Model. It's just there's a lot of uncertainty around the market right now and there's been limited adoption of this Model. There's not a lot of consensus around this as a Model going forward. There's an ongoing lawsuit with the existing rules on this topic that the Biden Administration issued which replaced the Trump Administration rules, and the new Trump Administration is likely to act on the issue. So at this point, we think that there's enough turmoil in the market that even if it makes sense to have an NCOIL Model, it may make more sense to re-look at this down the road with a different Model.

Rep. Pollock thanked everyone for their comments and stated that when the Committee meets again in April, we'll have an opportunity to determine what the next step is with this Model. If anyone has any questions or comments on this, please reach out to myself or to the NCOIL staff.

ADJOURNMENT

Hearing no further business, upon a Motion made by Sen. Utke and seconded by Rep. Carl Anderson (SC), the Committee adjourned at 2:30 p.m.