NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2025 NCOIL SPRING MEETING – CHARLESTON, SOUTH CAROLINA
APRIL 25, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Francis Marion Hotel in Charleston, South Carolina on Friday, April 25, 2025 at 11:15 a.m.

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

Other members of the Committee present were:

Sen. Mark Johnson (AR)
Rep. Bill Sutton (KS)
Sen. Julie Raque Adams (KY)
Rep. David LeBeouf (MA)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Jeff Howe (MN)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Rep. Brian Lampton (OH)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Sen. Mary Felzkowski (WI)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Eddie Lumsden (GA)
Rep. Brett Barker (IA)
Rep. Elizabeth Wilson (IA)
Rep. Rita Mayfield (IL)
Sen. Julie Morrison (IL)
Rep. Adrielle Camuel (KY)
Rep. Mike Clines (KY)
Sen. Donald Douglas (KY)
Rep. Vanessa Grossl (KY)
Sen. Franklin Foil (LA)
Del. Mike Rogers (MD)
Rep. Robert Foley (ME)
Rep. Joe Aragona (MI)
Rep. John Fitzgerald (MI)
Rep. Kristian Grant (MI)
Rep. Greg VanWoerkom (MI)
Sen. Walter Michel (MS)
Rep. Jennifer Balkcom (NC)
Sen. Bill Gannon (NH)
Rep. Meredith Craig (OH)
Rep. Forrest Bennett (OK)
Sen. Hanna Gallo (RI)
Rep. Alex Finkleman (RI)
Sen. Matt LaMountain (RI)
Rep. Joe Solomon (RI)
Del. Irene Shin (VA)
Rep. Calvin Callahan (WI)
Rep. Barbara Dittrich (WI)
Sen. Mike Azinger (WV)
Sen. Cale Case (WY)

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. Lana Theis (MI) and seconded by Asm. Erik Dilan (NY), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Mary Felzkowski (WI) and seconded by Del. Walter Hall (WV), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 22, 2024 and March 14, 2025 meetings.

INTRODUCTION AND DISCUSSION OF NCOIL PRIOR AUTHORIZATION REFORM MODEL ACT

Rep. Pollock stated that we'll start today with the introduction and discussion of the NCOIL Prior Authorization Reform Model Law. As a reminder, at our meeting in San Antonio, we heard a presentation on the prior authorization reform landscape, and now we have Model language to discuss which is based on legislation recently passed in Mississippi. You can view the model on the website and app and in your binders on page 20. We won't be taking any action on this today - just starting our discussions. Before we can go any further, I'll turn things over to the sponsor of the model, Sen. Walter Michel (MS).

Sen. Michel stated that at the NCOIL summer meeting in 2021, I heard an update on the Texas Gold Card prior authorization law. In the first month of the 2022 session, I was approached by a group of physicians who were disappointed that prior authorizations were taking so long. So, we had multiple hearings and received input from many and passed prior authorization legislation in the 2023 session. One of the attorneys who drafted the bill is here with us today, Sam Martin. At that time, he was an attorney with the Mississippi Senate. Now he's here today representing the Mississippi Hospital Association. I'm proud that he's with us today. I'm offering this legislation as a starting point and I look forward to our discussions today as this model evolves.

Melissa Horn, Director of State Legislative Affairs at The Arthritis Foundation, thanked the Committee for the opportunity to speak and stated that I am very excited to see model language on this and your consideration and discussion on it. It's a very important topic, and certainly one that is close to the arthritis community. Currently, there's over 54 million Americans that are living with doctor-diagnosed arthritis, and that doesn't just include adults, that includes kids. And there are over 100 different types of arthritis. So, whenever you're thinking about chronic disease, obviously the name itself explains it, chronic. Our patient communities have to go through a lot of navigation of the health system. And one of the biggest barriers that they have reported back to us has been around utilization management. Now it's just important to note, I am the State Legislative Affairs Director for the Arthritis Foundation, I cover all 50 states, and we're very excited to work with all of you back home in the districts on this issue because I know sometimes it can be a state-specific solution. But there are principles that kind of travel from state to state that are pretty consistent whenever it comes to making sure it's less burdensome for the patient. So, I'll go ahead and just share some information that we've collected whenever it comes to barriers to care. We like to really emphasize that any legislation be focused on the patient. So, a patient-centered ideal model of care is kind of the terminology that we use as we work around the nation to emphasize the patient perspective, especially from a chronic condition like arthritis. We actually launched a whole multi-year project called our ideal model of care, and I put some links on there and shared it, and I know it's in the presentation materials too. But we did survey over 3,500 of our patients, who have reported their experiences with utilization management, navigating health insurance coverage. And, of the issues that they

reported back to us, prior authorization was the top barrier. It was the top two, which tied in directly also with step therapy or that fail-first protocol that is often required before you get to the medication that was prescribed by your provider.

So we collect a lot of information from our patient community and also surveyed in 2023. Both of these are recent reports of the last two years here where a lot of our patients reported back to us that they had to go through prior authorization, at least every plan year, if not more frequently, for the medications that they take to treat their arthritis, which, again, is not ever going away. This is something that they will live with for the rest of their lives, especially if they started as a toddler or had juvenile arthritis. Most patients had to wait quite a bit of time for their appeal – 31% of patients actually reported that they had to wait over seven business days for a response from the insurer. So, this is quite a big hurdle to overcome, especially whenever it comes to arthritis. It takes months to years to even diagnose arthritis, much less get control and manage it. Pain is a big barrier for those living with arthritis, and it is actually the leading cause of disability nationwide and in every state. So, whenever it comes to the cost, I just want to make sure that the committee and everyone knows the real costs that are associated with healthcare in general is not just related to the system and the price of medications, but of course the cost to our economy and the well-being of individuals who are trying to work and live and play, especially for our kids that are diagnosed with these diseases. So again, navigating these appeal processes can be overly burdensome, resulting in multiple points of contact. We're trying to again collect that information on how much time it actually takes one of our patients to navigate a prior authorization process.

So, I'll switch over to some more of the results here. Whenever there is an unsuccessful prior authorization appeal, patients are forced to switch medications. Those medications might not work as well or carry a whole host of other side effects. I myself am a three-time cancer survivor. I've been on this journey as a patient for more than half my life starting as a young adult in high school. So I know what it is to have to navigate health care systems across state lines and to continue to fight for medications for diseases that aren't going away. Again, all of these diseases are chronic. So, when it comes to navigating appeals, if you are constantly going back to an insurer or if you switch plans and have to repeat that process, it's really difficult for the patient who is already struggling to go through a chronic condition like cancer or arthritis or Alzheimer's or something else that might impact their livelihood and life. And if you're switching medications, those side effects can be pretty dangerous. They can land you in the hospital. Pain management is a big side effect for our patient community, and we certainly don't want to get into a situation where we're adding to an already epidemic level of opioid use. We want to make sure that patients are ahead of it whenever it comes to their symptom management, but also that they're able to afford the medications that they're prescribed, especially if they switch to a different kind. So, paying out of pocket is a high barrier for them, but again, any of these interruptions in care, if they are delayed, they could end up in the hospital. The disease could progress whenever it comes to joint swelling and inflammation, it impacts mobility. So, it impacts literally everything from waking up in the morning to going to work, to getting your kids ready for school, every aspect of life for our patient community. And we don't want them to miss work and have to be on disability or not participate in the things that they want to do in life. In fact, our whole motto is we want to empower our patient communities to not be disabled and to be able to say yes to more things in their life.

There is a lot of great information here. We are a part of a national coalition called the State Access to Innovative Medicines Coalition (SAIM), and this really brings providers, patient organizations, pharmaceutical companies all to the table to talk about what are the key elements that we would like to see in prior authorization. Again, patient-centered, prioritizing

continuity of care. So again, patients living with chronic disease, it's a life-long thing. Ensuring timely access and administrative efficiency whenever it comes to the process, especially as patients are switching plans. It can be really confusing and cumbersome to navigate that. But also, what are the processes for appeals and exemptions? If they're in an emergency situation, what do they have to go through? But one last point I just want to emphasize whenever it comes to patients that are navigating chronic conditions, this is a lifelong thing. And as much as it is a great goal to have to eradicate or cure diseases, most people are living with chronic disease. So, navigating that and navigating prior authorization, other utilization management protocols, while I understand it's necessary, it doesn't have to be that burdensome. Again, I mentioned I'm a cancer survivor. For being a thyroid cancer patient, I don't have a thyroid. So, I have to take a medication every day for the rest of my life to navigate that and stay out of the hospital and stay healthy enough to work and again do everything that I want to do in life as a young person. It's not growing back so why do I have to keep repeating the prior authorization process whenever you don't grow back organs? These kind of conditions and exemptions are the things that we're talking about whenever we're looking at legislation. So, I just urge the committee again to take note of that and really think about the patient experience. Again, arthritis patients and any patient that is living with a chronic disease often are navigating more than one as well. So, it's not like they're just dealing with this for one drug or one service or if they have a prosthetic, one limb. They are dealing with this for all of their conditions and all of their care. So, I just want to applaud again the effort of this committee and NCOIL overall, especially from the state of Mississippi, to really navigating this and putting a model forward because it's so important and it's such a great start. But really reduce the burden on the patient. Make sure the response times and the appeals processes are very clear. Try not to wait too long for the patients.

Terry Cunningham, Senior Director of Administrative Simplification Policy at the American Hospital Association (AHA), stated that I really appreciate the opportunity to talk about what I believe to be extremely important and meaningful model legislation before this committee. What I want to do today is to go over kind of the general overview of prior authorization and why it's a necessary space for reform. I'll talk about the overall legislative and regulatory landscape with particular focus on some of the stuff at the federal level. I'll dive specifically into the proposed model before you, highlighting some of the fantastic things included therein. I'll also talk about some opportunities for potentially improving some areas where we might want to go further or tweak some of the language. So, the current problem with prior authorization is really, there's a lot of kind of ways you can categorize it, but I like to categorize it in two-fold. There's one, the patient impact, and I'm not about to say I can sit here and give you as good of an overview as Ms. Horn just did. But two ways in which it's a problem is, it's often a disruption or delay in a patient's care. And then it often can lead to potentially inappropriate denials of care. Care that should have been approved that prior authorization leads to a denial. And so both of those present unique and problematic issues for patients.

The second area is with the administrative hassles that are caused by the specific protocol of health insurers. The way in which prior authorizations are submitted today are often unique to each individual health insurer and its often ways that are not efficient like fax machines or phone calls. And then there's also a lack of transparency related to what information is required to seek a prior authorization, when a prior authorization is required and what the criteria that the plan intends to use to determine whether or not it is an approval of a prior authorization or a denial. When I talk about delays and disruptions in care, one thing I noted is that Kaiser Family Foundation came out with a survey a couple of years ago where 16% of all insured adults, that's not commercially insured, just all insured adults, reported a problem accessing needed care as a result of prior authorization within the previous 12 months. So, this is a significant chunk of all

Americans that are dealing with their care. And why is that a particular problem with prior authorization? Well, it often leads to a direct impact on the health outcomes of patients. I'm sure the American Medical Association (AMA) will speak on this more so I won't go into too much detail, but the AMA came out with a survey recently where they surveyed physicians, and 93% of those physicians' reported delays in care as a result of prior authorization for their patients. Perhaps more alarmingly, 82% reported that, at least sometimes or frequently, patients are abandoning treatment as a result of prior authorization. So, not only is their care delayed, but they're just not receiving the necessary care, which can lead to a whole host of subsequent issues both for the patient as well as for the healthcare system on the whole. And then 29% of clinicians reported serious adverse events related to a patient waiting for a prior authorization result. And as a result, what happened to them - his includes things such as death or hospitalization or other things.

The other thing I wanted to point out is a U.S. Senate report that came out last year specifically focusing on prior authorization in the post-acute care space, and this is when a patient is done with their acute care and they're seeking to be transferred to something such as a skilled nursing facility or a long-term care hospital. The report noted exponentially higher denial rates within prior authorizations and overturned rates of subsequent denials. And so, ways in which prior authorization seems to be used to potentially delay access to care, and frequently it's being used to deny only to have subsequently overturned access to these treatments, which leaves a patient in an acute care bed or unable to start the appropriate next stage of their rehabilitative process. I talked earlier about the denials of appropriate care, and I'll just point out two Health and Human Services (HHS) Office of the Inspector General reports, which these were looking largely at Medicare Advantage spaces, but the large players in the Medicare Advantage space are also the large players in the commercial and state spaces that would be affected by this bill. The 2022 HHS report found that 13% of prior authorizations and 18% of claims were denied despite them actually meeting the medical necessity requirements of the program and being consistent with nationally accepted care guidelines.

And so, this is a large chunk of patients who went through the prior authorization process or went through only to be denied despite that care actually being appropriate. And so only a small proportion of those folks actually went through the appellate program. And so instead it was prior authorizations leading to patients receiving not what their clinicians believe was the most appropriate level of care for them. And another aspect that probably is even more alarming when you consider the first report is the 2018 HHS Office Inspector General report found that 75% of all prior authorizations that are appealed are overturned. Unfortunately, it's like 1% of prior authorizations that end up getting appealed and that's partially because you might not have the time for your patient to be waiting to forego a long appeals process. It might be in their best interest to let's do an alternative treatment at this time because it's certainly not ideal for me to go through this long exhaustive prior authorization appeals process. It's time to move on to the next stage of care. So, the other thing I talked about up front was the administrative hassles that physicians are dealing with and there's a number of ways in which this occurs but one is knowing whether or not prior authorization is required for a particular service. Oftentimes this is something that you'll see in a provider bulletin that an insurer releases or something they're going to post on a website and it's not clear up front if at the time of treatment unless you've gone through those bulletins, does this treatment require a prior authorization? And if so, to the second bullet here, what do I need to do in order to achieve a prior authorization approval? What information do I need to collect from this patient and send along to the health insurer so that they can agree that this is in fact an appropriate treatment for my patient? And the third thing that clinicians are frequently dealing with is, how should I send this information? Each plan has a different way of requiring it. They could require you to send it by fax. They

could require you to call them. They can require you to use a specific transaction called the X12278 transaction, or there can be a portal online, each one with a different way of doing it, and each one with a very specific process that you need to be aware of as you're trying to achieve your patient access to appropriate treatment.

So quickly, I want to go over the current legislative and regulatory framework of where things stand now. I want to note that last year, the Interoperability and Prior Authorization Rule was finalized by the Centers for Medicare & Medicaid Services (CMS) and this established things for all Medicare Advantage plans as well as Medicaid plans, Medicaid managed care plans, Children's Health Insurance Program (CHIP) plans, as well as plans sold on the Federal Exchange. They created a standard way in which plans have to offer prior authorization. So, it's relaying exactly how much, relaying specifically to a physician within their electronic health record (EHR) whether or not something requires prior authorization and what information needs to be pulled so that they can submit a prior authorization request. It also created shorter time frames, requires plans to report on specific metrics related as to how their prior authorization programs are working, including things such as how long in which an average prior authorization takes and things such as that. It also required plans to include specific and detailed reasoning if they're going to deny prior authorization, which provides people with better ability to appeal in an efficient manner. There was also some movement in the CMS Medicare Advantage space focused on medical necessity criteria. They required specific transparency requiring plans to specifically post a list of what requires prior authorization as well as making sure that those medical necessity criteria were both transparent and clinically valid and based on nationally accepted care guidelines. They also addressed some reviewer credentials making sure that physicians with an appropriate level of expertise were the ones denying prior authorizations on the plan side.

Moving to this model which I want to start off by saying this is fantastic – if it was to pass exactly as it's written now we would be very happy with it because it addresses things such as the following: it requires disclosure of prior authorization requirements. So, this would require that a clinician knows if something is subject to prior authorization up front. There would be transparency as to what medical necessity criteria needs to be used when you're, what do you need to satisfy? What are the rules in order to achieve prior authorization approvals? Those criteria need to be evidence-based, nationally recognized, and flexible for a specific patient's individual medical circumstances. And it requires a 60-day notice if a particular form of treatment is going to require prior authorization when it didn't previously. Really, this makes sure that the physicians know when they're providing care what they need to do to ensure that their patient can access necessary treatment. They also sped up time restrictions to seven days. This speeds it up to seven days for a standard prior authorization and 48 hours days for urgent requests, that’s extremely important. Specifically, just making sure that this does not prolong care. It requires the denial specifics which I just talked about. Some of the specific restrictions for the plan grants prior authorization, they need to honor it - they can't deny care later that was previously approved as medically necessary. It also has some provisions related to continuity of care. And the last thing I'll focus on which is so important is enforcement. Enforcement in this space is so important because just having the rules on the books without any teeth can lead to them not being adhered to. And in order for this to truly make sure that plans are utilizing it and going to actually make the meaningful changes necessary to impact patient care it’s important to have enforcement. I think this model does a great job on that.

Again, as it stands this model is great - if there are things that I would recommend potentially tweaking, the model requires the plan to have an electronic standard for all physicians that are submitting prior authorization to use the same electronic standard. However, it allows each plan

to have their own specific way of doing it and it can be portal based. And what that can lead to for a physician is I've got 15 different insurers I am working with and I'm going to have to still navigate 15 different online portals. I'm going to have to log into each one to extract information for my EHR and upload them to their specific portal. And so, while that's a much better system than using fax machines I think because of some of the requirements that plans are going to be able to be required to adhere to there are federal requirements that the same form is used across plans. There's the National Council for Prescription Drug Programs (NCPDP) for prescription drugs and the Da Vinci standard for the Medicare Advantage program that I talked about earlier. I think moving to that instead of requiring each plan to devise their own way in which they're doing it will standardize and make sure it's more efficient. I mentioned post-acute care earlier and I think rather than have a specific carve out for post-acute care and as to how to addresses prior authorizations, I think one way to make sure that the problems with post-acute care access to care would be satisfied is for this model to classify all post-acute care authorizations as urgent. You don't want a patient waiting, they're already ready when this prior authorization is being submitted, they're ready to transition to the next stage of care, you don't want them waiting seven full days to find out whether they're approved, and then subsequently having appeals processes. It's better to make that a quicker process so you don't have patients waiting in an acute care bed to figure out if they can go to the next stage of treatment.

Reporting requirements in this model are extremely important because we want to make sure we can track how plans are doing it. However, it's based on aggregate data instead of service specific data, and the reason I found that to be potentially problematic is, if you're trying to figure out is a plan denying too many prior authorizations, are there too many being upheld on appeal, that might almost encourage more prior authorizations so that you can have more readily approved prior authorizations on the front end so that your aggregate number looks better as opposed to if you've got a high denial rate on specific services. And so, in order to make sure you classify the problem areas, I think it's good to have some form of service specific data reporting. Regarding reviewer credentials, I think the language on making sure that appropriately trained physicians are reviewing appeals is important. But I think that should be moved forward to all denials, not just appeals. And that's kind of a compromise. You're not necessarily requiring all prior authorizations to be reviewed by that physician, but if you are going to issue a denial it has to be reviewed by an appropriately trained clinician reviewer. My key takeaway is this is an area ripe for reform and I want to stress the plans are already required to follow most of these provisions because of the Medicare Advantage requirements, so health insurers can do this. This model is fantastic and the AHA stands ready if there's any desire to work on any language or anything related to this model.

Sam Martin thanked the Committee for the opportunity to speak and stated that I'm currently an attorney and lobbyist in Mississippi and I previously served as staff attorney for the Mississippi Senate Insurance Committee. I just want to give a brief overview of the Mississippi bill as it really came through the process of a lot of compromise along the way. It was a four-year ordeal of really figuring out what would work in our state amongst all stakeholders. We started in 2022 with the prior authorization bill that also included gold card legislation. That bill died pretty early in the session and ultimately, we decided to take the gold card legislation out of the bill when we introduced it in 2023. The bill in 2023 ultimately passed more or less unanimously, ultimately to be vetoed by the Governor. Some of the Governor's concerns really were traced to the fact of some of the timelines and essentially a lot of those timelines what we did was we basically doubled what they were. So, for urgent circumstances we required a 24 hour turnaround and so as a compromise we changed it to 48 hours. In non-urgent circumstances, we had it at a two-day turnaround, and we changed that to seven days. And perhaps most importantly, we previously had the Department of Health overseeing the whole administrative process. And the

Governor particularly did not like that because he thought that the Department of Health, since it provides care at county health departments in the state, could potentially have conflicts of interest. So we changed that to the Department of Insurance, which we feel actually made the bill a lot stronger because the Department of Insurance already has oversight over many health plans and has the ability to audit those health plans and ultimately punish them if they do not comply with the bill. Once we passed that bill in 2024, we had the thought that if the Governor were to veto it, we could come back and override it or pass another bill that took into account any sort of his considerations. I think you all can appreciate that over a four-year process, this bill took many different curves and ultimately a lot of compromise occurred along the way. We got it done, and I'm proud that Mississippi was able to do that.

Emily Carroll, Senior Legislative Attorney at the AMA, thanked the Committee for the opportunity to speak and stated that it was such a pleasure to speak to you all in November when we started talking about this issue, and we're thrilled to see this model being offered. Thank you to Sen. Michel for offering it and all the work that's been done in Mississippi to address this important issue. I know when I was here in November, I spoke a bit about our prior authorization statistics and annual survey that we do of physicians, and I won't go too deep into those statistics again or that information. But I do want to let you know that we reissued our annual report in February and the numbers didn't look much better. Prior authorization is still an incredible burden on patients and physicians in the healthcare system. On this slide, I'll just want to highlight again that box in red, 29% of physicians report that prior authorization has led to a serious adverse event for a patient in their care. So, I really would argue that the time is right for reforming this process and protecting patients.

On the next page I'll just again highlight the burden this places on physician practices. Certainly, in the face of an existing physician shortage we're asking physicians to complete 39 prior authorizations per week, that's per physician not per practice, and that adds up to about 13 hours each week completing prior authorization, so a whole workday. And practices are hiring staff just to do this alone, talk about burnout for an individual who is required to argue with insurance companies all day long on behalf of sick patients. And then we know the impact this is having on employees and their employers – 58% of physicians report that patients in the workforce are being impacted, their job performance is being impacted by prior authorization and the delays and denials that come with that. And then finally, just generally there is a waste in our healthcare system as we squeeze the balloon on one end by not allowing access to medically necessary care, we're inflating it on the other end. So, we're seeing tons of use of unnecessary medical services, medical care, like hospitalization, emergency room visits, unnecessary appointments with your physicians as a result of this prior authorization process. So, 88% of physicians reported that prior authorization leads to higher overall utilization of healthcare. As you all know, so many states in this room have already started to address the issue of prior authorization and we're just so grateful for the momentum that's been building in the states on this issue. I think there were over 100 bills this year introduced that addressed prior authorization, some big massive reform bills, and some very targeted bills that are a result of perhaps a patient situation in a state or a legislator experiencing the process. But we continue to see that momentum and we know you all are working so hard to do that.

Over the last year there were about 12 prior authorization laws enacted in the states, and over the last several years we've seen about 20 states enact really broad comprehensive bills that really try and address this problem. And we see those states come back and try to add on. Kentucky's a great example as you passed wonderful legislation over the years and then you continue to come back and improve the process and address issues that come up and we're grateful for that work. So, going to the model, we think this is a fantastic start. It addresses so

many of the critical problems that we see with prior authorization, including the transparency and integrity of the clinical criteria. If you're starting with bad clinical criteria on the plan side, all this other stuff doesn't really matter because if we're not addressing medical and necessary care using evidence based standards then we're not going to get the right care at the right time. And physicians and patients need to know what that criteria is. So we much appreciate that transparency that's offered in this model. The notice of new requirements, that's a big thing. When it feels like these prior authorizations to physicians and patients are constantly changing, especially in the drug space, as rebates and other things are negotiated over time, it's really important to give notice as these new requirements come up so you don't find out when you get to the pharmacy counter that prior authorization was required and you lose a patient to treatment abandonment or whatever else happens.

The data and metric reporting, it's great to have that information both available to the patient who is looking at plans that might be appropriate or not for them based on their medical conditions, but also as states continue to come back to the issue of prior authorization, that data is so important to consider new meaningful reforms for their states. So we love both that plans are required under this model to publicly report that information, but also that that information and that those metrics are going into the Department of Insurance, so that regulators can be looking and studying the impact of prior authorization on patients. Regarding the prohibition on retroactive denials, oftentimes we hear prior authorization is not a guarantee of payment or coverage. We think that it probably should be. If you're going to go through the process of getting a prior authorization and determining that care is medically necessary, we don't want that later cost shifting onto the patient or physician as a result of a denial when you've counted on that prior authorization for approval. So, we were glad to see that in this model. There's also several continuity of care provisions that we thought were just fantastic. That grace period for patients when they move from one plan to another and not having to start over with the prior authorization right away. Giving the patient that 90 days to navigate the new plan and get coverage for that care really will prevent disruptions in care and the loss of function or negative impact on patient outcomes that comes with those delays.

And then preventing disruptions when there's a change in coverage criteria on a patient who may be stable on a medication or service and ensuring that those changes that are going on in the administrative side of the plan are not impacting the health outcomes of patients. And then finally, the enforcement provisions in this model are great - we continue to see in the states when some of these laws pass that enforcement may lack a bit whether that's because it's unclear for the physician and the patient what kind of coverage they have, is it state regulated or not? Where do they go to report problems? I think the enforcement provisions in this model are excellent, especially allowing the physician to have the ability to talk to the regulator and to report problems, that's not something we see in every state. If I were to nitpick, there were a couple of things that I would suggest changing. We just heard from Mr. Martin that they originally started with tighter time frames on response times. We know that longer delays impact patient outcomes. So, 93% of physicians report care delays, and 82% report treatment abandonment, and 29% report those adverse events that we talked about. And there's a lot of data out there that looks at the harm associated with these delays. Another one I put up here is an American Society of Clinical Oncology (ASCO) survey that said those treatment delays cause things like disease progression and death of patients. So it's really important that those response times from the plans are tight.

We would recommend 24 hours for urgent and 48 hours for non-urgent care. We think that's really doable. I'll note that the Part D standard is 24 hours for urgent and 72 for non-urgent. So, these standards exist at the federal level. And then we have several states that have been able

to enact legislation that puts 24-hours for urgent care - Vermont, Kentucky, New Mexico are some of those. And then we have a bunch of others that do less than the seven days - California, Illinois, Iowa, Wyoming, so these timeframes are existing in another states and we would urge some edits to the model to reflect those. The length of the prior authorization is another area I would mention. When you have a chronic condition, those chronic conditions don't go away but why are we asking this to return to their physicians, experience the delays that are associated with prior authorization again and again? I really would recommend reflecting what's at Medicare Advantage plans now as a result of the new rules that were mentioned that the prior authorization should be approved for as long as needed for the treatment so that we're not asking patients to return and we're not wasting resources as folks go back and forth from their doctor's office to get those prior authorizations. Several states have enacted legislation around reducing those repeat prior authorizations, including Vermont, Minnesota, the District of Columbia and Colorado most recently. And then finally, the qualifications of the reviewer at the initial level. We appreciate putting some requirements around who's reviewing denials at the appeals level, but so few prior authorizations actually get to those appeal levels. Our survey says that about 75% of physicians say denials are increasing in the last five years, but only one in five say that they always appeal and some of those reasons can be a perceived outcome that they're going to lose on appeal since there may be a lack of resources and they don't have the staff time or ability to put all those prior authorizations through the appeals process, or because the patient needs the care right now, so they look for a less desirable alternative as they need to address the patient's situation immediately.

A Kaiser Family Foundation (KFF) study said that only 11.7% of Medicare Advantage prior authorization denials were appealed, but of those, 81.7% were overturned. So, when you do appeal, it shows the decisions were usually wrong the first time on those appeals, but unfortunately so few folks are getting to that appeal level. So, we need to make sure that the decisions are being made correctly at the initial review level. And so we would really recommend that the reviewer at that level, if they're recommending a denial, that it be reviewed by a licensed physician in your state of the same specialty and with experience treating that condition. This language is reflected in new Medicare Advantage rules and we have a bunch of states that are adopting language around there including Arkansas, D.C., Kentucky, Oregon, Pennsylvania, Rhode Island, Tennessee, Washington, and Wyoming. So, it's a really important provision as we need to make sure we're getting prior authorization decisions right the first time. I would just like to say the AMA is here to offer any help and would love to see this model adopted by NCOIL and we're happy to offer any resources.

Miranda Motter, Senior VP of State Affairs and Policy at America's Health Insurance Plans (AHIP), thanked the Committee for the opportunity to speak and stated that AHIP is the national trade association that represents the health plan community, over 120 health plan members providing access to health care through health insurance to 205 million Americans all across this country and residents and constituents sitting in each one of your states. Certainly, our member plans offer a wide variety of coverage in the individual market, in the employer market, in the Medicare market, in the Medicaid market so we're partnering with your states on the ground and certainly for many of you through state employee plans and self-insured coverage. I am really pleased to be able to be here with my provider partners to really talk about this important issue. I know at various points in time we have been sitting together and really talking about how to improve prior authorization. So, what I'd like to do is just spend a couple of minutes talking about why prior authorization is used, who uses prior authorization, how it is used, and certainly talk to the improvements to prior authorization. Again, I know many of you know that in 2018 we all sat together and looked at what those improvements can be and talked about those. And

then I'll just quickly end with a couple of comments on areas in the model and we certainly look forward to further discussions over the course of the year with all of you on this important topic.

So let me just quickly start with what is prior authorization. Prior authorization provides a vital check and balance to ensure that patients receive safe and evidence-based care and to reduce low value and inappropriate services so that ultimately coverage for those patients and for the individuals that offer that coverage to patients, mainly through employers in your communities, is as affordable as possible. We all know that doctors provide important care and life-saving treatments, but we also know that we have been impacted by low value care. Low value care is that kind of care that has little or no clinical benefit and where the risk of the harm for that care really outweighs the benefit. And low-value care has a significant impact on our health care system, and, more importantly, it impacts patients. The U.S. spends more on health care than any other country and many experts agree that up to 25% of care that is provided is wasteful at best and harmful at worst. And in addition to low-value care and how it impacts our country's health care system, low-value care exposes patients to harm and imposes additional out-of-pocket costs to that care that they are receiving that may not be appropriate. And it certainly impacts their quality of life as 87% of doctors have reported negative impacts from low-value care. So, 87% of doctors themselves have reported negative impacts. They have also reported that at least 15% to 30% of medical care is unnecessary. The other thing that I always like to talk about is that medical knowledge doubles every 73 days, and to keep up with the pace of those changes, primary care providers would have to practice at least 27 hours a day. So this is why this discussion is so important. It is important that health plans, doctors, hospitals, are all working together to reduce that low-value care and protect patients from unnecessary and potentially harmful costs in care. And going to who uses prior authorization, it's really important to remember that private and public markets and purchasers utilize prior authorization - employers, employers in your community in the fully insured market, in the self-insured market, state employee plans.

Many of you receive your own health care coverage through your state employee plan that may be self-insured, and it utilizes prior authorization. Medicaid plans through the programs that they are trying to initiate, making sure that value and the care that state taxpayers are paying for is high value and is outcome-driven, they impose prior authorizations. Regarding how health plans use prior authorization, health plans use prior authorization selectively, focusing on clinical areas that are prone to extreme variation in cost or misuse that can harm patients or saddle them with unexpected or costly medical bills. So let me spend a quick moment on selective use, because this is really important. Prior authorization is selectively used, targeting low-value, unsafe, inappropriate care and not consistent with evidence-based clinical guidelines and where there is wide variation in that practice. And a recent survey of AHIP members commercial plans, the kind of coverage that we're talking about through this model, reported that the majority of commercial claims are not subjected to prior authorization. So, for an average commercial plan approximately 96% of pharmacy claims are not subjected to prior authorization so that means only 4% are. For an average commercial plan, approximately 93% of medical claims are not subjected to prior authorization - only 7% are. As I point out on this slide and what the data shows I would also just note that as you're looking through all of our statistics, it's really important to make sure that the statistics follow the markets and what this model is addressing. And I would just note a couple of the statistics that Mr. Cunningham mentioned are related to Medicare Advantage and it's not that those aren't good to look at, but I would encourage you all as you see the links and the bullets, to make sure that you're going to the statistics and understanding what kind of patient is actually impacted. Because we're wanting to make sure everyone understands that this model looks at the fully insured market, the Medicaid market,

which all of you have an instrumental impact in making decisions on because you're making financial decisions and care decisions, and then again, your own state employee plans.

Let's talk a quick second about improvements. As I said, at least three of our organizations sat at a table back in 2018 and made a strong commitment as organizations. One, really committing to the fact that we all recognize that prior authorization is burdensome for all involved, for providers, for patients, for health plans. But in that consensus statement, we all agreed, quite frankly, that prior authorization was important because of the variation in the kinds of care that is happening today. Health plans have worked hard to improve the process both for providers and patients and taking action to make sure that we're all working towards this shared goal. The efforts really include waiving or reducing prior authorizations for providers with a demonstrated track record and practicing evidence-based care through gold carding programs. I know that we've heard references to gold carding legislation that may be pending. Gold carding programs are really important when there is an ability to make sure that that provider has a high track record of evidence-based care where it's a contracted provider so there's a relationship and there's an ability to make sure and review that providers practice on an ongoing basis. Again, making sure that the patient is at the center of that. The other thing I would note is that gold carding programs work and are really important when they are part of a value-based relationship. So where that provider is actually at risk for the kind of care that they're getting from a financial and an outcome based perspective, those really work. In instances where they're not, it can be really challenging. Also streamlining prior authorization, plans have been doing that for certain chronic conditions to promote continuity of care. As you can imagine, that is extremely important for continuity of care. I would say that perhaps the most impactful approach to streamline prior authorization is to invest and promote electronic prior authorization. The commitment that we all sat here in 2018 and made was electronic prior authorization (EPA). And EPA has shown to simplify prior authorization requests to shorten decision times and to lower administrative burdens on providers and plans alike. And we know this.

I won't go into a lot of details, but after that consensus statement, health plans really worked and put together what was called a fast track, a technology portal, and we worked with providers and really went into their offices and said, okay, we're building the electronic system. You use that electronic system and let's see what happens. And really what we found, the providers themselves said that it was quicker to decision, quicker to patient care, less burden from phone calls and faxes. And this one is really important and I know I noted this back in November when I spoke, but there is a significant potential reduction for that time. We know from our data that today at least 60% of prior authorizations for medical services are still submitted in a manual way and similarly 40% of prior authorizations for prescription drugs are submitted in a manual way. We also know, and I know Ms. Caroll said this in November that her own members report that their main mode of submission is by phone. And I say it again because it’s really important and many of your states have recognized how important that this is and some of the legislation that Ms. Caroll talked about and others talked require that not only plans build an electronic system, but that actually the providers are using it. Because if we're building a system that's not being used, we're not all really working towards reducing the administrative burden, ultimately for the patient, ultimately getting that care quicker to the patient and reducing the time for providers. We know that at least nine states plus D.C. have passed this two-way legislation that requires health plans to accept it and providers to actually use it. And in some states where there are turnaround times included in that legislation, they actually require the provider to use it to avail themselves of the quicker turnaround times, which makes a lot of sense. If you're going to have a quicker turnaround time, you should be submitting it electronically.

I'll end by saying thank you and I did want to quickly highlight a couple of the things relative to the model and I look forward to the opportunity to continue to talk about this. I would say first, I think it's really important given that the model applies to your state employee plans, your Medicaid programs, and employees, to really sit down and talk to them about how they use prior authorization. I think it's also instructive to listen to your self-insured employees. I know that the AHA is self-insured and knowing how they use prior authorization for their own employees I think is really important to know from a safety and a cost perspective. The other thing I would say is I appreciate in the model the recognition that electronic prior authorization is important, both for plans and providers, so that provision is in there. And it recommends that for providers to avail themselves of the quicker turnaround times, they have to use that system. And again, we just ask around turnaround times for more discussion. Certainly, we've talked about a lot of turnaround times in terms of consistency and uniformity for providers and that will be important. And then for continuity of care, we look forward to that conversation as we move forward.

Rep. Jim Dunnigan (UT), NCOIL Secretary, asked Ms. Motter about the data from HHS on Medicare Advantage and whether that's applicable and has a high correlation to the other commercial plans. Ms. Motter stated that it's really good to look at that data and understand what the data is saying. I think ultimately from a Medicare Advantage perspective, Medicare is driving better care, it is driving better costs, and Medicare Advantage individuals like their plans. And so I think it's important to look at all statistics, but I also think it's important to make sure as you're thinking about the markets that the model would govern that you're actually talking to the purchasers and the stakeholders that would be impacted. Rep. Dunnigan stated and regarding electronic requests, I think that makes a lot of sense. If somebody wants to get a quick turnaround time, it should be submitted electronically. It speeds it up all the way around. My final question is, one of the criteria is patient flexible criteria. Can you do that? Can you have a quick turnaround and still meet patient flexible criteria? Ms. Motter stated what I would say is certainly today health plans have to adhere to turnaround times and almost all plans are accredited by national accreditation standards. I'm not quite sure what patient flexible criteria is. Ultimately at the end of the day, you want the patients in your districts to be getting evidence-based clinical, safe care and I think that's probably an area we should continue to talk about.

Rep. Dunnigan asked if patient flexible criteria is defined in the model? Ms. Motter and Mr. Cunningham stated that they don't believe it is. Rep. Dunnigan stated that it would seem to be very important to have that defined if it's in the model. Mr. Cunningham stated it sounds like something we need to include in there. It generally means if you have a general set of medical necessity for a patient, it might say that this patient does not meet this particular level of treatment because there's a different drug they should be taking. But if that individual patient is allergic to that specific drug, they might otherwise need to qualify for it so I think what they want to make sure is that a bright-line set of rules doesn't lead to a denial that might be specific to that patient. Rep. Dunnigan questioned who determines those guidelines and stated that it seems that they should be defined.

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, stated that I want to thank Sen. Michel for bringing this model forward. I do think prior authorizations are important. They lower the cost of health care. The data that I've seen is about 30% of the time for any medication, if you put a prior authorization on it, it will reduce the number of requests for that. So, it is an important cost-containment strategy and I think I like the fact that we're reforming it rather than getting rid of it because I think our costs would be much higher. I also hope everybody remembers that prior authorizations, by definition, involve decisions about medical necessity. That is and always will be the practice of medicine. It can't be anything else. And so, it's important as we contemplate this model that we keep in mind that the practice of medicine

should be accountable. And people who are practicing medicine should have sufficient expertise and specialty, and they should be accountable to the state that passes the law. Because that is the mechanism by which we regulate the practice of medicine, nationally speaking, is that for each state that a person's practicing medicine and making decisions in, that state needs to be able to regulate that provider's behavior in case they grossly fall below the standard of care and need to be held accountable. So I just want to offer that up. I think it's really important that we keep in mind that prior authorizations are the practice of medicine.

Rep. Pollock stated that I know there are a lot of questions on this issue but we do have to keep on time. I encourage you to e-mail NCOIL staff, myself, or Sen. Michel with any questions because obviously this is truly a big deal for all of our states. And we want this to continue today but due to time, we're going to get one more question and then we've got to move on. In terms of process for this Model, I would like to continue the conversation at our summer meeting Chicago and then make any changes to make the model as good as it can be. And then come November, I hope we get the model over the finish line so we can take it back to our states.

Sen. Lana Theis (MI) stated that having been on the wrong end of a prior authorization, I certainly understand the issues that are being brought forward. However, I have one general question for all of you who have presented. Do your companies provide self-insurance, and do they use prior authorization for your insurance? Mr. Cunningham stated that I believe there is prior authorization on some of the insurance that is offered. And again, I think the key thing here is we're trying to reform prior authorization, not do away with it. And I think making sure that it is administered in a way that is not disruptive to patient care is important because yes, it does achieve cost reduction and that is an important thing. But if it's being administered in a problematic way, you're kind of stuck either way. And so I think what the power of this model could be is allowing prior authorization to still serve the purpose that we see, cutting unnecessary spending for particular services, as Rep. Oliverson said, but having it done in a way that doesn't lead to detrimental patient outcomes. You're kind of caught in a no-win situation, and that's where this model could really fix this. Ms. Carroll stated I absolutely agree. We do use prior authorization. But we use the term a lot, right-sizing prior authorization. We think it's overused generally, but our goal is not to get rid of it. We want to bring it back to what it originally was meant to do, which is target high costs and new treatments on the market and not used for things like generics and other every day tools.

DISCUSSION ON RESOLUTION REGARDING AUDIOLOGY SERVICES, HEARING INSTRUMENT SPECIALISTS SERVICES, AND CLASSIFICATION OF NON-OVER THE COUNTER HEARING AIDS AS PRESCRIPTION DEVICES

Next on the agenda is an introduction and discussion on a resolution on issues regarding hearing aid classification. At our fall meeting in San Antonio, my friend and colleague, Rep. Deanna Frazier-Gordon (KY), who couldn't make it here today, raised this issue for potential discussion and now we have this draft resolution before you, which I'm proud to sponsor alongside her. You can view the resolution on the app and website in your binders on page 34. This deals with changing state law in light of a recent regulatory change from the U.S. Food and Drug Administration (FDA) regarding classifications of both over-the-counter and non-over-the-counter hearing aids. That classification has resulted in confusion among practitioners and policymakers at the state level, which is why the change in law is necessary to clarify things.

Julian Roberts, President & CEO of the American Association of Payers, Administrators, and Networks (AAPAN), thanked the Committee for the opportunity to speak and stated that this is something that we somewhat see as a technical fix that is needed due to passage of regulations

by the FDA. It is an access to care issue from a payer and patient perspective, and this has been addressed to some degree in about 22 states, either legislatively or regulatory-wise. And from an issue basis, it's something that not only audiologists and hearing aid instrument specialists deal with but plans and other organizations are jointly working together to pass this in the various states. So we're very excited that NCOIL is looking into this resolution. In August of 2022, the FDA established a new category of over-the-counter hearing aids, while classifying all non-over-the-counter hearing aids as prescription medical devices. This change, which took effect in October of 2022, means that traditional hearing aids, and those are hearing aids that are more common for those that have medium to more severe hearing loss, can now only be obtained with a prescription or order from a state-licensed practitioner. This policy shift was intended to improve safety and oversight, but it has created confusion. The FDA does not have the authority over who is licensed to prescribe or order hearing aids. That power rests with the states. The FDA's own guidance makes it clear that it was never their intent to disrupt access to hearing aids dispensing by state licensed audiologists and hearing instrument specialists.

In fact, the FDA explicitly stated that the same professionals who recommended, selected, fitted, and dispensed hearing aids before the new rule should continue to do so now. However, many state laws and regulations have not yet been updated to reflect this intent. As a result, there is uncertainty about whether hearing instrument specialists, who have long played a crucial role in recommending, fitting, and dispensing hearing aids, are still authorized to provide these essential services for prescription drug hearing aids. This uncertainty threatens to limit access to care, especially for those in underserved or rural communities where hearing instruments specialists are often the primary provider of hearing health services. If we do not act, we risk creating unnecessary barriers for patients, undermining insurance coverage and reimbursement policies, and disrupting a system that has worked efficiently and effectively for decades. So, I urge your support for this resolution to make it clear that licensed hearing instrument specialists, along with audiologists, have the authority to order hearing aids. This action will ensure continuity of care for patients who rely on trusted hearing instrument specialists, prevent disruption in insurance coverage and reimbursements, align state laws with FDA guidance and long-standing practice, and protect access to hearing care for those who need it, especially vulnerable populations.

Rep. Pollock thanked Mr. Roberts for this comments and stated that we'll continue this discussion at our summer meeting.

CONTINUED DISCUSSION AND POTENTIAL CONSIDERATION OF NCOIL IMPROVING AFFORDABILITY FOR PATIENTS MODEL ACT

Rep. Pollock stated that next on our agenda is continued discussion and consideration of the NCOIL Improving Affordability for Patients Model Act. You can view the model on the website and app in your binders on page 37. We've been discussing this issue since last year's spring meeting and I do think we're at a point where the model can be considered. Of course, if during our discussion today it becomes clear that we need more time to get it right, we can always pause things but I do think the model is very strong as is. Before we go any further I'll turn things over to the sponsor of the model, Rep. Oliverson.

Rep. Oliverson stated that I want to begin by saying how proud I am to be able to carry on this work that was actually started by past NCOIL president Rep. Deborah Ferguson, DDS before she left the Arkansas legislature. We appreciate her leadership very much on this issue and I'm honored to be able to pick it up and carry it. This model is really focused on one area of facility fees charged by a facility and that is situations where facility fees are charged when a patient is

seeing a physician in an office that happens to be owned by a facility. And I have to tell you, as a physician, I have some pretty strong feelings on this. I see this as a recent issue that has come up only as a result of vertical consolidation. I grew up in a healthcare world where there was no such thing as a facility fee charged on an evaluation & management (E&M) code, and I think that most physicians probably feel that way unless they happen to be employed by a hospital that can levy these fees. And I see it as being particularly harmful. I will tell you that this is the e-mail I get more often than not from constituents. They took their loved one to go see the doctor themselves, and they got a fee for the doctor, which they were expecting, and then lo and behold, they got a completely separate bill from a facility, which they were not expecting. And from a physician standpoint, the reality is that we all understand and know as doctors when we sign contracts with insurance plans that what you bill for when you charge for an E&M code type visit, the overhead cost of that visit is baked into the fee you get as part of your professional component. So, this relatively recent phenomenon is aggravating for patients, it's doubling or in some cases tripling the cost of health care for folks who are simply seeking to get medical advice and continue management of chronic disease. I do think that this model provides sufficient prohibitions while at the same time balances the need for certain exceptions and provides transparency. I am strongly supportive of this and it's my hope that we adopt this today.

Randi Chapman, Managing Director of State Affairs at the Blue Cross Blue Shield Association (BCBSA), thanked the Committee for the opportunity to speak and stated that the model effectively addresses the trend that we've been seeing with higher costs in hospital outpatient departments in those settings. Having certain limitations on certain facility fees and requiring unique provider identifiers distinct from a facility's main campus and other off-campus facilities are very important steps to chip away at the higher health costs for patients. As we all know, health care costs are astronomical, and we are all trying to work together to do what we can to ensure that patients are able to access the care they need in the most affordable way possible. We at BCBSA want to thank NCOIL and this committee and Rep. Oliverson for his leadership in this area as well as former member Rep. Ferguson for her leadership in this area. And as always, we stand ready to partner with you all and help out in any way we can.

Eric Waskowicz, Senior Policy Manager at United States of Care, thanked the Committee for the opportunity to speak and stated that we're an organization that ensures everyone has access to affordable health care. We just want to express our strong support for this Model. It very much aligns with our work on the issue and legislation passed into law in 18 states. In addition to this model here, we also encourage the committee, where possible, to consider establishing other protections for patients, including some sort of analysis to understand the impacts of facility fees on people's access to care, as has been done in Colorado and Maine. And also, when you're thinking about how to identify where facility fees occur, we found that it's actually kind of difficult to make that connection sometimes and we encourage the committee to consider language that would create some sort of mechanism by linking affiliated providers and systems by requiring some sort of identifier. And looking at the future as this committee considers further ways to lower health care costs, we urge you to consider site-neutral policies that would allow for fair billing practices to make sure that no matter where someone accesses care, the care is the same regardless of the site of service. I want to thank Rep. Oliverson for his leadership on this model and just want to appreciate the opportunity to speak and support this bill here today.

Rep. Brenda Carter (MI) thanked Rep. Oliverson for sponsoring the model and stated that it’s sorely needed.

Hearing no further questions or comments, upon a Motion made by Rep. Carter and seconded by Sen. Mark Johnson (AR), the Committee voted without objection by way of a voice vote to adopt the Model.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Rep. Pollock stated that next on our agenda is a consideration of re-adoption of model laws. Per NCOIL bylaws, all model laws must be re-adopted every five years or else they sunset. The models up for re-adoption are on the app and website and appear in your binders starting on page 48. The models are the Transparency in Dental Benefits Contracting Model Act and the Short-Term Limited Duration Interest Model Act. We'll handle these separately as there are different processes with each model. Starting with the dental benefits model, Sen. Justin Boyd (AR), and Vice Chair of this committee ,is sponsoring some proposed amendments to the model and Asm. Jarett Gandolfo (NY) is co-sponsoring the amendments as well. We won't be taking any action on the amendments today. For now, the amendments have been offered by the sponsors for the committee's consideration to discuss throughout the year. Before we go any further, I'll recognize Asm. Gandolfo for some brief remarks.

Asm. Gandolfo stated that I will be brief and just say I think these amendments will go a long way in improving the dental care experience for patients, and that's what a lot of us are here to seek to do as the patients are our constituents as well. And I think it is prudent for NCOIL to always look for ways to improve our models. But with that said, I would hope and I would ask for after we hear from our speakers today that the model be readopted until our next meeting to give us ample time to discuss the proposed amendments.

Chad Olson, Senior Director of Gov't Affairs at the American Dental Association (ADA) thanked the Committee for the opportunity to speak and stated that I'm here to provide introductory comments on the proposed amendments to the model. These amendments represent important progress toward improvement in dental insurance for patients and providers. So, there are three basic things that the amendments accomplish. First is tightening up language in the model to reduce confusion. For example, in the current version of the model there are various terms used for dental insurance coverage including "dental plan" or "benefits." The amended language simplifies this to "dental benefit plan." Second is improving the model language based on real-life patient and provider experience. I have an example - the current model is not specific about how long a dentist may opt to not receive a virtual credit card as payment. What we have found is some dental plans react by only honoring that choice once or for a certain time period, and then revert back to paying with a virtual credit card. The amended language would make the choice permanent unless the dentist proactively wants to receive a virtual credit card as payment. Third is the amendments incorporate into the model two additional issues that fall under the umbrella of transparency in dental contracting. These are, first, a time limit on retroactive denial - basically the ability of a dental plan to claw back claims they have paid. And second, the ability of a patient to choose to have an out-of-network dentist be paid directly by a dental plan. That's otherwise known as assignment of benefits. And I know Rep. Pollock, you recently were sponsoring legislation like this successfully in Kentucky. The model language is much like what was passed in Kentucky. These simple and reasonable reforms are critically important protections for patients and providers, reducing financial barriers to seeking and receiving care. There's an old adage, "if it ain't broke, don't fix it." I have no doubt that the opposing witnesses up here with me today plan on emphasizing that point but NCOIL's model laws should not be viewed as immutable objects. Instead, the model laws should be nimble and responsive to changing landscapes and new data and the reauthorization process for the model acts is exactly the time to make considerations like those in the proposed amendments. I would

like to emphasize how important these reforms are for patients and providers. Laws based on the model continue to improve the dental plan benefit experience, eliminating some of the confusion in what is often a difficult process and empowering choices to help maximize the value of the dental plan policies. Improving the language, as these amendments will do, will only amplify this effect. I would like to thank Sen. Boyd and Asm. Gandolfo for sponsoring these needed amendments and I'm happy to answer questions.

Bianca Balale, Director of Gov't Relations at the National Association of Dental Plans (NADP), thanked the Committee for the opportunity to speak and stated that NADP's members represent more than 200 million Americans with all different types of coverage and I appreciate the opportunity today to comment on the amendments that Mr. Olson laid out. First and foremost I certainly want to acknowledge the hard work of this group in adopting this model in the first place. The original model represents very strong public policy and that's demonstrated by the broad adoption we've seen across the country with 11 states implementing the virtual credit card provisions and 15 adopting the network leasing provisions. The current set of the proposed amendments that are before us now introduce major new concepts to the readoption process. They are extremely impactful and complex and need further consideration. We believe these changes go far beyond the scope of a typical readoption process and as I mentioned do require additional conversation. Currently we're actively gathering feedback from our members at this stage and need additional time to discuss the scope and impact which we would appreciate this model being renewed until the next meeting to allow us that time. We want to ensure that we understand the intent behind the changes because the intent is critical in ensuring we're responding appropriately. And we want to ensure the process reviews all possible consequences of the amendments that are being proposed. As I mentioned we are still reviewing these amendments, but upon initial review from a very high level, the shift from a opt-out to an opt-in in the leasing and virtual credit cards provisions would result in a significant increase in burden on both plans and providers. A change that would remove electronic communications also would cause severe inefficiencies that may raise costs both on plans and providers. And we also believe that the payment parity for in-network and out-of-network providers undermines the values and integrity of the network structure. And finally, the shorter timeframes to recover overpayments and erroneous payments, particularly the inability to recover payments from our network providers, which is included in these amendments, raises severe fairness concerns. So respectfully, we would like to have a robust conversation about the policy rationale for these amendments and we would like to ensure we have the time needed to review them and finally, limit the scope of the readoption to the current provisions of the Model Act. New or substantial revisions should be considered through a thorough and separate process to ensure that it's properly vetted.

Owen Urech, Senior Policy Advisor with America's Health Insurance Plans (AHIP) thanked the Committee for the opportunity to speak and stated that I want to briefly echo NADP's comments. We support renewal of the model as it is currently written and would have some concerns about the impact of the substantial policy changes, not only to the existing sections that would be majorly reworked by the proposed amendments, but the additional language that included which are separate and significant policy issues that warrant their own discussion and process. We look forward to continuing to work with the committee on the readoption of the model.

Jill Rickard, Regional VP of State Relations with the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak and stated that life insurers do also write dental coverage and so many of our members are in this space as well. ACLI agrees that the proposed amendments are substantive and inappropriate for a model readoption. Some of them were actually considered and rejected when the initial model was proposed and drafted. They

would have the potential to significantly disrupt the way that the dental marketplace works currently and potentially harm consumers by raising costs and decreasing access to dental insurance. Along with NADP and AHIP, we'd like to understand the rationale behind some of the changes and discuss the negative impacts on consumers and the market, especially to help ensure that out-of-pocket costs for consumers do not rise at this age when medical debt is at an all-time high and consumers are looking for options to reduce health care costs. We look forward to further discussions on this.

Hearing no questions or comments, Rep. Pollock stated that I will entertain a motion to readopt the model until our next meeting in July rather than for the full five years. Upon a Motion made by Rep. Bill Sutton (KS) and seconded by Asm. Gandolfo, the Committee voted without objection by way of a voice vote to readopt the Model until the committee's July meeting.

Rep. Pollock stated next, we'll consider the Short Term Limited Duration Insurance Model Act for re-adoption. This model represents a rare instance of an NCOIL model not seeing any traction in our states. Based on staff's research and comments from some stakeholders the model hasn't been adopted in any states. In light of that and also because of the turmoil that surrounds this issue at the federal level I think it might be best to let this model sunset. There's ongoing litigation right now as well on this issue and then there is expected federal action as well from the new administration. Letting the model sunset of course doesn't preclude us from discussing the issue again and perhaps even developing another model, but for now, letting it sunset seems to be the best path forward. Of course, I'm open to hearing otherwise.

Hearing no comments about the Model, the Committee then voted without objection by way of a voice vote to let the model sunset.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Rep. Oliverson, the Committee adjourned at 1:00 p.m.