NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
INTERIM COMMITTEE MEETING – SEPTEMBER 19, 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, September 19, 2025 at 12:00 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. Rita Mayfield (IL)
Sen. Donald Douglas (KY)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Paul Utke (MN)
Sen. Hillman Frazier (MS)
Asm. Jarett Gandolfo (NY)
Sen. Pam Helming (NY)
Asw. Pam Hunter (NY)
Asm. David Weprin (NY)
Rep. Carl Anderson (SC)
Rep. Barbara Dittrich (WI)

Other legislators present were:

Rep. Jeff Cornilles (ID)
Rep. Daniel Vollmer (ND)
Asm. Ken Blankenbush (NY)
Asm. John McDonald (NY)

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, 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 today's meeting is to conduct some business ahead of the Annual Meeting in Atlanta in November to ensure that we can address the agenda there with efficiency and hopefully get some pending matters across the finish line. Today's meeting will focus on two model laws that have generated significant interest so far this year. The NCOIL Prior Authorization Reform Model Act and the Transparency in Dental Benefits Contracting Model Act. These models will not be voted on today. Instead, this meeting provides an

open forum for comments, questions, and discussion, giving us the opportunity to refine our understanding and prepare for hopefully a productive vote in November.

CONTINUED DISCUSSION ON NCOIL PRIOR AUTHORIZATION REFORM MODEL ACT

Rep. Pollock stated that we'll start by continuing our discussion of the NCOIL Prior Authorization Reform Model Act. As a reminder, this model was first introduced during the April meeting, and since then we've received extensive feedback from interested parties during and after the July meeting. A revised version of the model was distributed last week, which you can view on the website along with all other materials for this meeting. Unfortunately, the sponsor of the model, Sen. Walter Michel (MS), had a last-minute schedule change, so he wasn't able to join us today, but he will be with us in Atlanta in November. However, Sen. Michel did ask me to provide some remarks to everyone on his behalf, which he and I have discussed.

He apologizes for his schedule change, but he is looking forward to seeing everyone in Atlanta. The revised version of the model that was distributed last week does not represent a final work product. Rather, it represents the next step in the process that hopefully we will be able to finish by November. He is open to making modifications to the model and indeed the revised version reflects that, but he did ask me to make clear that he was frustrated by some of the comments submitted, particularly on the plan side, as they were so extensive that if we accepted them then the model would look nothing like the Mississippi law which serves as the basis for the model. Sen. Michel believes strongly in the Mississippi foundation, and while hearing everyone's perspectives is obviously an important part of this process, there's only so much to change before the model turns into something else entirely. So, with that Sen. Michel asked me to make clear that between now and November he will continue to review the comments submitted as well as the comments made today and he will make further modifications to the model but what's put forth in November isn't going to stray too far from what was originally introduced.

Hope McLaughlin, Senior Director of Gov't Relations at Elevance Health, thanked the Committee for the opportunity to speak and stated that the industry has done a tremendous amount of work in the states, and also from a national perspective, to simplify, reduce and streamline prior authorization including earlier this summer when the industry came together and really elevated our commitment to connect patients more quickly with care and minimize the administrative burden to providers. We released a series of measurable commitments to streamline prior authorization. We really appreciate the process that you all have allowed us to be a part of here. The collaboration on this model is really important, but there are some additional changes that we do hope to see made and we don't feel that they stray too far from the core purpose. As we are a national organization, like many of the folks on the call, we really think that the definitions that are included should be aligned with the federal definitions that already exist. Also on that note, the turnaround time should really be consistent with those federal requirements that are in the 2024 Interoperability and Prior Authorization Final Rule. We also think that this model is meant to address prior authorization, and therefore the model shouldn't stray too far from that. We don't need to blend in the claims process which is really a separate and distinct process from prior authorization. Some of the language in Section 12 of the model does that. And then as all the folks on the call here know, it's essential that we work together with our provider partners in this

process. And so, while carriers are required to implement the application programming interfaces (APIs) in this, there's no requirement for providers to implement electronic prior authorizations or APIs. And with that requirement existing for us, then we're really being required to build a bridge to nowhere. And so, it's essential to have that other connectivity with the providers if we want this to work to its best for our patients and our members. Those are the general overarching issues we see with the existing model and we look forward to discussing more with you and others on the details.

Sandy Guenther, Director of State Government Affairs for the American Association of Oral and Maxillofacial Surgeons (AAOMS) thanked the committee for their efforts on the model and stated that oral and maxillofacial surgeons are the surgical branch of dentistry straddling the medical and dental worlds. Due to their unique role, they are some of the few dental providers who regularly bill medical insurance. As noted in our comment letter sent in conjunction with the American Dental Association (ADA), we support the provisions of this model, but recommend further additions to ensure our members can be included in the protections offered. All of our members hold a dental degree, but only about half hold a medical degree. We're concerned, as currently drafted, those single-degree providers who perform the same scope of practice and engage in medical billing just like their colleagues with a medical degree would be unable to qualify for the protections found in this model. We urge these slight amendments to be inclusive of our membership and to be better positioned down the line as dental and medical care continues to integrate.

Terry Cunningham, Senior Director of Administrative Simplification Policy with the American Hospital Association (AHA) thanked the committee for the opportunity to speak about this fantastic piece of model legislation. I really like some of the changes that were made to the model. I just want to speak to a couple of additional changes that I think would support the intent of this legislation and move it towards a place of impacting even a greater degree of reform in this space. The first is the recent revisions include the pharmacy standard for a standardization process for pharmacy prior authorizations, but it doesn't include the corresponding medical services prior authorization. As mentioned, there's a federal standard that was released in 2024 and specifically involves utilization of the Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) standard. And so I would encourage, just as you included the National Council for Prescription Drug Programs (NCPDP) script standard, I would encourage you to include the aforementioned HL7 FHIR standard in the model as well, which would keep the state regulated processes consistent with the reforms that are going to be controlling the federally regulated processes, which leaves providers with a better situation of not having to do two different workflows depending on if the patient has a specifically governed type of plan.

The second thing I want to highlight is the need to encourage that in the appeals process, the review of an actual clinician for all denials and not just on the appeals process takes place. Currently, the process requires an adequately trained physician to review appeals, and that's obviously to ensure that denials of prior authorization are consistent with medical guidelines. However, that would require a patient to have to endure not only a denial and the delays associated with that, but then having to navigate the entire appeals process before they can have an actual trained clinician that would be responsible for ensuring that the denial is actually consistent with medical advice. I would encourage that change, which is consistent with federal law and other laws in this space, so that a trained clinician has to review all denials that take place rather than just

only those that are appealed by patients and their providers. And the final thing I would point out is I would encourage you to reconsider the recommendation that the model consider all post-acute care prior authorizations to be categorically considered urgent, and this is because of the nature of post-acute care, which is when you've got a patient who's already ready to be transitioned when a prior authorization takes place so any delay is a delay in which a patient's taking up a bed that is not needed for them and is not the optimal place for them to be rehabilitating.

Holly Bruggen, Senior Director of Gov't Affairs at the American Clinical Laboratory Association (ACLA) thanked the Committee for the opportunity to speak and stated that ACLA is the national trade association representing independent clinical laboratories. We want to share our support for the model, while also highlighting some recommendations that will help to better align prior authorization policies with the clinical laboratory workflow. Laboratories are suppliers of services and prior authorization policies can run counter to the basic workflow of laboratory testing resulting in denials for medically necessary services already performed. Importantly, for laboratory testing, the date of service is when the specimen is collected, not when the test is run. Thus, in practice, a physician or other clinician typically orders a laboratory test and sends the patient's sample, such as blood or tissue, to the lab with the lab order. By the time the patient's sample is collected, the date of service has already occurred, making prior authorization practically impossible. Our recommendations are really focused on aligning prior authorization policies with laboratory order processes in the following ways. One is requiring payers to accept prior authorization requests from laboratories as suppliers of services. Often, providers may not secure prior authorization before they collect that patient sample and submit the test order. So, we would really like to see laboratories be explicitly allowed to submit prior authorization requests for the services they perform.

Second, because of this date of service challenge, we would like to see payers accept prior authorization for clinical laboratory tests either before specimen collection or between specimen collection and the date that a timely claim is submitted to the plan. This helps to account for that workflow issue that I mentioned, and since we don't receive that order until after specimen collection generally, this flexibility would allow labs to secure that necessary information to submit prior authorization for these services before submitting a claim. Finally, laboratories generally only receive the test requisition form, which often includes a number of the necessary components to determine medical necessity. We would really like to see some language included that would require payers to request only medical documentation that is reasonably necessary to evaluate a prior authorization request including accepting the test requisition form as part of this medical documentation. We have a few other recommendations that we mentioned in our comments, but those three key pieces are unique to addressing some of the prior authorization challenges with the clinical laboratory workflow.

Chad Olson, Senior Director of State Gov't Affairs with the ADA thanked the committee for the opportunity to speak and stated I'm here to emphasize our support for the changes that were recommended by Ms. Guenther from the AAOMS. Those changes will show support for the idea that the mouth is part of the body, which is something the ADA very much supports and it's very important in a situation like an NCOIL model to establish that. We support consideration of the changes proposed by AAOMS to ensure that the maximum number of people are benefiting from this model.

Keith Lake, Regional Director of State Affairs at America's Health Insurance Plans (AHIP), thanked the committee for the opportunity to speak and stated that I want to start out by saying that we recognize that some of the red lines that we submitted to Sen. Michel are perhaps the cause for some of his frustration, but it wasn't our desire and design to stray too far from the model. In fact, we would argue just the opposite. We want to make sure that the model is focused tightly on prior authorization and doesn't stray into other areas beyond prior authorization. We also echo some of the comments that we've heard on here from Elevance and from some of the others as well. We think it's important that we align the model with the federal laws and regulations to have consistency. That will help avoid confusion for not only the plans, but also for patients and providers. Third, we echo the comments made by Elevance that we should focus a little bit more on a two-way street with respect to electronic prior authorization. We need the model to make sure that both plans and providers are moving away from some of the outdated manual submissions, which you've all heard at the meetings earlier this year, are still persistent in the process. And in fact, almost half of submissions today are still being submitted manually. And I think that we need to make sure that we strengthen efforts to require electronic submissions. So, we appreciate the fact that the sponsor and NCOIL are open to further edits to the draft. We'll go back and take a look at what we've submitted, but we would still hope to see some of the additional edits and red lines that we submitted earlier be considered for the next version of this model. I would just conclude by saying that if Rep. Pollock or Sen. Michel were to hold an offline work group with some of the stakeholders, we'd be very happy to participate and take the time to kind of dig more deeply into some of these issues.

Emily Carroll, Senior Legislative Attorney with the American Medical Association (AMA), thanked the Committee for the opportunity to speak and stated that we are really appreciative of many of the changes that were made to the model. I'll mention a couple of things now and I'll follow up with a letter that outlines a few more detailed suggestions. First, there is still a concern of lack of requirements around the qualification of the reviewer at the initial adverse determination level rather than putting those qualifications to some reviewer at the appeal level. We know from data that patients and physicians rarely appeal decisions and when they do they're largely overturned. But we just think making sure that there's a qualified physician with experience, expertise and training at that level is really critical to get it right the first time.

Also, in some of the reporting data requirements, we'd really like to make sure the data is as useful as possible and therefore move away from this aggregated data idea into ensuring that we're seeing data at the individual service level. The more granular we can be in that data, the more policymakers and other stakeholders can use that data to make meaningful reform changes in the future and really understand the black box of prior authorization that physicians and patients sometimes feel there is. So hopefully some of those changes to the data sections can be considered. And then finally, as a couple of folks have mentioned, we really appreciate your focus on a standard transaction for the drug benefit, but we'd really like to see that automation reflected for the medical services portion of the benefits. There are now federal requirements around medical services automation and we have included some of those suggestions in our previous letters and we just want to make sure that we're aligned with the federal standards so there is less administrative burden as the process is easier for patients and physicians when there is alignment.

Brian Warren, VP of State Gov't Affairs at Biotechnology Innovation Organization (BIO), thanked the Committee for the opportunity to speak and stated that we have some concerns around the response timeline requirements in the model and it seems like in some of the comments that have been submitted, people are urging extending those. We would generally align ourselves with the letter submitted by the AMA seeking to reduce those timelines and specifically, we would look at the federal timelines that have been put in place as a floor and not a ceiling. There are some timelines in those that are quite extensive and we fear would put patients at risk. But it does sound like something that perhaps a number of stakeholders on this should continue a discussion on because there doesn't seem to be a lot of alignment in terms of different organizations here.

Joe Hrdlicka, Senior Manager of Gov't Affairs at Genentech, thanked the committee for the opportunity to speak and stated that we do not want to stray from the intent of this legislation, but I would echo Mr. Warren's comments. We took a look at this and we want to make sure there's clarity on the timeline elements, particularly as it relates to emergency services situations. We have a few products in our portfolio where time is of the essence with a stroke or heart attack type situation so that raised concerns with us, but we hope to work with the group to make sure we have clarity on those elements.

Cara Cheevers, VP of Coverage Policy at Inseparable, thanked the Committee for the opportunity to speak and stated that Inseparable is a national mental health advocacy organization working to make sure that we are allowing folks to access the mental health care that they need with the insurance that they have. We generally very much support this model and appreciate and celebrate the amount of work that's gone into this language. We've got a few areas of recommendations for improvement and like the AMA suggested, we'd also like to provide a little bit more nuance in writing after this call. First, we encourage that peer reviewers must have current knowledge, expertise, and training in the area of care being provided or being reviewed, and we'd also really encourage that they're able to utilize their training at the top of their licensure or specialization and using the best practice guidelines regardless of the plan's internal clinical guidelines and medical necessity criteria. We have concern about the automation of medical services. And then in terms of the data reporting requirements, I think this is a really exemplary and positive section of this model. We really support annual reporting to the regulating and enforcement agency. We do believe that data should be reviewed and analyzed by service or drug rather than an aggregate. I think that will provide a much more accurate story of these reviews and the percentages of approvals and denials. And when I say percentage, we do support using number rather than percentage because we do believe that tells a clearer story.

And on the mental health and substance use disorder side of this conversation, while this data in aggregate is very compelling and will tell an important story, it's incredibly important to bifurcate the reporting requirements to ensure that mental health and substance use disorder services and prescriptions are being reviewed, one, in compliance with mental health parity requirements, and also, that the access and potential denials of these services, which are objectively very different than the medical and surgical services, are also being reviewed by those with, one, the expertise to do so, and then, two, no more restrictively than physical health services. We also support including the post-service utilization reviews that have been removed.

Rep. Pollock thanked everyone for their comments and stated that he looked forward to discussing all of this with Sen. Michel and seeing where he wants to take this in advance

of our Annual meeting. I feel confident that we'll end up in a place where we can get this finished at that time. In the meantime, please be sure to reach out to Sen. Michel or NCOIL staff or myself with any further comments.

CONTINUED DISCUSSION ON PROPOSED AMENDMENTS TO THE NCOIL TRANSPARENCY IN DENTAL BENEFITS CONTRACTING MODEL ACT

Rep. Pollock stated that next up is a continued discussion on proposed amendments to the NCOIL Transparency and Dental Benefits Contracting Model Act. We had a productive discussion on this during the summer meeting in Chicago. Since then, I know interested parties have been actively working with each other and the sponsor, Sen. Justin Boyd (AR), Vice Chair of the Committee, and the co-sponsor, Asm. Jarett Gandolfo (NY), to advance specific items.

Sen. Boyd thanked everyone who has worked on this so far and provided input. As noted, the interested parties have been working on trying to come to an agreement, which I'm encouraged by, but it's my understanding that we're not quite there yet. It's my hope that today's dialogue will serve as a springboard for both sides to continue those conversations and that hopefully we can accomplish what we need to accomplish at our annual meeting in November.

Asm. Gandolfo stated that similar to what Sen. Boyd said, we do appreciate all the work that has gone into this. Going through this process, I've probably learned more about dental insurance than I ever wanted to, but it's been an enlightening experience. And I know the reason there has been some friction on this is that it is a pretty significant departure from the original model, especially on the network leasing provisions. That said, these laws are not supposed to stay the same forever. There is room to change, and I know both parties will continue to work and try to come to an agreement that satisfies everyone by November. This has been going on for a long time now, but I am encouraged that everyone has stayed at the table and continue to have discussions.

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 to start with some context for everyone, the original model was the result of thoughtful negotiations. We believe it balances the needs of consumers, providers, and plans. And the proof of its success is in its adoption rates. In more than two dozen situations, we've seen legislators take a look at this model and decide that the model struck the right balances for their state, both in the network leasing and the virtual credit card spaces. The model allows providers choice. It ensures patients have access to robust networks, and it allows plans to build and manage those networks responsibly. A few things on what the model as it's written currently offers. For consumers, more robust networks with a wider pool of participating dentists. It also offers lower in-network costs, which directly translates to savings at the dentist's office, which is significant. Additionally, it offers predictability around out-of-pocket expenses, something we know patients deeply value when making their healthcare decisions. More provider options are offered so families aren't forced to switch dentists when coverage changes, and clear quality standards are offered that ensure patient protection and access to quality dental care. For providers, the opt-out system is empowering. They aren't locked into a take-it-or-leave-it arrangement. They receive notices for networks when their network is leased, and they know what payment options are available to them. And critically, they have the ability to walk away if the arrangement doesn't provide value or suit their needs.

From an administrative standpoint, building a network is like building a bridge. It takes time, investment, and coordination. An opt-in requirement would force plans to rebuild those bridges. That creates confusion for providers and would result in weaker networks for consumers, making the entire system less efficient. As noted by Asm. Gandolfo, the amendments that have been proposed are a significant change from what is currently in the model, a drastic departure from what currently stands. It is a fundamental shift moving from opt-out to opt-in. While it might sound like a technical change, in practice, it does flip the entire framework upside down. There isn't a strong policy justification for rewriting the model. Providers of all sizes join networks because they see value in greater patient volume, predictable reimbursement, and administrative efficiencies. That's true whether they're part of a large dental group or solo practice. Networks, including lease networks, are carefully constructed. Lease networks specifically help smaller carriers compete with larger players. For example, a regional dental plan may not have the resources to build a nationwide network, but through the process of leasing, it can give its members access to care across state lines. That creates competition and additional choice in the market and ultimately, more competitive pricing for consumers. In short, what looks like a technical policy tweak represents a major shift in practice and operations. It places a significantly heavier burden on providers who want to expand plan options or elect a payment method best suited for their practice. We believe that there are opportunities to improve the model without upending the framework and what we did was draft some amendments that we believe would do just that. That doesn't mean a massive change is needed, but instead just simple tweaks that could improve things for plans, patients, and providers. Therefore, we've proposed the following updates. Within the network leasing section we are proposing an “affiliate” definition, which clarifies language to ensure everyone, providers, plans, and regulators know exactly how leasing applies. This would reduce confusion and build trust in the process.

Additionally, we have added an additional notice, which would occur following the execution of a lease, giving providers more time and information, both before the lease takes place, which is currently in the model, and then following the lease's execution, in order to make better business decisions, and to increase transparency. And then in reference to electronic payments and virtual credit cards, we are proposing future-proofing payment options. This is something that was proposed in the opt-in amendments that have been proposed by our counterparts. Specifically ensuring that as technology and payment methods evolved, that the model remains effective and allows for the opt-out to apply broadly. We have also added alignment with existing federal requirements to provide further protections for providers related to electronic payments. And finally, also as included in my colleagues' amendments, the sticky opt-out choices as what we're referring to it as. So once a provider opts out, that decision stays in place until they choose otherwise, or for the duration of the contract in order to save time and avoid any unnecessary back and forth. We believe these are common sense updates that make the model stronger, more transparent, and more future ready, all without tearing apart what we know is already working. So, with that, I do appreciate the time to present before you. We believe the model as is with these changes empowers providers, protects consumers, and ensures competition in the market.

Mr. Olson stated that from the ADA's perspective, there was a lot of loaded language used in the NADP’s presentation, things like using words like “drastic.” I have to say, as a representative of the dentists around the country, I always find it amusing when dental plans choose to speak for providers. I would just refer the legislators on the committee

to the letter that was submitted a few days ago from not just the ADA, but a whole host of provider oral health organizations that all commented in support of the amendments as they were drafted and submitted by Sen. Boyd and Asm. Gandolfo. But I'd like to talk a little bit about opt-in and as Ms. Balale spent much of her time speaking about opt-in and how this would be a drastic change, I think it's important for the committee to understand a couple of things that we've covered in the past. NADP's comments were very similar to what you all have heard so I'm going to do a little repeating of things that you've heard. Opt-in is a solid policy choice. It is something that empowers both patients and providers. On the provider side, you all know that you receive e-mails or communications, and if you are forced to opt out of something, you often end up signed up for something that is not appropriate or not something you're interested in. This is a very critical issue for small businesses as largely that's what dental offices are still around the country.

For these small businesses around the country, it can be a huge financial burden to be forced into something and then have to opt out later. I know it's convenient for the plans to build their networks in the manner that they have been doing, and it has spread like wildfire around the country to lease networks. I would push back on the comments that these are carefully considered. I think that in the past, dental plans built networks in a way that was considered, and there was connections made with providers in the plans. That is no longer the case. It is a patchwork, and it is trying to enter into spaces without a relationship, and who's left holding the bag? It's the providers. I would also point to the confusion that occurs for patients. Ms. Balale alluded to lower fees that the patients may pay. I will tell you that being in and out of a network based on whether you're jumped in or out is also confusing for patients. I can detail examples where providers have found out that they've been jumped into a network, and then they have to work with their patients to tell them why they're no longer in the network, and it causes confusion all around. Again, an example of dental plan interference getting between the doctor and patient relationship.

I'd like to jump through the amendments that are proposed by NADP. Again, they do not address the opt-in and do not build on the original amendments that we set forth, except for virtual credit card. The proposed definition of “affiliate” is unnecessary and does not adequately address the issue that entities that do not share a brand are claiming affiliate status around the country. The original amendments better addresses this issue by clarifying that brand status needs to be transparent for providers to access. On the issue of leasing, this is not a drastic change. I wouldn't characterize it as something that's just a tweak as we know that this is a shift, but it is a necessary one, and as I said, it would be helpful to both providers, and I’ll remind you, all providers support this, and it also is helpful to patients to keep things transparent. We support the plans being able to build networks but we think they should do it in a way that is better based on connection with the provider. Now, as Ms. Balale alluded to, we are closer on virtual credit card but again, they have avoided opt-in and the issue of explicit acceptance. We would ask that the legislators on the call support this. This is critical for providers to make good choices. Additionally, we are pleased to see that the industry sees the wisdom of permanent selection of the virtual credit card or some other form of payment but again, we feel our language is superior. But this is the closest that we came to accepting some of our language. Again, I would just emphasize for all the legislators on the call that this is an issue where the dentists and patients want to get the care they need when they need it and want to understand what the coverage is as much as possible. The amendments as originally drafted reflect that, and we urge you to support them.

Owen Urich, Senior Policy Advisor at AHIP, thanked the Committee for the opportunity to speak and stated that AHIP supports the comments made by NADP and the proposed alternative amendments as they do a couple of things. One is build on the success of the existing model. As Ms. Balale mentioned, the model has been adopted in over a dozen states. This is a method where carriers have developed practices that have been proven effective. But I do want to note, on the side of our proposed amendments we are trying to address concerns that have been raised on this without upending the apple cart and also making sure that this is as transparent and clear as possible without making significant changes that could cause issues. The opt out method as it is currently included in the model would be preserved in our amendments but in addition to that, you are also going to be giving additional notices. We're making sure that this is clear and upfront as possible. I certainly welcome a dialogue with Mr. Olson and with others about education and other things that would be important for our members but we want to make this process as clear and as straightforward as possible. I think that's the unified goal, both on leasing and on the electronic payment section. Again, that's why in the amendments that were proposed by the industry we were pointing to federal standards as it relates to electronic payments. I think it's a shared goal to make sure that there's more speed and efficiency and transparency in payments and we're trying to achieve that with our proposed amendments and, again, build off of the success of the model.

Jeff Klein, representing the American Bankers Association Health Savings Account Council, thanked the Committee for the opportunity to speak and stated that some folks on the banking side who are involved in the virtual credit card area asked me to weigh in in support of NADP's and AHIP's position in view of the fact with respect to virtual payments that we have 11 states that have adopted the existing model language. The system seems to be working. We don't want to do anything in the way of overregulation in constricting the way virtual credit cards can be made available. Of course, like everybody else on this call we use dentists and we support transparency and understand the goals associated with that.

Jill Rickard, Regional VP of State Relations at the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak and stated that many of our members write dental insurance for the smaller dental plans. I just wanted to weigh in again in support of NADP and AHIP and the position that the model should be readopted as is or readopted with the amendments proposed by NADP. The proposed ADA amendments would result in a major change in how the dental market operates and cause significant disruption for patients who benefit from networks and the existing opt-out process for network leasing. ACLI and its member companies are committed to transparency, and the amendments proposed by NADP would enhance that transparency without disrupting the market.

Del. Walter Hall (WV) asked Mr. Olson how many states have implemented an opt-in approach to network leasing? Mr. Olson replied we've seen one state, and it's, again, reacting to the difficulties that providers and patients are seeing. Oregon has adopted virtual credit card with an opt-in, and that was a recent adoption. So, we're seeing that this policy choice is starting to shift. Del. Hall asked for clarification that the answer was one state with regard to network leasing. Mr. Olson replied yes, one so far, but we're also seeing introductions of bills that include opt-in with network leasing. Del. Hall asked Mr. Olson which state was the one that adopted the opt-in approach for network leasing. Mr. Olson replied that I can get that answer for you after I do some research.

Rep. Brenda Carter (MI) stated that I'm going to review these proposed amendments and the model as a whole and will provide some feedback before the Annual meeting.

Sen. Boyd thanked everyone for their comments and stated that they will be taken into consideration as we move forward but I hope that we can find some resolution and closure to this at the annual meeting. Asm. Gandolfo agreed with Sen. Boyd.

Rep. Pollock thanked everyone for their comments and stated that before we wrap up, I would like to offer my perspective on this as Chair, particularly on the network leasing issue. I agree with some of the comments that have been made today regarding making sure that we're all clear about the amendments to the model. We've been discussing it for a while now, and the more I've heard and listened to, the more drastic these amendments seem to be, and they really would represent a significant policy shift from the original model. I know it's our job as policymakers to listen to the concerns of constituents and of the industries that we oversee and then respond appropriately with legislation, but I'm not quite sure I've heard enough justification to make such a significant change to the NCOIL model. Perhaps this might be an issue that's better left to the states that wish to take it up. Also, from the NCOIL procedure perspective, I think it's very proper that our models come up for review every five years, but I would say that at the first five year review after initial adoption, any changes to the model should be reserved for clarifications or perhaps changing something that is outdated or maybe responding to a policy shift in the states. This change seems a lot more substantive in nature and is not something that a lot of states have done. Again, it kind of goes back to my comments since the beginning of the year of keeping the main thing, the main thing. But overall, this has been a great discussion and this is what NCOIL is all about. I look forward to meeting again in November and working with Sen. Boyd and Asm. Gandolfo to finalize everything. In the meantime, if you have any questions or if you would like to share feedback, please feel free to reach out to me or NCOIL staff or Sen. Boyd or Asm. Gandolfo.

ADJOURNMENT

Hearing no further business, upon a Motion made by Sen. Utke and seconded by Rep. Carl Anderson (SC), the Committee adjourned at 1:00 p.m.