NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2025 NCOIL ANNUAL MEETING – ATLANTA, GEORGIA
NOVEMBER 13, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Whitley Hotel in Atlanta, Georgia on Thursday, November 13, 2025, at 10:00 a.m.

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

Other members of the Committee present were:

Rep. Camille Lilly (IL)
Rep. Matt Lehman (IN)
Rep. Bill Sutton (KS)
Rep. Chad Aull (KY)
Rep. Edmond Jordan (LA)
Rep. Robert Foley (ME)
Rep. Brenda Carter (MI)
Rep. Kristian Grant (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Jeff Howe (MN)
Sen. Paul Utke (MN)
Sen. Walter Michel (MS)
Sen. Jerry Klein (ND)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Sen. Pam Helming (NY)
Asw. Pam Hunter (NY)
Rep. Meredith Craig (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Rep. Barbara Dittrich (WI)
Sen. Mary Felzkowski (WI)
Del. Walter Hall (WV)

Other legislators present were:

Rep. Carolyn Hall (AK)
Rep. Naquetta Ricks (CO)
Rep. Elijah Pierick (HI)
Rep. Emil Bergquist (KS)
Rep. Cindy Neighbor (KS)
Rep. Sean Tarwater (KS)
Rep. Mike Clines (KY)
Rep. Mike Meredith (KY)
Rep. Shaun Mena (LA)
Del. Mike Rogers (MD)
Sen. Paul Utke (MN)
Sen. Bill Gannon (NH)
Rep. Garland Pierce (NC)
Rep. Mark Tedford (OK)
Rep. Greg Scott (PA)
Rep. Trey Wharton (TX)

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 Rep. Brenda Carter (MI) and seconded by Rep. Ellyn Hefner (OK), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Barbara Dittrich (WI) and seconded by Rep. Brian Lampton (OH), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 18, 2025 and September 19, 2025 meetings.

PRESENTATION ON POLICY INITIATIVES TO SUPPORT MATERNAL HEALTH

Sarah Duggan Goldstein, DrPH, MPH, Managing Director of Health Equity Policy at Blue Cross Blue Shield Association (BCBSA), thanked the committee for the opportunity to speak and gave a brief introduction on the blue system and our commitment to maternal health, both at the association and across our health plans as well, both in maternal health in reducing disparities, and supporting maternal mortality review committees. BCBSA is the trade association over all 33 independent licensee plans which have their own service areas. It's really the depth and the breadth of the blue system that have really drawn me into the potential impact that you can have on public health and member wellness. Locally, the blue plans are woven into the fabric of the communities that they serve and then nationally, the trade association helps them with their networking programming. This is a very deep footprint. We still cover one in three Americans across every zip code, which is about 114 million members. And from that, we also have very deep networks with our providers in our hospital communities.

Back in 2019-2020, the Blue System made a commitment that was led by BCBSA to reduce disparities in health, specifically in maternal health. The board doubled down on this in November of 2024 to this commitment to reducing disparities in maternal health even more. These three pillars were sort of the framework by which the Blue System was going to approach this, both in approaches to care, so integrating new care models and very robust data and analytics across all lines of business, and of course investing in our local communities, all of this bolstered by our policy and advocacy work at the national and the state level. I'll take a minute here to talk a bit about how the blue system from the plans have really taken this challenge individually. And you can see some of these examples up here. This is not exhaustive. Lots of work has been done by the plans in integrating doulas and midwives into care models which I'm sure everyone here is familiar with. And then down here on the bottom, you'll see some of the system commitments that we at the association made as well, starting with the March of Dimes partnership to improve implicit bias training, and as well as our Health of America reports that really dove into data, both in commercial and Medicaid populations, as well as an FEP doula pilot that has been very successful and is showing great data going forward.

She continued with a brief overview of some of the data stating that this is one of the clinical initiatives that has come out of our network side. You'll see here that rates of hypertensive disorders in pregnancy continue to rise, both in commercial and Medicaid members. This data we actually brought up because one of our programs, the Blue Distinction Centers for Maternity Care, works directly with plans in their service areas to work with hospitals that need a little bit more help in improving their outcome rates. And so you'll see that these have gone up over time and this is important because hypertensive disorders are obviously one of the major risk factors in maternal morbidity and mortality. On the policy and advocacy side, nationally, we've continued to advocate for good maternal health legislation. This, of course, includes the Preventing Maternal Deaths Act, Healthy Moms and Babies Act, Black Maternal Health Momnibus, which has several parts, about 13 bills inside of that, as well as the Maternal Health

Quality Improvement Act. But, of course, the Preventing Maternal Deaths Act is one of the most important here because it's the one that supports the Maternal Mortality Review Committees (MMRC), which is what we're here to talk about today.

If anyone's unaware of what a MMRC is, they are multidisciplinary state or local groups that are the only group that provides a comprehensive review of pregnancy-related deaths, both clinical and non-clinical factors. They're independent groups. It's very important that they are also apolitical in some way and that they really provide these comprehensive recommendations and strategies to improve health for moms. Unfortunately, the data continues to be very poor for maternal mortality, and you don't have to see the numbers on the slide to see on this left-hand graph to see that one thing does not look like the other. These disparities the bars show reach to the sky there are for black women, and then you have all other ethnic groups behind it. So, there's still a lot of work to be done, which is why MMRCs are critical to improving the status quo for what we have right now. State legislation and state legislators are very important here. As I said, these are state federal partnerships, these MMRCs, and so states really play a critical role in supporting the fact that they can enable the dissemination of the recommendations that come out of the MMRCs and support national data reporting which is very important to see because some of these numbers are small, so in order to see the impact of some of this, you need to be able to see everything at a national level. And states can ensure that MMRCs maintain that they're independent and they're multidisciplinary structure.

Dr. Yolanda Lawson, Executive Medical Director of Maternal and Infant Health at Healthcare Services Corporation thanked the Committee for the opportunity to speak and stated that I'll address the role of MMRCs in strengthening maternal health through data, data review and accountability. I never assume that everyone is at the same point when we talk about maternal health. When we talk about maternal death or maternal mortality, that's defined by the World Health Organization as the death of a woman while she's pregnant, or within 42 days of the end of the pregnancy, irrespective of the duration or site of the pregnancy and think about ectopic pregnancies, those types of things. Secondly, versus pregnancy-related death, that's when a birthing person or a pregnant woman dies during pregnancy, or within one year after the end of their pregnancy from health problems related to pregnancy. When we talk about the U.S. in deaths per 100,000, you'll see this here, 23.8. That is the U.S. rate of deaths per 100,000 for all women in the U.S. and you'll look at us compared to other high-income or developed nations. You look at Australia, that number's two. Germany, 3.6. And then you look here, you'll see U.S. white women are at 19.1, U.S. Hispanic women at 18.2, and then U.S. black women at 55.3. This is 2022 data. And so, when I'm talking to audiences, I make it very clear, all women in the U.S. fare worse than other high-income nations and then the work we know we also need to do is dealing with these racial disparities.

In 1987, the pregnancy-related mortality rate was around a little over 7 per 100,000. And then you see this spike here. This is 2021. So, over the last five to six years, there is a maternal health crisis because of this steady, consistent rise, and then we get to 2021, and we hit 32 deaths. Again, remember, seven over here in 1987. And then you begin to look at 2022 and lots of interventions and focus and advocacy around this, and we get down to that 23.8 number. This is a snapshot of 2018 to 2023. And so, again, as I talk about the spike we saw in 2021, of course, likely contributed to the pandemic and you'll see that in 2022 and 2023, the numbers do begin to decrease and we would hope that would be the case. Many of you worked at your state levels putting into place programs and initiatives and such to help. The one thing I remind us of, while we saw the U.S. rate overall decreasing in 2023, we did not see the racial disparities decrease. So, we still have these differences that occur between certain populations. Those are still stark and there's still work to do. I quickly want to address postpartum and the

considerations you should take into account. This postpartum phase is critical to all women for childbirth. I practiced OBGYN in Texas for 23 years and people didn't realize that those conditions that are pregnancy related, even after the baby, you can still get preeclampsia. The body just doesn't realize today, I'm no longer pregnant. And 40% of women do not have a follow-up postpartum visit. It's very important as that's how we recognize dangers. And of course, attendance is lower for those women with less resources or access to care, and certainly those on Medicaid. And that lack of follow-up contributes to those disparities that we see, not only the mom's health, but also the baby or the infant. I'm often asked, “what are people dying from?” From day 43 after you have a baby up until one year, the leading cause is going to be cardiovascular disorders, then mental health conditions, and then embolism or blood clots. Those are some of the leading causes.

Oftentimes, people are so focused on labor they're forgetting about postpartum, but about 52% of those deaths occur in postpartum or after one gives birth and about 13% occur to the day of delivery. So, as I just shared with you, the U.S. maternal mortality rates are highest in the developed world. I think if we look at the U.S. broadly, about 80% of those deaths are preventable. I was just presenting in Illinois last week and I think it's 91% are preventable in the state of Illinois. So, we do see some nuances there. Our target for the U.S. is to get this number to less than 15.7 per 100,000 live births and eliminate those racial disparities in outcomes. And again, rural and Medicaid populations, we know that they're disproportionately affected for a number of reasons but the things we want to raise up today are these fragmented data systems. They hinder targeted interventions. And so, to reach the U.S. health goal, we must strengthen standardization of that data and the accountability and that's what's rooted in our MMRCs. So, I'm going to take you to do a little bit of a historic journey around data interventions in the U.S. And so, in 1986, The Centers for Disease Control and Prevention (CDC) began maternal mortality surveillance due to gaps in the data. It was really difficult and very fragmented in the U.S. and the first year reporting was in 1987. And so, I want to make sure you're clear on pregnancy mortality surveillance versus the work of your MMRCs.

Review committees perform detailed work and information on deaths beyond just vital statistics data. The first MMRC in the U.S. was established in Iowa in 1970. They were established in the early 20th century to investigate deaths when rates were the highest on record. In the 1980s, many of them became inactive and that was due to state funding. Many states just didn't make it a funding priority. You now have 49 states, D.C. and New York City, Philadelphia and Puerto Rico, that are legally required to review pregnancy-related deaths. Ten states, D.C. and New York City, require the committee's reports to address racial disparities, and six states and New York City track maternal morbidity data. When we do a deep dive in looking at MMRCs, they're multidisciplinary state-based committees composed of clinical and non-clinical individuals to review each maternal death in detail to determine, number one, the cause of the death, was it preventable, what were the contributing factors, and to make recommendations for action to address it so it doesn't happen again. The data is de-identified and it is standardized and the CDC has a national database. It's called MMRIA, the Maternal Mortality Review Information Application and that's the national system that provides reports on the U.S. maternal mortality trends. It informs those healthy people targets you heard me mention and also, more importantly, it directs the Health Resources and Services Administration (HRSA) and the CDC funding priorities. Also, these are confidential, and the confidentiality protections also need to stay in place.

The National Vital Statistics System, they use death records for maternal mortality rates and those are deaths that occur within those 42 days in the U.S. And they have legal authority for the registration of these events. And that's all 50 states and two cities, Washington, D.C., and

New York City, and then five territories, which include the Virgin Islands, Puerto Rico, the American Samoa, and the Northern Mariana Islands. So that's everyone that participates in the National Vital Statistics. That's how we know how many births occur in this country. Then when you look at the Pregnancy Mortality Surveillance System, that provides national data that tracks trends of pregnancy-related deaths and it uses those death and linked birth records to provide that data, and it does not include any injuries but all 50 states participate. When you look at MMRCs, they review the deaths to determine pregnancy relatedness, that one year I talked about. They identify prevention recommendations and do include injury deaths, and they investigate those deaths during pregnancy, and up to one year after. They use death records, any linked birth records or fetal death records, medical records, social services records, health related social needs screenings, autopsies, and informant interviews. So, they get a lot more in-depth data than what our regular vital statistics and mortality systems would. The data is standardized in how the states collect the data and analyze maternal death data. And so, what it does is creates a centralized, secure, and comparable national data set. It allows for the evidence to shape smart policy and clinical practice recommendations, and also allows better benefit design. Many of you have likely heard this term, “what gets measured gets paid,” or “what gets measured gets improved.” That's what MMRCs do. They inform an intentional investment where the data shows the greatest need. All maternal deaths usually tell a story and MMRCs and the MMRIA system ensure that we learn form each of these deaths going forward.

This here is the CDC Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) at present in the U.S. Texas is the only state not participating in the MMRIA system for that centralized data set. You will see the darker blue states are all participating and funded by the CDC and the lighter blue states are participating but not funded federally. And so why does this matter? Because you heard me state 80% of these deaths in the U.S. are preventable. Rising costs, health disparities, those all signal, at some level, a system-level failure and without MMRCs, we'd lose that structured case-level understanding of why women died during pregnancy. We would know how many women died, maybe, but we wouldn't understand root causes or if those deaths were preventable and then we'd also lose the ability to identify when and where women are most vulnerable during their journey in pregnancy. As you think about 60% of pregnancy-related deaths occur after birth, that means they're outside of the hospital, and then mental health and substance use deaths. Some of the reasons we know this data is because of the work of our MMRCs because those deaths occur up to 6 to 12 months postpartum, so after delivery and those would not be captured with hospital data alone.

This chart outlines what we would lose and why MMRCs matter. So again, we lose data around prevention, the timing and location of these deaths, what are the clinical causes, are they associated with social determinants of health, disparities, what system level failures exist, national comparability, looking at our standardized multi-state data set, and then family and community voices. MMRCs take all of that into account to structure prevention and interventions. So why do they matter to health insurance companies? They provide us comprehensive cross system data that insurers are unable to access elsewhere. There are limitations on our claims data and in my work, I'm constantly addressing state level data to inform work, interventions and programming. MMRCs review the full continuum of care - clinical notes, hospital records, autopsies and such. I'll give you an example. There's a 32 year old woman, she has been good in her prenatal care with several prenatal visits on the record per her claims data. But the MMRC review shows she had a missed blood pressure follow-up and delayed referral to the cardiology and that's what contributed to her death. It wasn't that she wasn't getting her prenatal care. And so insurers need these insights to develop targeted interventions to the member or with providers, quality improvement incentives, and also enhance our member outreach. MMRCs also provide the context that's needed to understand

why high-cost, high-risk events occur and which interventions would prevent them. MMRCs are a feedback loop for quality improvement and also value-based strategy design.

Why do MMRCs matter for you as legislators? I strongly feel they provide and articulate actionable policies and legislative levers that you can use across coverage, care coordination, workforce decisions, non-medical drivers of health, and performance transparency. You'll look at recent legislation passed last year in Illinois. Much of that was from the 2023 Maternal Morbidity and Mortality Report, taking those recommendations, and translated into coverage policies on doulas, lactation consultants, midwives. In Indiana, part of the work of their MMRC really promoted them extending postpartum coverage to 12 months and they had an enhanced focus on substance use and mental health disorders and through the work of the committee, they realized these are issues effecting our communities. And they established a women's health task force. In Texas, the MMRC findings led to Texas extending Medicaid postpartum coverage to 12 months, ensuring that hospitals adopt best practices, adopting those Alliance for Innovation on Maternal Health (AIM) bundles around obstetric emergencies, hemorrhage, and certainly the cardiac conditions. And then thinking about policy alignment with the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), maternal health measures, and certainly Section 1115 waivers for postpartum coverage. Earlier this year, Arkansas was awarded the Transforming Maternal Health award and was granted a $17 million federal grant to improve maternal health outcomes, certainly with a focus on their Medicaid recipients. I also speak to legislators thinking about the support from other funding resources through the data and the work of your MMRC that help you get awards such as Arkansas received this past year. Regarding the current policy landscape, we've talked about some of the funding instability, and authorizing the Preventing Maternal Deaths Act of 2025 is important along with national coordination through the MMRIA data set. Again, every maternal death tells a story, and MMRCs make sure we hear it and act upon it.

Rep. Brenda Carter (MI) stated that Dr. Lawson said that with black women, their deaths are preventable. Tell me what systemic issues are attributing to the continuing rise of maternal deaths with black women? Dr. Lawson responded I want to clarify 80% of deaths broadly in the U.S. are preventable and the disparities with black women, there are multiple contributors such as access to care, access to health insurance, and racism and discrimination have been cited as causes. And also, again, that higher burden of the social determinants of health.

Rep. Edmond Jordan (LA), NCOIL Treasurer, stated in Louisiana we have, if not the highest, certainly one of the highest maternal death rates in the nation and most of that would be, I think, with African-American women so that's a grave concern for us. In the last few years we have given them access to doulas and midwives and tried to make some of that more accessible so I'm just wondering is that one way to prevent it or are there other ways that we might be missing? Dr. Lawson stated I spend quite a bit of time doing advocacy work in Louisiana. It is in the right step to think about access to doulas. I've practiced over 20 years and always use doulas in practice but it's not everything because doulas don't offer clinical care. Keeping your hospitals open is important. I live in Dallas and some hospitals have closed maternity wards. Looking at that for your districts is important and thinking how do you support them in the hospital and outside of the hospital in the home with maternal home visitations with someone who can go out and do screenings is important. And also making sure you're supporting your MMRC to understand the social determinants of health issues for your state so you can be intentional. Is it that they don't have transportation and food? Is it housing? You should really dive into the data that they produce for you.

Rep. Ellyn Hefner (OK) stated in Oklahoma we used to have a program that we stopped funding, which was maternal home visits. New Jersey had a statewide program, and this is what I heard in looking to run some legislation to try to get more money into that program in Oklahoma because the minimum of two visits have changed New Jersey's maternal mortality rate from 47th to 28th. So, tell me a little bit about putting more effort towards the state putting money into programs like that and how it helps. Dr. Lawson stated Illinois passed similar legislation to implement maternal home visitation starting next year so we are working on supporting that effort. Some of the work we're doing are training maternal home visitors, training doulas. Also, thinking about who are your partners in the state who can help me first get the workforce in place, we've seen that be a common challenge also. Once the workforce is in place, then thinking about working with your insurance partners to implement payment for that. Because some of my patients with means were able to have these things regardless. It didn't take legislation, but the majority of the population can't afford it. And so, I applaud you. I think that's wonderful and we are here to help and support you through that.

Rep. Hefner stated we talk a lot about about prenatal care and my concern is for those young adolescents and I wish insurance companies would put more money in the education for young females before any of that, because in Oklahoma once they're pregnant, especially if they have some chronic disparity health conditions, it's already too late and babies end up in the Neonatal Intensive Care Unit (NICU). What do you think about that kind of education that the insurance companies can take on helping those young women? Dr. Lawson replied I fully support it. That's probably my soapbox, thinking about how do we make sure all women, even adolescents, enter pregnancy healthier and have the information, education, and resources, and even our listening sessions yield that. They want to get more information and understand. I'm happy to work with you offline and we're investing in some community-based partners who are doing that work for us, not integrating into the school, but integrating with a focus on adolescents.

Sen, George Lang (OH) stated I was really shocked by the spike that you showed in 2021 and at least in Ohio, that correlates to a spike in overall morbidity rates amongst the African-American community as it related to COVID. I'm just curious if the spike you showed was in any way related to COVID? Dr. Lawson replied yes, it was. I was still practicing during COVID and for those who don't know, when you're pregnant, all respiratory viruses are extremely dangerous and require hospitalization. And so, for pregnant women, the rates of pneumonia were high. They were afraid to go to visits and we were seeing people dying at home and so yes, COVID certainly did contribute to the spike. We saw ectopic pregnancies, delay in care, hemorrhage, sepsis, mental health issues, suicide. All of that burden during the pandemic contributed to that spike that I shared with you.

Rep. Greg Scott (PA) stated I'm a proud member of the Pennsylvania Black Maternal Health Caucus and this is our second term that we've had this. In Pennsylvania, as you highlighted, black women are two times more likely to die from what should be one of the most joyous times of their life. And as a proud father of a 14-week-old, I wanted to acknowledge that you did paint a very stark picture, but there are scientific-backed research ways that we can prevent this. And in Pennsylvania, I'm happy that put $30 million into this. We expanded Medicaid coverage for doulas. We've established maternal care access zones in health deserts. We've required that private insurance cover blood pressure monitors. We've expanded Medicaid coverage for blood pressure monitors. But one of the things that we have not been able to figure out is how do you regulate implicit bias? Where best should we focus our attention? Is it in the training? Is it in the hospitals? I feel like we're coming up short. We're throwing a bunch of daggers at this thing and we're still producing doctors that don't listen to women when they cry out in pain. Can you

please shed some light on where you think we can make impact on that? Dr. Lawson stated it should be all of that. There are oaths that we take entering the medical profession so it certainly should be in medical school. It should certainly be in residency and fellowship training and it also should be in hospitals. But I live in a state where it's illegal to perform implicit bias training and so how do we go about this where we think about it broadly and openly? And for me, it's around language. It's all of these things that can contribute to bias and so we should take the opportunity to train and educate and make sure there's awareness at every opportunity we have available. Some states do it through their medical board licensure process. They require bias training to get your licensure. Some hospitals require it to get your privileges at a hospitals so I think you can use all of those levers to advance the work.

INTRODUCTION AND DISCUSSION ON NCOIL CHARITY MEDICAL CARE AND MEDICAL DEBT REFORM MODEL ACT

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President and sponsor of the Model, stated that the charity care portion of the Model is based on a bill that we ran in Texas. It was essentially an issue that just sort of came to my office's attention, and the concept is pretty straightforward. There are hospitals and hospital systems in each of our states that are granted tax-exempt status in exchange for providing charity care and being willing to reduce the financial burden on patients who cannot afford the health care that they desperately need. And although my state is held out to be sort of the poster child for good things in terms of regulating and making sure that charity care is actually providing charity to patients, what we found in Texas is that we had situations where hospitals were sending people to debt collectors and destroying their credit, and then subsequently writing that off as bad debt and claiming that they did charity by destroying someone financially. We had situations where hospitals were putting drinking fountains in the lobbies of their hospital and claiming that was a community benefit and that should be counted as charity, just miscellaneous things like that.

I believe in tax-exempt status for charitable things. I think that's a great incentive, and I do believe very strongly that hospitals provide incredibly important services to our community. I myself have worked as a hospital-based physician in multiple hospitals, both tax-exempt and for-profit, for the last 20 years, but I will tell you, as a provider, I see no difference in terms of how indigent patients are treated by for-profit hospitals and tax-exempt hospitals at the end of the day, which is alarming considering what the tax-exempt hospitals are getting. I should be careful to point out that nothing that we're talking about today impacts hospitals that would fall under the disproportionate share definition. So, your rural hospitals, your critical access hospitals are completely unaffected by anything we're discussing today. However, for the big hospitals that are getting the benefit, this simply requires that before they send a patient to a debt collector and destroy them financially, they have to first verify whether or not the patient would have qualified for charity care under their own guidelines that they self-regulate and self-promulgate. It was a very interesting hearing in Texas on this. It's gotten a lot of press as I think everybody's kind of waking up to the idea that we really are giving away something for very little in return, and it's time that we took a little closer look at it.

Jared Walker, Founder of Dollar For, thanked the Committee for the opportunity to speak and stated that Dollar For has a very simple mission - we want to make charity care known, easy, and fair. I started this organization because I watched my own family go through a medical emergency and realized when you have a medical crisis, a lot of times you have a financial crisis. So, I wanted to help people in this situation. I started a crowdfunding platform to help people pay medical bills. I paid hundreds of thousands of dollars in hospital bills for low-income patients, and then I met Eli Rushbanks, General Counsel & Director of Policy at Dollar For, who

told me about hospital charity care, and I realized I had spent years of my life paying hospital bills for low-income patients that all would have been eligible for these programs. And I felt like a chump so I thought what is going on here? Hospitals don't do a great job of telling people about charity care. This is not uncommon. Every year, millions of people go on payment plans or declare bankruptcy for bills that they actually do not have to pay. So, I started helping patients access these programs. I started reading through policies and filling out applications. I started faxing applications to hospitals, because that's how they like to receive them. Applications were lost in the mail, I was waiting on hold for hours and being told to schedule an appointment with a financial counselor. I was answering questions about how much money patients have in their retirement funds, how much livestock do they own, if they've raised any money on GoFundMe. I saw how difficult it is to actually get charity care but once I knew how to jump through the hoops, it worked. In a few months, Mr. Rushbanks and I got over $1 million dollars in medical debt to disappear for low-income patients. So, I wanted to get the word out, which unfortunately, led me to TikTok and I made a 60 second video that told people what charity care was, how to access it, how to apply, and it exploded - that video got over 30 million views, and why is that? Because it was new information as no one knows about charity care which is a huge problem. Most patients leave the hospital without any knowledge of these programs and if they do know, it's very difficult to get, and if they do get it, it can take eight months or more.

So, here's how Dollar For is trying to solve this problem. We've built a database of every hospital in the country and all of their eligibility criteria. We can tell patients if they're eligible in a matter of seconds. We took it a step further. We've automated the application process. You can fill it out on your phone, tablet, computer and it will map to your hospital's application. We submit it and advocate on your behalf. We know a lot about charity care. We've read every policy that exists. We know what they say on paper, but we've also submitted over 40,000 financial assistance applications so we know what they look like in action. And we've worked with hospitals and states to make these programs better. We've helped relieve over $120 million in medical debt for patients all across the country. And here's what we know. First, Dollar For should not have to exist. This is crazy as I have to raise money through philanthropy to fund a nonprofit that has to enforce policies that nonprofit hospitals are legally required to have. We should be mad about this. You should want to put me out of business. Please put me out of business. Only 29% of patients that are eligible for charity care actually get it. This is about as bipartisan as it gets. I think most people agree that you shouldn't lose everything because you get sick. Most people know someone going through this right now. Most of us have contributed to GoFundMe accounts for friends and family members to pay medical bills, and we all hate it. So, for the patient, it goes much further than just a medical bill. Patients can buy better quality food, put money in savings accounts, make their rent on time, continue their education, buy their first home. Medical debt is still the number one cause of bankruptcy in America. It is still the most likely thing to push someone into a cycle of poverty. So, if you care about every day working folks in your communities, I think this is the lowest hanging fruit to help them, and I don't even think it's close.

Mr. Rushbanks thanked the Committee for the opportunity to speak and stated that I'm realizing I should probably let everyone know that when we say charity care and financial assistance, we're talking about the same thing as both terms are used in the industry. Medical debt from hospitals is very widespread, and it wreaks havoc on communities. The quick stats that I pulled are 15% of families in the U.S. currently have past due medical debt. Two-thirds of these families have household incomes below 200% of the federal poverty level and 73% of these people owe at least some of their debt to hospitals, and 28% of these people owe their debt exclusively to hospitals. The fallout from this is that one in four patients skip or delay needed care and 62% of bankruptcies are related to medical debt, and people with medical debt are up

to three times more likely to be housing and or food insecure. These medical bills are clogging debt collection dockets. They're affecting patient health and affecting the very foundation of people's lives. Hospital financial assistance is supposed to help these patients. If they're low and middle income, they're supposed to submit an application and have the bill reduced to an amount that they can pay or potentially to zero. The problem is these programs are broken. Patients aren't learning about financial assistance, they don't understand it enough to apply, and they can't navigate the bureaucracy at the hospital on their own, often while sick and recovering. Also, only 29% of these people that are eligible actually receive these benefits. So, we think the solution, which is part of the NCOIL model, is to just screen these people before they have to apply and remove the application process entirely. There's a few states that have already started experimenting with a model like this. Oregon is probably the furthest along. We're still waiting for data to come out from the state to see how this is going statewide but the little bit of data that we do have shows that OHSU, the largest hospital in the state, implemented presumptive screening for every patient that passes through their doors. Before they did that, 12% of their patients received financial assistance. After they did that, 64% of their patients received financial assistance.

The best part about all of this is that if you get financial assistance up to 100% of those eligible, that this isn't going to cost the hospital a significant or a meaningful amount of money. We published a report yesterday where we partnered up with Dr. Naman Shah at the L.A. County Department of Public Health. We looked at MEPS data, which is Medical Expenditure Panel Survey data published by the Agency for Healthcare Research and Quality, and we found that if hospitals gave charity care to every eligible patient under the terms of their own policy, it would have reduced what they collected in net patient revenue by 0.7%. And so, this really isn't surprising when you think about where hospitals get their money. There's three main sources. They're going to get it from private insurance. They're going to get it from some sort of government payer source like Medicaid or Medicare, or it's going to be an out-of-pocket payment made directly from the patient. The out-of-pocket payment portion is exclusively where charity care comes from because it doesn't apply to insurance or government payments, and that's about 2.5% of revenue for hospitals. So really what we're talking about here is if we were to accept that we could reduce hospital revenue just from patient services, not from any other revenue source that the hospital has, by 0.7%, less than three-quarters of 1%, we could dramatically reduce bankruptcies, wage garnishments, hunger, and homelessness, and we could greatly improve treatment and public health outcomes.

Aaron Wesolowski, VP of Research, Strategy & Policy Communications at the American Hospital Association (AHA) thanked the Committee for the opportunity to speak and stated we want to highlight some of the operational considerations that we hope you take into account as you look at legislation like this and we're lucky to have here as well Van Loskoski, CEO of Stephens County Hospital, a community hospital in Georgia, to talk through the practical process of charity care from his perspective. First, I think it's really important to remember that charity care is one component of community benefits that not-for-profits provide. There are a lot of other components. The big components are charity care and Medicaid shortfall - the losses that hospitals incur treating Medicaid which typically pays below the cost of care. Those two pieces together represent the bulk of the benefits that hospitals provide to low-income patients, whether they're uninsured or whether they're in public assistance programs that reimburse low. And oftentimes hospitals incur losses on those Medicaid patients. What we see when we look at that bigger picture of community benefits of not just charity care but charity care in relation to things like Medicaid shortfall is that they tend to move in tandem so the more Medicaid patients you have oftentimes the fewer uninsured patients you have. The more uninsured patients you have, the fewer Medicaid patients you have. So as one goes up, the other goes down.

From our perspective, it's really important to take a step back and look at the other big components of community benefit. There are a lot of other categories like medical education, research, and subsidized services - services that hospitals incur a loss on even when you include higher commercial rates. And things like trauma care, burn care, and behavioral health in a lot of cases. A lot of different things drive into community benefit but the two primary components are charity care, and Medicaid shortfall. I want to offer that context. The other important piece of context that we want to highlight here is that charity care doesn't just apply to the uninsured. I think a lot of times when folks think of folks who are eligible for charity care they think of people who have no insurance. Increasingly we see people who have some form of insurance also needing charity care and that can be for a variety of reasons. Obviously it can be the financial situation that they're in but in a lot of cases it's the plan benefit design that they're living with. So, whether it's high-deductible health plans or other kind of skinny plans, just having insurance doesn't mean that you don't need assistance when you when you receive a bill. So, increasingly patients with some form of insurance make up a big chunk of the charity care that that hospitals provide. I mentioned that because as you're thinking about the pool of people who are potentially eligible for charity care in the context of this legislation it can be the entire patient population so that's just a really important point to highlight if you're screening potentially eligible people, in a lot of cases that means screening the entire patient population. Another important context around specifically the uninsured is that we've seen in the last few years consistent drops in the number of uninsured. We're about to see really big increases in the number of people who don't have insurance. Some of the impacts of HR1 in terms of folks rolling off of Medicaid and the potential expiration of the enhanced marketplace subsidies in January, it's unclear what's going to happen with those in Congress, but there's a very good chance that those tax credits will expire and the Congressional Budget Office (CBO) has predicted that will result in millions of people rolling off of insurance and becoming uninsured.

Add to that some of the big layoffs that we've seen recently at companies like Amazon and UPS, the trend is towards an increase in the uninsured which is something we haven't seen in a few years. So, that's all important context to think about this in that we will be seeing the need for charity care increase. We're going to be seeing more people coming through the door. Bear that in mind as you think about charity care and any legislation around it. Mr. Loskoski can talk a little bit about this in more detail but with a large pool of potentially eligible people for charity care, both insured and uninsured, the process for screening for eligibility is really important. There are a few different ways that eligibility is assessed, and Mr. Walker and Mr. Rushbanks talked about the tools they provide to people they work with to try to make that process easier, but from a hospital perspective, generally it either looks like a manual process where you ask somebody if they want to apply for charity care, and then there's a manual back and forth of documentation, income information, and employment information. There are automated versions of that as well. There's something that folks refer to as presumptive eligibility, which is a more automated approach and it involves pulling in data so that some of that stuff can happen in the background. That process we think works better than a completely manual process, but the issue with that is there are vendors who sell those services to hospitals and they can be very expensive so it requires a sizable investment to be able to tap into those resources to automate that. Without those resources there isn't an easy way to automate that process to make it less manual.

If this is a universal screening for hospitals that don't have access to those kinds of resources, this manual process can be resource intensive for everybody. Also, I know in the model that you all are considering there's steps of violations if the hospital doesn't meet the requirements of assessing eligibility. It's important to understand what is and isn't a violation in that context. Was an assessment not conducted at all or did something fall through the gaps? If there was manual documentation going back and forth, was there a good faith effort to try to determine eligibility or

was assessment not conducted at all? And a manual process opens up a lot of opportunities for gaps like that. We think it's important to make sure that as you're looking at processes like this, that you're helping hospitals have the resources they need to make this process easier. A lot of times that means connecting them to data. There are the third-party vendors that hospitals have to pay for, but you all as legislators have the ability to make state data available. State wage databases or eligibility for public assistance programs, that kind of information would help hospitals conduct eligibility. Moving in the direction of trying to automate this process we think is helpful, and we hope you consider that in terms of making it easier. I just want to end with a few questions to ask as you're thinking through this. Does any policy that you're looking at, first of all, reduce the need for financial assistance, which we think is pretty fundamental. Does it help hospitals in assessing eligibility as opposed to just putting mandates around assessments in place? And does it recognize the natural complexity of determining eligibility and that in a lot of cases, it's a very manual process?

Mr. Loskoski thanked the Committee for the opportunity to speak and stated that just to get a glimpse of where the hospital is, we're about as far northeast in the state as you can get. We're a 96-bed hospital. We have 15 emergency department beds and six operating rooms. We also operate nine ambulatory care centers, two assisted living facilities, and we operate the county emergency medical services (EMS). We provide indigent care and financial assistance in all of our facilities and for all of our services. There are some challenges that we face in our community. If you look at one hospital, then you've seen one hospital. Each hospital is unique and has its own unique challenges, and that's based off the population that you serve. In our particular community, we have a particular problem because there's no Federally Qualified Health Center (FQHC) in the county. We are the only provider of indigent care in the entire county. We're up in the mountains so there are transportation issues. There are very few sidewalks in the county. There are very few options and decreasing options for low-income housing, especially when you consider our under and uninsured population. We have a transient population and there are some reasons for that that I'll go into in later slides, so it makes the follow-up and continuity of care for our patients extremely difficult. When you have patients that are constantly changing addresses or their cell phone might be disconnected the day after we saw them, it makes continuity of care extremely challenging and has an impact that we see in our emergency department. There are educational barriers. In a rural community like ours, we do see higher rates of illiteracy, and those present challenges when it comes to providing financial assistance to many of our patients. We have a significant and higher-than-state average rate of substance abuse disorders. That also translates into mental health disorders. And we're also seeing the cost of care continue to rise. Our supply costs are increasing. Our utility expenses are increasing. Providing care in general is just getting more expensive. It's the same thing as going to a grocery store. Everything that you're buying now is a little bit more expensive than it was a few years ago. That's the reality of the world we're living in. The majority of uninsured care that we provide in our organization is through our emergency department as 16% of our ER visits are accounted for by uninsured patients. Only 8% of those patients will pick up and complete an application for financial assistance.

I mentioned the coordination of care and how difficult that can become. Our uninsured patients are 15% more likely to return to the emergency department within 30 days than our insured population. There are a lot of reasons for that, but how that translates into cost for our hospital, we are not a wealthy health care system. We are a non-for-profit hospital and $10.3 million in charges over our last 12 months have been billed out to uninsured patients. We have been reimbursed $236,000 of that, just over 2% of what we actually bill out, and $7.9 million of that has already been adjusted off to our indigent care program or to bad debt and 85% of that to our indigent care trust fund and 88% of uninsured patients have made no payment toward their care

in our hospital over the last 12 months. It all goes back to what is the priority of the patient. You're in a hospital. You're getting discharged from the hospital. What are your priorities? Well, for a lot of our uninsured patients, it's where's their next meal coming from or where am I going to sleep tonight or how am I going to feed my children? The last thing on their mind is how am I going to pay for that hospital bill that's going to come in a month or so. I'm really worried about what is present of mind today, and that is the fact that it's cold outside and I don't know if I'm going to be able to be warm tonight. There are some other barriers for those that do want to participate in our financial assistance program. Again, I've mentioned only 8% of patients will actually complete an application for financial assistance of those who qualify. We've done everything we can up to deploying a community paramedicine team, a pro bono team of nurses who visit our indigent population at home post-hospital discharge to make sure that they got their medication, that they understand how to use medical equipment that we've given to them, and that they have all of the information they need so that they can apply for financial assistance. Yet still, 92% of the qualified patients won't go through that process. A lot of them we might never hear from again. Again, we go to call them, and that phone has been disconnected. We send them a letter. We deploy people to their home to help them but their address has changed. It makes it nearly impossible for us to effectively screen and help provide that financial assistance to all those who may qualify for that service. So, those are just some of the perspectives that we have from our organization.

Dave Almeida, Senior Director of Gov't Affairs at Blood Cancer United, thanked the Committee for the opportunity to speak and stated that medical debt is a significant issue for us because blood cancers are extraordinarily complex and difficult to treat and expensive to treat. In fact, the average price to treat acute leukemia just in the first year is around $500,000 and about 42% of patients exhaust their entire life savings paying for that treatment. And then what happens? They incur medical debt. We did some extensive polling and I've got some figures but I'll forego those figures and provide you with that polling information. Essentially, what we concluded is that medical debt is a serious issue for blood cancer patients, and it's one that very much affects not only their financial well-being, but also their medical well-being because as a highlight of what we found in that study is that people were making treatment decisions based on medical debt. They were foregoing treatment, they were delaying treatment, or they were not going back to the same provider where they owed money. A big component of where we see a solution is a two-pronged approach, as is reflected in the model. The first is to prevent patients from incurring medical debt in the first place and I'll stop there and say that we believe very strongly that hospitals are essentially the first line of defense when it comes to medical debt. And it's important, as we've heard, for patients to be made aware of the financial assistance programs that are available to them. But to put yourself in the shoes of a patient, just remember that oftentimes they have just been recently diagnosed. They are facing uphill battles as it relates to treatment. Perhaps in an ideal world, they would also consider enrolling in charity care, even as it's presented to them, but we think hospitals should go one step further, which is to actively help those individuals whom they have screened and they have determined are eligible for charity care to help enroll them in that charity care.

We are pleased to see that the model provides this provision. We would recommend, however, reconsideration of the exemption of disproportionate share hospitals (DSH). They are by their very nature serving populations that are most in need of these supports. They are also likely to be a step ahead as they already screened patients' finances to qualify. But, again, we ask them to take one step further, which is not only to screen but also to help enroll. The second component to preventing people from medical debt is to ensure that they are not subjected to the more egregious collections practices, such as the seizure of a primary residence or a vehicle, income through wage garnishment, negative credit reporting, and the imposition of high

interest rates on outstanding balances. In the interest of time, I'll focus on credit reporting. We strongly support the section of the model that keeps medical debt off credit reports. As many of you are aware, the Consumer Finance Protection Bureau (CFPB) recently issued an opinion stating that states are preempted from taking this action and not just that the states can't regulate how credit agencies use that information but even going so far as to say that states can't keep providers from reporting that information. The CFPB clearly states it's not a legally binding rule, and many legal scholars do not share this opinion. In fact, 15 states already have laws on the books and we would encourage you to consider keeping this model.

Rep. Bill Sutton (KS) asked Mr. Rushbanks about the reduction of 0.7% revenue if the charity care is issued - is that before or after the collection costs that the hospitals are currently utilizing to collect debt? Mr. Rushbanks stated that number is purely the reduction in revenue. It doesn't consider any potential costs the hospital might have with collection efforts. Rep. Sutton asked if the data generated any information on how much is being spent on those collection efforts? Mr. Rushbanks stated we don't know as I don't think the data would be publicly available. I think a hospital would have to offer that up voluntarily. Rep. Sutton then noted to Mr. Loskoski that the model exempts DSH's so that should help. Mr. Loskoski stated that I do understand that and I'm here to represent all hospitals. I think it's an important distinction that you make and well noted. There are very few mechanisms to help hospitals that provide indigent care, and DSH augments a little bit of that but I will say you're generally collecting 40% of cost. Rep. Sutton stated absolutely and I would agree that is certainly a distinction so presenting data for DSH's in regards to this model should share that distinction, which means it doesn't particularly apply.

Rep. Carter thanked Rep. Oliverson for sponsoring the model and stated that communities like mine are disproportionately impacted by debt and when people need to have medical services, the last thing they need to think about is how they're going to pay for it and how it's going to impact them in the future. I hear more collaboration between the speakers than I hear opposition, which opens the door for us to work together to come up with a solution to this problem of how hospitals can be made whole without running patients into bankruptcy. And in my community we have a high mortality rate because people can't afford to go to the hospital, and talking about the mountainous area, we have the upper peninsula in Michigan and right now hospitals are closing every day, and if a person is pregnant, they have to go miles to see a doctor. I would love to see how you could work together to put something in the hands of us legislators where we could address this.

Sen. Lang asked Rep. Oliverson about the intent of the model. Is it to prevent hospitals from turning debt over and ruining people's lives, or is the intent to prevent a provider from trying to get charitable status if they do turn it over? So, if a hospital wants to continue to go after bad debt, does that just mean they can do that but they just can't apply for charitable status because a bad debt isn't only a detriment to the consumer, it's also a detriment to the provider, and we all know that they don't eat those costs. There's just a cost shift that takes place.

Sen. Mary Felzkowski (WI) stated I just downloaded 500 990s from our hospitals in Wisconsin and I think every legislator should do that and you would be very surprised once you do. Our hospitals are all nonprofits and on average they do less than 12% charity care and if you think your hospitals are losing money, you're going to be very surprised. Less than 16% of our hospitals have lost money in the last nine years and their net incomes have far exceeded our retail, manufacturing, and construction revenues. And on average, if I pull out our rural and DSH hospitals, 30% of their expenses goes to their top executives. And they're not doing their charity care and when we added up what their tax base would be, it's in the billions of dollars and I kind

of find it insulting that the AHA pulls in a DSH hospital to represent them here today of all the hospitals in the U.S. I think this is an amazing model and it's time we do something like this.

Rep. Oliverson noted that DSHs are not the problem here and I represent some community hospitals as well, and actually this data would show that rural hospitals and hospitals that are critical access are way ahead of the curve in terms of actually meeting their obligations as a not-for-profit hospital and providing charity care. And that's why we're not talking about you today because you're already doing a better job in what we think. So, the reality is that the only thing that this model is about is making sure that the tax incentives that your states are already giving to tax-exempt hospitals are actually in exchange for charity care being provided to people who desperately need access to it. Hospitals shouldn't destroy people financially when they can't afford to pay their bills and should actually be providing charity care instead of naming a ballpark after yourself and calling that community interest or putting water fountains in the lobby and calling that community interest or taking out an advertisement in the town gazette or sponsoring a float in the Thanksgiving Day Parade which is free advertising and calling that community interest. We're all aware that we have entered into a time in which in our country things are less affordable than they used to be, and medical care is no exception to that. And so my question has always been and will continue to be whether or not these supposed costly things that we're asking for that they're already supposed to be doing in exchange for tax benefits meet or exceed the value of these tax incentives, and I know that they're not. And as we work on the model we will need to make a decision about whether we want this model to be applicable generally to any case where somebody has an unmet patient portion, insured or uninsured, that cannot afford to pay their bill or whether we want it to be focused specifically on the uninsured. How broadly applicable do we want it to be? Because in my conversations with the AHA they have stated that the model seems ambiguous on that point. I look forward to working with everybody on this. I think it's a great bipartisan model, and I think it's really going to help our folks back home.

CONSIDERATION OF NCOIL PRIOR AUTHORIZATION REFORM MODEL ACT

Rep. Pollock stated that next on the agenda is consideration of the NCOIL Prior Authorization Reform Model Act. The model was first introduced at the April meeting and it has received substantial feedback from interested parties and legislators. Several amendments to the model have been incorporated throughout the process from a range of interested parties. Both myself and the sponsor of the model, Sen. Walter Michel (MS), believe that the model is now in a strong position for consideration today.

Sen. Michel noted that as Chair the Mississippi Senate Insurance Committee, several years ago I was approached by some medical providers who wanted to address the prior authorization process. They said the process was taking too long and needed reform. We were in the middle of a session and didn't have time to address it with legislation, so we promised we'd have hearings that summer and we wanted to hear both sides of the issue so we talked to health plans as well who also said that the process could use improvements and oftentimes the reason that the prior authorization is not addressed in a timely manner is because the forms were not being filled out correctly or the process was antiquated through faxes and through phone calls. So, in our Mississippi legislation, we set up a web portal and all required data is on the portal and the process is streamlined. We set up categories for emergency medical services, urgent care services and non-urgent services. We set up a review process for denied prior authorization requests. We set up a statistical reporting system to show the results of approvals, denials, appeals, and timetables in the system.

All these items are contained in this model that we have before us today. The model has generated a lot of feedback received throughout the year. We've heard from multiple perspectives on this issue. This latest version of the model reflects feedback we've received. I have participated in many conference calls throughout the year, and if you review the minutes from our September interim committee meeting, you will see that we heard from 10 additional interested parties on this model and if we were to accept additional changes to the model that have been offered, it would veer too far from the law that is the basis for the model. We have three minor changes to the model that are printed before you that I want to present to you today. First, there's an edit made to Section 2 to reinforce that the purpose of the model is to regulate prior authorization[1]. Second, I've added a drafting note to Section 4 just to make sure that states need to cross-reference their statutory codes to make sure certain definitions used in the model align with definitions elsewhere in the code[2]. And third, I've added another drafting note to Section 20 to make clear that the rules set forth by the insurance department should include reasonable enforcement provisions for adherence to Section 6, which is the electronic prior authorization process[3]. This all came back from feedback we've received over the last year. This model can be used by states as a tool to use when implementing prior authorization legislation. Individual states are free to modify things like the time provisions, the review process, the statistical supporting systems, and other matters of the model. That being said, I encourage the committee's support in moving this model forward today.

Miranda Motter, Senior VP of State Affairs & Policy at America's Health Insurance Plans (AHIP) thanked the Committee for the opportunity to speak and stated that she appreciated the dialogue and the engagement that has happened over the past year on the model and certainly on this issue in general. My comments this morning are going to focus on three areas. First, the industry's prior authorization initiative. I know that when we were here last meeting, I sat here with the BCBSA and we spent a lot of time talking about the proactive, significant work that the health insurance industry brought forward as it relates to prior authorization. Since that meeting, I wanted to update this group on a couple of things

First, there are now 57 companies that have voluntarily agreed to move forward in this initiative, and what that essentially means is that more than 260 million Americans covered in the commercial space, in the Medicaid space, in the Medicare space will be impacted by this industry initiative. We believe this is significant. This is the industry proactively coming forward to help streamline and reduce provider abrasion, while at the same time making sure that patient care is safe and affordable. Those areas span across six different initiatives and items, and one of the things I wanted to reiterate here is we really believe the most significant initiative is working to address the use of outdated manual systems that we know providers continue to use today. So, since that announcement, the sort of work has been actively underway, the work to gather the data to do industry aggregate reporting. And what I commit to is that we can come back and share that at the end of first quarter next year. The second area is the significant need to move past using outdated manual systems. Over the course of the last year, you've heard me

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[1] The purpose of this Act is to regulate prior authorization by: protecting the health care professional-patient relationship from unreasonable third-party interference; preventing prior authorization programs from hindering the independent medical judgment of a physician or other health care provider; and ~~to~~ ensure~~ing~~ the transparency of a fair and consistent process for health care providers and their patients.

[2] Drafting Note: States may wish to ensure that the definitions in the Model conform with the definitions of these same defined terms elsewhere in a State's statutory code.

[3] Drafting Note: These rules should include reasonable enforcement provisions for adherence to Section 6.

stress the need to move away from those systems. Today, almost 50% of providers are using phone, fax and mail and we strongly appreciate the language that is currently included in the model which requires plans to build but providers to use electronic systems but what I would say is that the model still lacks any real enforcement against providers to actually have to use those electronic systems. While there are significant enforcement measures for plans to build the electronic systems and to do reporting, there is nothing included in the model that will actually move the needle for providers.

We believe that if providers want to avail themselves of the quicker turnaround times in the model, they should have to submit electronically. That should be a common sense solution to really making sure providers are moving away from outdated systems. The last thing I would say is we have appreciated the opportunity to engage in this process by providing comments several times but I still think in some areas it is unclear to us why certain language was included while other language was not and one example is the turnaround times for urgent care. Those turnaround times that sit in front of you today are not only a drastic departure from what the Mississippi law is, but it was actually turnaround times that were rejected during that process. They are not aligned with federal law, and our concern is that that will only lead to confusion amongst consumers and providers. Lastly, I commit to you that we will bring that data relative to the industry initiative early next year and I would just ask as you look to make sure that this is the right policy, that you're looking at it from a perspective of patient care and patient affordability and making sure that these are really driving to those issues which we know are incredibly important to the constituents in your communities.

Emily Carroll, Senior Attorney at the American Medical Association (AMA), thanked the Committee for the opportunity to speak and thanked Sen. Michel for bringing this critical issue to the committee and working so hard to advance it and getting it to a place where we believe it will help states establish meaningful reforms to protect patients from the delays and harms that result from prior authorization abuse. This model will also reduce administrative waste by helping to automate the system and reduce the time physicians spend on insurer requirements so they have more time to spend with their patients and on clinical care. I want to note every provision and solution in here has been negotiated and adopted in states across the country so these are tested ideas. While we had some modifications we would have liked to have seen incorporated, we think you ended up with a pretty balanced compromise. If adopted, I know physician groups and other advocates in the states will use this model as a foundation for reform efforts. As such, we urge the committee to adopt the model and we thank you for all your time and letting us be part of the conversation.

Terry Cunningham, Senior Director of Policy at the AHA thanked the Committee for the opportunity to speak and stated that I think the sign of any good piece of legislation is where no party is completely satisfied and that’s where you've arrived at a compromise and I think that's what we've got here. You've heard from the AHA several times on this throughout the year and there are some things that we think could be stronger in the model, and AHIP has identified some things that the plans think could be addressed better, and I think that might be a good sign that you have reached an appropriate compromise and we support passing this model as it sits before you.

David Lloyd, Chief Policy Officer at Inseparable thanked the Committee for the opportunity to speak and stated that this Model is a step in the right direction. He urged the committee to support the model and said he looks forward to working with states on implementation to address these important issues.

Randi Chapman, Managing Director of State Affairs at BCBSA thanked the Committee for the opportunity to speak and stated that she echoes the comments made by Ms. Motter. BCBSA is proud to have participated in the industry commitments mentioned by Ms. Motter and we stand by those as well. We are also very concerned about the need for enforcement for providers to participate in the electronic prior authorization process. And we are also very concerned that the model still does not have the needed alignment with some of the federal requirements, particularly those in the Centers for Medicare and Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule.

Sen. Lang asked Ms. Motter about the reporting data that will be available at the end of the first quarter of 2026. He asked what kind of information and data will be included in those reports? Ms. Motter stated there are six areas of this commitment, and each one of the commitments have varying timelines associated with them. One of the first timelines is the commitment to reduce the number of claims that are subjected to prior authorization. The other one relates to standardization of data and standardization of the elements. Those are the kinds of things that will be coming as part of our organization's gathering this data from the plans that have committed voluntarily, and we will bring that as an aggregate report to this committee.

Rep. Jim Dunnigan (UT), NCOIL Secretary, asked Ms. Motter what is the solution to the comments made regarding getting requests by fax and things like that. Ms. Motter stated I think ultimately we want to move away from those systems. And providers should have to use new systems. We know many of your states have passed prior authorization laws and you have required insurers to build those new systems and regardless, we still sit here with a significant number of prior authorizations submitted manually. Generally, what we will hear is that departments of insurance don't necessarily have enforcement authority over providers. You could look at that in different ways if you could have licensing boards do that, but we think at a minimum, to allow the providers to avail themselves of some benefits, we must make sure that they use the new systems. It’s common sense to require that if you are going to use the quicker turnaround times, that you have to submit it electronically.

Rep. Oliverson stated I have never met a provider that enjoys using a fax machine to turn in paperwork for prior authorization. This process needs reform. When you are the butt of a joke on an entire South Park episode, as prior authorization has been, it is time for change. I passed gold carding legislation through my committee in Texas reforming prior authorization which was infinitely less favorable to the health insurance companies, and they like it a lot less. And the model is a very measured, balanced, careful approach. I want to applaud Sen. Michel for his work on this because I think it threads the needle very well. I think we need to adopt this. We need to put something down and push back against the status quo. I assure you that if 100% of insurers went to electronic mechanisms for submitting prior authorization tomorrow, there would be an infinite uptake on the part of providers who would be grateful to not have to make phone calls and sit on hold for three hours and submit stuff via snail mail and fax machines. That is not a construct that is favored by anyone on the provider side of this equation. Because it's a delay tactic. I love this model. I hope we adopt it today and I just want to thank Sen. Michel for his thoughtful and careful efforts to listen to all parties in working on this.

Ms. Motter stated it’s important to note the 2018 consensus statement of all of our industries coming together voluntarily and saying what needs to be done on this issue. One of the places that we all agreed to was automation and in 2025, we're still sitting here with almost 50% of those submissions being done by fax, mail, or phone. Insurers are building these systems. We are required to do so in many of your states and unless we actually move the needle and require that those be used by providers, I fear that we will be sitting here five years from now

having the same conversation. We have to move away from those outdated systems. We have to do that for the patients that we're actually trying to get faster care to. Rep. Oliverson stated I understand that but the number one thing I hear from providers when I go around and I talk to them about issues in insurance is “when are we getting away from the fax machines?” And I agree that we’ve been talking about this for a long time. It is not up to the providers to get rid of the fax machines and I think they will gladly go for a faster, more seamless approach that provides a more timely decision, but insurers have to build the system and they will come. I just find it to be almost a red herring kind of issue that we're sitting here talking about, “well, providers aren't going to want to do this.” Of course they're going to want to do this. They've been asking for this for more than a decade.

Rep. Sutton asked about the expedited prior authorization verbiage in the model. I've heard that the 24 hour requirement has been used in other states but not in Mississippi. What states has it been used in, and how did it affect the rejections for prior authorization? Ms. Carroll stated that several states have adopted that 24-hour turnaround time but she did not have the specific list in front of her but she would get that list to Rep. Sutton. It is becoming a more popular provision for sure. I think that it has improved access to care. Plans can do this as about 90% of prior authorizations are approved, so it's just matching up data in a short amount of time. And 24 hours, if you need urgent care, is a lifetime to be waiting on approval from the health plan for that care that your physician has already determined is medically necessary and urgent. It seems to me that 24 hours is a pretty reasonable requirement. Rep. Sutton stated I'm curious as to how the insurers feel about that and also how it has it affected other states. You mentioned 90% are approved, and that's exactly right, but it's the 10% that are actually reducing costs and saving lives and so we don't want to necessarily sweep that 10% under the rug just because it's a small number.

Mr. Cunningham stated regarding the turnaround time, I'll point to the pledge that Ms. Motter talked about earlier in which they're pledging to move the overwhelming majority of their things to real-time authorizations, so much faster than 24 hours. We're talking real-time, and so that involves getting to the standards that need to be built that they're talking about. But again, the notion of what's best for the patients and what insurers are already on the books as trying to move to is real-time prior authorization response so I think 24 hours is a completely reasonable number to move forward with.

Rep. Scott stated that the timeline, especially on the appeals, is incredibly important. I really love Section 10 of the model dealing with personnel that are qualified to review appeals, especially considering in my district we've had three people that have been detrimentally affected by insurers using artificial intelligence (AI) to streamline these processes. So having a human review is incredibly important and I do think that we've got to move as a committee to really focusing on insurers and the use of AI and the data that they use to get it. I'll get into more with the sponsor, but I just want to lift up the fact that AI is taking over a big part of this, and Section 10 of the model covers a lot of my concerns.

Rep. Hefner stated that there are new advances and the barriers that we put in, like before in the panel talking about applications, if anyone's filled out a Medicaid application, it's like a second job. And so, there are new things coming up that have to do with AI, such as an AI agent. It just streamlines a lot of information so people can get through those applications. It took me three weeks to try to get a medication done for my son because someone wasn't answering the phone or I was on, and then they asked for a fax. It's a problem if we want to help save lives, and I'm hoping that we are all open about maybe talking about AI again and how we

can put those guardrails on for our vulnerable populations, but not go away from innovation so we can take care of these barriers that are just worthless.

Sen. Lang stated that a recent meeting of the NCOIL Property & Casualty Insurance Committee, we talked about the importance of quality over time and I think most of my colleagues agree that it's important that we have prudence to make sure all considerations are given fair consideration. I appreciate the fact that we've had multiple hearings on this issue but based on new evidence I heard today that there will be some reports coming out in 2026, I am not recommending a no vote but I am recommending that we delay this until we see those reports and we see what actions that the free markets are taking to correct this problem. Because I believe much more in free markets knowing best how to fix a problem than I do in government knowing how to fix a problem.

Sen. Michel stated that if we delayed this any further we would probably get the same results that we had from our September interim meeting and instead of 10 speakers we probably would have 20 or 25 speakers want to comment on the issue. I think we have a balance on the model and states are certainly free to make changes to it that they think are more suitable to their needs and I think we should consider the model today.

Hearing no further questions or comments, upon a Motion made by Sen. Michel and seconded by Asw. Pam Hunter (NY), NCOIL President, the Committee voted by way of a voice vote to adopt the proposed amendments earlier referenced by Sen. Michel with Rep. Pollock determining that the yes votes clearly outnumbered the no votes. Then, upon a Motion made by Rep. Oliverson and seconded by Asw. Hunter, the Committee voted by way of a voice vote to adopt the Model with the amendments with Rep. Pollock determining that the yes votes clearly outnumbered the no votes.

CONTINUED DISCUSSION AND CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL TRANSPARENCY IN DENTAL BENEFITS CONTRACTING MODEL ACT

Rep. Pollock stated that next on the agenda is consideration of proposed amendments to the NCOIL Transparency in Dental Benefits Contracting Model Act. He reminded the committee that a large set of amendments to this model were introduced earlier this year and the committee voted to readopt the model at our past two meetings on a meeting-to-meeting basis to allow time for further work and discussion on the proposed amendments. Throughout the process, I've worked with the sponsors and interested parties to make clear that since this model is back before the committee on its first readoption review five years after initial adoption, and since the model has been very successful in terms of being adopted by several states, the only amendments being considered today are those related to virtual credit cards. The first review for re-adoption isn't meant to be an opportunity to take the model and go in a different direction, unless the model has become outdated or there is a policy shift in the states that the model should respond to. I do recognize that the network leasing amendments are very important, but those are relevant to the entire health care system, not just to dentists, so that conversation should have more time next year and involve other interested parties. But for today, I understand some states have gone in different directions with the virtual credit card provisions, so I'm happy to have the committee entertain changes if that is the sponsor's intent. Unfortunately, the main sponsor of the amendments, Sen. Justin Boyd (AR), Vice Chair of the Committee, is unable to be here due to a canceled flight, but Asm. Jarett Gandolfo (NY), co-sponsor of the amendments, is here with us.

Asm. Gandolfo thanked everyone for their work and comments on this throughout the year. There's been a lot of conversations over the last about year about this and I've learned a lot about dental insurance from both sides and it's been great and I appreciate all the engagement from the dentists and the dental plans. It's really been an enlightening process. Regarding the virtual credit card amendments, Sen. Boyd and I took into account some of the changes that the dental plans were looking for and the spirit of our amendments focus on shifting from an opt-out approach to an opt-in approach for providers. Six states have gone in this direction, most recently Florida, California and Pennsylvania so we believe that these amendments are reflective of a trend we are seeing in both red and blue states. I understand there is an alternative approach to the virtual credit card amendments that we might be hearing about today, but Sen. Boyd and I would like to see the model re-adopted with the amendments we have put forward.

Rep. Robert Foley (ME) thanked everyone for their work on this and stated that I'm going to defer to the sponsor on how he'd like to proceed as I know he's worked very hard on these amendments. But I just wanted to make it clear that I am offering an alternative approach to the virtual credit card amendments that was referenced by Asm. Gandolfo. After both approaches are discussed, I'll defer to the path Asm. Gandolfo would like to proceed with, but I'm offering the alternative approach that I think strikes a good balance of making a tweak to the model during the re-adoption process, but not doing something that significantly changes it like shifting from the opt-out to the opt-in approach. And that is the core difference between the approaches to the virtual credit card amendments, the opt-in vs. opt-out change. The approach I'm offering maintains the opt-out approach while the Sen. Boyd and Asm. Gandolfo amendments switch to an opt-in approach.

Chad Olson, Senior Director of State Gov't Affairs at the American Dental Association (ADA) thanked the Committee for the opportunity to speak and stated that there are three reasons to adopt the amendments as proposed by Sen. Boyd and Asm. Gandolfo. It is good policy. It is in line with the legislative trends we're seeing in the states, and it makes a positive change to the 2020 model and keeps it current. First, why is opt-in fee-based payment good policy? If a provider decides to accept a payment with a fee associated with it, that provider should have maximum power of choice. We have found that opt-out isn't providing that, but opt-in will, and here's why. Opt-in supports the basic contracting notion of an offer and acceptance after due consideration. For example, with opt-in, before ever receiving a virtual credit card, dentists would be asked if they would like to receive that kind of payment and, after considering what worked best for their practice, could say yes or no. That's sound policy. Not so with opt-out. The dentist is at the mercy of the carrier sending a virtual credit card, one where the carriers may be receiving a small percentage of what it costs for the dentist to use it, and if the dentist doesn't want the virtual credit card, she has to go through the process of asking to receive money a different way, causing delay, burning staff time and confusion if the carrier is subcontracting to another entity, which may not honor an opt-out sent to the carrier. For small business owners, this is a big deal.

Second, opt-in matches legislative trends we're seeing around the country, and dental plans are already complying with opt-in in many states. Six states - Vermont, Missouri, Maryland, Oregon, Florida, and California have opt-in as law. And according to the 2024 National Association of Dental Plans Enrollment Report, this already represents coverage for 41 million, or 25%, of the 170 million enrolled lives in the U.S. today. Lastly, the amendments represent positive changes that fit the spirit of the model, while keeping it relevant to the experience on the ground between dental carriers and dental offices. In opposing the amendments, the dental plans have used phrases like "drastic" and "180-degree change," and you'll likely hear them again in just a

second. But we strongly disagree. The spirit of the model was to ensure that dental plans are transparent in their actions and that providers are empowered to make proper decisions on behalf of their practices and patients. Adjusting to opt-in on fee-based payments fits that spirit perfectly. This is good policy, it's in line with legislative trends, and it's a positive change that fits the spirit of the model. For these reasons, I urge committee members to vote in favor of the amendments.

Bianca Balale, Director of Gov't Relations at the National Association of Dental Plans (NADP), thanked the Committee for the opportunity to speak and acknowledged the thoughtful discussion surrounding this model and the decision to defer consideration of network leasing to allow for a more comprehensive discussion at that time. There is something I want to address before I get into some of my comments, and I will be brief. There was a reference to six states that have adopted an opt-in approach. Just to be clear, for three of those six states, those virtual credit card provisions are related to all health insurers, not specific to dental. We are speaking on a dental-specific model here. The additional states that were referenced, while they have an opt-in provision, they do not align with what is before you today. What is before you today includes an "express acceptance" definition that would require an opt-in physically in writing. So I want to make sure that is clear to the committee as we are further discussing this. But I do want to speak to the opt-out approach. We believe it preserves flexibility for plans and providers and provides both a clear and transparent way to receive payments. The proposal raised by Rep. Foley is aligned with the amendments introduced by Asm. Gandolfo and Sen. Boyd, but does maintain the opt-out structure, which is currently in the model.

So, that would prevent this from being a full rewrite of the model within the re-adoption process. These amendments from Rep. Foley increase transparency, offer additional protections for providers, and ensure the model remains viable for the duration of the re-adoption period. This is in addition to the existing model provisions, which include strong notice requirements and consent provisions. Maintaining the current opt-out structure, which has been adopted in 15 states to date, allows providers to utilize existing credit card terminals to accept payments promptly without increasing administrative burden on their practices. It allows these small dental providers to elect what's best for them. We urge you to renew the model with the amendments offered by Rep. Foley and to maintain that opt-out structure. Shifting to an opt-in approach would rewrite the model, while adopting the amendments proposed by Rep. Foley allows for meaningful targeted improvements within the framework that has proven effective.

Vince Ryan, Regional VP of State Relations at the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak and for the thoughtful discussion and deliberations on this proposal. He continued that the ACLI joins NADP in opposing the overhaul of the model's payment provisions proposed by the ADA, and supports the compromise amendments proposed by Rep. Foley. Virtual credit cards provide security and convenience especially for small offices that may not utilize electronic records and what is being proposed by the ADA would upend the current system and make it harder for providers to access the virtual credit card payment method if they so choose. Finally, the current model already has protections in place around payment methods but these amendments proposed by Rep. Foley would add additional safeguards while allowing providers to retain meaningful control over their payment methods via the right to opt out.

Asw. Hunter commented in support of Sen. Boyd's and Asm. Gandolfo's opt-in amendments. In New York, we had an opt-out situation relative to an insurance issue that caused so much problem and concern with not only policyholders but carriers, and we had to change that. So, I support those amendments and would ask all of my colleagues to do the same.

Rep. Matt Lehman (IN) asked Ms. Balale if I provide a service you're going to pay for and you offer me a virtual credit card and I say no, doesn't that automatically trigger a secondary payment of a different method? Send me a check. Why is there any delay in that? I'm hearing there's a delay and I don't get paid. Why would an opt out not immediately trigger a secondary payment? And then question two is if that's the only method I'm being offered, is that contractual, or how do you get away with not offering multiple methods of payment, especially to maybe a smaller dentist? Ms. Balale stated under the current NCOIL model, plans are required to offer additional methods of payment. Rep. Lehman stated but it sounds like are there some states that when they adopted this, they didn't adopt that portion or maybe Mr. Olson can provide examples where dentists were not paid immediately when they opted out of the virtual credit card. Mr. Olson stated yes - I'm thinking of an email I received from an Ohio dentist that was trying to opt out of the virtual credit card that was received. Like you said, it's basically, "I don't want to take this form of payment" and then it was another company that was involved in actually issuing the credit card, so in notifying the carrier they weren't able to "opt out" in a timely fashion so there was a delay in the payment, and that's what I was speaking to.

Rep. Lehman stated it perplexes me why that's not simple. The other thing is I've heard from some other entities that are kind of watching this to see if it's going to be changed to an opt-in because they want to come and kind of latch on to that. Then it really starts to concern me that we're opening up a re-adoption of a model that is a significant change and it's going to be utilized by others to kind of use as their model now to go forward. So, I just have some concern with changing it that way. You said six states have adopted this as opt-in so then you can go back to your state and change it to opt-in if it's a problem. But I think this is going a little bit farther than what I think the intention of a re-adoption of a model would be. I would say bring back a separate model that deals with multiple practices for an opt-in or opt-out payment system.

Mr. Olson stated in response to Rep. Lehman's concern, with network leasing there were discussions to withdraw the amendments and have that discussion next year and that was really appropriate. What I would say is that we have a large number of states that have already adopted opt-in, but the backing of NCOIL would have that discussion be, I think, broader. And even in places that have passed into law opt-out, maybe a reconsideration would be appropriate. Because I think what I'm hearing from the dentists that I work with is that it is something that they feel in their offices as small business owners and I think it also speaks to making NCOIL reactive to what's being faced on the ground when these laws are already enacted, and makes it more meaningful in terms of how relevant the model would be. It's a real targeted approach that Asm. Gandolfo and Sen. Boyd are looking at, and I think it's appropriate in the reauthorization process. I know that's my opinion.

Ms. Balale stated I think Rep. Lehman makes a very good point in setting a precedent in the re-adoption process with a lot of eyes on this model and potential interest on how this will go. And as I indicated previously, while we have seen some states adopt opt-in, again, that is not what's before you today. There is an opt-in before you but the language does not mirror what has been adopted in the states that have looked at opt-in. It is far stricter. It requires an in writing election which runs a significant risk of further slowing down the process, causing confusion, delaying payments, as well as potentially putting our plans out of compliance with prompt pay laws in your states as well.

Rep. Scott stated that he supports the amendments put forward by Sen. Boyd and Asm. Gandolfo. I sponsored House Bill 1664 in Pennsylvania, and it started out because I went to the dentist and found out about this issue and how my dentist was forced to receive his payment on

a virtual credit card. Mind you, this is not only a consumer protection issue or a small business issue, this is also a patient safety issue as well. With the 5% that his dental insurance virtual credit card payment was charging, once we passed this bill and absolved that, he was able to hire two more dental hygienists at his office, which then boosts his office. I also just want to point out that ultimately our bill was expanded to other practices. It's important to note that in this healthcare sector, we have a lot of providers, especially specialties, that are being bought by private equity because of the sometimes over regulation or the hardness of just doing the small business aspect and this would help bring more revenue into the provider's office. So, I'm very supportive of this and I think that it's about time. And I think the only other solution would be the insurers absorbing the cost of that fee. If they want to absorb the cost of that fee and not put it on the backs of the business owners that have already negotiated a smaller fee than they would normally charge then I'd be happy to entertain that but until then let's support this.

Ms. Balale stated to clarify the issues on fees, the fees that you are referencing could be associated with the actual use of the card as dental plans do not charge fees for this. Rep. Scott the dentist that's providing the service has already negotiated a fee with the insurer so they're entitled to that fee. If the cleaning's $150 and you negotiated $75, they should be able to get their $75. If you want to charge a fee for that or if they want to get the money off, they shouldn't have to pay a 5% fee for that. Ms. Balale stated they are absolutely reimbursed at that negotiated rate you referenced. Rep. Scott stated yes, but minus the fee. Ms. Balale stated it depends on their payment election.

Rep. Carl Anderson (SC) thanked everyone for their work on this and stated that before traveling to this meeting he received a note from the South Carolina Dental Association supporting the amendments from Sen. Boyd and Asm. Gandolfo. The Ass'n stated that the model has made a big difference for dental patients in South Carolina and the amendments would be another step forward for improving the oral health of South Carolina patients.

Rep. Camille Lilly (IL) asked how the amendments would impact health savings accounts (HSAs)? Mr. Olson stated I think that the plans would have to follow up on the answer to that question. Ms. Balale agreed and stated I'm not aware of any impact at this current moment, but I would definitely want to follow up with you on that.

Rep. Pollock asked Asm. Gandolfo how he would like to proceed. Asm. Gandolfo stated that he wanted to move forward with the Sen. Boyd and Asm. Gandolfo amendments.

Hearing no further questions or comments, upon a Motion made by Asw. Hunter and seconded by Rep. Anderson, the Committee voted by way of a voice vote to adopt the Sen. Boyd and Asm. Gandolfo amendments with Rep. Pollock determining that the yes votes clearly outnumbered the no votes. Then, upon a Motion made by Rep. Anderson and seconded by Asw. Hunter, the Committee voted by way of a voice vote to re-adopt the Model with the amendments with Rep. Pollock determining that the yes votes clearly outnumbered the no votes.

ADJOURNMENT

Hearing no further business, upon a motion made by Asm. Gandolfo and seconded by Sen. Lang the Committee adjourned at 11:45 a.m.