NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2025 NCOIL ANNUAL MEETING – ATLANTA, GEORGIA
November 14, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Whitley Hotel in Atlanta, Georgia on Friday, November 14, 2025 at 3:15 p.m.

Michigan Senator Lana Theis, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Brenda Carter (MI)
Sen. Jeff Howe (MN)
Sen. Jerry Klein (ND)
Rep. Meredith Craig (OH)
Rep. Brian Lampton (OH)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Carolyn Hall (AK)
Sen. Larry Walker (GA)
Rep. Camille Lilly (IL)
Rep. Sean Tarwater (KS)
Rep. Chad Aull (KY)
Rep. Daniel Grossberg (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBoeuf (MA)
Rep. Robert Foley (ME)
Sen. Michael Webber (MI)
Rep. Garland Pierce (NC)
Sen. Jeff Barta (ND)
Sen. Bill Gannon (NH)
Sen. Tim McGough (NH)
Rep. Julie Miles (NH)
Asm. Jarett Gandolfo (NY)
Rep. Tim Barhorst (OH)
Sen. George Lang (OH)
Rep. Matt Morgan (TX)
Rep. Trey Wharton (TX)
Rep. Calvin Roberts (UT)
Rep. Calvin Callahan (WI)
Sen. Mary Felzkowski (WI)
Sen. Cale Case (WY)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Meredith Craig (OH) and seconded by Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Justin Boyd (AR) and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 17, 2025 meeting.

PRESENTATION ON INDIVIDUAL COVERAGE HEALTH REIMBURSEMENT ARRANGEMENTS (ICHRAS)

Sen. Theis stated we'll start with a presentation on Individual Coverage Health Reimbursement Arrangements (ICHRAs). I am excited to hear about ICHRAs as they are an emerging health product and I look forward to the Committee learning more about them during our conversation today. This topic was brought forward by Rep. Meredith Craig (OH), who sponsored a bill in her home state dealing with ICHRAs.

Rep. Craig stated as noted, I'm currently sponsoring a bill in Ohio. You can view the legislative analysis of the bill on page 184 in your binders. The bill itself is on the website and the app. The bill is pretty straightforward. It authorizes a non-refundable tax credit for any small business that has 2 to 50 employees who offer an ICHRA. First and foremost, I should ask the room, who knows what an ICHRA is? For those that don't, it is an individual coverage health reimbursement arrangement. This was something that the first Trump administration tried to push forward. Part of the conversation earlier today revolved around the marketplace and trying to get healthy individuals into the risk pool. So, this was formed to help provide an option to employers to contribute a pre-tax amount of money into an ICHRA, similar to a health savings account (HSA), for an individual to go buy a plan on the individual exchange so that person can shop around for what works for them. And again, that alleviates the cost and the burden on the employer by allowing the individual to take control of that. Overall, the bill encourages those employers at that 2 to 50 employees mark which are not required to offer health insurance. Ohio, and I think other states, are looking at work requirements for Medicaid, and so as that is rolled out, we're going to want to incentivize folks to get insurance some way and this should help with health care choice and accessibility. So, it's a great topic for the committee to discuss and I look forward to working on potentially looking at a Model Law here at NCOIL.

Peter Nelson, Director of the Center for Consumer Information and Insurance Oversight (CCIIO), thanked the Committee for the opportunity to speak and stated I'm really happy to be here. I've been working on public policy issues, mostly at the state level, but as you all know, state and federal health care policy intersect in many ways. And so, at the state level, I always had to deal with the federal laws, and I was always trying to think through ways to give states more flexibility within a federal framework across so many dimensions in federal law. I come from Minnesota, so my experience in Minnesota, starting off, we had a Republican Governor with mostly a Democrat legislature. And we were thinking a lot of different, more bipartisan opportunities to improve our health care system when I started working. Some of my first reports were on state exchanges and the potential benefits of state exchanges. Another report that I led off with was a report on some problems with employer-sponsored health insurance. And not that employer-sponsored health insurance is bad, but they create some obstacles for consumer choice. Mostly, usually when you get a health plan through your employer, you really don't get that many options. Oftentimes, you don't get any options at all. That's, of course, driven by the tax preference for employer-sponsored coverage. There was always this sense back before the Affordable Care Act (ACA) was passed that you couldn't have the type of health insurance coverage through your employer that gave employees choice and gave them basically a defined contribution of dollars that they could then use and go out into the individual market and shop for their own coverage that would then be portable if they left their job.

Potentially, if another employer offered a similar defined contribution approach, they could then, in that other job, carry their insurance with them. But fundamentally, it's about choice. It's about being able to, as a consumer, have a choice over your health plan and have more decisions over factors like what sort of level of premium do I want compared to the cost sharing and the deductible amount that I want. Before the ACA passed, there really wasn't that much of an opportunity. There were some opportunities for that sort of arrangement. After the ACA passed, I was very optimistic that this was going to be able to take shape and the reason why I was optimistic is because the regulatory structure between individual market plans and small group plans pretty much equalized and that was one of the obstacles. And so, there's a lot of us that thought you could do that. However, in 2013, the Obama Administration issued some guidance that restricted that. Then I spent several years looking at the law and making some arguments that, no, actually, you should have some opportunities here. And I had the honor of being hired in the first Trump Administration and when I got there, we immediately set to work on developing rulemaking to allow what we're talking about today, ICHRAs. And these are health reimbursement arrangements that an employer can set up and put a defined contribution of dollars into the health reimbursement arrangement that allows the employee to pay for an individual market premium and have that choice. And this cures a lot of issues for employees over choice and gives them a lot of power to basically define what's good for them and their families, but it's also really important for employers. There are a lot of employers that just don't offer health coverage because it's very complicated and this can be a simpler way to allow employers to provide a pre-tax contribution for their employees that they otherwise wouldn't provide. Before the first Trump Administration, there really wasn't that structure in place. We put in place rulemaking that provided a structure.

I'll just give a high-level overview of that rulemaking. One of the issues with health reimbursement (HRAs) could be that employers would try to separate their employees by their healthy employees and their sicker employees. So, we had to draft some careful rules to ensure that employers weren't dumping sick people into the individual market. And so, we did that, and that rulemaking is now in place, and I'm really pleased to say that the Biden Administration left that rule in place, and I think they left it in place because they saw that there are substantial benefits potentially for some employers in this situation. It's a good option. And we have seen some bipartisan support for these policies. We are seeing Connecticut, they have developed tools through their state exchange to facilitate this. We're seeing Georgia, who's here today, I understand we're making some progress on that front there and I think Colorado is also doing some work on this. But there are some issues that we still have, and that's what I'm really excited to hear about from the panel here, because we issued these rules, and we have a lot of policies in there to ensure that this works, that we're not undermining the individual market. That doesn't mean there aren't some obstacles, and we recognize that. And there are also some enrollment challenges that we might experience in the market, because there's not right now yet, I think, the simplified tool for the small employer to just take off the shelf and use, which is why some state exchanges are jumping into this game to help support that. So there needs to be better support tools for businesses.

And there's also a lack of awareness and one of the reasons why is because right when we did the rule, COVID happened, and no business was going to change their business health benefits at that time. And then when the Biden Administration came in, there was some questions over whether this policy was going to stick. It has stuck now. I think moving forward, we're going to have some more interest in this. We've already seen a lot more interest from a lot of companies and we're really excited to see that. I'll just conclude that from a federal level, we see ourselves as facilitators. We want to facilitate this approach to make sure there's a fair level playing field for this approach. One of the things we just did is ahead of the open enrollment period, we

released data for off-exchange pricing and plan attributes to make sure you can set up those tools. So, we're creating the framework for this. We're still creating that framework right now, and that's where we think with this framework in place and with the interest we're seeing from insurance companies and from other states, I'm excited to see this take off.

Danielle Winiecki, Director of Business Development at Ambetter Health, thanked the Committee for the opportunity to speak and stated Ambetter Health is a subsidiary of the Centene Corporation. We focus on Medicaid, Medicare, and marketplace insurance. ICHRAs are very meaningful to us. We have it as a major part of our strategy. We want to be able to offer more benefits to more consumers and have them select those plans under an ICHRA. A lot of us have already talked about sort of the base level of what an ICHRA is. I'm just going to highlight some of the key things. We've talked about how it was established in 2020 and that the Biden Administration further reinforced it, where now we're coming back to a place where it's starting to increase in adoption. We're starting to see more consumers enrolling under an ICHRA and the reason that they're doing that is because we're finding that costs can be more predictable for employer groups. So, they're saving money out of their own pocket from a business perspective and being able to offer that defined contribution or subsidy to their employees to then go choose the plan that's personal for them. So, getting into my second circle here of plan personal, it's really focusing on being able to choose the plan that's right for you and your family as an individual and as a family. And then lastly, it makes coverage possible. We're finding more small businesses are able to offer benefits to their employees under an ICHRA. We talked about tax subsidies as it relates to small business owners from that 2 to 50 employee space. More consumers are able to be insured because of ICHRAs.

I love to do this comparison here between group insurance and ICHRAs just to better set what this looks like. From a group insurance perspective, employers typically create that benefit offering for their employee base. They look across their employee base and they decide maybe 2 to 3 different plan options for their employees. That doesn't create a lot of choice, to Mr. Nelson's point earlier. What we're looking to do is create more options and more individuality when it comes to that consumer's need for healthcare. So, group insurance really makes it look like one T-shirt size fits all and we know that that's not really what works. It's good to take some of the good things about group insurance and carry them over and carry them forward into an ICHRA, being able to offer dollars to that employee base so that they can then select the plan that's right for them. You'll see those 5 different images here under ICHRAs. It's really a whole lot more choice than that. I'll give you a good example case that we have. In the last two years we had a group that implemented an ICHRA with 500 employees. The reason they did that was because they faced a really heavy increase in the group insurance market, over 40%. So, they went to their broker and said, what are our options? What can we do? An ICHRA was presented to them on the table, and they said, "okay, what does this look like? How do we implement this for our employees?" It comes with a communication strategy, a plan of attack to help educate those consumers and those employees on what works well for them. They went from 3 different plans to now 180 different options. Now, 180 is a huge number, but the cool thing is a lot of the enrollment platforms that leverage ICHRA that help promote it for us will offer decision support. That doesn't necessarily always mean it's technology-based decision support, but they also have licensed professionals on phone calls to help people enroll in those plans. So, alongside an ICHRA, we're also educating people how to utilize their health care based upon their needs.

So why now? Why does this make sense? I think this is really an important time. There's a lot happening in the world, a lot happening in the U.S. with healthcare. I think it's important for us to have more choice for employers to offer benefits to their employees that are accessible, affordable, flexible, and individual. So right now, it feels like the right time to make this happen.

The image that you'll see on this slide just showcases that small group premiums are typically increasing at a faster rate than the individual market is. So, our individual marketplace that we've developed under the ACA has been able to help us to mitigate those cost increases. Even though we see some increases year over year and this year especially, we're still increasing at a slower rate than the group marketplaces. So, it's important to note that there are other options out there for employers, small, mid, large sizes. And there are plans that are ACA compliant as well as showcasing options across HSA compliant plans, Preferred Provider Organization options. Bronze, silver, gold plans. So, there's still a lot of choice there for those consumers. And then lastly, what's next? How can you all help us to push this forward? We want to work with you all to help educate people about what an ICHRA is, increase the awareness, increase the adoption, work with local organizations and associations such as Chambers of Commerce to help push this forward alongside you all. One statistic that I'll leave you with is there are over 170 million Americans covered on group insurance today. It's a little bit broken. We want to be able to offer more choice. The individual marketplace has roughly 25 million Americans covered today. We don't expect that to be a huge shift, but we do expect ICHRAs to be a viable solution for employer groups to offer benefits to their employees.

Brooke Tiner, Director of State Government Affairs at Oscar Health, thanked the Committee for the opportunity to speak and stated that stated Oscar Health is a healthcare technology company that was created in 2012. We are in 18 states currently, 20 as of January and we offer ACA individual marketplace plans. We do not do that as our only line of business, so we are expanding our reach and continue to expand our reach into different states and into different markets, and this is a place that we look at as being able to expand our offerings and expand our options to our members and to those that are currently either without plans altogether or cannot afford them. You've already heard a lot about what an ICHRA is and how it works. I'm going to talk a little bit about what's already in place right now across the federal and state landscape. I'm not going to go through all these, but the point of this slide is to just to show you the state activity that's already taken place this year and will take place next year. One of the bills that's left off this slide, unfortunately, is the New Jersey bill. There is a bill in New Jersey that creates a tax credit. Most of these bills are fairly similar to what Rep. Craig described in the Ohio bill and creates a tax credit for employers who offer ICHRA plans. The Georgia bill has a sunset of that tax credit for 5 years. So, they differ a little bit, but most of them are fairly similar, and the idea behind these bills is to create awareness and to create an incentive for employers to look at these plans and to look at these options, especially those that may not be able to even offer plans to their employees.

The education is a really important piece, and using these pieces of legislation and places like this to educate on what ICHRAs mean is critical. I do want to point out that the Florida bill is a little bit different in that it actually creates a marketplace for ICHRA plans in the state, and it creates a platform for ICHRA plans in the state. It does not have a tax credit attached to it. So, it's a little bit different, but it's similar to some of the activity that Mr. Nelson spoke about and some of the things that the state-based exchanges are doing to allow a place and to create a place where employers can go and buy these plans and administratively access these plans. We are very hopeful and we are continuing to advocate for these bills in states because we think it's really important that if we are able to offer additional affordable options, especially in this time that we're in right now, to those who need them, that's where everybody wants to be. We really appreciate the partnership and want to continue the partnership on the state and federal level. My next slide just talks about what's going on with the federal legislation. We do have two bills right now that are active at the federal level. What's interesting about the Choice Act (S 2875/HR 5463) in particular is that the acronym ICHRA is sometimes a little bit difficult for people. This rebrands ICHRA as Choice - Custom Health Options and Individual Care Expense

arrangements, which actually I think explains it a little better. It's a choice option and we're all talking about choice. What's interesting about the other bill from Representative Van Duyne (TX) is it is an education bill on ICHRAs (HR 5498). It does not approach the tax credits. It is a bill that directs the Small Business Administration to do education on ICHRAs. We believe that will also be extremely helpful in getting brokers engaged, getting other states engaged, and it's another interesting approach to getting awareness out there about these plans and about what's happening in the marketplace.

Martin Sullivan, Chief Deputy Commissioner and Chief of Staff at the Georgia Department of Insurance and Safety Fire, thanked the Committee for the opportunity to speak and stated that at the Georgia Department, we're very fortunate that we have such strong support in our legislature who give us the resources and tools we need to make sure we accomplish our goal, that there is no wrong door when it comes to finding healthcare options. Several years ago, they gave us the authority to create Georgia Access, which has been extremely successful. That's our state-based marketplace in Georgia that we've gotten 1.5 million people enrolled in. And one of the greatest things as we've gone around and talked to Chambers of Commerce and different business groups around the state is that they love that kind of access and support of offering insurance to their employees. That is where we came up with, in speaking about ICHRAs, rebranding it in Georgia as Georgia Access for Business (GAB). GAB is going to be a state-administrated platform for managing ICHRAs. Its core mission is to expand access to affordable, flexible health care coverage for employers and employees. This is being built in partnership with Georgia Access, our state-based exchange, NFP, and Zizzle Health. GAB offers a turnkey solution for ICHRA adoption across employer sizes and sectors. It's designed to support both currently insured Georgians and those who remain uninsured, bridging gaps in coverage through employer funded benefits.

GAB provides the digital backbone for ICHRA setup, administrative, and compliance and it employs our agents, and we currently have over 20,000 agents writing on our state-based exchange. It gives them the training and the certificate programs they need to be able to write ICHRAs and it connects certified agents with interested employers. The platform will also provide onboarding assistance, planned configuration, compliance guidance, and dedicated support for navigating both Internal Revenue Service (IRS) and ACA roles. NFP and Zizzle Health deliver full-service ICHRA administration including documentation, billing, and reporting to make sure we provide this simple and easy for Georgia employers. The ecosystem will help simplify the transition from traditional group health plans to define contribution ICHRAs. It supports employers seeking cost control and flexibility, multi-locations or remote teams, and organizations with low performance in group plans, which I think is highly important. If you've got employees all over the state of Georgia, and you pick a plan from the Kaiser network which is not available outside Atlanta, your employees wouldn't be able to take advantage of it. So, GAB ensures that all stakeholders, agents, employees, and vendors operate within a compliant, ethical, and efficient framework. And why can employees choose GAB over traditional group plans? Because rising group costs make ICHRAs an attractive alternative. It enables defined contributions based on employees' class or criteria and employee empowerment through plan choice and portability and payroll integration for additional employee contributions. Employers shift from managing benefits to managing budgets, with GAB handling all the complexities. GAB will also help employers understand how ICHRAs interact with the Advanced Premium Tax Credits (APTCs). ICHRAs disqualifies APTCs if deemed unaffordable, and employees may opt out if it is cheaper and better for them to choose APTCs. GAB provides tools and guidance to assist affordability based on household income versus benchmark plan costs, ensuring compliance and transparency. Our Department's goal is to make sure every Georgian has

access to affordable, quality health insurance, and we believe ICHRAs will help us move forward to reaching this goal by leaps and bounds in the years to come.

Rep. Jim Dunnigan (UT), NCOIL Secretary, stated if an employer gives an ICHRA allowance to an employee and they take that to the marketplace, are they also eligible for the APTC? Mr. Nelson stated within the framework of an ICHRA, they would not be qualified for a tax credit. That would be considered a group health plan. That would disqualify them from a tax credit. However, there is something called a qualified small employer HRA, which adds some further complications to this question and there is a circumstance where they could, if the employer gives them a contribution that's not big enough to deem that affordable, under the ACA framework for a group health plan, if that happens, then the employee can use the employer contribution alongside. Rep. Dunnigan stated that's going to be a very limited subset. Mr. Nelson said yes, and that's clearly not the ideal situation. We would, of course, want employers to offer a contribution that allows someone to buy an affordable plan.

Rep. Dunnigan stated healthcare costs and insurance premiums for healthcare are not going down. So, if I'm an employer and I want to control my costs with a defined benefit, maybe I give an employee $400 a month, you go to the exchange, we've got an ICHRA, and that stabilizes my contribution. The employee buys a plan. Next year, rates go up 10% or 15% and I still keep it at $400. Somebody's going to pay that. It's going to be the employee. So, the sales pitch about being stable for an employer can be true, the same thing is true on an employer-based plan. The employer can say, “I'm not providing an increase. I'm just keeping my group contribution the same.” But then it's going to be shifted to the employee. They'll have more choices. Maybe they can find a plan. But it doesn't take very long unless the employer escalates that. The employee's going to have a challenge. I know in our state, the individual rates are higher than the group rates already. In January, they're going to be significantly higher. So, the question is, are you better off to be on an employer-sponsored plan where they're contributing? Maybe you only have two or three choices or are you going to be able to take that defined benefit and maybe not be eligible for a tax credit so your employer contribution is not going to go as far and you may be better off in not even doing that and just going to the marketplace. So, the question is, if an employer offers an ICHRA, can I opt out and go get a subsidy, or the fact that it's offered to me, does that prohibit me from getting a subsidy tax credit?

Ms. Tiner stated the short answer is yes, you will be able to opt out. Rep. Dunnigan stated ok, and I understand it's a strategy like we have employer groups and they have somebody that's got really high claims and it's killing their group and they want to take them to the individual market to unload the risk. Ms. Winiecki stated the other strategy that we didn't talk about today but I want to call out for your question is that you can develop eligibility classes across your employee population. So, you could say for all full-time employees in Indiana, we're going to offer them an ICHRA because it makes sense because the individual rates are less than group rates in that state. But in your state, where they are not, you could offer a group health plan still and that could be affordable for both the employer and the employee and then everybody wins. So, this is really just an alternative, another option to try to help mitigate the cost of healthcare.

Rep. Dunnigan stated it's going to be very state specific. I've got to say one more time, the concept that this is going to control the employer's costs and defined benefit, yeah, but that just means we're shifting it to the employee and how long can they bear that? And then one other thing with ICHRAs, and it sounds like you're all working on it in Georgia especially, they're clunky to set up and they're not easy. Mr. Sullivan stated that's why Georgia specifically is working on this platform. There will be a website, and we're working with two organizations, NFP and Zizzle, to be able to simplify it and make it easier. We'll be training agents specifically

on it that are ready to sell ICHRAs so they can hit the market and run and make it seamless for both the employer and the employee. Ms. Winiecki stated one other thing is I've been in the employee benefits industry for over 15 years, and I think group benefits are also clunky. But ICHRA is new and young so it's going to be even clunkier as it's going to take time to build. Rep. Dunnigan stated they're both clunky but this one's clunkier. Ms. Winiecki agreed.

Rep. Dunnigan stated to Georgia, on the 1.5 million in the marketplace, what are you going to do with them now that they're losing those enhanced subsidies? Mr. Sullivan stated while I wish we could control what Congress is doing, we're holding over 100 events around the state, signing up people for coverage. We are having a multimedia approach to remind people that it's open enrollment. Unfortunately, the state does not have the resources to subsidize the plans like the federal government, but we're doing everything in our control to make sure every Georgian knows their options, whether it's the plan that they currently have, maybe it's a bronze plan, and it's why we are the first state-based exchange that is enhanced direct enrollment and agent-focused, and we encourage all Georgians to talk to an agent to help them figure out the plan that best fits their needs.

Rep. Tim Barhorst (OH) stated I just wanted to follow up on the hook and the carrot, obviously it sets up a great framework for an option and a choice employers have, and that's a great thing. How do we create the vibrant market that goes along with it, and what does that look like in Georgia? Are there any other states that have got the seeds already out there and moving, and how does Ohio in particular help ourselves germinate such a seed to maybe make Rep. Craig's bill when it gets through useful? Ms. Tiner stated the key to this is getting involvement from people like the Chamber of Commerce, which we're doing in Ohio. We're holding events with the Chamber in Ohio educating on these plans and educating on what Rep. Craig is doing with her legislation. We are working to do that in other states as well because one of the issues is, and I think all my colleagues would agree with me, people just don't know about this. Once they start hearing about it and once you start describing it, we may have disagreements, we may have questions, but those are the discussions we want to have. We want people to understand what's available and then how can we best serve. To do that, we need the businesses. We have partnerships with the National Federation of Independent Business (NFIB) and a number of states that are working with us on this and especially the brokers that already offer and can help us educate. So, it's a combination of all of that.

Mr. Sullivan stated I think one of the core things is educating agents because we see ICHRAs really as another great tool in the toolbox to help people get covered. We like to remind people all the time, as the Department of Insurance, we love every type of insurance. We love it if you have small group. We love it if you're on the marketplace. We love it if you have an ICHRA. We want to have the insurance that best fits you and your employer's needs. And this is the best way. We don't want a single person in Georgia to not have access to insurance. We think this is another great tool for employers to be able to offer a plan to get their employees to stay if they can't afford small group coverage. Because in Georgia, a lot of times the ACA plans are cheaper than the small group plan. Some counties, they're not. One of the great things when we roll this out is if an employer puts in all their information, it might come back and say, "Hey, a small group plan might be best for you". A Qualified Small Employer Health Reimbursement Arrangement might be best for you. A Multiple Employer Welfare Arrangement might be best for you. So, we want to make sure we use this platform to connect agents, employers, and employees with the best plan that fits them. The best way to do that, I think, is to get the word out, and we're working with agents and companies to get the word out as quickly as we can.

Rep. Barhorst stated that was helpful but I probably didn't frame the question as accurately as I wanted. When I say vibrant, I mean the carriers and the plans want to be involved in this and they actually file rates and have plans out there for it. So, what does Georgia look like? How many carriers do you have? How many plans are out there? How would Ohio bring that to a vibrant marketplace that an ICHRA with the tax advantage and an employer administration platform be able to take advantage? Mr. Sullivan stated we currently have 10 carriers writing in our marketplace and I can't tell you the exact number of plans offered, but it is a significant number of plans. We have 159 counties in Georgia. Each county has at least 3 carriers writing in it. So, no matter what county you're in in Georgia, whether you're in the metropolitan area of Atlanta or you're in the small rural area of Tolliver County, you're going to have options with an ICHRA. You'll probably have more options than you would in some of the rural areas with small group plans, because you're going to have 3 or 4 different tiers, whether it's gold, silver, bronze and in a lot of companies, they only offer you one or two plans. I was talking to my Dad about that who owns a small business and he said he always felt bad because his employees got the plan that best fit our family because he was going to pick the plan that supported our family, not necessarily the rest of them. So, this will give every employee the right to do it. When my boss speaks to Chambers of Commerce he likes to point out, “why do we let employers pick our healthcare? We never let our employer pick out our car insurance.”

Sen. George Lang (OH) stated currently, a large self-funded employer can utilize a Medical Expense Reimbursement Plan to incentivize their employees to move into a spouse's plan. Is an ICHRA limited just to the exchanges, or could an employee use it to pay for coverage available in a plan through another employer that they have access to? Mr. Nelson stated I'll try to answer it, but this is also maybe one of those questions that I would need to take back. I believe through a different sort of HRA arrangement, which would be a group coverage HRA arrangement, that an employer could establish an arrangement where you could use HRA dollars to help fund a spouse's plan. But that's a different arrangement than we're talking about today. Sen. Lang stated so the ICHRA is just for the exchanges? Mr. Nelson stated it’s not, it's for the individual market and the reality is off or on exchange.

Sen. Lang stated my other question has to do with the $400 tax credit, that feels about right. In Ohio, that would be similar to a $15,000 tax deduction, which is probably the equivalent of family health coverage in Ohio in general. But how would a state with no income tax utilize a tax credit? I'm sure there's a way. I just don't understand it. And does it make sense to consider expanding it beyond 50 employees, and also indexing it not for inflation but for trend? Because we all know health care costs go up significantly higher than inflation. Ms. Tiner stated regarding the number of employees, yes, it could be expanded. Typically, as we're discussing and starting with these pieces of legislation, it is about the 2 to 50 market simply because that's typically the market where you see coverage not available, and you see coverage not offered and it gives the ability for a step to then expanding that once people understand how the tax credit works and how it will work for the employer. As to how the tax credit will work, I can't specifically answer that question for a couple of reasons. Number one, specifically in Texas, the legislation did not pass yet. So, the legislation directs the Department of Revenue to do rules around how this will work. So, I can't answer that specifically. It's a good question, and it's something that will have to be discussed on a state-by-state basis as we work on these bills and as we work with the Departments of Revenue in the different states, depending on how it looks.

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, stated we don't have an income tax, but businesses do pay a gross margins tax called a franchise tax. So, it's a $400 credit against the franchise tax. That was the bill that we filed this year.

DISCUSSION ON CCIIO PRIORITIES

Mr. Nelson stated I just want to start by talking a little bit about just how much I appreciate the role of the legislators in this process. I come from Minnesota, and I've worked in my prior career at a state-based policy organization. I work directly with state legislators, and I know how important the state legislature is in obviously developing the laws for the state and actually developing the policies. And that's where the innovation happens, with policy at a state level. And so, most of what I'm going to talk about today is how state lawmakers right now can look to some flexibilities in federal law around 1332 waivers and potentially a 1333 compact. But before I get into that conversation, I did want to just touch base a little bit on where we are with the open enrollment period. These open enrollment periods for the individual insurance market and the insurance exchanges across the country opened up on November 1st, and we are seeing some higher premiums in that market space right now, but we still have a lot of affordable premiums out there. The average person that actually is in the market right now is still going to see premiums that are actually less than $25. So, there's still some high-level affordability in the markets, but we are going back right now to the standard ACA premium subsidy structure. We are seeing the COVID-related enhanced subsidies falling away, and we made sure to have some flexibility this year to make sure people have time. We had originally proposed to have the open enrollment period go from November 1st to December 15th. We want to make sure that people have time to enroll and so we extended that to January 15th but if you talk to people the one thing I want to make sure everyone knows is that if you don't get coverage by December 15th you're not going to get January 1st coverage.

I just want to be clear about that and so with that I want to jump in and talk a little bit more about 1332 waivers and this is something I hope a lot of you are familiar with, section 1332 of the ACA which allows states to waive certain requirements under the ACA that allows states to set up some alternative programs. This is an important flexibility for states especially for this time when the enhanced subsidies are expiring, and people are talking a lot about affordability issues in the individual market. There's a lot of things you can't waive under the ACA, for instance the guaranteed issue requirements, the community rating requirements, a lot of those sort of fundamental requirements around the individual health insurance market, but you can waive some other requirements. You can waive things around the essential health benefits. You can waive things around the premium subsidy structure. You can provide some more flexibilities in plan design. Those are really great, but one thing that is now clear and has clearly provided a huge benefit for the states that have done this is the ability to implement a reinsurance waiver.

Eighteen states have implemented a reinsurance waiver. In 2016, I was in Minnesota, and I was working on policy issues in Minnesota, and we saw a huge spike in premiums, just like many states are seeing today. We knew we needed to do something to provide some premium relief, and we ended up relying on a reinsurance program, and the way that it's structured within this framework is we actually waive the single risk pool requirement in the ACA, and in doing so, you can then provide state contribution to a reinsurance program that pays high-cost claims. And you pay high-cost claims in a range that usually starts at an attachment point say at $50,000 and then pays a portion of the claims up to a cap which is usually around $250,000. And when the state pays a claim, that reduces the premiums which then would reduce the premium tax credit the state would otherwise receive. And when the state reduces the premium tax credit, within the ACA there's an allowance for pass-through funding. Then you're able to get federal pass-through funding to help leverage those state payments that reduce premiums even more. In Minnesota when we did this, we were able to reduce premiums by about 20%. When you look at the states across the country that have the lowest premiums on the individual market, the last time I checked, I think 8 of the 10 most affordable states in the country had a

reinsurance program. I want to make sure everyone understands that this is an option for your state going forward. We implemented 18 of these reinsurance waivers in the first Trump administration and we definitely encourage states to look at this option.

Under a 1332 waiver, there's also other opportunities, and we are happy to work with states on some other opportunities. We released in the first Trump Administration some concept papers about how to maybe use different types of waivers so you could maybe use more of an account-based approach. We talked about health reimbursement arrangements and how they provide some more choice and opportunities. You could create some different subsidy structures around an account-based approach. You could also change some subsidy structures to encourage young people to sign up for coverage. And I'm happy to speak to any of those ideas with anyone after this session. I'm definitely willing to have some calls about other opportunities. I also want to speak briefly to 1333 compacts. The ACA also provides the opportunity to basically buy insurance across state lines, which is something that Republicans have talked about a lot, but the compact approach is a little bit different which does this in a way that actually was pretty much a bipartisan approach to the idea of buying insurance across state lines before the ACA passed. It was really a program to help smaller states create a larger market space to be able to attract more issuers into their markets and to make it easier because it basically allows you to potentially equalize some of the requirements and a lot of the administrative procedures around form filing and those sorts of things within the insurance space and so it fundamentally allows for that sort of thing. Another thing it can do is it can potentially allow the group of states that create these compacts to bring back some level of federal authority that exists around qualified health plans. We've seen that there are basically certain things that just sort of flip-flop from Administration to Administration and that creates regulatory instability. One of the things states consider is grouping together to take some of that flexibility back. We've seen regulatory instability around network adequacy requirements, around the requirements around standardized health plans, and states can potentially bring some of that regulatory authority back to sort of remove themselves from some of this flip-flopping that happens from Administration to Administration. So, there's some potential there. That's just a very brief overview of that. Please come to me if you have any questions regarding that.

And I heard about how to create that thriving market and we talked about affordability of premiums. I just want to just conclude with sort of a vision that I have for the individual market. When the ACA passed, it kind of envisioned that there would be a subsidized portion of the market and an unsubsidized portion of the market. We are now at a place where we're largely a subsidized portion of the market, where you don't have a very large number of people who are paying the full premium and communicating the value of the full premium to them by actually paying that full price. And in any competitive market, you need a consumer that's paying the full price to communicate the value of the product that's being sold on that market. And without unsubsidized people in the market, that market will lack competition. And that's one of the reasons why I think we're seeing premiums go up as much as they have over the course of the time the ACA has been around. If you had more unsubsidized people in the market, you'd have more competition to drive premiums down. And that's one of the reasons why I'm so excited about ICHRAs. I really encourage you to think about them because yes, premiums are going up this year. I will note they have stalled over the past 4 years, but they are still going up more than we would like, and I do think this can help.

Sen. Theis asked what is your sense of what this Administration is thinking about doing with respect to additional 1332 waivers? Mr. Nelson stated we are open for a lot of ideas, whether it's reinsurance waivers and maybe some modifications to that or other types of waivers. We have regulations in place that are more restrictive than I think we'd like to see, so we're thinking

through whether there's some more flexibilities that we can provide through future regulations. But there is a lot of stuff that we can still do under the current regulatory structure, and so that's how we're operating right now but we're definitely looking for some advice on where states think we should be going to provide some more flexibility on 1332 waivers because we ultimately do think that states are where this sort of policy should lie. I think when it comes to the individual health insurance markets and the small group insurance markets, these are state-focused, and states are in the best position to regulate in this space. We think it's better policy to the extent we can devolve authority back to states. And you can do that through 1332 waivers. You can do that through 1333 compacts. We're just looking at ways to make sure states have as much authority to do that as possible under the law.

Sen. Theis stated my next question is with respect to mandates. There was a discussion previously about state mandates and how after the ACA and in the marketplaces, it was developed that the states were supposed to absorb additional costs associated with new state level mandates. Has CCIIO done any analysis on what those look like and if it was actually charged to the states how much that would be? Mr. Nelson stated referring to the defrayal requirements under the ACA for essential health benefits, in the first Trump Administration, we asked states to do some better accounting for that. That regulation actually got pulled back by the Biden Administration, but states are still supposed to be defraying the cost, and that's not really a change right now to the system. And so, if there's a benefit that a state requires and it's not an essential health benefit, then the state's still supposed to defray that cost.

Sen. Theis stated my last question has to do with ACA mandates that may have driven cost. Is there any research out there showing mandates that don't have significantly better health outcomes or large-level health outcomes but are driving costs? Mr. Nelson stated the way that the Obama Administration put the regulations in place, they allowed states to choose a benchmark plan and for the most part, most states are still operating under the benchmark plans that they chose or something similar, and that benchmark plan was tied to a small group that basically the default was the largest small group plan in the state. And most states are under that framework. That is often a lower benefit plan. It still has good benefits but compared to some maybe large group employers or the federal health benefits that are available, there may be a little bit lower benefit. I haven't actually seen any research out there to suggest that the individual market benefits before the ACA were that much different from the essential health benefits after the ACA in terms of driving up costs. Sen. Theis said interesting - that's not the feedback I got.

Sen. Paul Utke (MN), NCOIL Vice President, stated regarding the 1333 compact and being able to buy health insurance across state lines. If I was buying insurance from North Dakota, wouldn't they have to sell us a plan that meets the Minnesota set of benefits? Or is this compact something that allows us to pick and choose different plans according to what's being sold in that home-based state? Mr. Nelson stated when you've heard a lot of people talk about this in the past, one of the selling points is, and this is under what I would call a preemption approach to buying insurance across state lines where, say, the federal government were to step in and require this to be provided where a consumer could choose whichever state they wanted to. If they chose North Dakota and it had fewer benefits and they were in Minnesota, then they could choose the plan with the fewer benefits if they wanted to maybe choose a lower premium option with less benefits. And if that was a federal approach and the federal government required that, then yes, that's how that would work. But the compact approach depends on North Dakota and Minnesota agreeing on it together and so if Minnesota and North Dakota wanted to create that arrangement under a compact, they could. And I didn't get into the details for time reasons on how the compact operates, but the way the statute is drafted, it says

that you can enter into a compact to allow the sale of a Qualified Health Plan (QHP) into another state, and only the laws and regulations of the state where the QHP is issued or written will apply. However, there's important exceptions and these exceptions make sure that the state where the person lives, where certain requirements are still applied from the state, the insurance company still has to be licensed in the state where the person lives.

And also very important consumer items like if a consumer has a complaint, they still go to the state where they live. Other requirements where we think the state's where the person lives is better equipped to make determinations, like network adequacy, and rate review. Those things still stay with the state where the person lives. And so, there's those exceptions in place. But something like the essential health benefits, that's something like the benefit structure, could differ between states if the states agreed to allow that but the states would have to agree to that. So, there's a lot of things that might differ, but there's also some things where the state retains control. I should add, within that structure, there's also guardrails, just like the 1332 waivers, that to be able for the federal government to approve it, the compact has to meet a set of guardrails that make sure that any compact provides coverage that's at least as affordable and comprehensive as they can get under the ACA, and also provides coverage to at least the same number of people as under the ACA, and also it can't increase the federal deficit. And the final thing is that a compact can't weaken the state protections under those exceptions that I just talked about.

Sen. Utke asked if any states are doing this currently? Mr. Nelson replied no. The ACA actually required regulations to be drafted by 2012 or 2013 but that didn't happen so there's actually no federal regulations on the books. We're currently looking at compacts right now. We looked at this in the first Trump Administration, but there's still no regulatory structure. But I'm encouraging states to start thinking about compacts because we're looking at issuing regulations. We're actively looking at that. We just want to make sure states have a heads up that, “Hey, look, this is an opportunity under the statute”. We want you to start thinking about it right now because you’re state legislators, you're looking at January. Many of you are looking at January for your sessions to start and if you want to start this process, one of the key things under the statute is you have to pass a state law to get this going. You all are very important in this process and I want to make sure you have a heads up on that.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Sen. Theis stated next on the agenda is the readoption of the NCOIL Insurance Business Transfer (IBT) Model Act. This Model was initially adopted in 2020. It largely followed an Oklahoma law which was considered very innovative at the time and they've been a leader in the IBT space.

Robert Redpath, Senior Vice President, Regulatory & Special Projects Director at Enstar, thanked the Committee for the opportunity to speak and stated I actually did a presentation here before the implementation of the Model. Really what I want to do is provide an overview of what's happened since then and I’ll be very high level. So just a little bit of a reminder as to what the IBT process and Model is. Basically, an IBT is the ability to transfer a block of insurance business from one insurance company to another without the need for policyholder consent. It's a very rigorous process, and this is the process under the NCOIL Model and other states such as Oklahoma and Rhode Island that had statutes prior to the Model. So, there are a number of key elements. You require an independent expert report. You require the regulatory non-objection of the insurance regulator of the transferring company, the state where the business is coming from. You need the approval of the regulator of the assuming company.

After the regulatory approvals, then there is a court approval process which includes the notification to policyholders and other stakeholders, regulators, reinsurers, and guaranty funds. Ultimately, you end up with a court hearing and an enforceable order. So, just to reiterate, at the completion of this IBT process, all the insurance policies and corresponding assets, which would include reinsurance, are statutorily novated to the assuming company and the transferring company has no further liability to those policyholders. Rhode Island had a statute prior to the Model and has amended it so it's much closer to the Model. Then followed Oklahoma. Then the Model was adopted. Then Arkansas, Illinois, and Georgia now have the IBT Act. And Texas has had two attempts. It has passed in the House twice, but it's not made it through the Senate to date. Illinois did have some changes. They decided to exclude life, health, and accident & health insurance.

So what I wanted to talk about is back in 2018, it was all very new. Since then, there have been four IBTs, all into Oklahoma domestic companies, three of which I'll talk about that we at Enstar did. We have a company called Yosemite Insurance Company. It's a 49-state licensed company, which we moved into Oklahoma for this process. The first IBT we did was actually the most complicated. It was a mix of business. This was Providence Washington Insurance Company. It was also owned by Enstar. It was the second oldest continuous writer founded, I think, in 1799. So, a lot of old business there. We transferred all the remaining business out through this process into Yosemite. It was a mix of direct insurance, all commercial. So, no real consumers involved, but it did involve a lot of notifications and we did look back in some instances 50 years for old policies which involved 60,000 notifications. Ultimately, the transfer went very smoothly the only difference here with this transfer was that New York has been reluctant to grant a license to Yosemite. That's the one missing state so we had to retain the New York policyholders transfer by way of reinsurance. The other transactions that have happened have all been assumed reinsurance again to Enstar and one of them with R&Q. Just of note, the two of our transfers were internal, so between intercompany, two different owned companies. But in both instances, what we did was we transferred all the policies out of a company, so all the liabilities were gone, and then we sold those companies as clean shells. There's a very big market for shell companies in the insurance industry.

Having done this now for the last 5 or 6 years, looking at some of the positives off IBTs. Really, what we've seen is it's a good method to restructure a group of insurance companies. It gives the ability to align portfolios. If you think about some of the bigger insurance companies that have maybe 5 or 10 writing companies, there may be circumstances where it makes sense for them to streamline their business. They may have little pockets of types of insurance in multiple companies that they would prefer to have in one company. So that's one thing. The main thing we found, and what we did again with two companies, was it is a very good way of creating a clean-shell company. What you're doing is you're making a clear division of old and new business. Historically, shell companies were sold with reinsurance. So effectively, if you were buying a shell company, the old business was being reinsured out usually to the selling company. So, it was done through reinsurance. So, you had economic transfer of the business, but you never had full finality of that business. So, if theoretically one of those two elements, the old company or the new company, if there was an insolvency, there would be all kinds of problems in the sense that either new policyholders could end up in an insolvency mixed up with the old policyholders or vice versa. This gives clarity. It cuts out disputes. Really what it is, you can have finality, you can move. You can have a clean shell that does not have any concern about the financial strength of the old company, the policyholders are split. The other thing, and again, two of the transactions I talked about, they were legal finality for companies who were looking to divest non-core books of business, so the R&Q transaction with Sentry, again, Sentry had a non-core book they wanted to move out, and the same with the Hanover Insurance

Company, the last transaction we did, they had some non-core business they were looking at old legacy liabilities to get off and get finality. And then my final comment is the IBT is a very useful restructuring tool, but it may not be appropriate in all situations, it's just a tool, it's to be used carefully in certain situations.

Oklahoma Insurance Commissioner Glen Mulready thanked the Committee for the opportunity to speak and stated that this process started when I was an Oklahoma legislator at a National Association of Insurance Commissioners (NAIC) Meeting and learned about Part 7 transfers. These are transfers that have been done in the U.K. and in Bermuda and elsewhere across the country. There have been over 300 transactions done over the last 20 plus years without a failure, without a problem. And so, it just made sense to us, and we thought, as legislators, this is a tool that could be a business tool for companies, and we need to do this back in our state. So, we did, and we started with Senate Bill 1111 in 2018. That created the IBT Act. Now what I'm going to just hit on quickly is just how we have tweaked that and most of that was just learning as we went along. And so, in 2019, we updated the language to require a specific listing of documents and things that are included in the opinion report. Mr. Redpath just talked about the independent expert that's involved, and so this specified some things that should be included in that and made in the application for that IBT confidential while we are reviewing it. So, once it gets filed with the court is when that becomes public. But right now, we have four transactions that are what I call in-house that are in with us. So those are confidential at this point. When they get filed with the court, those become public.

And then in 2022, we modified and updated some definitions, expanded the definition for "district court." The original legislation specifically cited Oklahoma County District Court. What we ran into was we had a judge that had been assigned to a case and they were promoted up to the appellate court, and that just delayed that process until they assigned someone. We also had the situation with the pandemic. We were two weeks away from a case coming and then the courts closed so we expanded that based on population. So, we now have three district courts that those could be heard in. We increased the number of days for notices. These are just some of those tweaks that were in 2022. We created a process for international locations. As you just heard about Part 7 transfers, this type of transaction is very familiar elsewhere. It had never been done in the U.S. before we did that first transaction, but there are international players in this. It also clarified requirements for notification for the policyholders and we added reinsurers as far as their notification process. When someone is notified of a transaction, we notify all 56 regulators as part of the NAIC.

As Mr. Redpath just hit on, it's the transferring State who has to, well, not approve it but they just at least must have a letter of non-objection to make that happen. And then we added language related to guaranty funds having to do with policyholders outside of the U.S. We've now completed 4, as you heard. Those came from Rhode Island, Wisconsin, Missouri, and New Hampshire. The first one was October of 2020, and our last one that was finally completed in May of 2025. We have 4 in-house that involve Arizona, Wisconsin, and Connecticut. There's been a lot of attention because we are the only state that's been able to accomplish this. We have other states, as you saw, that have brought on legislation that's not been able to put a deal together yet. We are hopeful that other states will accomplish that, and this becomes more of a normal way of doing business in the U.S. And a couple looks at some of the differences quickly. Rhode Island's is a lot more limited than ours is. The business has to be in runoff. In other words, they have not sold a new policy in at least 5 years, and its P&C only, not in the life and health business. Arkansas and Oklahoma permit transfers that are both open and closed and don't limit the line of business. That final bullet is about corporate divisions, which is similar. It's a restructuring mechanism that some other states have. It is not IBT, but Illinois, Connecticut,

and Pennsylvania do allow those. And as mentioned earlier, Illinois also excludes life and health. Legislation was run in Texas. I believe next year there's legislation that's going to be run in Florida, so there's a number of states that are now picking up on this. I will say, too, the Restructuring Mechanisms Working Group at the NAIC has been working on a white paper on this. We hope to finalize that. We have a final draft right now. It has gone on for literally years, but hopefully in Florida at our next meeting, that will be finalized with that.

Rep. Brenda Carter (MI) asked the speakers to talk about the consumer protections or guardrails that are in place with this process. Cmsr. Mulready stated the first thing is the notification. Policyholders receive notification of their requirements in the law and how that has happened. I will tell you that, Enstar was our very first one, and they would come in with their communication plan, and I sent it back to Mr. Redpath to say, “no, it's not good enough. We've got to do better in notification.” And because that was a block of business where policies hadn't been sold in 35 years, this is not active business. I teased Mr. Redpath that I have three sons, and I was much harder on my first one than my last two, and he's my first child coming through with this process, so we were a little tougher on him. But it really is about that communication plan. Mr. Redpath stated I would agree, but also note the court process. The court approves it, and people have the ability to come along and object if they want to and there is full notification there. Cmsr. Mulready stated the phrase that I don't know that you heard here, but it's the key that we are looking at and the independent expert is looking at, and the judge is looking at, and that is that no policyholders are “materially adversely impacted.” That's the key phrase.

Hearing no further questions or comments, upon a Motion made by Rep. Oliverson and seconded by Rep. Carter, the Committee voted without objection by way of a voice vote to re-adopt the Model.

Sen. Theis stated there are two other Models that we need to consider for re-adoption - The Market Conduct Surveillance Model Law and the Market Conduct Annual Statement Model Act. Hearing no questions or comments, upon a Motion made by Sen. Justin Boyd (AR) and seconded by Sen. Jeff Howe (MN), the Committee voted without objection by way of a voice vote to re-adopt the Models.

ANY OTHER BUSINESS

Rep. Oliverson stated I raised an issue during the Summer Meeting in Chicago regarding the 340B drug pricing program. I know it's a topic that a lot of us in the room are interested in and care about and are concerned about. And I would propose that NCOIL look at developing a policy requiring transparency in 340B through requiring some of the same data points that are communicated to the federal supervisors of the program be made available to our states as well so that we can see the value of these discounts and how much money is being collected, and most importantly, whether or not that money is being used on charity care and indigent care, which is what it's supposed to do. I think it would be a great idea for a Model next year.

Sen. Theis stated I completely support that and thank you for bringing that forward. Rep. Carter also thanked Rep. Oliverson and stated that I will definitely work with you if this is something you're willing to take on.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Howe and seconded by Rep. Craig the Committee adjourned at 4:45 p.m.