NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2026 NCOIL SPRING MEETING – LOUISVILLE, KENTUCKY
APRIL 17, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the Hyatt Regency Hotel in Louisville, KY on Friday, April 17, 2026 at 11:00 a.m.

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

Other members of the Committee present were:

Rep. Stephen Meskers, CT
Rep. Brett Barker, IA
Rep. Peggy Mayfield, IN
Rep. Adrielle Camuel, KY
Rep. Deanna Gordon, KY
Sen. Beverly Gossage, KS
Sen. Jason Howell, KY
Rep. Edmond Jordan, LA
Rep. David LeBoeuf, MA
Rep. Brenda Carter, MI
Sen. Mark Huizenga, MI
Rep. Mike McFall, MI
Sen. Lana Theis, MI
Sen. Paul Utke, MN
Sen. Tim McGough, NH
Sen. Jeff Barta, ND
Sen. Jerry Klein, ND
Asm. Jarett Gandolfo, NY
Asw. Pamela Hunter, NY
Rep. Tim Barhorst, OH
Rep. Meredith Craig, OH
Rep. Brian Lampton, OH
Sen. George Lang, OH
Rep. Ellyn Hefner, OK
Rep. Gregory Scott, PA
Rep. Tom Oliverson, M.D. TX
Rep. Calvin Callahan, WI
Sen. Mary Felzkowski, WI
Rep. Barbara Dittrich, WI
Del. Walter K. Hall, WV

Other legislators present were:

Sen. Jesse Bjorkman, AK
Sen. Robert Yundt, AK
Rep. Justin Wilmeth, AZ
Rep. Wendy Dant Chesser, IN
Rep. Michael Meredith, KY
Rep. Mike Clines, KY
Rep. Shaun Mena, LA
Rep. Yusuf Hakeem, TN
Rep. Mike Rogers, MD
Sen. Alonzo Washington, MD
Sen. Keri Heintzman, MN
Sen. Bill Gannon, NH
Rep. Julie Miles, NH
Sen. Kristin Roers, ND
Rep. Kellie Deeter, OH
Rep. Derrick Hall, OH
Rep. Emily Gise, OK
Rep. Christopher Kannady, OK
Sen. Mark Mann, OK
Rep. Mark Tedford, OK
Rep. Perry Warren, PA
Rep. Matt Morgan, TX
Sen. Jamie Wall, WI
Sen. Cale Case, WY

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Matthew Gambill (GA) and seconded by Sen. Beverly Gossage (KS), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Gossage and seconded by Rep. Tom Oliverson, M.D. (TX), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 13, 2025 meeting.

INTRODUCTION AND DISCUSSION ON NCOIL MODEL ACT ENSURING ACCESS TO EYE CARE SERVICES AND MATERIALS FOR PATIENTS THROUGH TRANSPARENT AND FAIR BUSINESS PRACTICES BY VISION BENEFIT PLANS

Rep. Pollock stated first up in our agenda, is an introduction and discussion of the NCOIL Model Act Ensuring Access to Eye Care Services and Materials for Patients Through Transparent and Fair Business Practices by Vision Benefit Plans (model)**.** I look forward to the committee learning more about these issues. We had a really good introduction and educational session on this at the Annual meeting in November. I'll note recognize the model's sponsor, Rep. Deanna Gordon (KY).

Rep. Gordon stated that I'm very proud to sponsor this model, which you can view on the website, app, and in your binders on page 23. I would also like to thank Sen. Justin Boyd (AR) for carrying this torch in my absence at the last meeting. My main goal in bringing this model forward is to address concerns regarding vertical integration and preserving the doctor-patient relationship. This model is patient-driven and is meant to improve transparency, fairness, and competition for our constituents. And it's important to note that this Model is not a one-off type of situation. There has been a trend across the country the past several years in terms of states passing laws like this one that you see before you today. In fact, many of the model's provisions come from those state laws. I am passionate about this proposed model, because I face these same issues in my private practice every day where I work as an audiologist. These what I call third party or vertical integration plans essentially turn doctors into contractors. They control all aspects of patient care from scheduling, examining, selecting, ordering, manufacturing, delivering and servicing, while I am the one that's paying staff, rent and overhead to essentially be the face of their plan. I look forward to the discussion today, and hopefully we can have something ready to finalize at a future meeting. I hope to earn your vote on this important matter facing our patients and our constituents.

David Parker, O.D. of the Mississippi Optometric Association thanked the Committee for the opportunity to speak and stated that I have practiced as an optometrist in Mississippi for over 30 years. I picked optometry because I had a family member who is an optometrist who loved his patients, and I decided to follow in his footsteps. In addition to my clinical work, I've held numerous leadership positions within my profession, both at the state and national level and my passion has always been caring for and protecting the patients and the people in my community. This passion led me to run for the Mississippi State Senate in 2013. I was fortunate enough to be elected at that time and served until January of this year when I retired. During that service, I chaired the veteran and military affairs committee, the economic development committee, and the accountability, efficiency and transparency committee. That experience has allowed me to analyze issues both from a doctor perspective and from your perspective as policymakers. And over time, I've learned to recognize patterns and try to prevent history from repeating itself. The

problem that we are facing right now as optometrists is that vision benefit managers or administrators are increasingly consolidating their power and oversight over the profession of optometry. They're acting simultaneously as insurer, retailer, supplier, practice owner and marketer. And that level of vertical integration creates clear conflicts of interest, in my opinion to the detriment of patients.

I want to give you a real-world example of one of those, as certain plans sometimes have provisions that you agree upon and that you sign up to when you select to be a participant doctor on the plan. But this year, for example, one of the vision plans that we accept in my practice has mailed us five different new subgroups within that, that have totally different provisions from what the one that we signed up had. Our plans mainly allow us to do what we call in-office finishing. In-office finishing means that if a young child comes in and has never worn glasses and has a very high need for glasses, we then on that day can cut lenses for the child, provide them with the glasses and let them leave the office that day with the product. Some of the new plans that I've seen pop up this year will not allow us to do in-office finishing at all. And it's not a term that something in our practice has agreed to, it's just been something that's been added on by vision plans. The problem is that we can't opt out of new imposed terms because to opt out would jeopardize our ability to remain with the parent plan which covers a number of the patients in the office. I don't see that as negotiation. I see that more as a coercive type of tactic. Your doctor should be able to choose the best lab or supplier based on what is best for the patient. Certain restrictions interfere with clinical judgment and limit patient-centered care. To give a historical parallel for myself, I've worked very diligently over the last 13 years on pharmacy benefit manager (PBM) legislation as both author and co-author of certain issues that have come up in our state. I think this issue very closely mirrors what we're dealing with in the PBM world, which I know you're all familiar with.

In my location about 20 years ago, I had a large pharmacy in the area come to me. We had just built a new building. They asked to buy my building and I said, "It's not for sale." They said, "Everything's for sale." I didn't sell it to them but they said, "This is the location we've determined that we need to be in." And I didn't sell to them so they bought the bank next door, built a pharmacy there, and then about four years ago they closed it and moved out and it was an empty building for about three years because what they did was they got in, they created what they needed, and then unfortunately, they left the community. They are not sponsors of sports teams in the community and not supporting community activities that we do as a practice. And it's a loss to the community. I don't want to see us make that mistake again in vision care because I think the PBM situation has gotten into a situation of desperation for pharmacists. So, the purpose of this Model is it creates clear definitions and applies consistent standards across all entities involved. It strengthens transparency through disclosure and oversight. It ensures fair reimbursement so that providers are not forced to deliver care at a loss. It prohibits coercive practices like steering and manipulation. It protects provider independence, ensuring that clinical decisions remain with the doctor, and it provides meaningful enforcement so that these protections actually matter. In short, it creates a fair, transparent framework that protects patients, supports providers and ensures accountability. This model draws clear lines. Patients come first, not profits. It restores trust, transparency, and balance to a system that has tilted too far towards corporate interests. That was my goal as chairman to promote accountability, efficiency and transparency in my past work in the Senate, and it continues to be what I strive for, and why I'm here today.

Matt Burchett, O.D. of the Kentucky Optometric Association thanked the Committee for the opportunity to speak and stated that I have been a practicing optometrist here in Kentucky for 24 years and this Model speaks to the care that we give to our patients. As we're all aware, there's a growing and significant concern regarding the practices of the vision benefit managers (VBMs).

The concerns are evident in how they structure their benefits for employers, as well in their lack of transparency regarding covered lives and the true scope of benefits that they provide to these lives. Additionally, their practices directly impact the doctors who deliver the care and the materials to the patients covered under these plans. Currently, there are numerous VBM's operating in the marketplace, collectively covering approximately two-thirds of Americans with vision benefits. Of those, the two largest VBMs control over 80% of the covered lives. In many communities, this creates a disproportional level of market control, limiting competition and effectively reducing provider autonomy. When multiple employers in a region rely on the same VBM, local providers often have little leverage to advocate for appropriate patient care, being forced instead to adhere to restrictions dictated by these entities.

The dynamic results in a de facto monopoly, eliminating meaningful negotiation and restricting both clinical decision-making and patient choice. A major contributing factor is the vertical integrated business model employed by the VBM's. Over time, these organizations have used substantial profits to acquire, not only competitors, but also eyeglass frame manufacturers, lens producers and optical laboratories. As a result, the coverage is often limited to products manufactured within their own corporate structure. Even when those products may not meet a patient's specific clinical needs. In many cases, providers are also required to utilize the VBM-owned laboratories, further reducing oversight and quality control. This consolidation ultimately restricts providers' ability to deliver optimal patient care. My own practice has been directly impacted by these practices. We were forced to make some difficult decisions in the last few years to discontinue participation with certain VBM plans due to several ongoing concerns, thus leaving some of our patients without the care they need. Some of these things were the limited coverage options. Patients frequently express frustration with the narrow selection of materials covered and the inability to access alternatives better suited to their needs. Before a patient was covered by VBMs, we had the choice of using any lab that will provide the materials that the patient needs. Costs were kept low through competition. But when patients are covered by a VBM, the vertical integration imposed have doesn't always allow patients to get the materials they need, and the cost is now fixed by the VBM for their own materials.

Quality concerns. We experienced repeated issues with eyewear quality from VBM-owned laboratories, including frequent remakes from lab error, and extended turnaround times for four-to-six weeks and more. That's not acceptable for good quality patient care and there is also inadequate reimbursement. Reimbursement for comprehensive eye exams have often failed to cover even half of the costs of the doctor that provides the eye care. As we all know, as business owners, there's a cost to doing business and there is a baseline cost to keeping the lights on. And most plans that we see in our area will reimburse $40 to $60, while the cost of in my office to see a patient is at least $110. So, we're making about half of what it costs to actually see the patient before any profits are realized on our end. And reimbursement has not changed in the 24 years that I've been in practice and that has most certainly hurt our ability to continue to provide the quality care that patients need, and ability to hire and retain good staff members by paying them what they deserve. Our challenges are not isolated. They reflect systemic issues within the VBM model. VBMs are multimillion dollar corporations which continue to expand through acquisition, yet these profits are not reinvested in the patient care or provider support. Instead, they're used to consolidate market control, reduce competition and limit both provider and patient choice. While VBMs will claim a willingness to collaborate with states and providers, the reality suggests otherwise. As an example, if meaningful reform were occurring voluntarily, we would not see multiple states pursuing and passing this legislation to address these concerns.

And furthermore, states like Illinois, who in 2023 passed a compromise bill with vision benefit administrators, have already found it necessary to revisit and revise prior agreements due to the

language not being abided by VBMs. Another common argument they have is that legislation will increase costs for employers and patients. However, evidence from other states that have passed this legislation suggest otherwise. Ongoing investigations by the U.S. Congress, the Federal Trade Commission (FTC), the Department of Justice (DOJ) and the Government Accountability Office (GAO) indicate that the rising plan costs are not associated with increased patient value. It is important to recognize that premiums are determined by the VBM's themselves. They are engaged in a competitive race to secure covered lives, often at the expense of quality and sustainability. Any increase in premiums is a corporate pricing decision, not a direct consequence of this legislation. Ultimately, the system places the burden on employers, patients and providers alike. This legislation speaks to correct these imbalances by ensuring transparency in coverage, access for patients to needed services and materials and establishing a fair reimbursement for providers providing the care. These are the fundamental requirements for maintaining access, quality, and integrity within the vision care system.

Julian Roberts, Executive Director for the National Association of Vision Care Plans (NAVCP), thanked the Committee for the opportunity to speak and stated that NAVCP membership consists of 14 managed vision care organizations across the country who provide vision insurance to over 220 million Americans and they do this in partnership with over 100 carriers, both national and regional across the country. If you're not familiar with vision insurance, it tends to be a voluntary benefit which means that consumers and employees can make the choice themselves as to whether vision benefits are important and valuable to them. If you're like me, and I see a few of you in the room happen to wear lenses and require correction, it is a very valuable benefit because I will need this for the rest of my life, and I want to be able to manage my out-of-pocket cost as I continue through this. So, as we look at the model that is before you today, it is not a consensus model from that perspective. Where it does borrow a few concepts from various states, the model goes much further and would fundamentally change the way vision care plans contract with providers. It would impose a sweeping framework that has not been totally or broadly tested in the marketplace and there's no documented consumer harm that justifies this level of intervention. For those reasons, we believe that this is a radical departure from collaborative policymaking and we'll dive a little bit further in some of the provisions.

JP Wieske, on behalf of NAVCP, stated the idea this is consumer bill is just not correct. For example, if you look at section 4(F) and 4(G), which allow providers to charge a higher rate to insured consumers. They're not required under contract to include a usual and customary rate. There are provisions in here that intend to control steerage, and I understand their concerns. But there are provisions here that require the insurers to hide lower-cost providers in their provider networks from consumers. That is not a pro-consumer bill. In addition, some of this language is functionally unclear. So maybe we're misinterpreting it, but it is certainly imprecise in the way I'm used to dealing with insurance code language. When we look at the pricing, it's interesting to look at the definitions such as the definition of "nominal". I was always told nominal is a small amount. Wisconsin statutes allow you to take a nominal item in certain cases subject to ethics laws. This is not nominal. This would open up those numbers. The Model nominal charge includes provider cost plus including profit. And so, we're looking at something that creates a provider price floor across the market which will lead to significantly less provider price competition. It requires, in fact, that every single provider has to be accepted inside a network at their rate. So, this is a problematic approach. This means that consumer costs are going to go up.

And it doesn't just mean that the insurance costs are going to go up. It means that when you're looking at co-pays, deductibles and other pieces that consumers are going to be paying more for their services and that's a concern. And then we take a look at consumer choice and maybe the language is imprecise but it doesn't just allow the providers to choose which insurer they want to

operate and it's not even some of the sub insurers, they're allowed to pick plan by plan, based on the imprecise language in this model. So, in other words, two employees who purchased two different plans from the same employer may have an entirely different network of providers. This creates huge problems from the standpoint of administration and from predictability and their ability to be able to to operate. In addition, these price floors will result in less competition in the market further creating the problems that they're intending to fix with this legislation.

And as a former regulator, I have strong concerns with this idea that you can have three layers of oversight over vision plans. This approach is untried across the country and it's untried in insurance generally. And so, you would be allowed under this legislation to have both an insurance regulator, which is perfectly appropriate, to regulate these plans. Then also Attorney General oversight which creates a competing effort and allows a $10,000 potential profit making lawsuit which is unprecedented. And as a former regulator, it also creates a large problem for you to have consistent regulation of the plans because now you're subject lawsuit to lawsuit, and judge to judge, to figure out what in fact the law means structurally. So, there's strong concerns from from that section as well. There's also significant statutory micromanagement of the plans. The 90-day timeframe is a problem. We understand that they've got offices, and they've got timeframes. We don't have any concerns with creating a more reasonable timeframe for them to be able to review. And again, when you look at reimbursement floors, fee schedules, and the lack of differentiation between plans, this creates a significant issue in the market. And as Mr. Roberts emphasized, this is insurance that is voluntary. So, it's a limited benefit that's offered to employees. They voluntarily pick it and in a number of cases or individuals purchase it separately. So, the cost and value is a significant issue.

Mr. Roberts stated that consumers and employers expect affordability and access when it comes to their vision care and vision insurance. This model ultimately harms the people that it claims to help with mandated cost increases that will drive up premiums pushing employers to scale back their coverage, cut access to preventative eye care, restrict plan operations, and force carriers potentially out of the market, which will be limiting the choice that employers and consumers have in the market. And when participation becomes economically unattractive, price-sensitive consumers are not going to get a better deal. They'll simply lose access. So, in closing, access to vision care is a critical health care need. I think we all agree to that. Employers and employees overwhelmingly see value in vision care insurance. In fact, if you check with your departments of insurance, you'll see that there are very few, if any, complaints from consumers in regards to their vision benefits. Vision insurance definitely saves out-of-pocket costs for consumers and vision care premiums have remained somewhat constant and consistent, slightly increasing, but nowhere close to what you've seen in regards to medical care. We as an organization are definitely supportive of collaborative legislation as long as it preserves access and choice and quality for the consumer and also allows for free market solutions.

Asw. Pam Hunter (NY), NCOIL Immediate Past President, stated that Dr. Parker mentioned what the model includes, and some of those are clear definitions and transparency provisions and it prohibits coercive practices. As I read through this Model, it seems pretty comprehensive but then I'm hearing conversation of price wars so specifically, does this model dictate the terms and conditions of the contract? Because if you look in section four, covered and non-covered services and material provisions, there seems to be some flexibility in pricing. Relative to pricing, there shall be no limitation on the ability of an individual eye care provider or a group of eye care providers who practice to have conversations relative to fees. And this is just one example. So I'm just trying to get to an understanding of does the model dictate terms and conditions of the contract? Because it seems like you should be able to get to the middle based on both sides of what you all are talking about on the panel. Can anyone answer that question? Dr. Burchett

stated that the language in there speaks to that criteria, but it also still allows for negotiations between the provider and the VBM.

Dr. Parker stated that the model does not dictate terms. As a practitioner, I think everyone should have the right to look at a contract and accept it or not accept it. But I have some contracts that I've signed up for maybe 15-to-20 years ago, and I don't know that I've gotten any correspondence back in many years on them. It would be good to receive an update on what changes may have occurred other than a new program that came along. But this is not about setting prices. This is not about the expense. It's about transparency and practitioners protecting their patients and their practices so that we don't become contractors and our patients don't just become consumers. My biggest fear is that everyone is a consumer and then you miss the patient aspect. There are patients that I treat and then diagnose for glaucoma, diabetic retinopathy and retinal detachments that are then treated with lasers that I do and all the other procedures. Detecting and treating ocular disease that are detected during the comprehensive exam is important. I'm going to keep seeing my patients whether you pass this legislation or not. But I don't want to see practices in the future close because they weren't able to remain the small town kind of eye care providers, and they were swallowed up by the bigger fish in the end.

Mr. Wieske stated first, read the bill and look at the definition of "nominal" and look at the requirement that you have the same payment rate that goes to other providers. We had a similar bill in Wisconsin when I was a regulator, and so we were looking at how to operationalize that. It would have required significant reporting across the state and the model does in fact set those and the definition of nominal is in there. It sets a floor. And we fully agree that a contract should be both sides. The Model turns this discussion into a one-sided contracting effort. We disagree with their sort of characterization that this is a two-sided contract. It now becomes a one-sided contract. I understand what their concerns are and we've got legislation that as a group we've supported in other states around this. But this one turns it the other way.

Mr. Roberts stated that I will also add that I have 14 vision care plans that are members of our organization. I can also tell you that all 14 have different business models in that regard. All of their contracts are somewhat different. With the structuring of this legislation, this would basically make all of these plans basically look alike in regards to their contracting with providers and that is at the time that you create a situation I talked briefly about potentially some players getting out of the marketplace. Once you all look alike and you all start commoditizing the product at this point in time, the strongest survives, the weaker ones tend to not. And so I think that also creates an issue of having new, smaller, up-and-coming organizations grow within our industry.

Sen. Mary Felzkowski (WI), Vice Chair of the Committee, stated that I'm going to direct this towards Mr. Roberts and Mr. Wieske. These are limited benefit plans. I always struggle calling these insurance, but that's what we decided to do a long time ago. So, let's say you have a $1,500 cap, and then you're going to have caps inside. So you painted a pretty harsh picture that this is going to drive up costs and drive up co-pays but if I have a $1,500 cap and that's all you're ever going to pay out, I need you to elaborate on that a little bit more. How are you totally harming employers and constituents and people inside of these plans that actually took them?

Mr. Roberts stated that I don't know that there's necessarily a $1,500 cap. In vision, there's two aspects to the benefit. There is the coverage for the exam, and then there is an allocation toward your first set of frames and lenses. As it relates to the exam, there is a fee schedule in place. And when we're talking about premiums for vision on an individual basis, you could be looking anywhere between $7 and $12 a month so the premiums that exist there are not that high. If you increase potentially the fees that are being paid by the plan for the eye care exam significantly,

there will have to be increases in premiums. Someone that may not utilize their benefits on a regular basis will potentially decide, well is it worth it? Do I want to pay that added premium when I only go to the optometrist every two years? In fact, I was having lunch today and somebody says, “I buy vision insurance every other year because I’m not going to go every year to an optometrist.” It’s a heavily selected benefit to where you’re not going to buy it unless you’re going to utilize it in that regard. So, that’s why there are some very underwriting sensitive numbers that we have to look at in that regard from a vision care plan perspective.

Mr. Wieske stated that maybe the language is imprecise because the word “health plan” and “plan” is used interchangeably throughout the model but it does appear that there is specific approval by the optometrists of what specific plan they’re willing to participate in inside a specific insurance company based on the language. That creates an issue where maybe they only want to operate in those. And then when you set floors and you set other requirements, it ends up being more expensive for the consumer, either premium wise or from their out of pocket so that’s sort of where the concern lands.

Rep. Adrielle Camuel (KY) stated just for clarification, I’m hearing the words “patient” and “consumer” used differently in this discussion. Could someone clarify what the difference is between the two? Rep. Gordon stated that as an audiologist I think the word “patient” infers relationship, and “consumer” is more transactional. We are here to preserve the patient-doctor relationship. Dr. Parker stated I think that’s where a lot of the confusion lies here. To have an example of where I’m going to just use my vision insurance every other year, that’s a patient who doesn’t understand what an eye exam is about. That’s someone who thinks they’re going to get just a pair of glasses and not an exam and in our practice we’ve detected so many things early, everything from brain tumors, to chronic disease to dry eye just because a patient comes in annually. Patients become your family. Consumers are just looking for a price.

Rep. Stephen Meskers (CT) stated that I think this highlights why NCOIL and what we do is so important. I think what we’re framing here is a conversation about two things - about quality of care and level of care and cost of care, and a community issue that we’re facing in all of our committees and across each of our states. We’ve got Amazon who does everything remotely. We’ve got Tesla who sends all of their profits to the great state of Texas or California. So, we’ve got a business model where we have local providers with potentially an increased cost, but providing cost and care with local offices and paying taxes locally, not part of a chain. And I’m not attacking the chain model. I think when we ask about the issue, it’s a model of where we want to go in each community. In reference, in Connecticut we have a liquor law where the supermarket can’t sell liquor. So Connecticut has what they call a package store that sells alcohol. The package store are managed and owned individually or in small groups, but the profits stay in the local community. They invest in the little leagues, they pay to the community. The same thing with our car dealerships versus a Tesla model. I think there are two pieces here: it’s a quality of care, the consistency of care and the business model. I’m not sure where I fall on this, because my glasses are from Amazon and they are readers but I think the question becomes, what do we do about the model and what potential changes are because I think the Model does address a concern that we’re x-ing out the individual providers over time. And I think it has to be acknowledged that if we don’t provide some steps, the local optometrist will disappear and that’s a question on policy that may not fit with insurance, but as I sit as Chair of the Commerce Committee in Connecticut, it sits with me there too. If you could both comment about the model and what it means to both of you. I understand there’s a cost issue, But I would challenge you on whether we’re getting the best competitive model if we aggregate all the business into larger providers.

Mr. Wieske stated that I would just say that from a model standpoint, this is not that. This turns it into something different. And there are consensus things but this is not a consensus model. If you ask ChatGPT or Claude, they will tell you less than one third of this specific model has even been looked at across the across the country. And the model is pulling from the American Optometric Association (AOA) website. And there are things that are consensus that can protect local aspects and we would be happy to work on a consensus.

Asm. Jarett Gandolfo (NY) stated to Dr. Parker that in your testimony you had mentioned coercion and coercive practices. What exactly do you mean by that? Can you expand a little bit? Dr. Parker stated that there's so much integration now where if a company owns the practice management software and they own the practice and own the lab and own the frame suppliers, they have the ability to, while the patient is scheduling an appointment to recommend certain things be done. One of my colleagues mentioned that she had a patient while she was in the exam room that got a text from her vision insurance that said, "At the end of your exam, go to such and such business, and get your contact lenses." That is a direction that has turned patients into consumers and is what I think is the danger to our smaller towns. I'll give this example. We had a terrible ice storm this winter, and we closed office for a week. I had a patient who lives about a half a mile from me, whose son accidentally shot her in the eye with a Nerf gun. So my son, who's also studying to be an optometrist, we got on our coats and we walked across the snow and ice to the house and we saw that young lady in her home. And that's what we do as optometrists. We go to the homes; we take care of the people. And if we lose that, much like I've seen that lost in the pharmacy world without me fighting for it, then I missed an opportunity to to express my concern.

Rep. Gordon stated that to put it in plain terms, it's self-dealing. They're referring the patient to your office and then they're dictating care. And they often own the very labs that they're telling you you have to purchase the product from. I think Sen. Felzkowski kind of hit the nail on the head. If you have a benefit amount, I can operate within that benefit amount but don't tell me how I have to to use that benefit. That's the crux of the problem.

Rep. Pollock thanked everyone for their comments and stated that here at NCOIL, I'm proud that what we do here is to create and make a good model for us legislators to take back to our states. And obviously this is the start of this situation here and I'm not sure that we've ever had any of this type of legislation, maybe bits and pieces, so this is the start of this conversation. If anyone has any questions or comments on this in advance of our next meeting, please reach out to Rep. Gordon, myself or NCOIL staff.

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

Rep. Pollock stated that next on our agenda is a continued discussion on the NCOIL Charity Medical Care and Medical Debt Reform Model Act (model). We've had great discussions on this at our previous two meetings, and it looks like we're getting closer to where this model could be voted on. The model is in your binders on page 17 and on the website and app. Before we go any further, I want to recognize the sponsor of the model, Rep. Tom Oliverson, M.D. (TX).

Rep. Oliverson thanked everybody who's reached out to me on this model. It sounds like this model has generated a lot of interest around the country. I think it's definitely timely and needed. As we mentioned back in November, this model is based on legislation that I had filed in Texas and essentially, it all began with a report that I received that we had tax-exempt hospitals and systems in our state that were sending patients, who would have been eligible for charity under the hospital's own definition of charity, to third party debt collectors and just destroying them

financially, rather than taking the time to screen them for the charity that they would have undoubtedly qualified for. And so that prompted this whole discussion. So generally what the model does is it prevents hospitals from pursuing debt collections on patients until after they have verified whether a patient is eligible for charity under the guidelines that they promulgate and are compliant with the IRS tax code. And you can see that in section four of the model. I have received some very positive feedback from a variety of stakeholders. I'd like to just say that I have I have found Ascension to be a a very good working partner, and Ascension has come forward with some very good suggestions and we've tried to incorporate those that made sense to us.

I'm not going to go through every single change that we made to the model, but I do want to highlight a couple of them. We clarify that this bill does not apply to for profit hospitals since they're not claiming a tax exemption and we wanted to be clear about that. There was some discussion of whether it should apply to all hospitals, but again, only a hospital that has a tax-exempt status designation is actually supposed to be providing charity in exchange for tax benefits. Although for-profit hospitals do provide charity, and in some cases, they provide the same amount of charity as a tax exempt hospital might, they are not getting any benefit from state government or federal or local tax benefits in exchange for doing so. They're just doing that from the goodness of their heart. We did provide some pretty strong clarifications in response to conversations with the hospitals with regards to what constitutes a violation and providing the Attorney General some discretion as to whether he or she wishes to bring an action against a hospital to revoke a tax-exempt status as opposed to mandating that they do so. We also included a section that may require some clarification and that has to do with that this is not meant to be a requirement on a hospital to essentially provide charity for cosmetic or non-elective care. Although I do think that we probably need to go back to the drawing board a little bit and define what we mean by "elective", because essentially, I'll give you a good example of this. A hernia may at some point be elective. However, if it remains untreated, it could become a life-threatening emergency. So, I think there is some continuum there on some of these things and I think we need to be clear about when we say "non-elective" versus "elective", what do we actually mean by "elective"?

I'm happy to continue to work with the stakeholders to define the term "elective". There are some unresolved questions that I am going to put to you, the committee members, that need to be resolved. So, I'm going to invite you to study this model and get back to me with your ideas. But these are the questions: should the model apply only to uninsured and self-pay patients, or should it apply to all patients? And I bring that up because as we live in the era of increasingly high deductibles and patient responsibilities, somebody may technically have coverage, but still essentially not be able to completely afford care in the event of of some type of emergency situation which they could not foresee. Should the screening process apply to non-medically necessary care? This gets back to the question I just brought up regarding elective care. I don't think we should be considering facelifts and breast augmentations and dental restorations and various cosmetic things to be subject to charity requirements, but maybe you do and I'd love to get your feedback on that. I would ask you to look at section 4(G) with the reimbursement process and I'm just going to ask the committee to consider whether they believe that is appropriate or would it potentially encourage bad attorney behavior? The last thing I ever want to do is adopt a model that creates a new form of lawsuit abuse. And finally, should the model require hospitals to issue an annual report to state departments regarding how their charity program is being implemented. In other words, how much of a tax break are you getting? How much charity are you actually doing? What are you defining as community benefit? You may recall we talked about this in November that there was a hospital that very famously put a drinking fountain in the lobby of the hospital and said that was a community benefit and claimed that was charity. Obviously, that's abusive, and I'm not trying to suggest that everybody does things like that but I think it's important as state lawmakers that if we're going to provide these exemptions and these tax breaks

that we're keeping some oversight. We don't want this to turn into another sort of fraud event where it's all over the news. Also, if anybody wants to be added as a co-sponsor on this model, I would be honored to have your support.

Rep. Pollock thanked Rep. Oliverson and stated that he would like to be added as a co-sponsor to the model.

Eli Rushbanks, General Counsel and Policy Director for Dollar For thanked the Committee for the opportunity to speak and stated that Dollar For is a nonprofit that helps patients nationwide access hospital financial assistance programs. We want these programs to be known, easy, and fair to patients. One such patient is to my right, Katie Smith, who lives here in Kentuck and I'm going to let you hear directly from her about her experience.

Ms. Smith thanked the Committee for the opportunity to speak and stated that in August of 2024, I had surgery and it was supposed to be a relatively short-term turnaround to becoming well but it became more complicated to the point where I had to have home health services. While I was in the process of trying to heal and recover, bills were coming in and that was making me very depressed. So, I contacted the hospital to say, "do you guys have a plan?" Because I couldn't go to work. And I asked whether they have a plan to help people that have financial difficulties? And they said "yes" and I was given paperwork to fill out. And I kept calling to see if any decision had been made and nobody ever said they lost my application, but he just kept saying that I need to fill out another application. And then I had a case manager who contacted me and I was just talking about how I'm frustrated with all these bills that are coming in and she said I'm going to find a referral for you. So she did call back and referred me to Dollar for, and they contacted me and said "Fill out the paperwork and we'll take it from here." And I did and I think it was probably only in about a matter of two months that I got a call that it was taken care of. And I'm just so appreciative because not only was I still trying to recover, but I was not at work, and of course I had all my other bills to pay so I'm appreciative and I don't mind sharing my experience.

Lucy Culp, VP of Government Affairs for Blood Cancer United thanked the Committee for the opportunity to speak and stated that if you're thinking who in the world are we are, it's a recent name change from the Leukemia Lymphoma Society. So a new name, but the same mission to help cure blood cancers and serve folks with blood cancers. So, just as a refresher, blood cancers are extraordinarily complicated to treat and extraordinarily expensive to treat. In the first year, on average, for a leukemia patient it costs about $500,000. So it's not shocking that about 42% of cancer patients report exhausting their entire life savings within two years of a diagnosis. And what happens then? They begin to accumulate medical debt. And I will say, Katie's experience and struggle plus the time it takes, and the process, we hear that a lot. And that's for the folks who even know to ask because many don't. And so many patients never get financially screened or don't get screened until well after the fact when they have a mountain of bills that they can't pay, and they call an organization like ours and we go through the process of applying for financial assistance. All of that is to say we're we're really pleased to support the model. We would support it as written. I will try to off-the-cuff answer some of those questions that you posed Rep. Oliverson because I think you're asking really great questions about how the model can be strengthened. We did some polling with some partners at the American Cancer Society, and Undue Medical Debt, and I think you probably all know that reforms in this area are extremely popular. When we polled on financial assistance screening in particular, we saw really overwhelming support across party lines, over 85% support from voters across the country.

So, just a couple of thoughts that I think could help strengthen the model as it exists or maybe worth considering for drafting notes. As you know, different states have different needs and some

things may be more applicable than in other places. I will say that the terms “charity care” and “financial assistance” do get used somewhat interchangeably and you may want to consider the term “financial assistance” in part because that is the term that the IRS uses. It’s also a little bit more understood by patients to be assistance that they are eligible for versus the term charity can sometimes come with a sense of shame or stigma in having to ask for charity when in fact this is financial assistance people are eligible for and they should know about and they should be screened for it. I think the other thoughts we had of hinge on the idea that for the most part, patients don’t have a lot of choice in where they’re treated. If the hospital that is closest to them has the service that they need, whether it’s a for-profit or a non-profit, if it’s in their state versus out of their state, if it’s a state facility versus not a state facility, they don’t have a lot of options. They’re going to the place that can serve them closest to their home for the most part. So, we just offer that as you think about whether this should apply to all hospitals. Certainly, for-profit hospitals don’t have to, but they can and many do. There is a study out of Harvard and the Lown Institute Hospital Index found there really isn’t a significant difference in charity care spending as a share of expenses between non-profits and for-profit hospitals. So I think that’s something to consider, if not for the model, then as you think about adopting this model in your states. Also, the model only applies to residents of the state where the hospital sits. And particularly in rural communities, people do have to go across state lines to get care. So, you may want to consider who is eligible and who should be screened in that section. We would really encourage you to have this apply to all patients. At my organization, with our medical debt case management program, about 95% are insured so it’s very much a problem for folks who do have insurance.

Joe Burchfield, National Director of State Policy for Ascension, thanked the Committee for the opportunity to speak and stated that I also want to express our sincere appreciation for Rep. Oliverson and his work on this issue and his willingness to work with us and other hospital stakeholders on the model. We’re a Catholic health system with a mission to deliver compassionate, personalized care to all with a special focus on the vulnerable. Our network spans 15 states and the District of Columbia with approximately 97,000 associates, more than 23,000 aligned providers, and 91 wholly owned or consolidated hospitals. We also operate 26 senior living facilities and a variety of other care sites, offering a wide range of services. Consistent with our mission, we approach financial assistance and charity care with a unique perspective and significant experience. In fiscal year 2025, Ascension provided $1.7 billion in care to persons living in poverty and other community benefit programs. That’s in addition to $1.8 billion in unreimbursed Medicare costs across our system. This level of patient support is guided by our compassionate, patient-centered financial assistance billing and collections policies which I’d like to share with you today. Patients with incomes less than or equal to 250% of the federal poverty level, which for reference is about $39,000 for an individual and about $80,000 a year for a family of four are eligible for 100% charity care. So, if you fall within that range your debt is completely resolved. Patients with incomes above that and below 400% receive a sliding scale discount based on the patient’s portion of the charges between 95% and 85%. And for reference, 400% of the federal poverty level is going to be about $62,000 a year for an individual, $129,000 for a family of four.

Patients who have incomes greater than 400% of the federal poverty level may also be eligible for financial assistance, echoing some of what we’ve heard earlier due to excessive total medical debt. When that can be proven to be greater than the household’s gross income, the 400% sliding scale would apply for that patient. And we would define that medical debt to be inclusive of anything owed to Ascension and other providers. So it is comprehensive, not just what’s on the books with us. In addition to that, all patients regardless of their eligibility for medical assistance are eligible for zero interest payment plans. To inform patients of this very important policy, all of our billing statements on the front page include a callout box with notice of our financial assistance policy. We provide a link, a phone number and a QR code so patients can access that information

and begin the process. Moreover, in close alignment with the model, we perform presumptive financial assistance eligibility screenings for uninsured patients. Between the first and second billing cycle, we work with a third-party vendor to use publicly available data based on patient demographics and information to determine their likelihood of eligibility for our financial assistance program. For patients who qualify, assistance is provided automatically in accordance with the categories I've just discussed. From a billing and collections standpoint, our policy is not to report medical debt to credit bureaus or to use extraordinary collection actions, except in extreme circumstances. An extreme circumstance would apply to an unpaid balance for elective, non-emergency, non-medically necessary care where a patient has been determined to have substantial resources and refused to pay the amount due. We do not pursue extraordinary collection actions for any account that has qualified for financial assistance.

We recognize the impact of medical debt on patients, whether that's due to being uninsured or as a result of health coverage that carries a high out-of-pocket cost. And we strive to maintain a program that supports patients' financial stability. In terms of the Model, we support applying the presumptive screening requirement to uninsured or self-pay patients. We believe that this approach supports the most vulnerable, while our clear plain language notice on financial assistance on all of our billing statements provides additional guidance and access to assistance for all patients. And while we support the proposed screening requirement in the model, the potential for penalties associated with non-compliance does remain an area of concern. Given the scope of the model to require presumptive screening before sending a bill, the threat of removing nonprofit status when there is no adverse action taken against a patient is concerning. Hospital billing is both a manual and automated process. It's high volume where tens of thousands of bills are sent each month in a given area. And as a result, there is legitimate potential for a bill to be inadvertently sent before a presumptive screening even though no adverse action is taken against that patient. So, with that in mind, we would recommend adding language that clarifies a violation of the act only occurs when a patient is sent to collections or reported to a credit bureau without first being presumptively screened for financial eligibility. Further authorizing the Attorney General to act when there's a clear pattern of behavior by a hospital would help reduce the risk to good actors in this space. Lastly, in terms of adding state level reporting data, Rep. Oliverson was spot on that many of those points are already reported to the IRS on an annual basis and we would recommend that any state level reporting mirror those reporting requirements to minimize the administrative burden and avoid any additional administrative costs. We truly believe this model can serve to establish standards across the health system that benefit all patients.

Rep. Emily Gise (OK) stated that in section six of the model regarding credit reporting and debt collection for debt related to life saving and emergency care, it was an effort that we tried to do in Oklahoma this session, but we saw some things coming from the federal government that barred state measures from exempting medical debt. Have you experienced any challenges with that? And how do you recommend we proceed forward? Ms. Culp stated that the Consumer Financial Protection Bureau (CFPB) issued a non-legally binding opinion that the federal Fair Credit Reporting Act preempts states from exactly this type of policy. I think there's been a lot of question about what that means, particularly for the 15 states who already have this kind of language on the books. In the comments that my organization put forward, we recommended a slightly different variation of approaching the issue and that's really to look at the contracts entered into between the provider and the debt collection agencies. That seems to be a space where there doesn't seem to be a preemption question. So it's another way to I think achieve the same goal of helping to protect folks without the potential for litigation that we're seeing pop up in a couple of states.

Mr. Rushbanks stated that I was having a conversation with the folks at the National Consumer Law Center and they were talking about this issue and they also said one strategy, sort of a belt

and suspenders approach, would be to prohibit the use of medical debt from credit reports if medical debt makes its way onto them for certain sensitive screening scenarios, like tenant screenings or something like that. Prohibit that specific behavior instead or maybe in addition to the actual reporting itself, in case this preemption issue becomes a problem.

Sen. George Lang (OH) stated that this is obviously a very noble cause and I think Rep. Oliverson has put a few safeguards in there that I'm mostly comfortable with the model. My only concern though is that we are the National Council of Insurance Legislators and I just don't see how this has any direct impact on insurance markets or insurance consumers. I see some indirect impact, but making sure you brush your teeth daily or eat a healthy meal has those same indirect impacts and I just I wonder if this legislation isn't better for one of the statewide models that aren't focused on insurance. Mr. Rushbanks stated that one nexus is to basically make this model apply to insured patients. There's an accounting firm, Crowe, that does studies on who has medical debt and their most recent one that I've seen shows that almost 60% of medical debt is held by insured patients, which is up from about 11% in 2013. And the federal law that makes nonprofit hospitals have to have financial assistance policies requires that those policies apply to all patients. There isn't an exception for insured patients and so we think that it's important for this model to apply to insured patients, which would kind of be the nexus to NCOIL.

Rep. Oliverson stated that just in summary, I thought it would be helpful to throw a couple of stats at you: 15% of the families living in your districts have past due medical debt, and two-thirds of those folks are below 200% of the federal poverty level; 62% of bankruptcies in America are due to medical debt and 29% of patients nationally who qualify for charity currently get it. So, that's the delta we're working with. Now on the hospital side, we're only talking about the out-of-pocket portion of hospital revenue, which is less than 2.5% of total revenue for hospitals. Which means that if everybody who qualified for charity across the country actually got the full measure of the charity they were required to get under this tax-exempt agreement, we are only talking about 0.7% of hospital revenue. So, I just want you to have those statistics. I'm happy to keep working on this.

Rep. Pollock thanked everyone and stated that this is a timely and important issue for NCOIL to explore. There's some time between now and Boston to answer some of the questions and the comments that were mentioned today. Hopefully we can consider voting on this model in Boston, but we'll see how that goes.

DISCUSSION AND POTENTIAL CONSIDERATION OF NCOIL RESOLUTION IN SUPPORT OF PUBLIC POLICY IMPROVING MATERNAL HEALTH

Rep. Pollock stated that next on our agenda is a discussion and potential consideration of the NCOIL resolution in support of public policy improving maternal health. We did have a great discussion on this topic in November, and now we have a resolution before us. I think it's great that NCOIL is discussing such an important topic and I'll turn it over to the sponsors of this resolution, Rep. Brenda Carter (MI), NCOIL Secretary, and Rep. Greg Scott (PA).

Rep. Greg Scott (PA) stated that I am proud to co-sponsor this resolution and I appreciate the opportunity to continue the conversation that we began in November. The resolution is available on the website, the app and in your binders on page 39. Before I begin my formal remarks, let me acknowledge Rep. Perry Warren (PA) sitting next to me, Chair of the Pennsylvania House Insurance Committee. Also, in my chamber we have three dynamic, substantive women who lead the Pennsylvania Black Maternal Health Caucus, and they are the thought leaders in our chamber on this issue and have helped me extensively. I want to lift up their names. They are Rep. Morgan Cephas, Rep. Gina Curry, and Rep. La'Tasha D. Mayes, and also the Caucus's Chief of Staff

Angelica Sanders. Women are dying during what should be the best days of their lives. It almost happened to my sister when healthcare professionals initially ignored her symptoms, only later to be diagnosed with preeclampsia. As a father of a daughter born eight months ago after a high-risk pregnancy, I've seen this danger up close, firsthand. National data continues to show troubling trends. More than 80% of pregnancy-related deaths are preventable and for every one of those deaths, there are roughly 70 severe maternal morbidity events, which are unexpected complications that have long-term health consequences. Maternal mortality events in the U.S. have risen over the past several decades, spiked during the pandemic, and even with recent declines remain higher than pre-pandemic levels. Access to and quality of care before, during, and after pregnancy directly affects outcomes for mothers and infants. Yet only a small share of mothers receive adequate prenatal care and conditions like hypertensive disorders remain strongly associated with severe maternal mortality or morbidity. We also know postpartum depression affects one in eight women and ensuring access to timely, evidence-based, and fast-acting treatment is essential. Insurance coverage plays a major role here, especially as rising premiums are causing some consumers to drop coverage altogether. I'm proud of the work we've done in Pennsylvania, including expanding Medicaid coverage for doulas, expanding a doula advisory board, and introducing the Pennsylvania Momnibus, which is a comprehensive legislative package crafted to directly confront the staggering rate of maternal mortality and morbidity in our Commonwealth addressing critical disparities in maternal health care, including measures that would improve access to essential services and eliminate maternal health deserts.

I'm glad that NCOIL is continuing to elevate these issues. At its core, this resolution recognizes that there are concrete, actionable steps policymakers can take to improve maternal health outcomes. We know the challenges are significant, but we also know that they are solvable. This resolution should serve as a starting point for conversations with stakeholders in your respective bodies. The resolution outlines several policy levers or buckets that should act as headers in proposed legislation and help guide those deliberative conversations. They include strengthening maternal mortality review committees (MMRCs), improving data collection, and expanding access to maternal support services. The resolution also calls for increased investments to expand doula services across Medicaid as a starting point but in your state, you could expand that to include others as well. I also want to highlight additional opportunities for states to lead, ensuring postpartum depression is identified and treated appropriately, expanding access to prenatal, inter-pregnancy, labor and postnatal care. Ensuring access to blood pressure monitors for pregnant and postpartum individuals, supporting innovative care and payment models that expand access to doula, midwives, and donor milk. Encouraging insurers to eliminate barriers to fast-acting treatments for postpartum depression. And I'll close with this, if history is precedent, we have future insurance commissioners and maybe even a Governor or two sitting in this room. Our Governor Josh Shapiro created a maternal health strategic action plan, the first of its kind from a state administration that challenges state departments, including our Department of Insurance, to cross collaborate and coordinate as they work to address maternal health from a state level. Together, the Pennsylvania Departments of Health, Human Services, and Drug and Alcohol Programs, and Insurance work to create a strategic action plan with clear work being done to address the needs of those with lived experience and those delivering care, and the steps we can take together to change the trajectory of poor maternal health outcomes and persistent disparities in Pennsylvania. So, as you can see, there are many levers that you can pull in states and this resolution reflects a thoughtful starting point that you can use to improve maternal health outcomes nationwide. I encourage the committee to support the resolution.

Rep. Carter thanked Rep. Scott for sponsoring this important resolution with her and stated that I don't have much to add to what Rep. Scott said. I'm very pleased that NCOIL is discussing this issue. I think the resolution contains valuable steps that states can consider taking to improve

maternal health. Importantly, this resolution isn't serving as any type of mandate on states. Rather, it simply sets forth policy states that states can consider implementing in an overall effort to support maternal health. I do have a very minor amendment to offer and I have discussed this with Rep. Scott and it is printed out before you and it's in the online materials. On page 41 in your binders, under the section titled "Improving Data Collection and Infrastructure", language is proposed to be added to ensure that as a part of data collection efforts, definitions should aim to align with existing state and federal data collection efforts to minimize duplication. Obviously, duplication of efforts benefits no one, and that's certainly not the intent of this resolution. That's all I have, and I encourage the committee to support the resolution.

Sarah Duggan Goldstein, DrPH, MPH, Managing Director of Legislation and Regulatory Policy, Health Equity Policy, at the Blue Cross Blue Shield Association (BCBSA), thanked the committee for the opportunity to speak and stated that we are so grateful to Rep. Scott and Rep. Carter and to the committee for consideration of this resolution. Maternal health is really not just a medical issue. It's a reflection of how well our systems function, how effectively our policies respond to real needs and how committed we are to protecting the well-being of women and infants. States play a critical role in this work. They shape the policies that determine access to care, quality of services, and the strength of the public health infrastructure that supports families before, during and after pregnancy. This is why strong, reliable data matters. States rely on accurate information to understand where gaps exist and how to close them. MMRCs and multidisciplinary bodies that examine maternal deaths are uniquely positioned to identify preventable factors and recommend solutions. But for these committees to be effective, they need consistent funding, independence and the ability to collect and analyze data in a centralized and standardized way. This resolution emphasizes several pathways for states to strengthen maternal health outcomes. First, by supporting and expanding the work of MMRCs, States can ensure that lessons learned from each case translate into meaningful policy and practice improvements. Second, by improving data collection, especially around severe maternal morbidity, states can better identify where interventions are needed most. Standardizing race and ethnicity data is also essential for understanding and addressing disparities. Expanding access to maternal support services is another critical step. Doula care, for example, has been associated with improved outcomes. Yet many women lack access. Investing in doula workforce development and ensuring hospitals integrate doulas into care teams can help bridge this gap. Maternal mental health also requires a coordinated response. Integrated care models that bring together obstetric providers, pediatricians, nurses and community-based support workers can help ensure that mental health needs are recognized and addressed early.

Finally, the resolution encourages hospitals to adopt evidence based clinical practices such as the Alliance for Innovation in Maternal Health Hypertension Bundle, which has been shown to improve the management of hypertensive disorders during pregnancy. Taken together, these measures reflect a comprehensive approach, one that recognizes the complexity of maternal health and the need for coordinated action across systems. States are key partners in this work. By strengthening data systems, expanding access to care, supporting maternal mental health, and promoting evidence-based practices, States can help ensure that every mother has the chance for a safe and healthy pregnancy. Improving maternal health is not only a matter of public policy. It is a commitment to the well-being of families and communities. The steps outlined in this resolution highlight the essential role states play in creating a future where maternal deaths are rare, preventable complications are addressed and every mother receives care that she needs.

Sen. Bill Gannon (NH) stated that we're getting a lot of money from the Rural Health Transformation Program. For us, it's $1 billion over the next five years. We're using it mostly on our northern cities and towns where we have a poorer population and they get less healthcare.

So we're hoping that it's going to be huge on maternal health and it will be one of the areas that the money goes to. Is this the same in all the states? Are they all getting a big share? And will a lot of it go towards maternal health? Ms. Duggan Goldstein stated that a lot of the states are using a significant portion of their funds to address maternal health in some way. Of course, all states are doing it a little bit differently. And some states got a little less, some states got a little bit more, but most states got about $1 billion over five years.

Sen. Beverly Gossage (KS) stated that as a health insurance agent for the last 22 years, I've seen rates that have gone up partially because of the accumulator. Correct me if I'm wrong, but when an actuary determines how are we going to price this plan, if you choose the exact same benefits, but you have a $250 deductible or you choose the exact same plan and you have a $5,000 deductible, the premium's going to be vastly different because they know that you are participating in this cost sharing and know that you're probably going to be a better consumer, watch how you spend, and how you use your medical care. And therefore, it's called consumer-driven health care. When you choose a $5,000 deductible and you have a lower premium, but somebody else is helping you to pay the balance of that deductible, it vastly changes the mindset of the individual and the consumer. Can you address what you've seen with the accumulator and how that has affected premiums? And might I just add the caveat, an insurance carrier doesn't know oftentimes that grandma's going to help pay for this or uncle is going to help pay for this but if it's an insurance carrier themselves or a provider themselves, they want that individual to get to the hospital and I would like for them to get to where they've met their deductible as soon as possible, because the insurance company is then going to start paying at 100%. Could you address that for us, please?

Rep. Pollock stated to Sen. Gossage that I think you may be talking about the accumulator adjustment program model which will be discussed later. This is the maternal health resolution discussion. Sen. Gossage stated that she will wait for her question.

Rep. Peggy Mayfield (IN) stated that I wanted to add to Rep. Carter's comments about having good, accurate data. I sit on our state's Commission for Women and the Commission for Latino and Hispanic Affairs. These are obviously two groups that are directly impacted by maternal care. I also sit on the insurance committee and I've been one of the premier pro-life legislators for the state of Indiana and yes, the pro-life movement is also very concerned about maternal health care. But one of the interesting facts I've seen is that it's usually flipping back and forth, the number one and number two causes of maternal mortality are homicide and suicide. When you say maternal mortality, you tend to think access to medical care. So, those two items, I think we need to not pull out. Their lives are very valuable too, but we need to separate the data for medical reasons versus environmental reasons and many of those deaths in the homicide are intimate partners and family members, which are very disturbing numbers. But I think if we are going to address this issue on the medical side, we need the medical data. If we're going to address it on the social side, we need that, and we might have to take different approaches. So, I just wanted to say regarding Rep. Carter's comments, we do need very detailed breakdowns of the numbers in maternal mortality. Ms. Duggan Goldstein stated that yes, and the MMRCs do collect all deaths regardless of cause so intimate partner violence is absolutely one of those. And suicide and mental health conditions are also obviously a big chunk of that as well. So, those are definitely collected so that every death can be analyzed appropriately.

Rep. Scott stated that I would just add that we all agree. If you look at the actual maternal health data that the committees are pumping out, they extract it. I'll be more than happy to provide Rep. Mayfield a copy of Pennsylvania's data. I think the data is incredibly important. We can't make decisions based upon emotions. We've got to make them based upon the data. So, thank you for that comment. Rep. Carter stated that I want to end thanking the state of Michigan for the

incredible work that they've been doing. We recently passed a black maternal health resolution where black women are dying four times the rate of any other population. And therefore, I want to thank Blue Cross Blue Shield of Michigan, the Michigan Department of Insurance and Financial Services and the entire Michigan Legislature for standing behind this work.

Rep. Pollock thanked everyone for their comments and stated that as a reminder, per NCOIL bylaws, all NCOIL votes are voice votes, except that a roll call vote shall be taken at the direction of the chair or upon the request of a committee member in instances where there are dissenting votes. Hearing no questions or comments, upon a Motion made by Rep. Scott and seconded by Rep. Barbara Dittrich (WI), the Committee voted without objection via a voice vote to adopt the amendment Rep. Carter offered to the resolution. Then, upon a Motion made by Asw. Pam Hunter (NY), NCOIL Immediate Past President, and seconded by Rep. Scott, the Committee voted without objection via a voice vote to adopt the resolution as amended.

DISCUSSION AND CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Rep. Pollock stated that last on our agenda is a consideration of re-adoption of model laws. As a reminder, per NCOIL bylaws, all NCOIL models are scheduled to be considered for re-adoption every five years and if it's not re-adopted, it sunsets. First, we will hear comments on the NCOIL Telemedicine Authorization and Reimbursement Model Act. The model is available on the website and the app and in your binders on page 51. We'll hear from Erin Hiley, Chief Legal Officer at American Specialty Health (ASH), who has some comments on the model and some potential suggested changes.

Ms. Hiley thanked the Committee for the opportunity to speak and stated that this is my first time presenting here so I thought I would take one moment just to introduce ASH. We've been in business for 39 years. We started with chiropractic networks in California 39 years ago and since then became the first restricted health plan in California. We moved nationally, and other than growing geographically, we grew our specialties from chiropractic to include acupuncture, naturopathy, podiatry, and more importantly physical therapy as well as some others. We also have other business units, but we work with health plans, employer groups, and direct-to-consumer in the healthcare and in the fitness and wellness space. I mentioned physical therapy being important because it's a rapidly growing specialty in healthcare. And ASH currently has 82,000 physical therapists and occupational therapists across the country, 81,000 of those provide services on a home-based or mobile service basis. And ASH also has 350 physical therapists and occupational therapists working in the telemedicine space. We are asking that this model remain open for consideration of a few changes. I want to thank Asw. Hunter for her foresight and innovation in getting this model passed. It addressed important pandemic needs, and it remains relevant today and requires very little edits to modernize it to make it less about the need to address COVID needs and more about utilizing telemedicine so that patients in all of these settings can have choice. I just want to highlight here that we're recommending very minimal change and ASH requests that the Model stay open for consideration of possible changes.

Asw. Hunter thanked Ms. Hiley for her comments and stated that as the original sponsor of this model, I do think it's worth having some discussions as to whether any changes to the model should be made. This model was adopted during the COVID pandemic, and such a tremendous amount has changed in the telemedicine landscape in the past five years. I'm not committing to making any specific changes but I think it's worth at least having some discussion around the current telemedicine landscape and how it may impact the model. That stated, I would recommend that the model be re-adopted until the summer meeting rather than for the full five years, so that we're afforded the opportunity to discuss and consider any potential changes.

Rep. Pollock agreed with Asw. Hunter. Hearing no further questions or comments, upon a motion made by Rep. Carter and seconded by Sen. Felzkowski, the committee voted without objection via a voice vote to re-adopt the model until the summer meeting in July.

Rep. Pollock stated that we will now entertain the remaining three model laws for re-adoption: the NCOIL Model Act Regarding Air Ambulance Protections, the NCOIL Accumulator Adjustment Program Model Act, and the NCOIL Employer Sponsored Group Disability Income Protection Model Act. Rep. Pollock stated to Sen. Gossage that regarding the accumulator adjustment program model, staff is going to work to provide you information on that. Rep. Pollock then stated that the models scheduled for re-adoption are on the website and app and appear in your binders starting on page 42. Neither NCOIL staff nor I have received any comments on these models.

Sen. Lang stated that he has some serious concerns with the accumulator model. The model goes against many things that insurance is built on. Insurance is built on good risk and if you look at a health insurance plan right now, you all know Pareto's law, the 80/20 rule, and in health insurance it's even worse. About 4% to 6% of your participants in a plan make up about 60% of your claims. So, the insurance pricing model is designed to get young people to participate in the plan because young people for the most part, their only significant risk of a catastrophic cost is an accident or pregnancy. And the risk for catastrophic cost is real, but it's infinitesimal. So, they price these plans to create a plan that has a high deductible and a low premium to get our young friends to participate to pay for folks like me. I'm battling stage four colorectal cancer right now and my wife and I sit down and we choose to take the high premium but the low out of pocket, low deductible cost for that. That's the way insurance works. We incentivize the young to participate to offset the cost for those of us that are aging. With this plan there is nothing stopping me from going into the plan designed for the young people, getting the high deductible plan, having the insurance companies pay my deductible, so my out of pocket cost now goes to zero, and I can scam the system and participate in the lower premium plan. Every single pharmaceutical company that I've met with I say if this plan is so vital, why don't you just lower your total cost for your drugs to benefit the entire market rather than trying to take a portion of the market and build it in so that you can have a higher overall cost? This does add cost. And keep in mind, the only people we are impacting with this cost are those that we control. Specifically, the small market risk pools. And in Ohio, we can regulate Medicaid and the state plan and some state university plans as well.

You cannot even do this in the Medicaid and the Medicare plans because it is illegal. It is considered a kickback. All of the universities have come to us because there's a bill right now being considered asking for a carve out so they do not have to participate in this plan. I've got a list of about a dozen other reasons why this is a bad idea, but for the sake of time, I would rather see pharmaceutical companies lower their costs and benefit everybody rather than lowering the cost and they will modify the coupon based on your deductible. If it's a $5,000 deductible, you'll get a $5,000 coupon for one month. If it's a $20,000 deductible, you'll get four $5,000 coupons. And I'll finish with this. Ten years ago, we controlled about 20% of the market in Ohio as it fell under our regulations. Every time we had an unfunded mandate, the most recent one being hearing aids for kids which is a noble cause but I fought against that. If it's a noble cause, let the state pay for it. Don't force the small businesses to pay for it. Our percentage of people that we control just in Ohio went from about 20% of the market to today down to 10%. The Farm Bureau just came out with their own Medishare program, similar to the ones that the health ministries have. I believe we're going to see other organizations coming out with similar programs, all designed to help the little business guy get out from under our thumb. The small business has figured out how to go partially self-funded. How to join a consortium. How to get out of everything

that we do to raise the cost because we only impact the little guys. And the little guys are competing against the big guy's of the world for talent, but we're asking them to compete with handcuffs and shackles on. I've got a whole bunch of other reasons to oppose this but for the purpose of time, I would just urge us to give serious consideration to this model and I would ask that we don't consider all three models at the same time for re-adoption.

Asw. Hunter stated that I just want to just briefly say I support the re-adoption of this model. It's been a very successful model adopted by several states. This is just a re-adoption, and we're not obviously forcing any state to adopt this model. I would like to move for re-adoption.

Kevin McKechnie, Executive Director of the American Banker's Association (ABA) Health Savings Account (HSA) Council, thanked the committee for the opportunity to speak and stated that the grand question of whether copay accumulators are a good or a bad idea is not part of my brief. But I want to raise the point that in the model law in section 4(C) that there is a compromise between the pharmaceutical industry and the HSA industry so that States that wish to legislate in this space can do so without impeding the contribution eligibility of people with high deductible health plans. In other words, it preserves the fully insured market for HSA-qualified insurance in your state. I am making a general comment in support of renewal because it's an important tool for us in these debates in states and it works. I'm not addressing the question or the concerns you brought up Sen. Lang. What I'm suggesting is right now it's working for us because when we enter these debates, we have to find a way to coordinate federal IRS rules with state rules and preserve your ability to legislate in the places you would wish to legislate, which is what section 4(C) does.

Sen. Lang stated that it may be working for you, but every unfunded mandate that we put in is not working for the small business employers in the state of Ohio. Mr. McKechnie stated that I was only referring to the coordination language in section 4(C). The grand question is something else; something you'll have to manage.

Rep. Pollock thanked everyone for their comments and stated that today is only about re-adoption and substantive comments are something that we can continue on discussing at a later time if necessary, but for today it's only about re-adoption. is the re-adoption of this model. Hearing no further questions or comments, upon a motion made by Asw. Hunter and seconded by Rep. Ellyn Hefner (OK), the committee voted by way of a voice vote to re-adopt the model with Rep. Pollock determining that the yes votes clearly outnumbered the no votes.

Then, upon a motion made by Rep. Oliverson and seconded by Rep. Mayfield, the committee voted without objection via a voice vote to re-adopt the NCOIL Model Act Regarding Air Ambulance Protections and the NCOIL Employer Sponsored Group Disability Income Protection Model Act.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Gossage and seconded by Sen. Lang, the Committee adjourned at 12:45 p.m.