NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2026 NCOIL SUMMER MEETING – BOSTON, MASSACHUSETTS
JULY 17, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Westin Copley Place Hotel in Boston, MA on Friday, July 17, 2026.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Sen. Tim Grayson (CA)
Rep. Stephen Meskers (CT)
Rep. Rita Mayfield (IL)
Rep. Peggy Mayfield (IN)
Rep. Adrielle Camuel (KY)
Rep. Deanna Frazier Gordon (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBoeuf (MA)
Rep. Robert Foley (ME)
Rep. Brenda Carter (MI)
Sen. Mark Huizenga (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Tim McGough (NH)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Asw. Pamela Hunter (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Matt Morgan (TX)
Rep. Tom Oliverson, MD (TX)
Rep. Dennis Paul (TX)
Rep. Calvin Callahan (WI)
Del. Walter Hall (WV)

Other legislators present were:

Rep Kerry Wood (CT)
Rep. Ben Fuhrman (ID)
Sen. Willie Preston (IL)
Rep. Daniel Grossberg (KY)
Rep. Michael Meredith (KY)
Rep. Poppy Arford (ME)
Rep. Michelle Boyer (ME)
Del. Pam Guzzone (MD)
Sen. Bill Gannon (NH)
Rep. Julie Miles (NH)
Rep. Kevin Norwood (OK)
Rep. Trey Wharton (TX)
Sen. Cale Case (WY)
Rep. Pepper Ottman (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. Brenda Carter (MI), NCOIL Secretary, and seconded by Rep. Dennis Paul (TX), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Peggy Mayfield (IN) and seconded by Rep. Rita Mayfield (IL), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 17, 2026 meeting.

PRESENTATION ON IMPROVING ACCESS AND AFFORDABILITY IN THE HEALTHCARE MARKETPLACE

Rep. Pollock stated that in keeping with NCOIL's focus on healthcare affordability, first on our agenda is a presentation from a health insurer that has a unique business model which aims to promote access and affordability in the healthcare marketplace.

Natalie Leino, General Counsel and Chief Compliance Officer at Sidecar Health thanked the Committee for the opportunity to speak and stated that affordability has certainly been a central theme throughout this conference so it's great to be able to share what we are doing because we do believe that the current system as it is, is broken, and something more than just minor tweaks needs to happen for it to improve. Prior to joining Sidecar two years ago, I've worked in other large health insurance companies, both at a Fortune 20 national insurer and also at a regional nonprofit so I have seen companies try to address challenges associated with rising costs through a number of different forms. Sidecar is a mission driven organization who aims to make quality health care affordable and accessible for everyone. Our first major medical product was introduced in 2021. We started offering products to large group employers 2022. And now we're focused on continuing to expand to new markets. So, what do we do? We lower costs by making healthcare shoppable. Almost all other things that people get in this country are shoppable, and healthcare is a huge exception to that today. What's the status quo? There's no transparency into cost and quality of care. There's little motivation for patients to consider cost in decisions.

And even when patients do have that motivation now because they're in high-deductible health plans or otherwise have high cost sharing, they can't do it because they don't have that transparency into cost in order to make those decisions. What traditional health plans have done in light of rising costs is they've begun to restrict care with things like smaller networks, prior authorizations, step therapy, and formularies. Sidecar believes we have to approach it in a fundamentally different way. We provide our members with complete transparency by providing cost and quality data upfront. We align incentives so we reward smart decisions when our members make good choices and begin to treat healthcare dollars like their own, and that leads to lower costs for everybody. We have found that aligning incentives does change behavior. Our members have higher rates of primary care utilization, 50% higher mental health utilization. This translates into 40% lower emergency room costs. They access prescriptions at lower cost pharmacies 75% of the time, 60% of colonoscopies are performed at lower cost facilities, and perhaps mostly uniquely, the average family on our plan earns $1,000 a year for making good decisions. So, just to give a very simple example. If you look at any given drug, there's a wide variation in how much that drug will cost when you go to different places. So here, Lipitor, about 30% of people age 40 and above are on a statin. A 90day supply varies from $11 to $32 in a particular geography. An annual cost for an employer when you add a number of people on, it can be quite significant. If you then translate this to every drug and every service, the amount of savings that can add up when members are making smart decisions is huge.

So, we have found that this approach does lower medical costs, an average total savings of 20%. The average member savings per member is $2,000 a year and this translates into 20% lower premiums for employer groups that pick Sidecar. So how does this work? All care has a

transparent budget. We refer to this as the benefit amount, and it's an amount the plan pays for any given service or drug. The key is this is not just a reference price. It is set to the typical cost where that member lives. There's a large number of inputs that go into it, and so it's very regionalized and specific in terms of how the benefit amount is set. Members then can understand what the benefit amount for any service is and then the cost at different providers in their area. And when they choose to go to lower-cost care, they keep half the savings. Sometimes members choose to go to a provider above the benefit amount, and they pay the difference. So, you can see here, a little visual, and we do have an app that will very clearly show you. Members can search by provider, or search by service. You'll see what you will pay or earn as a consumer. You pay for your care with a Sidecar Visa card. This is not a credit card, it's a benefit card that when you swipe the card, the provider gets paid at the point of service. But those funds come directly out of our Sidecar claims account. So there's no element of the member kind of having credit the way a traditional credit card works.

Then, when they make good choices, they earn money. So, the app will always show them how much they have earned. They can use those earnings for future medical care, and if they haven't used them by the end of the year, it is paid out in cash through their employer, and it is taxed at that point. Now I will quickly show some examples. This is an example of an MRI. The cost varies greatly for the exact same MRI. You can see that a member can decide where to go. They can either pay a significant amount out of pocket, pay zero, or in this case, they can earn $227 for getting that MRI at a lower cost provider. Another quick example for a colonoscopy, same thing, they can earn $1,100, pay zero or pay $1,400. And these are real examples of specific situations from our claims data. So, probably a question all of you are asking is do the lower cost providers equate to lower quality? Study after study shows that that is not true. There is no correlation between cost and quality. We include quality data on our app for members. After looking at various options, we decided to include something called GAM, Global Appropriateness Measures. It's done out of Johns Hopkins University. When you look at our data, 91% of claims by our members are at or below the benefit amount so where the member paid nothing or earned money were with four or five star providers. So, once you align incentives and members understand prices up front and make good choices, you don't need to restrict care in the ways that traditional insurers have been restricting care.

So, perhaps one of the most defining features of our plan is we do not have a provider network. Networks effectively are a tool through which traditional insurers try to reduce costs by having members see providers that they have contracts with. Our members can see any provider and that same benefit amount is available to any licensed provider. Likewise, we don't have prior authorization. That's another tool that has been used more widely by insurers to try to reduce costs. Formularies and step therapies again, we don't have those on our plan. So, I want to end just by saying that we are subject to the Affordable Care Act (ACA) and all state laws so we have all of the standard consumer protections that other commercial insurance plans have. And we also guarantee you can always have choices at or below the benefit amount. We have unplanned events protection, so if you thought costs would be a certain amount, and additional services are performed than were unexpected, we cover those at cost. In emergencies, our plan acts exactly as it does with traditional insurance. We never want anyone to have to think about shopping for care in an emergency. And we have additional programs in place that apply for higher complexity services. So, I'll just end by sharing on a personal note. I am a member of Sidecar. I've been one since I started. I have worked in health insurance for a long time, and I have learned far more about how our health system works, and how much services cost by being a member these past two years than I have in all my years working in insurance. Our members, the word we hear over and over again is that they feel empowered, they feel in control of their care and they would never want to return to the status quo.

Sen. George Lang (OH) stated what an amazing concept this is and I've not seen this before. Is there a mechanism in your system whereby the employer can take a portion of the savings of the employee? Ms. Leino stated we have thought about different models. I think one of the things that's core to our model is incentivizing consumers to make decisions and we found that retaining half of the savings is a way to do that. Our employers do save a lot and the premiums are 20% lower than what they would have with regular insurance. So, the way we think about it is that the employers save through the premium reductions and the employees save through choices. Employers do talk about traditional cost sharing, but we do have different plan options that have deductibles when employers want it. So, employers do have additional levers to lower their premiums by choosing things like what the amount of cost sharing will be.

Rep. Pollock asked how many different states are participating in this program? Ms. Leino stated that technically we have members in 48 states but in terms of where we are licensed as an insurer and can sell fully insured products, we're currently in Ohio, Florida, Georgia and Texas. We've just gotten our certificates of authority in a few different states and are filing in others. We just are launching in Texas in August so that's our most recent and most exciting launch. We want to expand, but we want to do so thoughtfully. I am not sure if you are all aware, but the federal government just updated regulations to allow for non-network plans on the exchanges so that's a very exciting change that we were really glad to see, and we're evaluating whether it makes sense for us to also offer individual plans on the exchanges.

Rep. Pollock asked if there are any hurdles from hospitals and doctors accepting your plan? Ms. Leino stated that the biggest hurdle for us is change and change is hard so there's definitely a change curve for our members. For providers, we do find different degrees in how quickly providers adapt and how excited they are. In general, smaller or independent providers get it right away. They're used to accepting cash. They love the idea of not having to wait weeks or sometimes months to get paid because they get paid on the spot. For larger hospitals, we have ones who have been really excited by it. In fact, in certain places where we do have a concentration of members, we've seen hospitals actually say, "Hey, what do I need to lower my prices to in order to have your members make us be the one that members want to see?" There are other providers that, unfortunately, genuinely don't know how much services cost. They have a tricky time being able to help our members understand a lot of the transparency laws that have come out of health. So, the requirement that providers give good faith estimates makes it so that providers do a better job of helping our members understand costs up front. But it's a very complex system and it is definitely a bit of a change for people that some are adapting to faster than others.

Rep. Tom Oliverson, M.D. (TX) stated I'm a huge fan of Sidecar and this has sort of been a dream for me to get a health plan where we're actually incentivizing patients to actually function like consumers and I think you've done that very nicely. You actually have unlocked a huge amount of savings with labs - can you talk a little bit about that? Ms. Leino stated labs are something that probably everyone in this room has had. When I would go to my appointments, they would give you the slip, you'd walk down the hall and you'd get your labs, and you never thought about how much those cost. Even though in recent years, I was on plans where that all went to a deductible and I ended up paying dollar for dollar for those costs. Our members know that there are facilities that are devoted entirely to labs that often are located a mile or less down the road from larger providers. Our members instead simply ask for the lab request form, walk down the street and to give potential numbers, something that might cost $100 in one setting will cost $10 at somewhere like LabCorp or Quest. In general, the same thing can be said about having a surgery at an ambulatory surgery center versus in a hospital. So, there's a number of items for which the site

of care, or where you get it makes a huge difference, and that's something that our members can shop for and understand and is a huge source of savings.

Rep. Stephen Meskers (CT) stated I want to understand the business model better. Ms. Leino stated we are an insurance company so we underwrite the policies and this aspect works very similarly to traditional insurance. So often working with brokers who sell the insurance policies to large employers. We provide to our members what we refer to as the benefit amounts and we have price information listed. We get that information both for the setting of benefit amounts and for sharing prices with our members from a variety of sources. As you all may know, there are transparency requirements that require providers to post information including on what their cash prices are and we have vendors and that we pay to obtain that data and bring it to us and then we make it available to our members.

Rep. Meskers stated, and then the members, if they find a lower price, do members enjoy a price sharing with the members on that procedure? Ms. Leino stated, correct, and they can find those lower prices on our app. So, our app will tell them when the provider's cost is below our benefit amount and tell them the savings earned. Rep. Meskers stated to Ms. Leino that he would like to have further conversations about the business model. Ms. Leino stated that we are absolutely a resource to anyone. We'd love as many organizations in this country and as many states to have these types of solutions.

Rep. Dennis Paul (TX) asked how do you set the price for the benefit amount? Ms. Leino stated that our rule of thumb is the benefit amount is always determined so that 50% of typical providers who provide that service are at or below the benefit amount. For the benefit amount number, we use commercial transparency data. We have data from a national actuarial firm, Centers for Medicare and Medicaid Services (CMS) benchmark data, our own claims data. And then we have an actuarial team that uses it, and it is specific to geography so we do have to get into things like if some counties are more rural, or if certain specialists can't be found in an area. Although we don't have a network, we hold ourselves to traditional network adequacy. Rep. Paul stated so somewhere in the middle of the range that you're looking at is what you'll be at? Ms. Leino stated yes, we aim to have 50% of providers at or below the benefits.

Rep. Paul stated that you said that the app shows you alternative choices, here's a list of these providers that provide that service. How do they get on that list? And if I as a consumer find somebody other than the provider on your list, can I still go to them? Ms. Leino stated you can absolutely see any licensed provider. We do attempt actually to have all providers. I'm a lawyer so I can't say we definitely have all providers, but we get data that includes information about providers throughout the country. There are some providers for which it's possible our data is wrong. In those cases, we do guarantee our members that the price they see in the app, we'll stand behind. So basically, they see the benefit amount, they see the provider, they can click and lock in a visit with that provider and they will earn or pay that amount regardless of if they end up going to the provider and they charge a slightly different amount. But if the provider's not there, that's fine too. Rep. Paul asked if the consumer is able to negotiate with these providers themselves? Ms. Leino stated yes. Most providers are very comfortable telling you what a discounted cash price is, but we absolutely have savvy consumers who negotiate and get a lower price and then they get the benefit of that lower price.

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

Rep. Pollack stated next on our agenda is our continued discussion on the NCOIL Vision Model. As a reminder, we discussed this model at our spring meeting and since that time, the sponsor, Rep. Deanna Gordon (KY), has been reviewing all the comments submitted by interested parties and determining next steps. There will not be a vote today but rather a continued discussion.

Rep. Gordon stated that by way of an update to the Committee since our last meeting, we've continued working with all interested stakeholders on this. Based on the discussions at our previous meeting in Louisville we did remove the private right of action section after hearing the concerns that were raised. I've also met with representatives from the Blue Cross Blue Shield Association (BCBSA) and we agreed to continue those conversations as they have suggested additional revisions for consideration. I've also met with the National Association of Vision Care Plans (NAVCP) to identify areas where we can work collaboratively. I'm optimistic we can continue making progress before the next meeting. We are also aware of a letter submitted regarding health savings accounts (HSAs). I appreciate the Committee's continued interest in this important issue. At its core, this legislation is about ensuring that patients and their providers have access to the tools and flexibility they need to deliver the highest quality care and to address concerns regarding vertical integration in health care as well as preserving the doctor-patient relationship. As these service integration models expand, it's essential that patients are given clear, transparent information about the programs they are being offered. True transparency helps ensure patients understand exactly what they are entitled to, and that their choices regarding care are fully respected and maintained. This model is patient driven and is meant to improve transparency, fairness, and competition for our constituents. I look forward to continuing these discussions and hopefully have something ready for voting at the November meeting.

Randi Chapman, Managing Director of State Affairs at BCBSA thanked the Committee and stated that my comments will be brief and will reiterate the written comments that we have submitted. First, I appreciate the opportunity to speak today and appreciate the opportunities that we've had to talk with Rep. Gordon about the model and I understand my colleagues have talked with her as well. So, I think we are on the way to helping make this model as strong as it can be. BCBSA supports the model's goals of transparency and fairness and believes that with some additional targeted clarifications on scope, payment integrity practices, and network participation and reimbursement flexibility, that the model can address some of the practices that it seeks to address without creating any unintended consequences for patients, providers or for regulators. We certainly appreciate the revisions that have been made in the draft, particularly with regard to the private right of action. We do think that there are additional areas where the language can be amended to make the model even stronger and keep vision benefits affordable and accessible for patients.

I'm going to focus my brief comments on three areas pertaining to scope, payment integrity, and business practices. First, with regard to scope, some of the definitions in the model are fairly expansive and make the model encompass the entire fully insured individual market and small group market, and could even capture self-funded employer plans. For example, because pediatric vision is a mandatory essential health benefit under the ACA, it's embedded in every fully insured individual and small group medical policy. And the definition of "health benefit plan" and "insurer" in the model currently extends the model's requirements to all ACA medical products even in situations where an issuer does not offer standalone vision benefits. We would recommend a scaled-down version of the definitions to ensure that it's focused on standalone vision benefit administration that better targets the model's requirements. And that's language that we're happy to work with Rep. Gordon on. Secondly, in looking at standard payment integrity in claims adjudication practices, section four of the model effectively eliminates standard tools that plans commonly use to detect fraud, waste, and abuse and shifts those costs onto patients.

Section four includes provisions that restrict coding edits, bundling logic, and modifier review and these are primary mechanisms that plans use to identify upcoding, duplicate billing and other improper claim practices. Section four also prohibits recovery of payments made based on invalid eligibility which removes a critical safeguard that plans often use against enrollment and identity fraud. These are not unfair practices that plans use to try and identify these fraudulent circumstances. These are essential to protecting the integrity of the vision benefit market and keeping costs affordable to patients. We would recommend that there's fraud exception language added to the model that could preserve the ability to recover payments made based on fraudulent misrepresentation of eligibility and we have included that language in our red lines that we submitted.

Finally, as we're looking at contractual issues and some of the interference with some existing contracts or disruption, there are provisions in the model that would automatically void contracts for notice and timing issues and we find that some of that language can be pretty destabilizing to the existing contractual relationships between plans and providers. For example, in section three, there's language there that would render amendments void and unenforceable solely due to the failure to meet a 90 day notice requirement regardless of materiality. But in practice and operation, many plans will update documents on a regular operational basis and that operational timing is embedded in contracts that have been agreed to and acknowledged by providers. So what we would recommend instead is a cure period and a materiality threshold that could protect providers without creating significant operational discussion.

Laura Minzer, President of the Illinois Life and Health Insurance Council thanked the Committee for the opportunity to speak and stated that we represent insurers in Illinois that provide major medical, dental, vision, life, and retirement products to millions of consumers, not just in Illinois, but across the U.S. I want to thank you for the opportunity to join you here today to share Illinois's very recent experience modernizing our vision care law. I hope it offers a useful perspective as you consider this model legislation. I did provide my testimony in written form so I'm going to provide the cliff notes version of that. I know is your time is limited, but I would like to touch upon three key points, and I expanded upon those in my written comments. Vision insurance should not be regulated like pharmacy benefits. The Illinois approach shows that provider protection and consumer affordability can coexist and balanced and collaborative policymaking is essential to producing good public policy. So, one of the central premises of the proposal before you is that vision care organizations should be regulated like pharmacy benefit managers (PBMs). Illinois reached a very different conclusion because vision insurance is fundamentally different. Unlike prescription drugs and as Ms. Chapman mentioned, pediatric vision, routine adult vision care is not an essential health benefit.

Consumers purchase vision coverage because they value it, not because they're required to do so by federal law. At a time when health care costs continue to rise, affordability also matters. Vision coverage remains one of the most affordable voluntary insurance benefits available today. And research consistently shows that people with vision insurance are more likely to receive routine eye exams and obtain needed corrective eyewear. Illinois' experience also demonstrates that meaningful provider protections and affordable consumer coverage are not mutually exclusive. So, in 2023, insurers, optometrists, legislators, and other stakeholders came together to modernize our vision care law. But as implementation progressed, we identified areas that needed improvement rather than dismantle the framework we had negotiated. We did return to the table just this spring and worked collaboratively to address those concerns in Senate Bill, 3707, that is now awaiting the Governor's signature. It was also important as we proceeded in that exercise to keep the regulation of vision insurance products consistent with how we regulate other supplementary accident and health insurance products. I would be remiss if I did not give

special acknowledgement to Sen. Cristina Castro (IL) and Rep. Jeff Keicher (IL) who set that collaborative table for us. And I'd also like to acknowledge Rep. Rita Mayfield (IL) and Sen. Willie Preston (IL) who are here today that also supported that compromise. So, thank you for that. So the result was bipartisan legislation that we found strengthened both provider protections and enhanced consumer transparency. It preserved broad access to an affordable vision insurance product that our employers, employees, unions, Medicaid, Medicare beneficiaries and families across Illinois rely on. And our experience reinforced an important lesson - good public policy recognizes that providers and insurers have legitimate interests, but neither succeeds unless consumers remain at the center of every discussion. As you consider this model legislation. I encourage you to preserve that balance and protect providers, strengthen transparency, but never lose sight of the importance of maintaining affordable access to the voluntary vision coverage that connects patients with the eye care that they need.

David Rose, Vice President of State Gov't Relations at MetLife thanked the committee for the opportunity to speak and stated that stated MetLife is a leader in providing vision benefits and strives to provide excellent vision benefits at affordable prices to its customers. In 2021 MetLife acquired Versant Health which has over 30 million people who have access to vision care through Versant's Superior Vision and Davis Vision contracted provider networks. MetLife and Versant are members of the National Association of Vision Care Plans (NAVCP). NAVCP did submit a letter to the Committee and to Rep. Gordon and we subscribe to those comments. So, I'm going to be very brief and sort of talk about what our experience has been before this committee on your favorite topic, which is dental, because we have both dental and vision. I've had the good fortune to work with many members of this Committee on a myriad of dental issues over the past few years, as MetLife is also a leader in providing dental benefits. My experience working on those past dental models included extensive collaboration between legislators, providers, and insurers, which led to significantly improved targeted workable models. Was everyone happy in the end? Of course not. But that typically is the result when parties engage in good faith negotiations. We have serious concerns that the proposed model's required reimbursement levels and limits on contracting flexibility will simply increase payments to providers without any benefit accruing to consumers.

Furthermore, new compliance disclosure and enforcement requirements could increase administrative costs, and there likely will be anticipated increases in state government expenditures. When payments are dictated by statute rather than the free market, plans have only a few levers left - higher premiums, higher co-pays and out-of-pocket costs, or reduced benefits. For many small and mid-sized employers, that will mean leaner vision benefits or no vision coverage at all. At MetLife and Versant, we strongly believe that vision health is critical to overall good health and we work to keep costs down to allow more people the ability to purchase affordable vision coverage in order to access vision care. For these reasons, MetLife and Versant have serious concerns with the proposed model because it would negatively affect consumers' ability to access important vision care and adds unnecessary confusion. This morning, Rep. Gordon arranged a meeting with NAVCP and the American Optometric Association (AOA) to have the first face-to-face discussion over this model. This was a necessary first step, and we encourage legislators, providers, and insurers to engage in negotiations over the coming weeks and months to attempt to craft a targeted and workable model that benefits from the feedback of all stakeholders.

David Parker, O.D., for the Mississippi Optometric Association thanked the committee for the opportunity to speak and stated that I just want to share with you my perspective as I practice optometry in Mississippi. I've been there for 30 years as a practitioner. Now we are a collaborative group, but we are not part of any corporate arrangement. We are kind of like a partnership but we

are not beholden to any corporate entities. I've held numerous positions within my profession and got so frustrated with some things that I decided to run for office several years ago. I was elected state senator in Mississippi, served for 13 years, retired in January, and there is an active campaign right now to have me come back but I'm not sure what I'll do.

But I do appreciate your time and effort here because I know you're already serving in the legislature so to come here and to look at issues like this is an additional amount of service that you're putting beyond that. I have seen this happen as I chaired accountability, efficiency, and transparency committee for most of my time in the Mississippi Senate and I've looked at issues like this as you are looking at in your state legislatures. My concern and the problem that we have with this is that the vision benefit paradigm as it exists, there is an increasing consolidation of power. As you all know, they are simultaneously the insurer, retailer, supplier, practice owner, and marketer and that level is creating more conflicts of interest. What I wanted to also share is that we're also seeing these plans evolve in ways that are putting more pressure on us as providers. The plans often begin with a certain set of provisions, they change those over time, and we never know how they're going to change. In our office, we've been fortunate enough for many years to make glasses for our patients, even ones on insurance plans, and what we're finding now is that plans that already are offering that as a benefit that we're participating in are removing that in additional ones and forcing us to go to plans that are outside of our area for fabrication. What that results in for my patient population is a longer wait time, a situation where we can't call and talk to someone about what's the status of something. And it leads to, in my opinion, patients who are more upset with their care. And I'll reference that there was a study that was done just recently by Vision Service Plan (VSP). VSP did their own research. They found that 81% of employees and 90% of HR leaders are not completely satisfied with their vision carrier, while 32% of employees are considering changing jobs for better vision benefits. Patients remain highly satisfied with their doctors of optometry but are dissatisfied with the vision benefit model and plan as it exists now.

The problem is not the quality of care being delivered by the doctors of optometry. The problem is the benefit design is increasingly placing corporate interest ahead of patients, employers, and the doctors who care for them. You know a lot about the model language, but I shared with you last time how I feel that there is some parallel here between this and our PBM issues that we dealt with in the state legislature, and you continue to deal with in your legislatures. As that corporate entity takes more control, it was interesting here when Ms. Leino was presenting and she listed the cost for a 90 day supply of prescription medicine. When I prescribe medicines such as Latanoprost and other glaucoma medicines, I have found the same thing. I've found that my local pharmacy has often got a lower price than what perhaps a CVS or Caremark has. And in our communities, if you leave the control more in the hands of the people within the community, I think you see happier constituents. You see happier patients. You see better care. And in the end, you see lower prices. At least that's what we've seen and I appreciate what Ms. Leino said on that because that was a perfect example of what I've noticed myself.

So I'm not going to tell you all of the things in the model, but as a father of a son who is now moving through the process to become a doctor of optometry himself, we were kidding earlier with the vision care benefit managers that we've lost a lot of hair. I've lost a lot of hair from being an optometrist, but I lost a lot of hair also from being in the legislative chairs that you're in and I would like our profession to not suffer the same types of things in the future that we've seen happen in the pharmacy arena. Because I do feel that if we don't remember the past, we indeed could repeat those mistakes. So, I thank you for your time and your interest. All I want to see is that we have transparency and balance in a system. I don't want to see any more money for me. I don't need any more money for me, but I do want the ability to continue to care for my patients

and for my son to care for those patients. And if we have a corporate model that owns the entire system, I can guarantee you that it is going to be a much more difficult task for him to do it than it was for me.

Matt Jones, O.D., for the Arkansas Optometric Association, thanked the committee for the opportunity to speak and thanked the previous speakers as they have a lot of knowledge and they're doing a job on behalf of the big corporations and wanting to see this go smoothly. But for myself and Dr. Parker, our jobs revolve around our small communities. I practice in rural northeast Arkansas. I have four small clinics in four very small towns where we're pretty much the only eye care providers around and that happens in rural America every day where you only have one doctor, or one pharmacist, or one dentist, and access becomes an issue. And in Arkansas, we did pass a pretty substantial vision benefit manager (VBM) law in 2025 and we're still moving through the rules process with the insurance commissioner but we have seen some success from a few of the VBMs that transparently and proactively followed the law, while others haven't. And we're seeing success in that. There's been no increase in patient costs. There's been no increase in patient premiums, and the businesses that are offering those services are still offering it. I practice in America's largest steel producing county in Arkansas. In fact, we have three nuclear plants, and two U.S. steel plants, and they all offer vision benefits to their employees. It's not the greatest financial decision for our businesses to accept vision plans but we do so, I do so. I feel like I want to accept all and any that my community and my patients have.

And it's not their fault what vision plan they have but I can tell you when they walk in the door, they usually don't know what they have. They're very confused about the benefits that they have. Very rarely would they have an insurance card and that revolves on us and our staff to figure that out for them. Most importantly, to just piggyback on what Dr. Parker said, this is all about preserving the doctor and the patient relationship, being able to do what's best for our patients in our communities, being able to provide what frames or lenses or glasses or medicines that we feel that they need without being led or steered or tiered to other places. I know they don't like the PBM comparison, but doctors are tiered on these plans and ranked not based upon quality of care but strictly based on how much of a certain product they sell that the VBM owns. That's certainly not transparent in my mind. So there have been previous state laws that have passed most recently in Louisiana with zero dissenting votes that was much more broad than this. That actually included a reimbursement floor for services. Optometry is unique in that we have medical issues where we take care of people with diabetes or cataracts or glaucoma, and then we also spin the dials, "which is better one or two". And so we do have medical insurance and then there's vision insurance and again, that sometimes gets lost in translation for the patient in our chair. So, the majority of this is just about fairness and accountability and transparency. As we said, as small business owners that take care of our patients and our communities and our members of boards and chambers and hospital boards, we don't have the ability to negotiate with these multibillion dollar industries. Most of these are strictly contracts of adhesion, take it or leave it type of plans. And we just want to see that change and hopefully this model language can help do that.

Rep. Jim Dunnigan (UT), NCOIL Treasurer, stated that I have worked with optometrists for some years in my state. I just have some general questions about the bill. You can choose to answer them or not. On section three, it talks about disclosure transparency, and it provides a significant list of information that has to be provided, not only the on the vision plans website but all materials. I mean this this could potentially run some pages long depending on the history of the vision service plan. I'm just wondering what's the purpose of that? Even on enrollment materials, you're going to go out with an enrollment form, and you've got to provide this laundry list of materials. Dr. Parker stated that we talked about that this morning with NAVCP, and I believe he had a very similar question. It gets back to transparency. I think any and everyone who is choosing to

negotiate or contract with anyone should have the right to know who you're dealing with. And for me, if I found a vision plan for example that owned the vision plan, owned the lab, was going to directly market to the patients and I shared this morning with NAVCP that I've had a patient in my chair who during the exam got marketing material from the vision plan asking them to go somewhere else after their exam and get their product.

Rep. Dunnigan stated that's not what I'm talking about, I'm talking about the legal address, any complaints against them, all agencies that have jurisdiction over them, and then it says all that information has to be provided on enrollment materials and sales materials. That's what I'm concerned about. Dr. Parker stated on that issue, we did have some conversations today that some of that might be a little bit laborious so there's room for some cleanup in that. What I found in my 13 years as a senator though is that you find one topic like that, and you make that be the reason to gut the bill. The reason I've traveled all the way here two times is to tell you the problem we have in our community and to tell you that this is model language that's been adopted in states like Illinois and other states. Rep. Dunnigan stated I want to stay on topic to my concern, and that is the significant amount of information that's required on all types of documents - employees don't want to see this. If you're giving an enrollment form to an employee, you've got to provide them a separate document with all this information. They don't want that. They don't care about that. That's just my input. I think maybe it provides a bunch to the doctor, so that you know what you're getting into, but certainly not to the employee and out on all the requests for proposals (RFPs) and things like that.

Rep. Dunnigan stated that also, in section 4(B), I just want to understand this, it says there should be no limitation on the ability of an individual eye care provider or a group of eye care providers under the same employer identification number (EIN) to negotiate and ultimately agree and so I agree that you should be able to negotiate. I'm just wondering what it means with "ultimately agreeing". What's the end game? What does that require? What if both sides don't come together? How do you ultimately agree? Dr. Parker stated I don't have the model in front of me but in any negotiation, I think there's always some give and take. We are in negotiations right now with one of our vision care plans about reimbursement rates and things like that and it has been a process of back and forth as we look towards getting to an ultimate agreement on that one issue. So, I think that's what it's intended but I do not have the language in front of me. Rep. Dunnigan stated I also have some concerns in section 5, but I'll stop there and let others ask questions.

Rep. Oliverson stated that full disclosure, I passed a bill along the same lines of this in Texas but there is some stuff in this model that we took out in Texas over some very specific concerns and I want to visit with you about it because interestingly enough, I find it back in this version. What is the purpose of including ophthalmologists in this model? Have you spoken to the American Ophthalmologic Society and asked for their opinion on this model? Dr. Jones stated we wrote the model for all eye care providers. We haven't spoken to them to my knowledge. Rep. Oliverson asked if you collaborated with the ophthalmologists on this model? Dr. Jones stated not the American Academy of Ophthalmologists. In Arkansas, we did. One of our lead sponsors was an ophthalmologist, and I know in Texas, ophthalmology was asked to be taken out. In Arkansas, ophthalmology was asked to be put in and so I think that can be different state by state as optometrists do work for ophthalmologists.

Rep. Oliverson asked what is the purpose of section five and let me qualify my question. I don't know that there's a whole lot of practice overlap here between what you do and what ophthalmologists do, and certainly not in my state. And so this is part of the problem we run into. My concern is that you've taken an insurance bill, which I think has some merit to it. We passed

part of this in my state, and we've now turned it into a scope of practice bill. So how necessary is section five to this model because I think it should be removed. Dr. Parker stated I would respectfully disagree. We did have that conversation this morning with NAVCP and they let us know that they do not see anything in here that deals with scope of practice. I will share that in my practice, we have an ambulatory surgical center. I have a total of four ophthalmologists who also come into my office and provide retinal oculoplastic and cataract surgery care. I work with them every single week. I'll bounce issues like this off of them, and to Dr. Jones' point, I believe there are some states that in model language would prefer ophthalmology to be included because the collaborations and the friendships are strong in states like mine, and as members of the legislature you know this issue, you may have states where that collaboration is strong, you may have states where they're not, but I believe that's the purpose of model.

Rep. Oliverson stated but my concern is that they're not here. You're speaking on their behalf. And so what I would like is when this comes back, if that section is still in this model, I would like to see a letter either from the American Medical Association (AMA) or the American Ophthalmological Society saying that they support Section Five of this model. Dr. Parker stated we will pass that along to the people who can make those connections.

Rep. Oliverson stated and I will say this, and nobody's talked about this, but the bill we passed in Texas which contains a lot of the similar language, about 85% of it's been struck down by the courts. Dr. Jones stated that was over the steering and tiering part which violates First Amendment rights. Rep. Oliverson stated one of my concerns is I don't want us to promulgate a model that has already been invalidated by the courts. Dr. Jones stated the steering and tiering provisions are still in the model but they have been adjusted to address concerns. Rep. Oliverson stated that's good to know. Dr. Jones stated we did work with people in Texas on that because they understood that dynamic.

Rep. Paul (TX) stated that I missed the last meeting in April on this so I apologize, but I don't even see what this model is supposed to do at all and it's got some very confusing things in it and it's very large and I agree with what Rep. Dunnigan. And it looks like you can't even negotiate a fee, or the benefit manager has to accept the fee that they provide. And section six, it's talking about you can't exclude any doctor. I mean if they have a problem with this person or not, there's no way they could get rid of a guy. What is the purpose? Could you tell me right now, if this is enacted, will my companies that buy this benefit plan pay less for insurance? And will the patients that go use eye service pay less for this? Is it going to save money for the companies or the consumer? But what does this do? Dr. Jones stated in in the states that have passed this, the fairness and transparency part provides the ability for the doctor to choose what labs to use to make glasses, which inherently lowers costs. Competition inherently lowers costs. There have not been any studies that show that costs have gone up or premiums have gone up on patients or employers in those states. Rep. Paul stated, so are you saying that what this bill does is allow you to use anybody to make glasses. Dr. Jones stated that's certainly one of the parts.

Rep. Paul stated what's this other part about money coming out and reimbursing people and I mean this looks more like a contract than a bill. Dr. Parker stated my intent in my remarks was to expound upon what we had discussed in Louisville. I had more detailed comments that I'll be glad to share with you afterwards on kind of the entire body of the bill, the merit of it and that kind of thing. I skipped over those as a courtesy. I don't mind doing that, but I do think that the fact that we do have a similar bill that is now in place in Texas that is continuing to be worked on would be a good reference for you to go to and I think there have been some discussions about other states that have put some of this in place and I think all of the parties involved, even from Blue Cross and others have recognized that the work by Rep. Gordon has been very well intended and has

been very productive as we continue to seek a solution here that will be good for all parties, and for all specialties. And again my ophthalmology friends are dear friends. We don't have scope issues in my state because we have fixed that problem and I hope that in Texas that will become kind of the issue too. We are more concerned in my state about Medicare Advantage plans than we are scope of practice now so I would encourage you in all of your states to try to move past that if you can.

Rep. Paul stated I understand your comments today weren't intended to address specific provisions in the bill and that's what the Chair, Rep. Pollock intended, but maybe someone else can answer will this let my employers pay less money for eye care and will the patients pay less? Mr. Rose stated that we believe that they're going to pay more as a result of this due to the administrative costs. We think the reimbursement rates are going to go up as a result of this, and as a result, employers and employees will have to pay more. Let's say it's 30% on a $10 monthly premium for their vision care, 30% of that is quite a bit, and this is a benefit that people don't have to have. It's not not an essential health benefit, and I think the consumers are very price sensitive to this type of benefit. So, we think that it will go up.

Rep. Pollock stated to Rep. Paul that today's meeting was meant to bring us up to speed. What was very healthy in this conversation on this particular model was there was a discussion this morning amongst interested parties to go ahead and get these conversations moving forward. This meeting today was to hear what came out of that meeting this morning and what we're moving forward to do. I'm sure there's going to be a lot more conversations between now and Florida. There will be an interim meeting I'm sure of some sort to decide where we're at to make sure that it's clear enough whether to have a vote in Florida. So, in the meantime, that will bring everybody up to speed on where we're at that point with this particular model.

Rep. Gordon stated I just would like to close by saying I think that it's important that we talk about the original intent and purpose in filing this bill. And I've said it before, I'm an audiologist and this is happening in my field as well. So, although it's a little bit different, it's on the same theme of there does not need to be any layers of bureaucracy between a patient and their provider of care. And when terms are dictated as far as products that can be used, the way that it's delivered, it's very confusing for the patient. Just like was mentioned, they come in, I become the face of a product and they associate me with that product instead of me as their provider of care.

CONTINUED DISCUSSION AND CONSIDERATION OF NCOIL CHARITY CARE AND MEDICAL DEBT REFORM MODEL ACT

Rep. Pollock stated next on our agenda is continued discussion and consideration of the NCOIL Charity Medical Care and Medical Debt Reform Model Act. We've had great discussions on this at our previous three meetings, and it looks like we're at a point where this model is ready to be considered.

Rep. Oliverson stated I want to thank Sen. Paul Utke (MN), NCOIL President, and Rep. Brenda Carter (MI), NCOIL Secretary, for co-sponsoring this model and for working with me on this. And I also want to say a special thank you to Joe Burchfield from Ascension for being a tremendously good partner, and really I think understanding the spirit of the model and offering some truly good suggestions. I'm not going to rehash the whole model, but since our last meeting in April, we made a few changes. So, first in section 4(A) we've added a drafting note addressing the issue of whether or not you want in your particular state for this model to apply to only uninsured or self-pay patients. Also, Section 4(B)(1) has been revised to say that this would not apply in a circumstance where a hospital was being asked to provide coverage for cosmetic procedures.

Next, I've deleted language in section 4(G) to try to avoid encouraging bad attorney behavior while still maintaining a process by which a patient can be reimbursed. There was some concern that it may may create sort of a new type of lawsuit abuse and obviously that's the last thing we want to do. And finally, I've added a drafting note to the end of section 4 saying that states may wish to consider reporting requirements to add a little bit of transparency to this model. Some ideas and concepts on that have bene brought forward since the model's introduction but rather than add a whole new section and extend this process, we've simply added a drafting note just saying, "here are other things that are out there, you may want to consider this as well." I really appreciate everybody's work on this, and I'm happy to hear any comments or questions and hope that everybody supports this.

Joe Burchfield, National Director of State Policy at Ascension thanked the committee for the opportunity to speak and stated that I just want to echo what Rep. Oliverson said and thank him for the collaboration. Ascension is still in our first year of participation at NCOIL and this is the first bill we've worked on here, and I think it's appropriate that our commitment is to a patient focused, patient friendly charity care policy and financial assistance program. And the opportunity to work with Rep. Oliverson, NCOIL staff, and you as a committee, we just greatly appreciate the collaboration. We are here to find solutions and to work together on things that make life better for your constituents and I think we're doing that here. Thank you for that opportunity and I look forward to continuing the work on future issues.

Rep. Rita Mayfield (IL) asked if there was any input or opposition from the American Hospital Association (AHA) on this model? Rep. Oliverson stated that there was definitely input, and there was opposition. We did our best to incorporate some of their suggestions to the extent that we could without compromising essentially what the model was attempting to do. I can give you one example of where we just couldn't come to agreement and that is I felt very strongly that when there is a tax exempt hospital entity that continues to violate the model, then at some point it should be an option for the state to remove their tax exempt status and they were very opposed to that and we just couldn't come to agreement. I felt that obviously that shouldn't be the thing you immediately jump to, but ultimately, if you have a repeat offender, there's got to be a hammer to swing.

Rep. Pollock then 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. Then, upon a motion made by Rep. Mayfield and seconded by Rep. Carter, the Committee voted without objection by way of a voice vote to adopt the model. Rep. Pollock thanked everyone and stated that the model will now be placed on the Executive Committee's agenda for final ratification.

DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL TELEMEDICINE AUTHORIZATION AND REIMBURSEMENT MODEL ACT

Rep. Pollock stated that last on our agenda is a discussion on proposed amendments to the NCOIL telemedicine authorization and reimbursement model act. As a reminder, at our last meeting in April, this model was re-adopted temporarily until this meeting in order to have some discussions as to whether any changes should be made to the model. Since that time, the original sponsor of the model, NCOIL immediate past president Asw. Pam Hunter (NY) has introduced some proposed amendments to the model. We won't be voting on these amendments today as they are still under development.

Asw. Hunter stated as I mentioned at our meeting in April, as the original sponsor of this model, I thought it was worth having some discussions on how telemedicine has evolved so much in the past five years since the model's adoption to see if any changes were warranted. And since that time, I've put forward some proposed changes to consider. The amendments are fairly straightforward and really focus on modernizing the model by removing references to COVID-19, updating telemedicine licensure provisions, and updating reimbursement provisions. I look forward to the discussion today and hopefully by November, these amendments can be ready to be considered.

Robert Baratta, on behalf of the American Telemedicine Association (ATA) thanked the committee for the opportunity to speak and stated that the ATA is the largest standing national organization focused on telehealth and virtual care. We were founded in 1993 and we have a coalition of over 400 companies and organizations that are part of ATA, and they range from major health systems to academic medical centers, payers, health plans, clinicians, pharmaceutical companies, remote monitoring organizations and digital therapeutic companies. ATA Action is also part of ATA, and that's our advocacy arm and they're active in all 50 states and with the federal government. What I'm going to address very quickly for you is to take you on a quick trip down memory lane first so we can kind of figure out how we got to where we are now and give some focus over the last five years and then try to look over the horizon and give you some comments on the amendments to the model.

First, I'll just share with you that advancements in virtual care we believe based upon our experience over the past three decades is they depend on the synchronicity of five major factors. The first one is technology itself and those that are pushing for the innovations of technology and the capital that goes with it. The other is the consumer, their demands and their acceptance of the technology. The third is a licensed practitioner's acceptance and their kind integration of the technology into the standard of care and patient treatment along with the economic incentives that exist in order for them to accept those into their practices. Next is payer buy-in, and then part of the reason why we're here is because we live in a regulated community, the actual affirmation through statute and rule, and that's really part of what the model is about. So, unless all those things come together, virtual health doesn't move very far. Now as I mentioned, ATA was founded back in 1993, and 1993 was an auspicious year. That was the year the World Wide Web was released to the public. Very soon after, all of us started getting those American Online CDs in our mail to try to sign up for that 56 kilobyte per second dial-up. Apple shipped the first Newton that year, Intel rolled out the Pentium microprocessor and Mosaic released the first web browser.

And that really kickstarted telehealth, the technology that was starting to form in 1993. By 1997, 35% of all households had a computer. You would also note about that same time cellular technology was taking off. I remember turning in my pager for a Blackberry back then. And by 2000, broadband came about and that changed things forever, because now we can have video conferencing on at speeds that are efficacious. We had a little speed bump over the dot-com bubble, but by 2007 the iPhone came out and that changed everything. Now, we have a smart device in the hands of consumers and they can have direct access to the internet and to all that technology. Kind of parallel with that, now we have the medical professions that are starting to look at telehealth and the development of telehealth and the Federation of State Medical Boards in 2014 issued its model policy on the appropriate use of technology in telemedicine and that really gave the different states the direction of how to address telehealth in the treatment of patients. But then, a few years later, the event happened that changed everything and that is COVID-19 and with COVID, we had a scramble among the states that those that were not progressive in their treatment of telehealth that the Governors had to issue executive orders and legislatures had to change statutes. And from 2019 to 2021, that's the environment that we all

lived in. From 2021 to 2025 we started to see at the federal government and in the states, efforts to make these COVID exemptions permanent. Some of them are still lingering out there because the U.S. Food & Drug Administration (FDA) and the Drug Enforcement Administration (DEA) are still trying to deal with the opioid use disorder issues of the exemptions that they had sent forward and they keep kicking the can down the road. But most states now have made permanent those changes that happened during COVID-19 and that's what's before you today with the model. Now we also see an increase in the direct to consumer telehealth that you see on TV all the time. And a lot of that stuff you deal with in terms of GLP-1's or reproductive health and all that you see in the different states. That has accelerated in this post COVID environment, and also, the remote patient monitoring integration.

In 2026, we've seen an increase in the prescription digital therapeutics. There are about 20 different ones now before the FDA, and now artificial intelligence (AI). This past year was about 600 pieces of legislation across the country dealing with AI of one kind or another. Most of those dealing with health dealt with chatbots and on the behavioral health side. On the horizon, what do we see? We see having to deal with AI integration, both in administrative and clinical assistance. We see what is euphemistically called the internet of things, and I don't know if you've heard that term before, but that basically describes the integration of all the smart devices that are out there talking to each other, gathering data, analyzing the data, and then putting those all together and trying to basically manage chronic disease and disease prevention and control. And these devices are everywhere, and it's growing. And so between that and AI, we believe over the next two or three years, we're going to have to determine how we deal with those and whether or not they get reimbursed for that matter. With that, I'll just turn to the legislation before you, and I'll tell you that the ATA fully supports the amendments to the model. In particular, we're supportive of that amendment that says that if you are an exclusive telehealth company, that you should be able to negotiate for lower rates, which kind of makes sense if you've got two willing contractors on both sides of that, you have a payer that wants to pay less and a provider that wants to accept less, that should be able to be done.

Elizabeth Horton, Associate Vice President at American Specialty Health (ASH), thanked the committee for the opportunity to speak and stated that ASH is a national health care services organization specializing in physical medicine and musculoskeletal care. For nearly 40 years, ASH has partnered with health plans, employers, and providers to improve access, quality, and affordability of care. ASH supports more than 62 million eligible members through a nationwide network of over 127,000 clinical providers and delivers innovative in person, home based, mobile and telehealth care solutions across the country. ASH is here in support of NCOIL's re-adoption of the model. We see three areas to consider addressing during the re-adoption process. The first being removal of the COVID specific language, the second address emerging opportunities for telemedicine-only services amid the rapid growth and wide acceptance of telemedicine over the last six years, and lastly, updates to cross state licensure language to reflect the current environment better. You'll see section 2(D) makes several references to COVID, and by striking this language the model gains permanence. More specifically, it ensures that the act provides a permanent framework for telemedicine access independent of emergency declarations or specific health crises.

The edits proposed to section 4(D) differentiate for telemedicine only services and prevent a mandate to utilize telemedicine only services. This strengthens telemedicine access while controlling costs. It ensures equal reimbursements for providers offering both in person and telemedicine services, protecting provider revenue and patient access. It creates cost saving flexibility by allowing telemedicine-only care to be negotiated to reflect costs appropriately. And lastly, it preserves patient choice by prohibiting insurers from forcing patients into telemedicine

only care. In section 5, we address telemedicine licensure with two options for consideration to address the current environment. Option one would be a full strike of the language, remove the licensing provision entirely as existing interstate compacts adequately address cross-state licensure and reciprocity. Option two, which we think is the stronger approach, is to retain the provision but with an interstate compact exception. This future proofs the language acknowledging the growing network of interstate compacts while maintaining a default licensure standard where no compact exists. So, I'd just like to thank Asw. Hunter and other NCOIL leadership for allowing me the opportunity to speak on these amendments today.

Rep. Dunnigan stated I have a couple of comments and I appreciate the work on this. In Section 4(C), I think it's in artfully worded in a couple of places and it could be said better. For example, it says, you can't require a patient to have a previously established patient provider relationship. And then it goes on to say you can't use a telephonic conversation to establish a patient provider relationship. Why do we need that? Because you just said above that you don't have to have one anyway then it says that audio only doesn't count. I don't understand what that is getting at. In Section 4(D), it says that an insurer shall reimburse the treating provider on the same basis that the insurer is responsible for coverage for the provision of the same service through in-person consultation. This could, in my opinion, be worded better. And then below that you're talking about telemedicine can be done but they could accept a lower rate. I believe this could be drafted better.

Rep. Pollock stated hearing no other comments or questions, I'm going to entertain a motion to re-adopt the model temporarily until November while the amendments can be further developed. Upon a Motion made by Asw. Hunter and seconded by Sen. Lana Theis (MI), the Committee voted without objection by way of a voice vote to re-adopt the model until November.

ANY OTHER BUSINESS

Rep. Pollock stated that I'd like to raise one quick item. A couple of years ago in Kentucky, we passed a law that requires health insurance coverage for speech therapy for people with stuttering problems. And Sen. Willie Preston (IL) passed that in Illinois as well. This is really targeted toward younger folks who have stuttering problems, and it's really made a big impact in our community in Kentucky. I think it's really worth our consideration in discussing that here at NCOL. I just wanted to plant that seed, and we'll see if we can start that discussion in November.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Oliverson and seconded by Sen. Lang, the Committee adjourned at 5:00 p.m.