

REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force Nov. 30, 2021, Minutes

Regulatory Framework (B) Task Force Nov. 9, 2021, Minutes (Attachment One)

Regulatory Framework (B) Task Force 2022 Proposed Charges (Attachment One-A)

Accident and Sickness Insurance Minimum Standards (B) Subgroup Nov. 1, 2021, Minutes (Attachment Two)

Accident and Sickness Insurance Minimum Standards (B) Subgroup Oct. 4, 2021, Minutes (Attachment Three)

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Employee Retirement Income Security Act (ERISA) (B) Working Group July 30, 2021, Minutes (Attachment Nine)

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group Aug. 5, 2021, Minutes (Attachment Ten)

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Regulatory Framework (B) Task Force
Virtual Meeting (*in lieu of meeting at the 2021 Fall National Meeting*)
November 30, 2021

The Regulatory Framework (B) Task Force met Nov. 30, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Glen Mulready, Vice Chair, represented by Mike Rhoads (OK); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by William Rodgers and Yada Horace (AL); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Evan G. Daniels represented by Erin Klug (AZ); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Chris Struk and Shannon Doheny (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Dana Popish Severinghaus represented by Ryan Gillespie (IL); Amy L. Beard represented by Alex Peck (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary D. Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Timothy Schott and Joanne Rawlings-Sekunda (ME); Anita G. Fox represented by Sarah Wohlford (MI); Grace Arnold represented by Galen Benshoof and Sherri Mortensen-Brown (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Laura Arp (NE); Chris Nicolopoulos represented by Michelle Heaton and Roni Karnis (NH); Marlene Caride represented by Philip Gennace (NJ); Judith L. French represented by Laura Miller and George McNab (OH); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger and Candy Holbrook (SD); Cassie Brown represented by Rachel Bowden (TX); Scott A. White represented by Julie Blauvelt, Bob Grissom, and James Young (VA); Mike Kreidler represented by Molly Nollette and Jane Beyer (WA); Mark Afable represented by Nathan Houdek (WI); and Allan L. McVey represented by Joylynn Fix and Ellen Potter (WV).

1. Adopted its Nov. 9 and Summer National Meeting Minutes

The Task Force met Nov. 9 to adopt its 2022 proposed charges.

Mr. Keen made a motion, seconded by Ms. Kruger, to adopt the Task Force's Nov. 9 (Attachment One) and July 28 (*see NAIC Proceedings – Summer 2021, Regulatory Framework (B) Task Force*) minutes. The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

Mr. Keen made a motion, seconded by Commissioner Clark, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Nov. 1 (Attachment Two), Oct. 4 (Attachment Three), Sept. 20 (Attachment Four), Aug. 23 (Attachment Five), Aug. 9 (Attachment Six), and July 26 (Attachment Seven) minutes; the Employee Retirement Income Security Act (ERISA) (B) Working Group, including its Oct. 8 (Attachment Eight) and July 30 (Attachment Nine), minutes; the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Aug. 5 minutes (Attachment Ten); and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. The motion passed unanimously.

3. Heard a Presentation on the NSA Federal Regulations and Implications for the States

Katie Keith (Out2Enroll) and Jack Hoadley (Georgetown University Health Policy Institute) presented on the recently issued federal No Surprises Act (NSA) interim final rules (IFR), interim proposed rules (IPR) and implications for the states. Ms. Keith provided an overview of the NSA's scope and its protections, including what types of plans it covers and where its protections apply for plan years beginning on or after Jan. 1, 2022. She said the NSA's IFR was issued July 1 with an effective date of Sept. 13. The IFR was issued jointly by the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), the U.S. Department of the Treasury (Treasury Department), and the U.S. Office of Personnel Management (OPM).

Ms. Keith said the IFR includes provisions focused on both patients and regulated entities. She explained that the patient-focused provisions outline how patients can calculate cost-sharing, include notice-and-consent waivers provisions, and establish a consolidated complaints process. The regulated entities-focused provisions outline how to calculate the qualifying payment amount and include disclosure requirements and provisions related to communications between insurers and providers.

Ms. Keith said the DOL, the HHS, the Treasury Department, and the OPM jointly issued IPR Sept. 10 concerns the submission of information about air ambulance services and the process the HHS will take to investigate and enforce NSA violations. She said the IPR highlights the states as being the primary enforcers for state-regulated insurers and providers. The DOL is the

primary enforcer for self-insured health plans. The federal government is backup enforcer if a state fails to substantially enforce. Ms. Keith said that it is anticipated that the federal agencies will provide enforcement letters to each state outlining provision-by-provision whether the state and federal government will enforce that particular NSA provision.

Ms. Keith said the DOL, the HHS, the Treasury Department, and the OPM jointly issued a second IFR Sept. 30. She said the major focus of this IFR is on the independent dispute resolution (IDR) process. Other provisions include requirements related to good-faith cost estimates for uninsured patients and patients who have insurance coverage but do not wish to submit a claim for services to their insurer and requirements related to the patient-provider dispute resolution process when cost estimates are wrong.

Mr. Hoadley detailed the major provisions in the first IFR. He discussed the scope of the NSA's balance billing protections with respect to the types of payers and providers subject to its requirements. He explained that IFR sets out provisions to determine the qualifying payment amount (QPA) for purposes of the federal IDR process. The IFR spells out definitions and methodology for determining the QPA. It also includes additional provisions affecting the QPA, including minimizing the influence of outlier prices that could skew the QPA higher. Mr. Hoadley also explained that the IFR defines what a "specified state law" is for purposes of determining what method will be used to determine the amount of payment to an out-of-network provider, which could be either a payment standard or arbitration or a combination of both. The IFR also specifies that states with self-funded opt-in programs can maintain those programs. If state law does not apply, the NSA applies.

Mr. Hoadley discussed the different state approaches to determining QPAs. Some states take a hybrid approach using both a payment standard or rule and an IDR process. Other states use a payment statement standard only or an IDR process only. He also discussed the federal agencies' requirements for entities conducting the IDR process to use in making payment determinations.

Mr. Hoadley reiterated that the IFR confirms that state departments of insurance (DOIs) are the primary enforcers of provisions that apply to insurers and fully insured health products. He also noted that state officials are responsible for enforcing the law against providers, but the HHS will enforce the NSA's requirements in states that choose not to or that fail to substantially enforce the law. The DOL will enforce the NSA's provisions for self-funded group health plans. Mr. Hoadley said that it is anticipated that the HHS will enter into collaborative enforcement agreements with many states. He said the IFR proposes a consolidated complaints process for patients and others.

Mr. Hoadley discussed provisions in the second IFR concerning the good-faith cost estimates for uninsured patients and patients who have insurance coverage but do not wish to submit a claim for services to their insurer and requirements related to the patient-provider dispute resolution process when cost estimates are wrong. He said the federal agencies are still working on federal rules for insured patients with respect to these provisions. It is anticipated these rules will be issued sometime in early 2022. He said that due to this delay in rulemaking, the federal agencies have agreed not to enforce these provisions during 2022, but entities subject to these provisions must still comply and adopt a good faith, reasonable interpretation of the law.

Mr. Hoadley discussed provisions in the NSA concerning data reporting and other mechanisms for purposes of determining the NSA's effect on various health care-related factors, such as its effect on health care costs, provider networks, and provider consolidation. He noted that for the states having balance billing protection laws prior to the enactment of the NSA, analyses trying to determine those laws' effect on similar health care-related factors is limited. Depending on the state approach taken to determine payment amount, some studies of these state laws indicate little impact, while others indicate mixed impacts.

Commissioner Conway asked about the good faith attempt to participate in a carrier's network a provider can cite and use in the provider's arguments for determining the appropriate QPA. He asked if this provision is tied to a specific carrier or the market, generally. Mr. Hoadley said he does not believe the IFR addresses that issue, but the provision most likely is tied to the specific carrier that is the subject of the arbitration process.

Commissioner Conway asked if the federal rules address the situation when a provider enters into the federal IDR process, but later it is determined that the plan involved is state-regulated and the state has its own IDR process. Mr. Hoadley said he believes the arbitrator, as one of its responsibilities, will screen cases and ultimately tell the parties they will need to use the state IDR process. He acknowledged that other situations could be more complex, including cases involving multiple state IDR processes. He said in such complex cases, the federal rules seem to indicate the federal IDR process would be used.

Mr. Keen asked about the notices the federal Centers for Medicare & Medicaid (CMS) sends out as part of its petition process about organizations applying to become a certified independent dispute resolution entity (IDRE). He noted that from a state insurance regulator's perspective, the given short time frame included in the petition process and the sparse information CMS provides on these organizations make it hard to evaluate them. He asked if Mr. Hoadley or Ms. Keith had any thoughts on what

state insurance regulators should be looking in their evaluation of these applicants. Mr. Hoadley said he has no insight on the issue, but he said it would be important for the states to discuss whether any state is familiar with an applicant and provide their experiences with that organization to other states. Ms. Keith said that from her perspective, the certification criteria in the federal rules is quite strong, which could be evidenced by the fact that only a small number of organizations have applied to date. She said that from her experience in talking to the states, the states are looking for organizations that have medical and billing expertise and understand market dynamics, among other things. Commissioner Conway asked about the ability for the parties to challenge the choice of arbitrator. Mr. Hoadley said the federal rules contemplate the parties agreeing on a particular arbitrator, but if the parties cannot agree, the federal agencies would select. He said that he does not believe the federal rules provide for a party to object to the selected arbitrator, unless possibly due to a conflict-of-interest concern. Mr. Hoadley said that for some states that use the arbitration process, the state has a list of potential arbitrators, and the parties can object to one or more being selected, but the federal IDR process is not structured this way.

Commissioner Clark said that in reviewing the list of IDRE applicants to date, a few currently perform external review of appeals for Kentucky. She acknowledged that Kentucky would need to do a bit more research to determine how they are structured, but a few of these applicants could be comprised solely of health care providers, which could be problematic. She asked Mr. Hoadley and Ms. Keith if they had any thoughts on this issue. Mr. Hoadley said that he has not looked in depth as to how some of organizations applying to be IDREs are structured. He said that certainly an IDRE would need medical expertise and because of this, the IDRE would need to be aware of, and address, any actual or perceived conflicts of interest. He said these sorts of issues and ways to address them will evolve over time.

Commissioner Conway asked for those states that had a surprise bill law prior to the NSA and are now thinking about aligning the state law with the NSA, what provisions should the state focus on as part of this process. He said Colorado has focused on those provisions it thinks would be preempted by the federal law to avoid confusion. Mr. Hoadley agreed that there will be confusion about which law applies, state or federal, in some situations. He said the states may look at the types of services, providers, and facilities covered under their laws versus the NSA as provisions to focus on. Ms. Keith agreed. She said states also will have to think about retaining those provisions in their laws that are more protective, such as Colorado's more protective ground ambulance provisions. Ms. Keith said one question has been raised is if those states with a state IDR process could opt to use the federal IDR process and as such, eliminate the need to maintain a parallel and potentially duplicative process. She said the federal agencies implementing the NSA have not been discussing this issue. Commissioner Conway agreed that in some cases, allowing an "opt-in" could be more efficient.

4. Discussed Model #76 and the NSA

Jolie Matthews (NAIC) said Section 110 of the NSA expands the scope of external review to include adverse benefit determinations related to disputes under the NSA, such as whether a plan or insurer complied with the NSA's cost-sharing and other protections. She said that because the NSA applies to grandfathered health plans, external review extends to those plans as well. She explained that federal Affordable Care Act (ACA) requires non-grandfathered group health plans and insurers offering group and individual coverage to comply with state external review processes so long as those processes met certain standards. She said that to meet the ACA's standards, state laws on external review must, at a minimum, reflect the consumer protections included in the *Uniform Health Carrier External Review Model Act (#76)*, and external review must be available for adverse benefit determinations based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. She said the NSA expands the scope of the adverse benefit determinations currently provided under Model #76. She said the Task Force has at least four options to consider to address the issue: 1) substantively revise Model #76 to expand its scope to cover NSA disputes; 2) non-substantively revise Model #76, such as adding a drafting note alerting the states about the issue; 3) develop a memorandum or directive to the states to alerting them about the issue; or 4) take no action.

Commissioner Conway suggested that the Task Force form an ad hoc group to work with NAIC staff to develop a recommendation for the Task Force's consideration to address the issue. There was no objection to his suggestion. Commissioner Conway asked Task Force members to send an email to NAIC staff expressing interest in serving on the ad hoc group. Ms. Matthews said she intends to have the ad hoc group meet sometime in January 2022 for it to make a recommendation to the Task Force on next steps in February.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Draft: 11/17/21

Regulatory Framework (B) Task Force
Virtual Meeting
November 9, 2021

The Regulatory Framework (B) Task Force met Nov. 9, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Glen Mulready, Vice Chair, represented by Cuc Nguyen (OK); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Jimmy Gunn, Yada Horace, and William Rodgers (AL); Evan G. Daniels represented by Jon Savary and Erin Klug (AZ); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented by Howard Liebers (DC); David Altmaier represented by Chris Struk and Shannon Doheny (FL); Doug Ommen (IA); Dean L. Cameron represented by Weston Trexler (ID); Dana Popish Severinghaus (IL); Amy L. Beard represented by Alex Peck and Meghann Leaird (IN); Vicki Schmidt represented by Julie Holmes and Tate Flott (KS); Sharon P. Clark represented by Daniel McIlwain (KY); Gary D. Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by Renee Campbell and Sarah Wohlford (MI); Grace Arnold represented by Galen Benshoof (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Laura Arp (NE); Chris Nicolopoulos represented by Michelle Heaton (NH); Marlene Caride represented by Chanell McDevitt (NJ); Judith L. French represented by Theresa Schaefer and George McNab (OH); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman represented by Katie Merritt (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Hilary Sayre and Michael Nored (TX); Jonathan T. Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt, Bob Grissom, and Bradley Marsh (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); and Allan L. McVey (WV).

1. Adopted its 2022 Proposed Charges

Commissioner Conway said prior to the meeting, NAIC staff distributed the Task Force's 2022 proposed charges for a public comment period that ended Oct. 22. He said the Task Force received comments from the American Bankers Association (ABA) Health Savings Account (HSA) Council, the NAIC consumer representatives, and the Obesity Action Coalition (OAC). He said the comments suggest that the Task Force add two new charges and revise the Task Force's existing charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup.

Commissioner Conway said at this point, he is not inclined to recommend that the Task Force add the additional suggested charges given the NAIC's incoming president's desire to have NAIC groups focus on their core work. He said the nature of the suggested new charges do not seem to quite fit into the Task Force's core work and could be better suited for other NAIC groups. He said despite his inclination against adding the suggested new charges, he believes the Task Force should hear from each of the commenters beginning with the ABA HSA Council.

Jeffrey Klein (McIntyre & Lemon PLLC), speaking on behalf of the ABA HSA Council, remarked on the ABA HSA Council's prior work with the NAIC and the states on several matters relevant to cost-sharing in general and on rules governing third-party payments on behalf of enrollees or insureds. He said the ABA HSA Council has been particularly cognizant of the recent federal Internal Revenue Service (IRS) correspondence with the Illinois Department of Insurance (DOI), its distribution, and awareness of it by other state DOIs. He said because so much of the NAIC's efforts in this area are on consumer protection, the ABA HSA Council is concerned that well-intended but misguided proposals can have an unintended consequence on HSA account owners and their ability to continue to contribute to their HSA, because the cost-sharing legislation of concern does not conform to IRS guidance. He said because the NAIC should, and does, share its concern in that regard, the ABA HSA Council suggests that the Task Force add a new 2022 proposed charge for the Task Force to "monitor, analyze, and report to the states the effect of cost-sharing legislative mandates and the efficacy of Health Savings Accounts (HSAs) and the relevancy of recent Internal Revenue Service (IRS) guidance about such mandates."

Carl Schmid (HIV+Hepatitis Policy Institute) said over the past few years, many of the NAIC consumer representatives have raised the issue of insurers and pharmacy benefit managers (PBMs) not counting copayment assistance as part of an enrollee's deductible and cost-sharing requirements. He said these policies significantly increase consumer costs and reduce access to prescription drugs and other covered services. He said given this, in response to the ABA HSA Council's suggested new 2022 proposed charge relative to copayment assistance for prescription drugs, the NAIC consumer representatives submitted an additional comment letter suggesting that if the Task Force adds the charge, the Task Force should consider broadening the charge to explore the impact of high prescription drug cost-sharing on consumers on their medication adherence along with the

value of copayment assistance. He also said the NAIC consumer representatives disagree with the ABA HSA Council's interpretation of the IRS guidance.

Commissioner Conway said this discussion, including the differences of opinion related to the IRS guidance letter detailed in the comment letters, indicates that before the Task Force actively discusses adding any new charges related to this issue, the Task Force needs to discuss them further. He said if he remains the Task Force chair for 2022, he will include a discussion of the copayment accumulator adjustment program and the IRS guidance for the Task Force's meeting prior to or during the 2022 Spring National Meeting. There was no objection to his suggestion.

Joe Nadglowski (OAC) said the OAC suggests that the Task Force add a new 2022 proposed charge, much like the Task Force's current charges related to mental health parity (MHP) and substance use disorder (SUD), to explore the effects of obesity on state-regulated health insurance. He said specifically, the OAC recommends that the Task Force explore: 1) obesity discrimination; 2) access to treatment and specialists; 3) costs on the health care system, particularly the insurance industry; and 4) insurer considerations for treating obesity as a chronic condition. Commissioner Conway said he appreciates the OAC bringing these issues to the Task Force for its consideration because they are issues that everyone should be discussing more. He said he believes the states have been individually looking at these issues and have taken different approaches to try to address them. He said Colorado is looking at incorporating an obesity component for its standardized plan, which it plans to launch sometime next year.

Commissioner Conway said as he indicated at the beginning of the meeting, he believes the Task Force needs more discussion on these issues before considering a new charge. He said he believes there will be additional opportunities for the Task Force to have such discussions. He also said he would like to have additional time to reach out to other NAIC groups that might be more appropriate to take on these issues instead of the Task Force. There was no objection from the Task Force for not adding the OAC's suggested 2022 proposed charge.

Commissioner Conway said the NAIC consumer representatives' first comment letter on the Task Force's 2022 proposed charges suggests revising the charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to flip the current charges such that the charge concerning the white paper is the first charge and the charge to develop a possible NAIC model regulating PBMs is the second charge. Mr. Schmid said the NAIC consumer representatives also suggest adding language to the second sentence in that charge as follows, "[b]ased on issues identified in the white paper." He said the NAIC consumer representatives' comments suggest that the Subgroup develop the white paper first and then consider moving forward with the new NAIC model after the white paper is completed. Mr. Keen expressed support for the NAIC consumer representatives' suggested revisions to the Subgroup's charges. He noted, however, that given the rejection of the proposed NAIC model regulating PBMs at the Summer National Meeting, after the Subgroup completes the white paper, he anticipates that there will be a lot of discussion on whether it makes sense for the Subgroup to develop the model due to differences of opinion on the scope and breadth of PBM regulation and whether state DOIs are the appropriate entity to regulate PBMs.

Mr. Keen made a motion, seconded by Mr. Trexler, to adopt the Task Force's 2022 proposed charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

[RFTF Nov 9 Minutes](#)

Draft: 11/8/21

Adopted by the Executive (EX) Committee and Plenary, Dec. 16, 2021

Adopted by the Health Insurance and Managed Care (B) Committee, Dec. 15, 2021

Adopted by the Regulatory Framework (B) Task Force, Nov. 8, 2021

2022 PROPOSED CHARGES

REGULATORY FRAMEWORK (B) TASK FORCE

The mission of the Regulatory Framework (B) Task Force is to: 1) develop NAIC model acts and regulations for state health care initiatives; and 2) consider policy issues affecting state health insurance regulation.

Ongoing Support of NAIC Programs, Products and Services

1. The **Regulatory Framework (B) Task Force** will:
 - A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
 - B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
 - C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
 - D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2022.
 - E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to association health plans (AHPs).
 - F. Monitor, analyze, and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.
2. The **Accident and Sickness Insurance Minimum Standards (B) Subgroup** will:
 - A. Review and consider revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).
3. The **ERISA (B) Working Group** will:
 - A. Monitor, report, and analyze developments related to the federal ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
 - B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
 - C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.
 - D. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) and modify it, as necessary, to reflect developments related to ERISA. Report annually.
4. The **Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group** will:
 - A. Monitor, report, and analyze developments related to the federal Paul Wellstone and Pete Domenici MHPAEA of 2008, and make recommendations regarding NAIC strategy and policy with respect to those developments.
 - B. Monitor, facilitate, and coordinate best practices with the states, the DOL, and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
 - C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to the MHPAEA.
 - D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC *Market Regulation Handbook*.
 - E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

5. The **Pharmacy Benefit Manager Regulatory Issues (B) Subgroup** will:
 - A. Develop a white paper to: 1) analyze and assess the role PBMs, pharmacy services administrative organizations (PSAOs), and other supply chain entities play in the provision of prescription drug benefits; 2) identify, examine, and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating, and spread pricing, including the implications of the *Rutledge v. Pharmaceutical Care Management Association (PCMA)* decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.
 - B. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). Based on issues identified in the white paper, the Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.

NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook

[RFTF 2022 Proposed Charges](#)

Draft: 11/18/21

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
November 1, 2021

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Nov. 1, 2021. The following Subgroup members participated: Laura Arp, Co-Chair and Martin Swanson (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Howard Liebers (DC); Chris Struk (FL); Robert Wake (ME); Frank Opelka (LA); Sherri Mortensen-Brown (MN); Camille Anderson-Weddle, Cynthia Amann, Amy Hoyt and Carrie Couch (MO); Glynda Daniels (SC); Rachel Bowden (TX); Tanji Northrup (UT); Anna Van Fleet, Christine Menard-O'Neil, Mary Block, and Jamie Gile (VT); Mary Schaefer (WA); and Nathan Houdek (WI).

1. Continued Discussion of Products Regulated Under Model #171

Mr. Schallhorn said the purpose of this meeting is for the NAIC consumer representatives provide a consumer perspective on the products regulated *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). However, before the Subgroup hears that presentation, the Subgroup will provide an opportunity for Jackson Williams (Dialysis Patients Citizens—DPC) ask his additional questions of the industry representatives related to their presentations during the Subgroup's Sept. 20 meeting.

Mr. Williams asked Cindy Goff (American Council of Life Insurers—ACLI) to discuss which category or categories of products, if any, regulated by the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*) and Model #171 pose the greatest risk of consumers being unable to seek and find value among competing vendors. Ms. Goff said she could not think of any category or categories of products that consumers could not seek and find value among competing vendors. She said all of the products regulated under Model #170 and Model #171 offer value to consumers. There are a large number of insurers in the market selling these products, which provides for a competitive market and keeps premiums at an affordable rate. Mr. Jackson asked the extent employers are active purchasers or in other words, the extent to which these products are put out for competitive bidding. Ms. Goff said group sales of these products are done through competitive bidding like other kinds of insurance products, such as major medical products. She said the ACLI has compiled figures showing that employer involvement in the sale of these products they offer to their employees on a voluntary basis is about 96% if those group products sold. Mr. Jackson asked if such sales are on an annual basis. Ms. Goff said that depends on the employer. Each employer differs on how long they keep the products in place. She noted that some products are sold with rate guarantees that can be in effect for three to five years. As such, in those cases, there would be no changes in the offering during that time frame.

Mr. Jackson asked Ms. Goff about the average commission expense ratio for supplemental products. Ms. Goff said the answer to this question depends on how a carrier sells the product. She said some carriers do not use independent agents to sell their products. Their employees who are agents sell them. She said if independent agents sell the products for a carrier, depending on the intensity of work required of the agent, for the first year, the commission could range from zero to 50% of premium. Ms. Goff said that generally, the premium for supplemental products is very low, typically \$50 to \$100 dollars per month. As such, the percentage commission paid on that premium is very low. She also explained that typically the first year the commission is high because the work is more intense. Over time, the commission levels off quite a bit from that high. Mr. Jackson asked if the average commission has risen over the past 10 years. Ms. Goff said that based on a polling of some ACLI members, the ACLI has not seen any increase in average commission during that time frame. She explained how commissions must be filed and approved providing little flexibility for carriers to lower and increase them. Mr. Williams said in asking these questions, he is trying to figure out why the loss ratios for supplemental products are going down. Ms. Goff expressed disagreement with Mr. Williams assertion that loss ratios are going down. She said there are loss ratio can fluctuate over the course of 10 to 20 years; and when an insurer sees such a trend, they try to make adjustments to address it. She also pointed out that supplemental products are very low premium products and cannot not be compared with other types of products, particularly comprehensive health insurance products.

Mr. Williams asked about payments made under critical illness plans for COVID-related illnesses. Ms. Goff said depending on the type of policy and whether the services are covered under the policy, payments are being made for COVID-related illnesses. She said many insurers have made adjustments in their plans, such as in their hospitalization benefits, to clarify to consumers that services provided in relation to COVID are covered. Mr. Williams asked if the ACLI knows with respect to critical illness

plans, how much insurers have paid out for COVID-related expenses. Ms. Goff said that for the ACLI to obtain this information, it would have to probably conduct a formal survey of its members. She explained that even if she conducted such a member survey, it would not complete because there are some insurers, who are not members of the ACLI, such as UnitedHealthcare and Aetna, that have big blocks of this kind of business. The ACLI does not have access to their information.

Mr. Schallhorn asked Ms. Goff if she has seen insurers specifically add COVID as a benefit trigger in their critical illness plans. Ms. Goff said she has not seen specific language, but insurers have made it clear to consumers that COVID is one of the triggers.

Mr. Williams said that in the ACLI's presentation, Ms. Goff said that a survey found that 89% of enrollees who made a claim agree that the purchase of the product was a valuable investment. He asked Ms. Goff if such a survey was taken at the time an enrollee switched jobs and terminated coverage, would a smaller percentage of enrollees agree that the product was a valuable investment. Ms. Goff said that for any type of insurance product, she would imagine that there would be a smaller percentage of enrollees agreeing that a product was a valuable investment under such a scenario. She said the important question is whether the product performed as promised and whether at the time the consumer needed it if the consumer found value in having the product, which would be an important question for any type of insurance product, not just for supplemental products.

Mr. Williams asked if the ACLI knew how much money a middle-aged enrollee would pay in premiums over eight years for the average supplemental benefits plan. Ms. Goff said the ACLI does not have that information. Mr. Williams asked about the typical claim payout for such an enrollee over the same timeframe. Ms. Goff said the ACLI does not have that information either. She would have to conduct a survey answer both questions.

The Subgroup discussed a question concerning the application of the *Coordination of Benefits Model Regulation* (#120), which was answered during the Subgroup's Oct. 4 meeting. Chris Petersen (Arbor Strategies LLC) reiterated that supplemental benefit product plans do not coordinate with other plans. These plans pay regardless of whether the consumer has other plans that would cover the same benefit. He said that except for dental and vision plans, Model #120 prohibits such coordination to ensure the consumer gets the full benefit of the premium dollars paid from both plans. Bonnie Burns (California Health Advocates—CHA) said Model #120 allows insurers to coordinate as secondary coverage when an individual is eligible for Medicare Part B, whether the individual is enrolled or not. She said this applies to limited benefit policies as well. Mr. Petersen said there are different coordination rules for Medicare. He said case law has determined that Medicare is always primary. Ms. Burns said she has raised an issue with the NAIC on several occasions regarding COBRA coverage, which limited benefit plans can use to coordinate coverage whether the individual is actually enrolled in COBRA coverage or not. Mr. Petersen said he would have to look at the issue before providing a definitive answer, but he believes that the issues Ms. Burns is raising is a Model #120 issue not an issue for Model #170 or Model #171. The Subgroup discussed what products Ms. Burns is referencing when using the term "limited benefit plan" because there are different interpretations of what that term means. Model #170 and Model #171 specifically define "limited benefit plan." However, "limited benefit plan" has been interpreted to mean other types of products such as so-called "mini-meds" and in some cases, thought of as "short-term, limited-duration plans."

Ms. Goff said the coordination of benefits process is very labor intensive. As such, with respect to products like hospital indemnity, accident-only and specified disease, except for possibly in some cases with respect to workers compensation, these plans do not coordinate even if there is some state law or rule that would permit such coordination.

Lucy Culp (Leukemia & Lymphoma Society—LLS) discussed the NAIC consumer representatives' perspective on the products covered under Model #171. She said it should not be a surprise to anyone that consumer without access to employer-based health insurance coverage are faced with a complex mix of options to obtain such coverage on their own. She said some of these plans may offer high quality coverage and be very expensive while other plans may be less expensive and appear to offer high quality coverage for the types of services a consumer might assume a comprehensive health insurance plan would cover. She said this complexity hinders the ability of consumers to make informed decisions in purchasing such coverage.

Ms. Culp said many of the products covered under Model #171 on their face could look like comprehensive health insurance coverage to consumers. She said although some of the products covered under Model #171 do appear to be supplemental coverage, if they are packaged and offered in a certain way, these products also could appear to be comprehensive health insurance coverage. Ms. Culp said that prior to the enactment of the federal Affordable Care Act (ACA), products covered under Model #170 and Model #171 had a clearer place in the health insurance market as being supplemental products that consumers could use for a short time to bridge the time in between jobs or after graduating from college and obtaining a job with employer-based health insurance coverage. She explained that today, post-ACA enactment, consumers have more high-quality options to obtain health insurance coverage, such as obtaining such coverage through the ACA health insurance

marketplaces and Medicaid expansion. She said the availability of these high-quality coverage options prompted the NAIC consumer representatives to urge the NAIC to review and revise Model #170 and Model #171 to address consumer confusion about these supplemental products, including the type of benefits they offer and their purpose in the marketplace. Ms. Culp highlighted the differences in requirements for ACA plans and, products Model #170 and Model #171 cover, non-ACA plans. She detailed the impact, particularly the out-of-pocket costs, of an individual undergoing lymphoma treatment who is covered under one of these non-ACA plans, a short-term, limited-duration (STLD) plan. She highlighted the differences in out-of-pocket costs for consumers enrolled in STLD plans for other diagnoses, such as lung cancer, as compared with ACA plans. She also discussed how enrollment in STLD plans is increasing, including broker-mediated enrollment in such plans. Ms. Culp also said STLD plans also on average have significantly lower loss ratios than ACA plans, which makes them highly profitable.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) said indemnity plans also raise concerns. She discussed some of the features of these plans that resemble traditional major medical health insurance plans that can confuse consumers, such as using “networks” of providers, the use of plan benefit schedules and using words such as “insurance” or “health plan” in marketing materials. Ms. Lueck said plans sold to employees can be just as problematic. She discussed the aggressive marketing of some of the products covered under Model #170 and Model #171 and consumer confusion. She also noted that even when information about these plans is disclosed, consumer testing shows that people do not understand the limits of some of these products, such as STLD plans. Ms. Lueck said the NAIC consumer representatives do not see the supplemental product market as one that everyone is working from the same set of information and is on a level playing field. There is a lot of confusion in this market making it difficult for consumers to make informed decisions.

Ms. Lueck pointed out a recent Georgetown University Health Policy Institute, Center on Health Insurance Reforms (CHIR) study “Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period.” She said the authors of this study created two sample applicants for a variety of different types of plans to test out what these applicants were being told and shown when searching for coverage. She said what the authors found through a number of telephone calls with brokers and agents and representatives of these plans was the lack of accurate information disclosed about a plan’s affordability, particularly as related to ACA marketplace coverage. She said that in some cases, these sample applicants were steered away from the ACA marketplace coverage even though these applicants had quite low incomes and were eligible for ACA plans at a very low cost, such as a bronze plan at \$0 premium and a silver plan with reduced cost-sharing starting at \$2 premium. Ms. Lueck said that in some cases, these sample applicants were offered alternative plans, such as STLD plans. She said that although some of these non-ACA plans are characterized as having really low premiums, even if that is the case for some consumers, given the changes in the marketplace, this is not true for everyone anymore. For the sample applicants in the study, these non-ACA plans, such as STLD plans, were expensive possibly \$70 - \$100 per month, which is not an insignificant cost. She said consumers, such as those like the sample applicants, can find quite affordable comprehensive coverage in the ACA marketplace, but they might not know it.

Ms. Lueck provided several key takeaways for the Subgroup to consider: 1) non-ACA plans covered by Model #171 often pose risks to consumers; 2) while some products, such as dental plans, are clearly not comprehensive coverage, many plans are structured in ways that blur the lines with comprehensive health insurance coverage; 3) too often, these plans are marketed in an aggressive, even predatory manner; and 4) this market may serve insurers and brokers and agents well, but it often does not serve consumers well.

Mr. Schallhorn asked Ms. Culp if some of the differences in out-of-pocket costs for STLD plans and ACA plans was due to assumptions related to preexisting conditions. Ms. Culp said she did not believe those differences reflected such an assumption. She said what she believes the Milliman study assumed was that consumers would need services that were not covered under the STLD plan and as such, would be paying out-of-pocket for these services.

Mr. Petersen said he believes many of the NAIC consumer representatives brought to the Subgroup’s attention during this meeting will most likely be address through the work of the Improper Marketing of Health Insurance (D) Working Group. Mr. Swanson, co-chair of the Working Group, said the Working Group is meeting at the Fall National Meeting. He said the Working Group is in the process of developing its agenda for that meeting. J.P. Wieske (Health Benefits Institute—HBI) said that some of the issues the NAIC consumer representatives raised during their presentation are issues that the industry also is concerned about. He said some of the HBI’s members also have conducted secret shopping, found some issues and followed up with agents and brokers to address those issues. He said the HBI agrees that these plans are not comprehensive health insurance coverage and should not be marketed as such. Ms. Goff agreed with Mr. Wieske’s comments.

Ms. Arp asked Ms. Culp and Ms. Lueck if the recent federal rule under the federal No Surprises Act (NSA), which requires agents and brokers to disclose their commissions for STLD plans, will help to address some of the issues raised in their

presentation. Ms. Lueck said any type of disclosure is helpful if it leads to more understanding and provides more information to assist consumers in understanding the how STLD plans work. However, she does not believe there is any mystery about STLD plans given the high agent and broker commissions associated with this product, which seems to incentivize their sale. Ms. Culp said she disagreed slightly with Mr. Petersen's comments that the Improper Marketing of Health Insurance (D) Working Group was the only NAIC group appropriate for some of the concerns raised in her presentation. She said particularly with respect to materials, including disclosures, provided to consumers about the products covered under Model #170 and Model #171 is important as well to address their concerns. Ms. Arp agreed. She said when the Subgroup begins its review of the provisions in Model #171 on disclosures, she anticipates a robust discussion of these provisions considering the issues that have been raised during these meeting and other Subgroup meetings. She said, however, that some issues most likely are not going to address the problems of bad actors in the market who intentionally try to confuse and mislead consumers about the some of the benefits associated with non-ACA plans versus ACA plans, but she believes the Subgroup can as part of its work in revising Model #171 make sure consumers know how these non-ACA products differ from ACA plans.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

[Nov 1 Minutes](#)

Draft: 11/1/21

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
October 4, 2021

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Oct. 4, 2021. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Chris Struk (FL); Robert Wake (ME); Sherri Mortensen-Brown (MN); Cynthia Amann and Amy Hoyt (MO); Shari Miles (SC); Rachel Bowden (TX); Shelley Wiseman (UT); Anna Van Fleet, Christine Menard-O'Neil, Emily Brown, Mary Block, and Jamie Gile (VT); Ned Gaines (WA); and Jennifer Stegall and Nathan Houdek (WI).

1. Continued Discussion of Products Regulated Under Model #171

Mr. Schallhorn said the purpose of this meeting is to allow questions from Subgroup members, interested state insurance regulators, and interested parties about the information provided during the Subgroup's Sept. 20 meeting on: 1) the different types of products covered under the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); 2) how they pay benefits; 3) what they are designed to do; 4) how they are marketed; and 5) how they are sold. During that meeting, the Subgroup also heard about the products Model #171 currently covers and, based on the revisions to the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), which is the companion model law to Model #171, what products Model #171 will be revised to cover.

Recognizing that most of the supplemental benefit products subject to Model #171 are sold through the workplace, Ms. Arp asked about those products sold to individuals through associations. She asked why these products are sold through an association and, functionally, how it works. J.P. Wieske (Health Benefits Institute—HBI) explained that associations provide such benefits as a value add-on to their members. He said some associations also use these benefits as a way to attract members and an opportunity to provide these benefits on a less expensive basis than it would be if purchased in the individual market. He said that typically, the association purchases the benefit on behalf of its members, but in some cases, members may pay directly for the benefit as part of their membership or as an add-in to their health plan coverage. Cindy Goff (American Council of Life Insurers—ACLI) discussed examples of different associations that have approached some ACLI members, and those associations desire to provide these benefits at lower costs. She also said ACLI members have become more sophisticated in researching organizations to ensure an association has been in business for a significant enough time and not recently created solely for the purpose of offering insurance particularly due to the federal Affordable Care Act's (ACA) provisions related to associations. Chris Petersen (Arbor Strategies LLC) explained that the *Group Health Insurance Standards Model Act* (#100) sets out many of the provisions Ms. Goff just discussed with respect to what it means to be a "true" association. Given this, Model #100 is the appropriate NAIC model, not Model #171, for determining what it means to be a "group," how to define an "association" or "employer group," and how an association or employer group can offer benefits, such as supplementary products. Mr. Wieske pointed out that Model #100 also includes provisions to ensure the association is indeed separate from an insurer and can make its own decisions independent of the insurer.

Ms. Arp asked about bundling supplemental benefit products. Ms. Goff said the ACLI has had a lot of discussions with the states about bundling and how a package of products is put together and marketed to consumers. She discussed two different ways such packaging can happen: 1) the consumers themselves select more than one product to address areas where they would like to mitigate their financial risk with respect to expenses not covered under their major medical plan; and 2) when an insurer puts together a "package" of products and markets them to consumers as though they are not distinct products with different and distinct roles to possibly lead the consumer to believe what is being offered is more comprehensive than it is or that these products are some kind of alternative to comprehensive major medical coverage. Ms. Goff said for the second method of bundling, she believes there are ways to address it. She said the Antifraud (D) Task Force recently established a new working group, the Improper Marketing of Health Insurance (D) Working Group, to discuss and consider different regulatory approaches to address this issue. Ms. Goff also noted that this issue of improper marketing of supplemental benefit plans goes to the issue of what is a minimum standards model and the purpose of such a model versus addressing inappropriate market behavior and ensuring state insurance regulators have the tools they need to address those issues as well. She said the ACLI has noticed that in some states, it appears they are looking to impose severe restrictions on what benefits can be included in these supplemental benefit products to prevent them from being inappropriately marketed to consumers. She said the ACLI believes that such an approach devalues these products with respect to the protections they offer to consumers to help pay costs not covered by their

major medical insurance. Ms. Goff said the ACLI believes that instead of imposing severe restrictions on benefits, the focus should be on making sure consumers understand each product they are purchasing and its distinct function and benefits.

Mr. Wieske explained that some supplemental benefit products are very low dollar. He said that in such cases, it makes sense for a producer to bundle them together to be able to sell them. He explained that although these products are bundled as a package, the producer will sell them as distinct products. Mr. Wieske noted that such packaging is particularly the case for associations that want to be able to offer a menu of products, while also having the ability to offer them separately. Mr. Wieske said that in situations where supplemental benefit products are bundled to make them appear to be ACA-compliant products, he supports Ms. Goff's comments. He said the HBI has taken action against producers who have engaged in such deceptive practices. The HBI believes that supplemental benefit products should not be developed, marketed, or sold as a replacement for major medical insurance.

Mr. Wieske also said that limiting the ability of producers to bundle products probably creates a bigger problem in the market because consumers want to buy certain products together. As such, producers are going to satisfy this desire by bundling products together from different insurers, which means insurers will most likely not be able to track such behavior. He said this is because the producer will sell each product individually, and given this, insurers will not be able to detect certain patterns of behavior and will be unable to take action to stop it. Mr. Wieske added that he believes prohibiting the bundling of products could result in an availability issue from a product perspective, an insurer perspective, and a consumer perspective. Mr. Petersen pointed out a few common product bundles, such as vision and dental insurance bundles. He explained that these products are commonly bundled together and offered to employers for their employees because many major medical policies do not include these benefits. Given this, Mr. Petersen suggested caution in using the term "bundling." He also suggested that the bundling of supplemental benefit products is not really the core issue; the issue is how supplemental benefit products are presented to consumers, which he believes is an unfair trade practices issue addressed in the *Unfair Trade Practices Act* (#880). Mr. Petersen also pointed out the importance of not confusing "bundling" with the idea of combining two federal Health Insurance Portability and Accountability Act (HIPAA)-excepted benefits products. He said HIPAA and the NAIC minimum standards models—Model #170 and Model #171—contemplate the combining of these products.

Bonnie Burns (California Health Advocates—CHA) asked if there was a clear linkage between Model #171 and the other NAIC models discussed as vehicles for addressing the bundling and marketing issues. Mr. Petersen said he believes there is a stronger linkage between Model #171 and Model #100 because the current version Model #171 applies to the group market whereas prior versions of it only applied to the individual market. As such, for a group to be able to offer the products regulated under Model #171, the group must be a "permitted" group recognized by the state as provided in Model #100. Ms. Burns suggested that as the Subgroup discusses revisions to Model #171, it should add references to those NAIC models that might apply to a particular model section. Ms. Arp said that from a state insurance regulator perspective, state departments of insurance (DOIs) use the NAIC minimum standards models when reviewing form filings to determine whether the filing complies with the models' coverage and disclosure and notice requirements. She said issues related to bundling and marketing would be within the scope of a DOI's consumer affairs division or market conduct division, not its form filing division. She said that with respect to the "group" issue, the Nebraska DOI includes in its form review checklist provisions for the review of whether the group that is to offer the product is a "permitted" group under state law and regulations. Ms. Arp said she believes the NAIC minimum standards models are linked with other relevant NAIC models depending on who and what DOI division is reviewing the product at a particular point in time. Ms. Goff said that she believes over the last few years, there have been some gaps identified in regulatory authority to address certain marketing practices. She said she believes the new Improper Marketing of Health Insurance (D) Working Group will work to address those gaps, which could involve reviewing and revising several NAIC models.

Ms. Amman asked if supplemental benefit product plans can coordinate with other plans. Mr. Petersen said supplemental benefit product plans do not coordinate with other plans. These plans pay regardless of whether the consumer has other plans that would cover the same benefit. He said that except for dental and vision plans, the *Coordination of Benefits Model Regulation* (#120) prohibits such coordination to ensure the consumer gets the full benefit of the premium dollars paid from both plans. Mr. Petersen discussed the purpose and nature of supplemental benefit products and how they are marketed to help the consumer mitigate financial risk by paying costs other than medical care costs. Ms. Goff noted that disability income plans coordinate with workers' compensation.

Ms. Arp asked for an explanation of calculating medical loss ratios (MLRs) for products, such as supplemental benefit and long-term care insurance (LTCI) products, that do not end after one year. Mr. Wieske explained that the MLRs in such situations are calculated over the course of a lifetime rather than the three-year loss ratio calculation for ACA plans. Ms. Goff noted that

dental and vision plans are a bit different. She explained that it is not an apples-to-apples comparison with respect to MLRs for supplemental benefit plans and major medical policies. They are two completely different types of products.

Lucy Culp (Leukemia & Lymphoma Society—LLS) asked Mr. Petersen about information he provided in his chart concerning the products currently regulated under Model #171 and those to be regulated under the revised Model #171. She asked how he determined that group short-term, limited-duration (STLD) plans are not to be regulated under the revised Model #171. Mr. Petersen said he believes group STLD plans do not exist because HIPAA provides that “individual” STLD plans are not individual health insurance. This means that these plans are not subject to HIPAA’s requirements for individual health insurance, such as guaranteed renewability. He said HIPAA provides no such exception for group STLD plans. He said he interprets this to mean that group STLD plans would be subject to certain requirements, such as guaranteed renewability and the ACA requirements, which is contrary to how STLD plans operate functionally. Ms. Arp said the Nebraska DOI reviews and approves group STLD plan forms. She explained the DOI’s rationale and process for the review and approval of such plans. The Subgroup discussed this issue and determined that STLD plans are a different kind of animal, not clearly individual market insurance and not clearly group market insurance, but they fall somewhere in between. Mr. Wieske said that with respect to STLD plans sold to individuals through an association, most state insurance regulators would consider those plans to be individual market insurance and subject to the requirements for the individual market. He pointed out a provision in Model #170, which permits a state to extend its jurisdiction to an STLD plan not delivered in the state, such as an STLD plan sold to an individual through an association. The same language is not provided for other products regulated by the NAIC minimum standards models. Mr. Petersen said language in Section 2A supports his conclusion that the NAIC minimum standards models do not apply to group STLD plans.

Jackson Williams (Dialysis Patients Citizens—DPC) asked Mr. Wieske about supplemental benefit product MLR trends and whether, as reflected in NAIC experience reports, the decline in MLR for these products over time is an actual trend. Mr. Wieske explained that he has not examined the underlying data for such findings. He said that given this, he cannot definitively state whether that assumption is true or not. He said that this is a snapshot in time and could reflect a higher number of new policies sold, enrollment numbers, or some other variable. He reiterated that MLRs for supplemental benefit products cannot be compared to MLRs for major medical policies.

Mr. Williams asked Mr. Wieske what information a consumer should have access to when shopping for STLD plans. Mr. Wieske said that from his perspective, it is important for the consumer to understand what the plan covers and does not cover, what the risks are, and time frames. Mr. Williams asked if consumers should be able to comparison shop for an STLD plan like they can for a mortgage or a credit card. Mr. Wieske said he believes consumers can currently comparison shop. He also noted that consumers have different needs and that STLD plans have some variation to meet those different needs. Mr. Wieske also said he believes that state insurance regulators should be looking at the information being provided to consumers and figure out if that information is intentionally confusing or misleading. Mr. Williams asked if consumers should have the ability to compare STLD plans on an apples-to-apples basis like they can for credit cards because of the federal Truth in Lending Act (TILA), which promotes the informed use of consumer credit by requiring disclosures about its terms and cost to standardize the way costs associated with borrowing are calculated and disclosed. He asked if there should be some sort of benchmark developed to allow for such an apples-to-apples comparison for a consumer to compare STLD plans with different benefit designs and determine which plan offers the best value. Mr. Wieske said he believes there should be information available to consumers to understand what benefits the STLD plan offers.

Mr. Williams said he has several questions for the ACLI. Mr. Schallhorn said the Subgroup would make time on its agenda for its next meeting for additional questions.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

[Oct 4 Minutes](#)

Draft: 10/12/21

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
September 20, 2021

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Sept. 20, 2021. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Chris Struk (FL); Robert Wake (ME); Sherri Mortensen-Brown (MN); Cynthia Amman and Camille Anderson-Weddle (MO); Shari Miles and Kathleen Kellock (SC); Rachel Bowden (TX); Tanji J. Northrup (UT); Anna Van Fleet, Christine Menard-O'Neil, Mary Block, and Jamie Gile (VT); Ned Gaines (WA); and Jennifer Stegall and Nathan Houdek (WI).

1. Heard Presentations on Products Regulated Under Model #171

Ms. Arp said as discussed during its Aug. 23 meeting, the Subgroup will hear presentations during this meeting on: 1) the different types of products covered under the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); 2) how they pay benefits; 3) what they are designed to do; 4) how they are marketed; and 5) how they are sold. She said the Subgroup will also hear about the products Model #171 currently covers, and based on the revisions to the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), which is the companion model law to Model #171, what products Model #171 will be revised to cover.

Chris Petersen (Arbor Strategies LLC) provided an overview of the type of products that are subject to Model #171 based on the current version and what products will be subject to Model #171 after it is revised. He said the chart he developed identifies each of the products subject to the Model #171 requirements and whether the product is covered under Model #171 based on being offered the individual market, the group market, or both. He said the biggest change as far as the products Model #171 currently regulates and will regulate after the revisions is the addition of individual short-term, limited-duration (STLD) plans. He said this product is not regulated in any NAIC model prior to revisions to Model #170, which added STLD plans. He explained that because of language in the federal Affordable Care Act (ACA), only individual STLD plans are covered under the models. Group STLD plans are considered comprehensive major medical coverage subject to the ACA's requirements. Mr. Petersen said another product added is fixed indemnity plans. He said fixed indemnity is recognized as an excepted benefit under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the ACA, but it was never included in Model #170 or Model #171, the minimum standards models. He said because STLD plans and fixed indemnity plans were never included, the Subgroup will have to develop minimum standards for them, such as minimum notice and disclosure requirements. He pointed out that for STLD plans only, the revisions to Model #170 allow for extraterritorial jurisdiction, which means a state can have its requirements apply to STLD plans issued outside of the state.

Mr. Petersen discussed the addition of group disability income protection products. He said when considering revisions related to these products, the Subgroup will have to keep in mind that they are establishing minimum standards because group disability income protection plans are very different from individual disability income protection plans. He explained that limited benefit vision plans and limited benefit dental plans were always included in the minimum standards models, but the definitions for these plans have been revised for consistency with the definitions of these products in HIPAA. He noted that the minimum standards models do not apply to group for these plans. He said the products he has not discussed, such as accident-only plans and specific disease plans, are products the minimum standards models currently cover and will continue to cover without much change. He said products that are considered comprehensive coverage and subject to the ACA's requirements have been removed from the minimum standards models. He explained that because these coverages were in the models, the Subgroup will have to carefully review provisions in Model #171 that might relate to comprehensive coverage, but because they relate to comprehensive coverage, it might not make sense for supplemental coverage.

J.P. Wieske (Health Benefits Institute—HBI) provided a history of Model #170 and Model #171. He said Model #170 was developed as part of state health reform efforts in the late 1980s and early 1990s to set up a regulatory structure for non-major medical health insurance products. He said the initial focus was to set minimum standards for these products to assist consumers in understanding them prior to purchase. He said at the time the Subgroup began work on revising Model #170, work on revising network adequacy standards had just been completed after approximately two years and work on revisions to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) was ongoing. He said because of issues related to

STLD plans, fixed indemnity plans, and stakeholder requests to address those issues in an NAIC model, a decision was made to make revising the minimum standards models as the next priority project. He said the Subgroup moved quickly to complete the Model #170 revisions. He explained that one of the main issues in the Model #170 revisions, particularly with respect to state regulatory authority over STLD plans, was what provisions belong in Model #170 and what belongs in Model #171. He said the Subgroup had extensive discussions on STLD plans from both a product and regulatory perspective, which led the Subgroup to specifically decided to treat STLD plans differently in the minimum standards models than the other products covered under the models.

Mr. Wieske suggested that as the Subgroup works on the Model #171 revisions, it keep in mind the following with respect to the products covered under the model: 1) most supplemental products sold through the individual market are guaranteed renewable; 2) many products sold through an employer are issued on a guaranteed issued basis, which means they are not medically underwritten; 3) unlike major medical products, consumers do not necessarily access the benefits of these products each year; 4) the products typically provide payment to the insured person and not to a medical provider; 5) payments can be used for any expenses the insured person wishes to use them for, and these payments are not coordinated with the consumer's major medical plan; and 6) the products are priced based on lifetime loss ratios. He said for some of these products, there is evidence that some consumers are buying them to use in conjunction with their high deductible health plans as one way to build up funds in their health savings accounts (HSAs) over time and then cancel the coverage. He explained that given rising deductibles and cost sharing in individual and employer-sponsored plans, the coverage provided by these products provides consumers with coverage for those cost-sharing amounts when they cannot afford it. However, he said the HBI strongly believes these products should not be developed, marketed, and sold as replacements for ACA coverage.

Cindy Goff (American Council of Life Insurers—ACLI) said in looking at the products Model #171 currently regulates and will be regulating following the revisions, as Mr. Petersen described, she would categorize those products as HIPAA-excepted benefits products and non-HIPAA-excepted benefits products. Most of the products subject to Model #171 are HIPAA-excepted benefits products. STLD plans are the only non-HIPAA-excepted benefits products.

Ms. Goff explained what HIPAA-excepted benefits are; the federal agencies that define how benefits qualify as HIPAA-excepted benefits for individual products and group products; and the primary regulator for such benefits, which are the states. Ms. Arp asked about the significance of being a HIPAA-excepted benefits. Ms. Goff said due to the ACA, one of the main benefits is products considered to be HIPAA-excepted benefits are not subject to the ACA's requirements because these products are not intended to be a form of primary coverage. She also discussed the differences between the group market and individual market, such as who holds the policy, whether the product is noncancellable or guaranteed renewable, and whether the product is medially underwritten. She said some of these differences, particularly with respect to the individual market, support the importance of the model setting clear minimum standards to allow insurers to assess the risk of providing coverage from the beginning because the insurer is setting the premium rate at the outset that will be in place for decades for some individuals.

Ms. Goff discussed what is meant by the term "supplemental benefits," explaining that industry and state insurance regulators have defined the term differently than HIPAA. Generally, "supplemental benefits" are considered financial products that are triggered by health events but are not expense-based and not specifically meant to replace income. She explained that disability income, as well as dental and vision coverage are often considered "supplemental" because they provide additional benefits not covered by major medical plans, but she noted that dental and vision coverage is often expense-based and uses provider networks. Given these differences, for the purposes of this discussion, she will not include them in her discussion of "supplemental benefits."

Ms. Goff discussed the supplemental benefit product categories, which include accident-only, specified disease, and hospital indemnity or other fixed indemnity. She discussed the type of benefits they provide and other characteristics of these types of supplemental benefit products, noting that they are financial protection products that help pay costs not covered by medical insurance. She also discussed what these supplemental benefit products are not, including that: 1) they are not comprehensive medical coverage and not intended to be sold as such; 2) they do not pay directly for medical expenses or claims; 3) they cannot pay benefits on an expense-incurred basis; and 4) they are not mini-meds or other types of medical expense coverage eliminated under the ACA.

Ms. Goff said supplemental products are popular, and based on a 2020 survey, consumers are highly satisfied with their purchase and the services they received. She said the ACLI believes the survey reflects such high consumer satisfaction, which is typically not the case with other health insurance products when the product is sold properly and used as intended. She also

discussed the importance and value of supplemental products due to the fragility of household budgets, particularly given their low premiums.

Ms. Goff next discussed dental and vision insurance, explaining how they are sold; the typical benefits offered; how the benefits are provided, which is typically provider network-based; and other characteristics of these coverages. She next discussed disability income insurance. She explained that this type of coverage is used to protect income by replacing a portion of an individual's salary when they must take off from work due to a serious illness or injury. This coverage can be short-term or long-term. Ms. Goff explained the characteristics of both types of coverages, including the typical benefits they provide.

Ms. Goff next discussed the only type of non-HIPAA-excepted benefits product in Model #171; i.e., STLD plans. She said this product does not neatly fit into any category. It sort of stands alone because it is defined in HIPAA as "not health insurance." STLD plans are also not considered excepted benefits under HIPAA. Ms. Goff said the ACA does not mention STLD plans, and as such, it is exempt from most ACA requirements. She said STLD plans are meant to be temporary primary coverage for individuals in transition into or out of major medical coverage. She described the characteristics of STLD plans, such as the typical length of such coverage and that medical underwriting is permitted.

Ms. Arp said the Subgroup has reserved its Oct. 4 meeting to take questions from stakeholders about the information provided in these presentations. She asked stakeholders who have any questions and would like to speak during that meeting to let NAIC staff know.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

[Sept 20 Minutes](#)

Draft: 9/14/21

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
August 23, 2021

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Aug. 23, 2021. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Chris Struk (FL); Frank Opelka (LA); Robert Wake (ME); Sherri Mortensen-Brown (MN); Cynthia Amman and Carrie Couch (MO); Kathleen Kellock (SC); Rachel Bowden (TX); Tanji J. Northrup (UT); Anna Van Fleet, Christine Menard-O'Neil, Mary Block, and Jamie Gile (VT); Ned Gaines (WA); and Jennifer Stegall and Nathan Houdek (WI).

1. Discussed its Next Meeting Agenda

Ms. Arp said prior to the meeting, she and Mr. Schallhorn discussed pausing the Subgroup's discussions of revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) to hold one or two meetings to educate everyone participating in the Subgroup discussions on: 1) the different types of products covered under Model #171; 2) how they pay benefits; 3) what they are designed to do; 4) how they are marketed; and 5) how they are sold. She said this discussion will be beneficial to everyone because it will provide a better understanding of the Subgroup's work as it moves forward in its discussions about revisions to Model #171. She said such a discussion is needed, particularly due to the turnover of Subgroup members since the Subgroup last met in December 2019. She said Cindy Goff (American Council of Life Insurers—ACLI) volunteered to facilitate a presentation to cover these topics, including which of these products are more frequently sold, how they are designed, the most selected dollar amount of coverage and dollar amount of claims. Ms. Arp said she believes the types of products to be covered under the revised model fall into at least three different groups: 1) short-term, limited-duration (STLD) products; 2) dental and vision products, which are excepted benefit products under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and 3) supplemental products, such as accident-only policies, specified disease policies, and hospital indemnity policies. She said the goal of the presentation is for everyone to better understand what each of these groups of products are, what they do, and how they pay. She also said following this presentation, the Subgroup is open to hearing from other stakeholders, particularly consumer representatives, on their concerns with these products.

Ms. Arp also discussed the approach the Subgroup could take with respect to STLD products. She said there has been discussion of separating the STLD plan provisions from the other types of products covered under Model #171. She said she believes this approach has been discussed particularly with respect to Model #171's consumer disclosure requirement provisions because due to the nature of STLD plans, they do not fit with the other types of products covered under Model #171. The Subgroup agreed. Ms. Arp also discussed other potential differences between STLD plans and the other types of products covered under Model #171, such as group versus individual coverage and guaranteed renewability requirements.

Ms. Arp also noted that the purpose of Model #171 is to set minimum standards for the types of products it covers. Ms. Goff agreed. She said the Subgroup needs to keep this purpose in mind as it considers revisions, and it should not include prescriptive provisions that could affect the ability of insurers, particularly for group coverage, to build on the model's minimum standard provisions. If the Subgroup chooses to do so, it should offer innovative product designs and benefits.

Chris Petersen (Arbor Strategies LLC) said the Subgroup also needs to be cognizant of what Model #171 covers and what it should cover. He explained that technically, Model #171 currently covers individual major medical products, but because of the revisions to the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), which is the companion model law to Model #171, the provisions related to individual major medical products in Model #171 need to be removed and other provisions revised for consistency with Model #170. He also noted that Model #171 does not cover STLD plans, but because the Subgroup agreed to add these products to Model #170, provisions related to these products will have to be added to Model #171. He also discussed other potential inconsistencies in the model's current provisions involving dental and vision products and disability products. Ms. Arp asked about the possibility of creating a document to assist in the Subgroup's discussion that would outline what products were covered in Model #171 prior to the Model #170 revisions and what products are to be covered in Model #171 after the Model #170 revisions. Mr. Petersen volunteered to create such a document.

Ms. Goff agreed that such a document would be useful. She also recalled the Subgroup's discussions when revising Model #170 on whether to add STLD products and how to do it given the differences in these products from the other types of products covered under the models. She said she believes this is the reason why the Subgroup's initial approach in revising Model #171 was to keep STLD plans separate from the other types of products.

Ms. Arp agreed with Ms. Goff's comments. She said she envisions the Subgroup moving through Model #171; making revisions for the supplemental-type products; and considering, when appropriate, different provisions for STLD plans. She said if, at the end of its review, the Subgroup determines there are too many of these provisions, the Subgroup might have to reconsider this approach and develop a separate section for STLD plans. She said she knows the Subgroup will have to develop different provisions for consumer disclosures for STLD plans. J.P. Wieske (Health Benefits Institute—HBI) expressed support for Ms. Arp's approach regarding STLD plans and the Subgroup's plan to pause its work for one or two meetings to discuss the products covered under Model #171, including the different product designs and purposes.

After discussion, the Subgroup decided to hold its next meeting on Sept. 20. Ms. Arp also asked that if anyone has any materials they believe would be useful to the Subgroup as it begins its level-setting discussions, they should send them to NAIC staff for distribution prior to the Sept. 20 meeting.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

[Aug 23 Minutes](#)

Draft: 9/7/21

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
August 9, 2021

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Aug. 9, 2021. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Chris Struk (FL); Robert Wake (ME); Sherri Mortensen-Brown (MN); Amy Hoyt, Cynthia Amman, and Carrie Couch (MO); Rachel Bowden (TX); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet, Emily Brown, Christine Menard-O'Neil, and Jamie Gile (VT); Jane Beyer (WA); and Nathan Houdek and Jennifer Stegall (WI).

1. Discussed Revisions to Model #171

The Subgroup continued its discussion of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) in relation to the guaranteed renewability and noncancellable requirements of most of the policies covered under Model #171. To address this issue, the Subgroup confirmed its intent to add language to Section 4—Effective Date.

The Subgroup next continued its discussion on whether to add language to Section 5A to address the issue of using language in the policy definitions in Section 5—Policy Definitions, such as “shall not be more restrictive” or “shall not be defined more restrictively than.” The Subgroup discussed Mr. Wake’s suggested language: “[e]xcept as provided in this regulation, to the extent these definitions are used in a policy or certificate, definitions used in a policy or certificate may vary from the definitions in this section, but not in a manner that restricts coverage.” The Subgroup discussed whether this language would in effect set a minimum floor for the policy definitions in Section 5 while also permitting insurers to provide more coverage to consumers if they choose to do so. The Subgroup discussed other language that could possibly require state departments of insurance (DOIs) to review policy definitions to determine whether an insurer’s changes to a policy definition are more favorable or less favorable to the consumer. After additional discussion, the Subgroup decided to accept Mr. Wake’s suggested language.

The Subgroup returned to its discussion of Section 5G and the Missouri DOI’s suggested revisions to the policy definition of “mental or nervous disorder.” The Subgroup discussed if “nervous” disorder is currently used. The Subgroup agreed that it typically was not used, but because Section 4A(14) of the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), which is the companion model law to Model #171, refers to “mental or nervous disorder,” the Subgroup would have to use the same terminology in Section 5G. Mr. Wake suggested that the Subgroup consider adding language to Section 5G to clarify that insurers may use other terminology such as “mental health condition or substance use disorder.” The Subgroup discussed whether this language should be a drafting note or substantive language. After additional discussion, the Subgroup agreed to accept the Missouri DOI’s suggested language and add a drafting note clarifying that insurers can use other terminology for this policy term. The Subgroup also agreed to add the words “or its successor” just in case the “Diagnostic and Statistical Manual of Mental Disorders (DSM)” is ever replaced with another source.

The Subgroup revisited its discussion of the references in several definitions to “shall not be more restrictive” or “shall not be defined more restrictively than.” Some Subgroup members suggested that each policy definition in Section 5 should state “means.” After additional discussion, the Subgroup agreed to use “means.” The Subgroup directed NAIC staff to go through each of the Section 5 policy definitions to make this change for the Subgroup’s future review and discussion.

The Subgroup next discussed the policy definition of “nurse” in Section 5H. The NAIC consumer representatives suggested adding “advance practice nurse.” Jolie H. Matthews (NAIC) said during its previous discussions, the Subgroup agreed to accept the NAIC consumer representatives’ suggested revision. J.P. Wieske (Health Benefits Institute—HBI) asked about adding advance practice nurses to this policy definition, given that insurers can use it in at least two ways—coverage determinations and qualifications to perform certain duties. He said it makes sense to add advance practice nurses to the policy definition, given that they have more authority, such as the authority to prescribe medications, than a registered nurse. He asked whether including advance practice nurses in this policy definition could somehow limit that authority. Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) explained that the NAIC consumer representatives suggest adding advance practice nurses to the policy definition of “nurse” to ensure that depending on how insurers use this policy definition, given the broad scope of their practice, they are somehow excluded from being considered a “nurse” for the purposes of the policy

definition. Ms. Arp pointed out that Section 4A(14) of Model #170 requires Model #171 to include a policy definition of “physician,” which is in Section 5K. She asked if anyone believes that a reference to “advance practice nurses” should be added to the policy definition of “physician” in Section 5K instead of the policy definition of “nurse.” Mr. Wieske said he believes this could be a state-by-state scope of practice issue. Given this, he suggested that the Subgroup might want to consider adding a drafting note to Section 5H alerting states to this possible scope of practice issue. After additional discussion, the Subgroup agreed to accept the NAIC consumer representatives’ suggested revision and add the drafting note.

The Subgroup next discussed the policy definition of “one period of confinement” in Section 5I. Ms. Matthews explained the Subgroup’s previous discussions related to this term. She said those discussions included deleting the term and moving it to a substantive provision in Model #171 because the term is not used in Model #171. However, she noted that because this is a policy definition and not a regulatory definition, the Subgroup most likely would change its mind about removing the term from Section 5. She also said during the Subgroup’s previous discussions, the Subgroup sought clarification on what this term means and how it is used in a policy. Mr. Wieske said he believes the term is used in a number of ways depending on the type of policy. Bonnie Burns (California Health Advocates—CHA) explained that she has seen this term used in policies to define the distance between one period of confinement and another period of confinement to determine whether it is a benefit period for which benefits have been paid or a new benefit period. She asked for clarification about this policy definition and whether it is tied to an in-hospital stay. The Subgroup discussed the nuances of how this policy definition is used and applied in different types of policies. After additional discussion, the Subgroup decided to leave the policy definition of “one period of confinement” unchanged. Ms. Howard stated from a consumer perspective that the Subgroup should consider adding language related to this policy definition in the substantive provisions of Model #171, given the potential varying uses and applications of the definition depending on the type of policy. The Subgroup discussed Ms. Howard’s suggestion and decided that it is not necessary to have varying definitions for the term because the terms defined in Section 5 are a minimum standard and meant to be a common policy definition across all policies if that term is used in the policy, and it may not be changed in a manner that restricts coverage.

The Subgroup decided to begin its discussion of the policy definition of “partial disability” in Section 5J during its next meeting Aug. 23.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

[Aug 9 Minutes](#)

Draft: 8/19/21

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
July 26, 2021

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 26, 2021. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Sherri Mortensen-Brown (MN); Amy Hoyt and Carrie Couch (MO); Rachel Bowden (TX); Tanji J. Northrup (UT); Anna Van Fleet, Emily Brown, Christine Menard-O'Neil, and Jamie Gile (VT); Ned Gaines (WA); and Nathan Houdek and Jennifer Stegall (WI).

1. Discussed Revisions to Model #171

The Subgroup continued its discussion of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) beginning with Section 5B. The Subgroup discussed the NAIC consumer representatives' suggested revisions to Section 5B, which would add additional facility types, such as "assisted living facility" and "continued care retirement community." Sarah Lueck (Center on Budget and Policy Priorities—CBPP) said the NAIC consumer representatives suggested this revision as an update to the existing language. The Subgroup discussed the suggested revision and whether it had preliminarily accepted the suggested revision during its prior discussions of this provision. Jolie H. Matthews (NAIC) said during its Sept. 16, 2019, meeting, the Subgroup decided to accept the NAIC consumer representatives' and the Missouri Department of Insurance's (DOI's) suggested revisions to Section 5B. Based on this information, the Subgroup decided to again accept the suggested revisions.

The Subgroup next discussed Section 5C and the Washington DOI's suggestion to delete it. Ms. Matthews said during its Oct. 7, 2019, meeting, the Subgroup accepted the suggestion to delete Section 5C. She said at the time, the Subgroup reasoned that a definition of "disability" was unnecessary because other terms in the model would better determine what a "disability" is, such as "partial disability," "total disability," and "residual disability." However, she said the Subgroup agreed to revisit this decision, if necessary. The Subgroup discussed whether to accept its previous decision to delete Section 5C. During this discussion, Subgroup members said an additional reason for deleting Section 5C is to avoid any possible confusion with how some states use the term "disability" to refer to "accident and sickness insurance." After additional discussion, the Subgroup decided to again delete Section 5C.

The Subgroup next discussed Section 5D. Ms. Matthews said during its Oct. 7, 2019, meeting the Subgroup decided to accept the Missouri DOI's suggested revisions to Section 5D(2). The Subgroup also decided to revise the language in Section 5D(2)(c) to reflect current terminology by deleting "drug addicts or alcoholics" and replacing it with "individuals with a substance use disorder." The Subgroup decided not to accept the NAIC consumer representatives' suggested revisions. Ms. Matthews said the Subgroup deferred deciding on whether to add America's Health Insurance Plans' (AHIP's) suggested language "facilities existing primarily to provide psychiatric services" to Section 5D(2). AHIP suggests this language because these types of facilities are not hospitals.

Chris Petersen (Arbor Strategies LLC) said the Subgroup's discussion about removing obsolete language and replacing it with current terminology raises a larger issue the Subgroup needs to consider and address in some manner. He explained that most of the types of policies subject to Model #171 are guaranteed renewable and noncancelable. Because of this, the Subgroup needs to consider how to address the application of any revisions to Model #171 on these types of policies. Mr. Petersen suggested that the Subgroup consider adding language to Section 3—Applicability and Scope to apply any revisions to Model #171 to policies issued after the effective date of a state's adoption of the revised model. The Subgroup discussed Mr. Petersen's suggestion. The Subgroup also discussed generally how policies covered under Model #171 operate, considering their guaranteed renewability and noncancelable requirements, which the *Uniform Individual Accident and Sickness Policy Provision Law* (#180) addresses. After additional discussion, the Subgroup agreed to add language to Section 4—Effective Date to address the issue. Cindy Goff (American Council of Life Insurers—ACLI) volunteered to work with other stakeholders to provide language for the Subgroup's consideration later.

The Subgroup returned to its discussion of the suggested revisions to Section 5D. Ms. Arp expressed concern with AHIP's suggested revision because of the lack of clarity as to what is means by "psychiatric services," which could include, for example, services related to Alzheimer's disease. Mr. Petersen asked about the Subgroup's previous discussions related to this suggested

revision. He suggested that if the Subgroup has already discussed this and decided to accept it or reject it, then in accordance with the Subgroup's previous agreement to not revisit settled decisions, the Subgroup should not rediscuss this suggested revision. Ms. Matthews said during its previous discussions of this suggested revision, the Subgroup deferred deciding. Mr. Petersen said given the Subgroup's previous decision to defer deciding, AHIP will submit new language to address the Subgroup's concerns for its consideration later.

The Subgroup next discussed Section 5E, the policy definition for "injury." Ms. Matthews said during the Subgroup's Oct. 28, 2019, meeting, the Subgroup agreed to delete "bodily injury" in Section 5E(1) because it was contradictory to other language in Section 5E and delete Section 5E(2). The Subgroup decided not to make any changes from its previous discussions on this provision.

Ms. Lueck asked for clarification on what Mr. Petersen meant by the four principles the Subgroup decided to accept with respect to its discussion of revisions to Model #171 and the revised *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), which is the companion model law to Model #171. Mr. Petersen explained that he believed the Subgroup had agreed to not revisit decisions made with respect to Model #170 in its discussions of revisions to Model #171. Ms. Lueck said she was unaware of any specific Subgroup discussions on this issue, and many of the issues the Subgroup discussed while revising Model #170 were deferred and to be addressed when the Subgroup revised Model #171. Mr. Petersen said in his opinion, if that was the case, it would not be considered revisiting the issue. Ms. Lueck suggested that the Subgroup rediscuss the so-called four principles so that everyone knows what they are, particularly if the Subgroup plans to follow them as it moves forward with its discussions of revisions to Model #171.

Mr. Petersen said he would recirculate his letter outlining the four principles. Ms. Arp said she recalls the Subgroup agreeing to the so-called four principles. J.P. Wieske (Health Benefits Institute—HBI) agreed with Ms. Arp. He said he believes nothing in the four principles is out of the ordinary. The agreed upon general guidelines suggest that the Subgroup should: 1) not reopen issues discussed and settled upon during its work revising Model #170; 2) acknowledge that Model #171 sets minimum standards; 3) not include topics not included in Model #170; and 4) acknowledge that the current supplemental market works and revise Model #171 in a manner to avoid market disruption. Ms. Arp said to date, the Subgroup's discussions of the proposed revisions relate to what the Subgroup agreed to during its previous discussions in late 2019, as reflected in the NAIC staff working draft. Mr. Schallhorn agreed.

Ms. Arp said despite this agreement to not revisit previous decisions, if there are things that someone strongly feels are wrong or if it is a procedural issue, they should let the Subgroup know so it can decide whether it wants to rediscuss the issue or not. Ms. Lueck said she did not have any real issues with the Subgroup's stance to not revisit issues, but given that this was discussed in late 2019, she believes the Subgroup should rediscuss the four principles so everyone knows what they are. Lucy Culp (Leukemia & Lymphoma Society) and Yosha Dotson (Georgians for a Healthy Future) agreed with Ms. Lueck's comments.

The Subgroup next discussed Mr. Wake's comments on Section 5F, the definition of "Medicare." Mr. Wake said his comments on this provision relate to the Subgroup's previous discussions and decision to create a new section in Model #171 for definitions of regulatory terms. The definition of "Medicare" looks like a regulatory definition, and if the Subgroup agrees, it should be included in this new section and removed from Section 5—Policy Definitions. The Subgroup agreed.

The Subgroup discussed Section 5G, the definition of "mental or nervous disorder." The Subgroup discussed its previous discussions of this provision, which decided to revise the definition to state, "mental health condition or substance use disorder means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)." Mr. Petersen suggested that the proposed revision definition for this term reads more like a "regulatory" definition, not a "policy" definition, because the suggested language does not use the words "shall not be defined more restrictively than." The Subgroup discussed his comments, including whether the revised language should refer to the most recent version of the DSM "at the time the policy is issued" to avoid making changes in the policy if the DSM is subsequently updated after policy issuance. The Subgroup also discussed this language to set a floor to allow insurers to be more expansive. Mr. Wieske said he did not believe it would be an issue if the language is not added, because he did not believe a revised DSM would require insurers to have to refile a policy because the coverage would not be changed. After additional discussion, the Subgroup agreed not to include the additional language.

Ms. Lueck asked if this definition, for the types of policies Model #171 applies to, is generally used to restrict coverage. Mr. Wieske said for disability income protection coverage, this definition would most likely be considered more expansive from a coverage viewpoint. He also pointed out that the NAIC consumer representatives' suggested revision to this definition is also

rather broad; however, he said the suggested revision to reference the DSM was probably a cleaner way to define this term because it does not require an interpretation of what terms such as neurosis, psychoneurosis, or mental or emotional disease mean. Mr. Wake said this discussion suggests that the Subgroup might want to consider adding language to Section 5A stating, “[e]xcept as provided in this regulation, to the extent these definitions are used in a policy or certificate, definitions used in a policy or certificate may vary from the definitions in this section, but not in a manner that restricts coverage.” The Subgroup discussed the merits of including such language. The Subgroup decided to continue the discussion during its next meeting on Aug. 9.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

[July 26 Minutes](#)

Draft: 11/22/21

Employee Retirement Income Security Act (ERISA) (B) Working Group
Virtual Meeting
October 8, 2021

The Employee Retirement Income Security Act (ERISA) (B) Working Group of the Regulatory Framework (B) Task Force met Oct. 8, 2021. The following Working Group members participated: Robert Wake, Chair (ME); William Rodgers (AL); Johanna Nagel (IA); Craig Van Aalst (KS); Victoria Bares (MN); Amy Hoyt (MO); Ted Hamby (NC); Laura Arp (NE); Stephanie Canter (NV); Laura Miller (OH); Landon Hubbart (OK); Jill Kruger (SD); Rachel Bowden (TX); Tyler Robbins (WA); and Richard Wicka (WI).

1. Discussed *Rutledge v. Pharmaceutical Care Management Association*

Mr. Wake said the purpose of the Working Group's meeting is to discuss revising the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) to include a summary of the Supreme Court's 2020 decision in the case of *Rutledge v. Pharmaceutical Care Management Association*, 141 S.Ct. 474 (2020). Mr. Wake said a preliminary draft of a summary to add to the ERISA Handbook was distributed prior to the meeting.

Mr. Wake said that the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup has a charge to develop a white paper on issues related to the state regulation of certain pharmacy benefit manager (PBM) business practices. He said the Working Group plans to focus on the case summary at this time and will wait for additional guidance from the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup before undertaking any additional analysis of the ERISA implications on other state PBM laws.

A number of state insurance regulators and interested parties expressed concern with the tone of the draft, stating that it did not match the tone in the rest of the ERISA Handbook and that the summary should focus more on the preemption analysis rather than opining on the particulars of PBMs.

Mr. Wake explained that the draft was intended to generate discussion, and he agreed that there needs to be substantial revisions to the substance and tone of the draft. He explained that the draft was developed for a continuing legal education class, so it needs to be modified to parallel the other case summaries in the ERISA Handbook. Ms. Arp said she found another *Rutledge* case summary by the NAIC that she thinks can be a starting point for the ERISA Handbook update. Ms. Arp, Mr. Wake, and Jennifer Cook (NAIC) agreed to work on a draft summary to expose for public comment.

Having no further business, the Employee Retirement Income Security Act (B) Working Group adjourned.

[10-8-21 EWGmin final.docx](#)

Draft: 7/30/21

Employee Retirement Income Security Act (ERISA) (B) Working Group
Virtual Meeting (*in lieu of meeting at the 2021 Summer National Meeting*)
July 30, 2021

The Employee Retirement Income Security Act (ERISA) (B) Working Group met July 30, 2021. The following Working Group members participated: Robert Wake, Chair (ME); Jennifer Li and Anthony L. Williams (AL); Jason Lapham (CO); Angela Burke Boston and Johanna Nagel (IA); Julie Holmes (KS); Victoria Bares (MN); Cynthia Amann and Amy Hoyt (MO); Ted Hamby (NC); Laura Arp and Martin Swanson (NE); Laura Miller (OH); Andrew Schallhorn (OK); David Bolduc (TX); Jaakob Sundberg (UT); Mandy Weeks-Green (WA); and Richard Wicka (WI).

1. Discussed *Rutledge v. Pharmaceutical Care Management Association*

Mr. Wake said the purpose of the Working Group's meeting is to discuss addressing the Supreme Court's 2020 decision in the case of *Rutledge v. Pharmaceutical Care Management Association*, 141 S.Ct. 474 (2020). He suggested, and the Working Group agreed, to include this case in the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) in the section summarizing seminal ERISA preemption cases. Mr. Wake said a preliminary draft of a summary to add to the ERISA Handbook has been developed. He asked state insurance regulators to email Jennifer Cook (NAIC) if they are interested in participating in a drafting group to develop a draft to circulate for public comment.

Mr. Wake said, in addition, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force has a charge to develop a white paper on issues related to the state regulation of certain pharmacy benefit manager (PBM) business practices. He said the Working Group has been identified to assist with addressing the ERISA preemption aspects of the *Rutledge* decision in the white paper. Ms. Arp said she would like the Working Group to explore the ERISA preemption implications of the *Rutledge* decision on other state laws, like laws that affect pricing. She said that there are state laws that are written to say they apply "except to the extent they are preempted." She said this raises questions about the application of such a law in light of the holding in *Rutledge* that the Arkansas pharmaceutical pricing law was not preempted. She suggested that the Working Group develop a list of factors that states need to consider in analyzing their state laws to determine whether the *Rutledge* decision has an impact and what that impact might be. She said it would be helpful to include the U.S. Department of Labor (DOL) in any discussions and get their feedback. Mr. Wake asked and Ms. Arp agreed to chair a drafting group to look at developing a "preemption road map" for states on this issue. Mr. Wake asked state insurance regulators interested in participating on this drafting group to email Ms. Cook.

Ali Khawar, who is the Acting Assistant Secretary for the Employee Benefits Security Administration (EBSA) at the U.S. Department of Labor (DOL), introduced himself to the Working Group. He explained that he has previously served in a variety of roles at the DOL, including as an EBSA investigator, in EBSA's Office of Enforcement, as EBSA's Chief of Staff in two administrations, and as a Counselor to the 26th Secretary of Labor, Thomas E. Perez. Mr. Khawar said he is looking forward to continuing the important collaborative relationship the DOL has established with the NAIC over the years. He said whether collaborating over regulations or enforcement matters, the ability to share best practices and tips on what states are seeing has been very valuable to the DOL. Mr. Wake agreed that the relationship the Working Group and the NAIC has enjoyed with the DOL over the years has been mutually beneficial, and he said that they look forward to continuing the relationship.

Having no further business, the Employee Retirement Income Security Act (ERISA) (B) Working Group adjourned and reconvened in regulator-to-regulator session pursuant to paragraph 1 (potential or pending litigation or administrative proceedings), paragraph 2 (pending investigations), paragraph 3 (specific companies, entities or individuals), and paragraph 9 (any other subject required to be kept confidential) of the NAIC Policy Statement on Open Meetings.

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Draft: 8/16/21

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Virtual Meeting
August 5, 2021

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met Aug. 5, 2021. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); Donna Lambert (AR); Mary Boatright, Leannette Henagan, Erin Klug, and Catherine O'Neil (AZ); Christopher Citko and Doris Walker (CA); Cara Cheevers, Damion Hughes, and Debra Judy (CO); Kurt Swan (CT); Howard Liebers and Mary Beth Senkewicz (DC); Melissa Carter and Sarah Crittenden (GA); Cynthia Banks Radke, Andria Seip, and Sonya Sellmeyer (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Chris Hollenbeck, Julie Holmes, Brenda Johnson, Kenneth Scott, Barbara Torkelson, and Craig Van Aalst (KS); Mary Kwei, Theresa Morfe, and Natalie Nelson (MD); Sherri Mortensen-Brown (MN); Cheryl Allen-Bivens, Tracy Biehn, and Teresa Knowles (NC); Maureen Belanger and Michelle Heaton (NH); Ralph Boeckman, Chanell McDevitt, Erin Porter, and Gale Simon (NJ); Diane Bilodeau, Paige Duhamel and Viara Ianakieva (NM); Todd Oberholtzer, Laura Miller, Molly Mottram, and Guy Self (OH); Cuc Nguyen (OK); Shari Miles (SC); Lisa Harmon, Candy Holbrook, and Jill Kruger (SD); Rachel Bowden, Valerie Brown, Debra Diaz-Lara, Katelyn Marak, Kenisha Schuster, and Matt Wall (TX); Carrie Backus, Heidi Clausen, Tanji J. Northrup, Jaakob Sundberg, and Shelley Wiseman (UT); Julie Blauvelt and James Young (VA); Diane Dambach and Darcy Paskey (WI); Joylynn Fix (WV); and Denise Burke and Mavis Earnshaw (WY).

1. Heard Presentations from Health Care Providers on Mental Health Parity

Ms. Dzurec said that the Special (EX) Committee on Race and Insurance has charged the MHPAEA (B) Working Group with researching disparities in mental health and substance use disorder parity and access to culturally competent care. She said state insurance regulators must incorporate equity and inclusion in their everyday work, appreciating the histories of discrimination, exclusion, incarceration, and the use of mental health as a weapon. She said past practices have skewed understanding and data sets and that history can make many people blind to inequities. She said the speakers could help state insurance regulators ask the right questions.

Dr. Edwin Chapman (addiction specialist internist) provided a profile of his patient population, showing they have disproportionate mental health, substance use, HIV, and hepatitis diagnoses. He said African-Americans represent only 5% of physicians and 2% of psychiatrists. He said different states and insurance companies allow different doses for medication-assisted treatment, so there is no consistent standard of care. He shared the limited availability of buprenorphine to Black and urban populations. He said there is confusion in standards for prescribing as they are interpreted by insurance companies, pointing out differences in standards from those allowed by the Substance Abuse and Mental Health Services Administration (SAMHSA). He said the No. 1 barrier to care is prior authorizations, followed by access to treatment, lack of integration, payment limits, same-day billing restrictions, and disconnects between the health care system and criminal justice system. Dr. Chapman said the complexity of his patients require integrated care delivery or coordinated care. He shared a hybrid model he developed to integrate primary care, mental health services, and community care for social determinants of health. He outlined how his system integrates care with the goals of reduced medical costs and non-medical costs. He compared the system costs of untreated patients, in-treatment patients who are not abstinent, and stable patients in treatment, with untreated patients costing the most. He said the American Society of Addiction Medicine (ASAM) recommends patient-centered treatment rather than standard fee-for-service evaluation and management billing. He said insurance company algorithms can be biased. He said among his patients alone, he has achieved \$8 million in savings from the criminal justice system.

Ms. Beyer asked whether the ASAM treatment model has been adopted by payers. Dr. Chapman said adoption has been a problem in Washington, DC, and he encouraged state insurance regulators to contact the American Medical Association (AMA) to find out more about where it has been adopted. Ms. Duhamel asked whether Dr. Chapman has worked with commercial payers to remove restrictions on buprenorphine restrictions. Dr. Chapman said he has presented to the federal Centers for Medicare & Medicaid Services (CMS) with that goal.

Dr. Walter Wilson (HealthPoint Family Care) presented on challenges and recommendations in mental health equity. He defined behavioral health equity and identified barriers to equity. The barriers include ethnic/racial/demographic disparities, geographic disparities, psychosocial barriers, and insurance-related barriers. He said there is stigma associated with mental health care generally, but some research suggests it is a larger problem in minority communities. He said language barriers can be significant and that electronic medical records systems can lack the ability to print visit summaries in Spanish. He shared SAMHSA data showing that, among those with mental illness, patients from minority populations access treatment at lower

rates than white people. He identified fragmented access as a barrier when patients can access one type of provider, but not others in their health system. He described the steps patients must navigate to access mental health services, from awareness of mental health itself to awareness of the resources available, resources for payment, service location, and quality. He recommended that state insurance regulators support insurers' educational initiatives, require up-to-date provider directories, promote easy-to-use website information that meets populations' health literacy, and use feedback from patients. He identified several reasons why providers may not join insurer networks and several recommendations for insurers to improve the provider experience.

Cheryl Fish-Parchman (Families USA) asked about inappropriate discharges from hospitals. Dr. Wilson said that in his experience, clinicians consider how many hospital days insurers will cover and that he has seen hospitals discharge patients who were not ready.

Having no further business, the MHPAEA (B) Working Group adjourned.

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