

## **REGULATORY FRAMEWORK (B) TASK FORCE**

Regulatory Framework (B) Task Force March 25, 2021, Minutes

Regulatory Framework (B) Task Force March 18, 2021, Minutes (Attachment One)

Pharmacy Benefit Manager Model Draft Dated March 12, 2021 (Attachment One-A)

Regulatory Framework (B) Task Force March 1, 2021, Minutes (Attachment Two)

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group Jan. 28, 2021, Minutes (Attachment Three)

Regulatory Framework (B) Task Force  
Virtual Meeting *(in lieu of meeting at the 2021 Spring National Meeting)*  
March 25, 2021

The Regulatory Framework (B) Task Force met March 25, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Ramge, Vice Chair (NE); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Jennifer Li and Yada Horace (AL); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Evan G. Daniels represented by Sterling Gavette (AZ); Ricardo Lara represented by Bruce Hinze (CA); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented Howard Liebers (DC); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Dana Popish Severinghaus represented by Shannon Whalen and Eric Anderson (IL); Stephen W. Robertson represented by Claire Szpara (IN); Vicki Schmidt represented by Tate Flott, Julie Holmes, Chris Hollenbeck and Shannon Lloyd (KS); Sharon P. Clark (KY); Gary D. Anderson represented by Rebecca Butler (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by Sarah Wohlford and Karen Dennis (MI); Grace Arnold represented by Peter Brickwedde (MN); Chlora Lindley-Myers represented by Amy Hoyt and Camille Anderson-Weddle (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread (ND); Chris Nicolopoulos represented by Michelle Heaton (NH); Marlene Caride represented by Chanell McDevitt (NJ); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Larry D. Deiter (SD); Doug Slape represented by Rachel Bowden, Richard Lunsford and Doug Danzeiser (TX); Jonathan T. Pike represented by Tanji J. Northrup and Jaakob Sundberg (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); and James A. Dodrill (WV).

1. Adopted its March 18, 2021; March 1, 2021; and 2020 Fall National Meeting Minutes

The Task Force met March 18, 2021; March 1, 2021; and Nov. 19, 2020. During these meetings, the Task Force discussed comments received on the draft the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model Act) and adopted the PBM Model Act.

Ms. Nollette made a motion, seconded by Commissioner Deiter, to adopt the Task Force's March 18, 2021 (Attachment One), March 1, 2021 (Attachment Two); and Nov. 19, 2020 (*see NAIC Proceedings – Fall 2020, Regulatory Framework (B) Task Force*) minutes. The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

Ms. Nollette made a motion, seconded by Commissioner Deiter, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup; the Employee Retirement Income Security Act (ERISA) (B) Working Group; the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Jan. 28 minutes (Attachment Three); and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. The motion passed unanimously.

3. Heard an Update on the CHIR's Work Related to the ACA

Justin Giovannelli (Center on Health Insurance Reforms—CHIR, Georgetown University Health Policy Institute) provided an update on the CHIR's work related to the federal Affordable Care Act (ACA) and recently enacted federal laws such as the federal No Surprises Act (NSA) and the federal American Rescue Plan Act (ARPA) and other issues of interest to state insurance regulators. He discussed the CHIR's efforts to assess the impact of the extended special enrollment periods (SEPs) into the federal health insurance exchanges, as provided in the ARPA, on access and affordability of coverage and how it will be implemented. The CHIR is particularly interested in assessing the impact of these provisions on the individual market given that some are temporary. He also discussed the CHIR's work related to the federal and state implementation of the NSA.

Mr. Giovannelli said the CHIR is also looking at the issue of the "family glitch" and potential solutions. The "family glitch" is the ACA rule that bases eligibility for a family's premium subsidies on whether available employer-sponsored insurance is affordable for the employee only, even if it is not actually affordable for the whole family. The CHIR is continuing its work to track state regulatory reforms affecting the individual market, such as the ACA's Section 1332 waiver program, including whether the states are looking at other options, in addition to reinsurance programs, considering the ARPA and other Biden administration changes, that could positively affect the affordability of comprehensive coverage. The CHIR anticipates publishing an issue brief on this topic soon.

Mr. Giovannelli also discussed some of the CHIR's upcoming work on network adequacy and standardized health plans and noncomprehensive coverage arrangements. He said the CHIR is continuing its work of tracking state regulatory approaches to the COVID-19 pandemic. Additionally, Mr. Giovannelli highlighted the CHIR's ongoing state technical assistance regarding insurance regulatory matters with the support of the Robert Wood Johnson Foundation (RWJF) through its State Health and Value Strategies Program and the support of the Laura and John Arnold Foundation (LJAF).

Commissioner Conway asked Mr. Giovannelli if the CHIR, as part of its work it plans to do with respect to noncomprehensive plans and health care sharing ministries, would be examining its appeal to consumers considering the ARPA and its new provisions enhancing the affordability of comprehensive coverage in the individual market. Mr. Giovannelli said the CHIR would be looking at this as part of its study.

#### 4. Heard a Presentation on the NSA

Jack Hoadley (Georgetown University Health Policy Institute) presented on the NSA. He discussed the NSA's scope, including what types of plans it covers and where its protections apply. The NSA does not apply to short-term plans and excepted benefits plans. It also does not apply to ground ambulance services, but it does apply to air ambulance services. Mr. Hoadley also described how the NSA protects patients from balance bills by requiring that patients be held responsible for in-network cost sharing only and barring providers from sending or collecting a bill for amounts other than in-network cost sharing.

Mr. Hoadley also discussed a key component of the NSA—determining the payment amount for out-of-network care when there is a payment dispute. He discussed how the payment amount would be determined: 1) for states with a “specified state law” that includes a method for determining the payment, the state method applies for the health plans regulated by the state and for the services to which the state law applies; and 2) for other states or for plans not regulated by the state (self-funded plans), the federal method applies. The state method is likely to apply in the 18 states with comprehensive surprise billing laws and in several states with partial protections for applicable services.

Mr. Hoadley explained that with respect to air ambulance services, consumers are protected from balance billing similar to the NSA's consumer protections for emergency services. The federal independent dispute resolution (IDR) system would apply. The NSA includes no protections for ground ambulance services, but it does include a provision establishing an Advisory Committee on Ground Ambulances and Patient Billing (Advisory Committee) that will make recommendations for the states and the U.S. Congress on addressing balance billing issues for such services.

Mr. Hoadley described the NSA's enforcement mechanisms and the role that the states will have in enforcement. The state departments of insurance (DOIs) are the primary enforcers of provisions that apply to insurers and fully insured group health plans. The federal government is the enforcer in the states that fail to substantially enforce the law and for self-funded group health plans. He discussed how the NSA's provisions will be enforced on health care providers. He explained that the states may enforce provisions on providers, including air ambulances, but the federal government will do so where a state fails to substantially enforce the law. He noted that unless addressed through federal rule-making, the NSA is silent on which state agency is responsible for enforcing provider provisions. Given that state DOIs typically do not have jurisdiction over providers, the states that have current balance billing laws have taken various approaches regarding provider enforcement, such as vesting that authority in the state DOI, health department, medical licensing entity or the state attorney general's office. Other states have taken a blended approach by allowing the state DOI or provider licensing entity to report patterns of unresolved or intentional violations to another entity for enforcement. Mr. Hoadley also discussed how, in some cases, determining the primary enforcer—federal or state—could be challenging, which is why the states need to begin communicating with the federal agencies charged with implementing the NSA to try to address and avoid these situations.

Mr. Hoadley discussed what questions remain with the NSA with respect to states that currently have balance billing laws and those that do not. He also identified specific opportunities and questions for the states to engage with the federal agencies implementing the NSA to obtain clarification on outstanding issues prior to federal rulemaking. Additionally, he discussed next steps regarding the NSA, including the timeline for anticipated federal regulations.

Commissioner Conway asked Mr. Hoadley if he had any thoughts on why the NSA does not address ground ambulance services. Commissioner Conway said Colorado does have provisions concerning ground ambulance services, but it was a struggle for Colorado to find the right balance in crafting its provisions. Mr. Hoadley said Colorado's experience in trying to address the ground ambulance services issues is reflective of possibly why the U.S. Congress could not reach agreement on provisions to include in the NSA on ground ambulance services. He said another issue is that ground ambulance services typically involve local county and city governments, which adds to the complexity of the issue. As such, the U.S. Congress punted the issue to the Advisory Committee.

Commissioner Conway asked about the NSA's enforcement provisions related to health care providers. Mr. Hoadley explained that the NSA makes the states the primary enforcers regarding providers with a federal backstop if a state fails to substantially enforce the NSA's provisions on providers. He said states that currently have balance billing laws have discovered the importance of educating providers on the front end about their laws' provisions rather than waiting for a violation. He said the Health Policy Institute has been talking to the states to learn more about their experiences on this issue and hopes to learn more.

##### 5. Heard a Discussion of the Decision in *Rutledge v. PCMA*

Katie Keith (Out2Enroll) discussed the recent U.S. Supreme Court's decision in *Rutledge v. the Pharmaceutical Care Management Association* (PCMA) and its potential effect on the ability of state insurance regulators to regulate certain pharmacy benefit manager (PBM) business practices. Among the roles PBMs play in the provision of prescription drugs, PBMs act as intermediaries between pharmacies and prescription drug plans. In that role, PBMs reimburse pharmacies for the cost of drugs covered by prescription drug plans. To determine the reimbursement rate for each drug, PBMs develop and administer maximum allowable cost (MAC) lists.

Ms. Keith said that in 2015, Arkansas passed Act 900. The Arkansas law effectively requires PBMs to reimburse Arkansas pharmacies at a price equal to or higher than the pharmacy's wholesale cost. To accomplish this result, Act 900: 1) requires PBMs to timely update their MAC lists when drug wholesale prices increase; 2) provides pharmacies an administrative appeal procedure to challenge MAC reimbursement rates; and 3) allows pharmacies to decline to sell a prescription drug if PBM reimbursement is below acquisition costs. The PCMA sued in the Eastern District of Arkansas, arguing that Act 900 is preempted under ERISA. Following a precedent set in a case, *Pharmaceutical Care Mgmt. Assn. v. Gerhart*, 852 F. 3d 722 (2017), involving a similar Iowa statute, the District Court held that ERISA preempts Act 900, and the U.S. Court of Appeals for the Eight Circuit affirmed that decision. Ms. Keith said the U.S. Supreme Court granted writ of certiorari in the case, held oral arguments Oct. 6, 2020, and issued its decision Dec. 10, 2020. She said that in a unanimous decision written by Associate Justice Sonia Sotomayor and concurrence by Associate Justice Clarence Thomas, the Court held that Act 900 is not preempted by ERISA. Ms. Keith said this decision most likely opens up a whole range of options for those states considering PBM regulation.

Ms. Keith explained the Court's analysis. She also summarized some of the standards from previous Court decisions related to ERISA preemption and how the Court in this case most likely weighed whether Act 900 was more like the *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) case, which the Court found concerned rate regulation that only affects the costs of ERISA plans, or the *Gobeille v. Liberty Mutual Insurance Company*, 136 S. Ct. 936 (2016) case.

Ms. Keith said the Court found Act 900 is more like the *Travelers* case. Act 900 is "merely a form of cost regulation" by requiring PBMs to reimburse pharmacies at a certain level that does not bear an impermissible connection with or reference to ERISA. The Court reasoned that "ERISA does not preempt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage." Act 900:1) does not "refer to" ERISA; 2) does not apply "immediately and exclusively" to ERISA plans; and 3) its application to ERISA plans is not "essential to the law's operation." Ms. Keith said the Court also held that Act 900 does not directly regulate health plans at all and applies to PBMs whether they act pursuant to an ERISA plan or not.

Ms. Keith said the Court rejected the PCMA's argument that Act 900's enforcement mechanisms directly affect central matters of plan administration and interfere with nationally uniform plan administration. The Court said Act 900's enforcement mechanisms do not require plan administrators to structure their benefit plans in a particular way: 1) Act 900 "simply establishes a floor for the cost of benefits that plans choose to provide;" 2) ERISA does not preempt state laws that merely increase costs even if plans decide to limit benefits or charge higher rates as a result; and 3) PCMA's position would preempt any state laws that could affect the price or provision of benefits.

Ms. Keith reiterated that she believes the *Rutledge* decision has big implications for the states with respect to PBM regulation, particularly on cost containment and the direct regulation of health care costs. She noted, however, that states are still not going to be able to regulate ERISA plans, but to the extent states are looking at hospitals and other actors in the health care system, the *Rutledge* case provides opportunities. She also said she anticipates more litigation related to these issues. Commissioner Conway said he anticipates more discussion of the *Rutledge* case as part of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's future work to develop a white paper on state options with respect to regulating PBM business practices and the ERISA (B) Working Group's discussion of the case's potential impact with respect to ERISA preemption.

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

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Draft: 3/22/21

Regulatory Framework (B) Task Force  
Virtual Meeting  
March 18, 2021

The Regulatory Framework (B) Task Force met March 18, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Ramage, Vice Chair, represented by Laura Arp and Martin Swanson (NE); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Anthony L. Williams, Jimmy Gunn and Yada Horace (AL); Evan G. Daniels represented by Jon Savary and Erin Klug (AZ); Ricardo Lara represented by Bruce Hinze and Sheirin Ghoddoucy (CA); Andrew M. Mais represented by Jared Kosky (CT); Karima M. Woods (DC); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip, Sonya Sellmeyer and Cynthia Banks Radke (IA); Dean L. Cameron (ID); Dana Popish Severinghaus represented by Shannon Whalen (IL); Stephen W. Robertson represented by Claire Szpara (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary D. Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by Chad Arnold, Sarah Wohlford and Renee Campbell (MI); Grace Arnold represented by Galen Benshoof and Candance Gergen (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Chris Nicolopoulos represented by Michelle Heaton and Jason Dexter (NH); Marlene Caride represented by Philip Gennace (NJ); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn and Mike Rhoads (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Larry D. Deiter (SD); Doug Slape represented by Rachel Bowden (TX); Jonathan T. Pike represented by Tanji J. Northrup and Jaakob Sundberg (UT); Scott A. White represented by Don Beatty, Stephen Hogge, Bob Grissom and James Young (VA); Mike Kreidler represented by Molly Nollette (WA); Mark A. Fable represented by Nathan Houdek, Richard Wicka and Jennifer Stegall (WI); and James A. Dodrill represented by Ellen Potter (WV).

1. Adopted the PBM Model Act

Commissioner Conway said that during the Task Force's March 1 meeting, the Task Force heard from various stakeholders who had submitted comments on the draft [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model). He explained that following that meeting, NAIC staff had revised the draft PBM model to add additional relevant state statutory citations suggested in some of the comment letters. He asked the Task Force members if anyone had any suggestions for additional revisions.

Commissioner Schmidt asked if Commissioner Conway had considered adding a reference to the *Rutledge v. Pharmaceutical Care Management Association* (PCMA) case in the Section 8—Regulations drafting note. Commissioner Conway said he asked NAIC staff if such references are typically included in NAIC models. He said NAIC staff said such language is not typically included. He also said that he anticipates more litigation involving state pharmacy benefit manager (PBM) regulation and because U.S. Supreme Court (Court) decisions tend to evolve over time, including a reference to this case could possibly be misleading in the future because stakeholders could be led to believe that the *Rutledge* case is the only relevant case when the Court could issue future decisions on the subject. Commissioner Conway also reiterated his support for further discussion of the *Rutledge* decision, but he suggested that the better setting for such a discussion would be in the proposed white paper, which the Task Force discussed charging the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup with developing during its March 1 meeting.

Commissioner Stolfi made a motion, seconded by Mr. Hinze, to adopt the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (Attachment One-A). The motion passed, with Connecticut and North Dakota voting against the motion.

Commissioner Conway asked NAIC staff about the Task Force's next steps to charge the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup with developing the white paper as has been discussed. Jolie H. Matthews (NAIC) said the Task Force will need to develop and adopt a new 2021 Subgroup charge prior to the Subgroup beginning its work. She said the Health Insurance and Managed Care (B) Committee also would have to adopt the charge.

Mr. Kosky explained that Connecticut voted against the motion because of concerns with the Section 8 drafting note's menu of options. He said Connecticut was concerned that the language in the drafting note could lead to inconsistency and the lack of uniformity in state adoption of the NAIC model. He said this potential lack of uniformity and standardization of language would appear to go against the NAIC's goal when adopting NAIC models. He also expressed concern about setting a precedent. Mr. Kosky expressed support for developing a white paper and the white paper as the more appropriate vehicle to describe state options concerning PBM regulation rather than an NAIC model. Commissioner Conway said he believes some states will

add provisions beyond the PBM model's core licensing provisions, but he believes the PBM model is a good work product with substantive core provisions that will be helpful to the states. He acknowledged that there is probably more work to be done on the menu of options in the Section 8 drafting note and that there will probably be discussion on whether the menu of options should remain in the NAIC model or be made part of the white paper.

Commissioner Schmidt noted that many state legislatures are moving forward with legislation to license or register PBMs with or without a NAIC model. She said there most likely will be no uniformity among the states as things are currently advancing in the states. She also noted how rapidly things are changing with respect to the state regulation of PBMs. She also agreed with Commissioner Conway that the *Rutledge* decision most likely will not be the last U.S. Supreme Court decision affecting the state regulation of PBMs, but she said she believes the PBM model is the best effort at this time.

Commissioner Altman said Pennsylvania voted in favor of the motion to move the discussion forward on the PBM model to the Health Insurance and Managed Care (B) Committee, but she also has concerns similar to Connecticut's concerns about the Section 8 drafting note and its menu of options. She said she does not know how Pennsylvania will vote on the PBM model moving forward, but Pennsylvania strongly supports developing the white paper. Commissioner Conway acknowledged her comments. He said he agrees that the Section 8 drafting note will be a point of discussion as the PBM model moves forward, particularly because the Task Force has agreed to move forward with the white paper.

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

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*Adopted by the Health Insurance and Managed Care (B) Committee - TBD*  
*Adopted by the Regulatory Framework (B) Task Force – March 18, 2021*  
*Adopted by the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup – Oct. 29, 2020*

Draft: 3/12/21  
A new model

## [STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

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### Section 1. Short Title

This Act shall be known and may be cited as the [State] Pharmacy Benefit Manager Licensure and Regulation Act.

### Section 2. Purpose

- A. This Act establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.
- B. The purpose of this Act is to:
  - (1) Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;
  - (2) Promote the solvency of the commercial health insurance industry, the regulation of which is reserved to the states by the McCarran-Ferguson Act (15 U.S.C. §§ 1011 – 1015), as well as provide for consumer savings, and fairness in prescription drug benefits;
  - (3) Provide for powers and duties of the commissioner; and
  - (4) Prescribe penalties and fines for violations of this Act.

### Section 3. Definitions

For purposes of this Act:

- A. “Claims processing services” means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:
  - (1) Receiving payments for pharmacist services;
  - (2) Making payments to pharmacists or pharmacies for pharmacist services; or
  - (3) Both paragraphs (1) and (2).

- B. “Commissioner” means the insurance commissioner of this state.

**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.

- C. “Covered person” means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.
- D. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.
- E. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

**Drafting Note:** States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

- F. “Other prescription drug or device services” means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:
- (1) Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;
  - (2) Disbursing or distributing rebates;
  - (3) Managing or participating in incentive programs or arrangements for pharmacist services;
  - (4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;
  - (5) Developing and maintaining formularies;
  - (6) Designing prescription benefit programs; or
  - (7) Advertising or promoting services.
- G. “Pharmacist” means an individual licensed as a pharmacist by the [state] Board of Pharmacy.
- H. “Pharmacist services” means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.
- I. “Pharmacy” means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.
- J. (1) “Pharmacy benefit manager” means a person, business or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to covered persons who are residents of this state, for health benefit plans.
- (2) “Pharmacy benefit manager” does not include:

- (a) A health care facility licensed in this state;
- (b) A health care professional licensed in this state;
- (c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager; or
- (d) A health carrier to the extent that it performs any claims processing and other prescription drug or device services exclusively for its enrollees.

**Section 4. Applicability**

- A. This Act shall apply to a contract or health benefit plan issued, renewed, recredentialed, amended or extended on or after the effective date of this Act, including any health carrier that performs claims processing or other prescription drug or device services through a third party.

**Drafting Note:** States may want to consider adding language to Subsection A above or Section 10—Effective Date providing additional time for pharmacy benefit managers to come into compliance with the requirements of this Act.

- B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the requirements of this Act.
- C. Nothing in this Act is intended or shall be construed to conflict with existing relevant federal law.

**Section 5. Licensing Requirement**

- A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without first obtaining a license from the commissioner under this Act.
- B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers under this Act.

**Drafting Note:** States that are restricted in their rulemaking to only what is prescribed in statute may want to consider including in this section specific financial standards required for a person or organization to obtain a license to operate as a pharmacy benefit manager in this state.

- C. A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the commissioner.

**Drafting Note:** States may want to consider reviewing their third party administrator statute if a state wishes to specify what documents must be provided to the commissioner to obtain a pharmacy benefit manager license in the state.

- D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee of \$[X].
- E. The commissioner may refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.
- F. (1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations,

including the payment of an annual license renewal fee of \$[X] and completion of a renewal application on a form prescribed by the commissioner.

- (2) Such renewal fee and application shall be received by the commissioner on or before [x] days prior to the anniversary of the effective date of the pharmacy benefit manager's initial or most recent license.

**Section 6. Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices**

- A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:
  - (1) The nature of treatment, risks or alternative thereto;
  - (2) The availability of alternate therapies, consultations, or tests;
  - (3) The decision of utilization reviewers or similar persons to authorize or deny services;
  - (4) The process that is used to authorize or deny healthcare services or benefits; or
  - (5) Information on financial incentives and structures used by the insurer.
- B. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.
- C. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:
  - (1) The recipient of the information represents it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and
  - (2) Prior to disclosure of information designated as confidential the pharmacist or pharmacy:
    - (a) Marks as confidential any document in which the information appears; or
    - (b) Requests confidential treatment for any oral communication of the information.
- D. A pharmacy benefit manager may not terminate the contract of or penalize a pharmacist or pharmacy due to pharmacist or pharmacy:
  - (1) Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by state law or the commissioner; or
  - (2) Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance with this Act.
- E. (1) A pharmacy benefit manager may not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person's cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price.

- (2) Any amount paid by a covered person under paragraph (1) of this subsection shall be attributable toward any deductible or, to the extent consistent with section 2707 of the Public Health Service Act, the annual out-of-pocket maximums under the covered person's health benefit plan.

**Section 7. Enforcement**

- A. The commissioner shall enforce compliance with the requirements of this Act.
- B. (1) The commissioner may examine or audit the books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine compliance with this Act.

**Drafting Note:** States may want to consider including a reference to the cost of examinations in the *Model Law on Examinations* (#390).

**Drafting Note:** States may want to consider incorporating their existing market conduct examination statutes into this Act rather than relying on the examination authority provided under this section.

- (2) The information or data acquired during an examination under paragraph (1) is:
  - (a) Considered proprietary and confidential;
  - (b) Not subject to the [Freedom of Information Act] of this state;
  - (c) Not subject to subpoena; and
  - (d) Not subject to discovery or admissible in evidence in any private civil action.
- C. The commissioner may use any document or information provided pursuant to Section 6C of this Act or Section 6D of this Act in the performance of the commissioner's duties to determine compliance with this Act.
- D. The commissioner may impose a penalty on a pharmacy benefit manager or the health carrier with which it is contracted, or both, for a violation of this Act. The penalty may not exceed [insert appropriate state penalty] per entity for each violation of this Act.

**Drafting Note:** If an appeals process is not otherwise provided, a state should consider adding such a provision to this section.

**Section 8. Regulations**

The commissioner may adopt regulations regulating pharmacy benefit managers that are not inconsistent with this Act.

**Drafting Note:** This Act is primarily intended to establish licensing standards for pharmacy benefit managers (PBMs). A number of states have enacted statutes or made suggestions that extend into the regulation of PBM business practices. The provisions below, which are followed by citations to state law where applicable, provide topic areas that states pursuing this Act may wish to consider in their proposed legislation:

- (1) PBM network adequacy (Ark. Code 23-92-505 and Okla. Stat. 36-6961) (Also, see provisions in the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) and the *Health Benefit Plan Network Access and Adequacy Model Act* (#74));
- (2) Prohibited market conduct practices (Ark. Code 23-92-506; MD. ANN. CODE § 15-1642; N.M. Stat. 59A-61-5 and 59A-61-7; Oregon Rev. Stat. §§ 735.534 through 735.552; and South Carolina Code §38-71-2230(A)(1));
- (3) Data reporting requirements under state price-gouging laws;

- (4) Rebates (O.C.G.A. §33-64-10(b) (Georgia); 24-A Maine Rev. Stat. Ann. Chapter 56-C; MD. ANN. CODE § 15-1624 and Texas Insurance Code §1369.502);
- (5) Prohibitions and limitations on the corporate practice of medicine (CPOM) (O.C.G.A. §33-64-4 (Georgia));
- (6) Compensation (Ark. Code 23-92-506(b)(5)(A) and N.J.S.A. 17B:27F-8 (New Jersey));
- (7) Procedures for pharmacy audits conducted by or on behalf of a PBM (Del. Ins. Code Chapter 33A §§ 3301A – 3310A; MD. ANN. CODE § 15-1629; Oregon Rev. Stat. §§ 735.540 through 735.552; and 40 PA. CONS. STAT. §§ 4511-4514);
- (8) Medical loss ratio (MLR) compliance;
- (9) Affiliate information-sharing (Ga. Code § 26-4-119 and § 33-64-11(a)(8));
- (10) Lists of health benefit plans administered by a PBM in this state (New Hampshire Rev Stat § 402-N:6)
- (11) Reimbursement lists or payment methodology used by PBMs (Ark. Code § 17-92-507; Colo. Rev Stat. § 25-37-103.5; Del. Ins. Code Chapter 33A §§ 3321A – 3324A; Kansas Rev Stat §§ 40-3829 - 40-3830; 24-A Maine Rev. Stat. Ann. Chapter 56-C; MD. ANN. CODE § 15-1628.1 and §15-1628.2; N.J.S.A. §17B:27F-2 (New Jersey); and Oregon Rev. Stat. § 735.534 and § 735.536);
- (12) Prohibiting clawbacks (Ala. Code § 27-45A-5; MD. ANN. CODE § 15-1628.3; Minn. Stat. 62W.13; N.J.S.A. 17B:27-7 (New Jersey); and Oregon Rev. Stat. § 735.534);
- (13) Affiliate compensation (Colo. Rev. Stat. § 10-16-122.3 and Ga. Code § 26-4-119 and § 33-64-11(a)(7));
- (14) Prohibiting spread pricing (LA. REV. STAT. ANN § 22:1867 and Va. Code § 38.2-3467(D)); and
- (15) Transparency provisions (24-A Maine Rev. Stat. Ann. Chapter 56-C; Texas Insurance Code § 1369.502; and RCW 43.71C.030 (Washington)).

**Section 9. Severability**

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of this Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

**Section 10. Effective Date**

This Act shall be effective [insert date]. A person doing business in this state as a pharmacy benefit manager on or before the effective date of this Act shall have [six (6)] months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.

Draft: 3/17/21

Regulatory Framework (B) Task Force  
Virtual Meeting  
March 1, 2021

The Regulatory Framework (B) Task Force met March 1, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Ramage, Vice Chair, and Laura Arp (NE); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling (AL); Evan G. Daniels represented by Erin Klug (AZ); Ricardo Lara represented by Bruce Hinze and Tyler McKinney (CA); Andrew M. Mais represented by Jared Kosky (CT); David Altmaier represented by Chris Struk and Shannon Doheny (FL); Doug Ommen (IA); Dean L. Cameron represented by Kathy McGill (ID); Dana Popish Severinghaus represented by Eric Anderson and Kate Morthland (IL); Stephen W. Robertson represented by Karl Knable, Alex Peck and Claire Szpara (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary D. Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Grace Arnold represented by Eric Taubel (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Angie Voegele (ND); Chris Nicolopoulos represented by Maureen Belanger (NH); Marlene Caride (NJ); Judith L. French represented by Theresa Schaefer, Laura Miller and Marjorie Ellis (OH); Glen Mulready represented by Andrew Schallhorn and Kim Bailey (OK); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman represented by Michael Humphreys and Katie Dzurec (PA); Larry D. Deiter represented by Jill Kruger and Candy Holbrook (SD); Doug Slape represented by Rachel Bowden and Doug Danzeiser (TX); Jonathan T. Pike (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afafe represented by Nathan Houdek, Richard Wicka and Jennifer Stegall (WI); and James A. Dodrill represented by Joylynn Fix and Ellen Potter (WV). Also participating was: Troy Downing (MT).

1. Discussed Comments Received on the Draft PBM Model Act

Commissioner Conway said the main purpose of today's meeting is for the Task Force to discuss the comments received on the draft [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model). He explained that the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adopted the draft PBM model late last year after an extensive, open drafting process. The Subgroup presented the draft PBM model to the Task Force for its consideration during a meeting last November. The Task Force decided to defer adoption of the model and open the model for a public comment period ending Dec. 22, 2020.

Commissioner Conway said the Task Force received seven comment letters from various stakeholders—America's Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA), the Health Benefits Institute (HBI), the HIV+HEP Policy Institute, NAIC consumer representatives, the National Community Pharmacists Association (NCPA) and the Pharmaceutical Care Management Association (PCMA). He said each of the commenters have been given opportunity to provide an overview of their written comments to the Task Force. He said that at the end of this discussion, he plans to discuss the Task Force's next steps, which most likely will involve discussion of the Section 8—Regulations drafting note and the impact, if any, of the U.S. Supreme Court's decision in *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* on the drafting note.

Kris Hathaway (AHIP) said AHIP supports the PBM licensing and registration requirements and the gag clause prohibition provisions in the draft PBM model. However, AHIP remains concerned with some of the provisions included within the draft PBM model, including the Section 8 drafting note and Section 6—Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices gag clause language. Ms. Hathaway said that specifically, AHIP believes provisions within the Section 8 drafting note language would significantly increase overall health care costs. She said other provisions in the drafting note are not clearly defined and appear to exceed the scope of the draft PBM model. Ms. Hathaway said that with respect to the gag clause language in Section 6, AHIP continues to encourage adoption of the federal gag clause language that was heavily debated and advanced with broad-based stakeholder support and more than 30 states have adopted rather than the language in Section 6, which has only been adopted by one state. She also said that if it is contemplated that additional work needs to be done considering the *Rutledge* decision, then the Employee Retirement Income Security Act (ERISA) (B) Working Group would be the more appropriate NAIC group to conduct such discussions—not the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup—because expanding the draft PBM model beyond its current language could jeopardize the hard work done to reach consensus.

Haile Dagne (BCBSA) said the BCBSA supports many of the core provisions in the draft PBM model and appreciates the Subgroup's decision during its drafting process to move the broad language from the initial draft of Section 8B to a drafting

note. He said this decision more closely aligns the draft PBM model with the Subgroup's charge to consider developing a new NAIC model to establish a licensing or registration process for PBMs within state departments of insurance (DOIs). He said the BCBSA suggests the Task Force consider modifications to the draft as follows: 1) requiring PBMs to notify state insurance regulators of any changes to their application within 90 days of the change and disclosing the list by health insurers and the kinds of health plans (e.g., health maintenance organization [HMO], preferred provider organization [PPO]) administered by pharmacy benefit managers (PBMs) within the state as suggested in Section 8B(10); 2) removing "financial and reporting" from Section 5B—Licensing Requirement and the drafting note suggesting states consider establishing financial standards if the state restricts DOI authority because Section 5 is intended to focus on licensing requirements—not financials or reporting stipulations; 3) modifying the language in Section 6 to mirror the federal gag clause provisions; and 4) deleting Section 6A(4) and Section 6A(5) because these provisions would allow pharmacists to disclose information to which a pharmacist would not have access and could lead to consumer confusion.

Commissioner Conway asked how the BCBSA draws a distinction between Section 6A(3) and Section 6A(4) and Section 6A(5). Mr. Dagne said that Section 6A(3) is limited to a pharmacist disclosing whether a claim is approved or denied (i.e., "the decision of utilization reviewers or similar persons to authorize or deny services"). Section 6A(4) is broader in scope and attempts to disclose information that a pharmacist would not be aware of—"the process that is used to authorize or deny healthcare services or benefits." He said that such information about the utilization management decision-making process or rationale is not available to pharmacists and that speculating on the process could be confusing to the consumer.

J.P. Wieske (HBI) said that although the draft PBM model is not perfect and the HBI has concerns, it supports the draft PBM model as drafted. He said the draft strikes the right balance with where most states are at this time without being divisive and allows for a lot of flexibility in its design. Mr. Wieske said that he believes the *Rutledge* decision has no major impact on the draft PBM model, but given its flexibility, those states that may want to explore the possibility of including similar provisions that were the subject of the *Rutledge* case can do so. He also said the draft PBM model reflects significant compromise from various sides of the issue including pharmacies, pharmacy benefit managers, insurers, and consumer representatives. The HBI supports the draft PBM model in the spirit of compromise.

Carl Schmid (HIV+HEP Policy Institute) discussed the role of PBMs in prescription drug access and availability using drug formularies and establishing prior authorization and other utilization management techniques. He also discussed the increasing role the HIV+HEP Policy Institute believes PBMs play in the high cost of prescription drugs in the U.S. He said the HIV+HEP Policy Institute is disappointed that the draft PBM model does not include provisions related to the second part of the Subgroup's charge to consider PBM prescription drug pricing and cost transparency. He said that instead of adding a drafting note to Section 8 providing examples of laws passed by states that address many of the important issues involving PBMs, the HIV+HEP Policy Institute believes the Subgroup should have proposed specific language pertaining to: 1) ensuring greater transparency in the work of PBMs; 2) ensuring greater enforcement; 3) establishing that PBMs have a fiduciary relationship with health carriers; and 4) allowing PBMs to pass rebates on to consumers. Mr. Schmid said the recent *Rutledge* decision provides more reason for the NAIC to adopt a stronger and clearer PBM model. He also said the HIV+HEP Policy Institute suggests in its comment letter additional state citations to the Section 8 drafting note.

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives are concerned that the draft PBM model will not provide states that wish to go further in their regulation of PBMs with direction and options that may be available to them. She said the NAIC consumer representatives recommend a deeper discussion of these issues and the Subgroup's development of a white paper to allow the NAIC to: 1) better analyze and assess the role that PBMs play in the provision of prescription drug benefits; and 2) to identify and describe emerging state regulatory approaches that curb the PBM practices that contribute to high drug prices and insurance affordability challenges. The white paper should address the breadth of topics that were ultimately left out of the draft PBM model, including transparency and reporting requirements; fiduciary duty and other business practices provisions; and consumer cost sharing and access. Ms. Howard said the NAIC consumer representatives also suggest reconvening the Subgroup to discuss the implications of the *Rutledge* decision on the draft PBM model, including any potential changes, particularly given the draft PBM model's limited scope. She said the NAIC consumer representatives also suggest adding additional state statutory citations to the Section 8 drafting note.

Commissioner Conway asked Ms. Howard what other areas a white paper should focus on in addition to the areas examined in the *Rutledge* case. Ms. Howard said the white paper should discuss the specific options and model language that states can use that might want to more extensively regulate PBMs, such as the business practices listed in the Section 8 drafting note.

Matthew Magner (NCPA) said the NCPA, and the other signatories to its comment letter, have been concerned for a while about the outsized impact PBMs have had on prescription drug benefits and patient access to pharmacy services. He said PBMs not only administer pharmacy benefits for health plans, but also some own their own pharmacies, which creates a conflict of interest that interferes with the patient-pharmacy relationship and can also raise prescription drug costs for consumers. Mr. Magner said the NCPA believes that given the decision in the *Rutledge* case, state legislatures will be pursuing legislation to increase PBM oversight in their states. He said the states will be looking to the NAIC's model to determine how best to accomplish this. As such, the NCPA requests the Task Force consider its suggested amendments to the draft PBM model to better prepare the states to address PBM practices that limit patient access to community pharmacy services and increase prescription drug costs, such as provisions: 1) ensuring pharmacy or patient choice; 2) imposing a fiduciary responsibility between the PBM and the health carrier; and 3) concerning pharmacy audits. Mr. Magner said the suggested amendments reflect provisions enacted in one form or another in one or more states. He said the NCPA also recommends including a reference to the *Rutledge* decision in the Section 8 drafting note for the states to know where to go to obtain more information about their authority to include such provisions in their laws.

Commissioner Schmidt asked if the NCPA had any comments on the NAIC consumer representatives' suggestion for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper. Mr. Magner said the NCPA supports the development of a white paper and would be happy to participate in the discussions during its development to provide a community pharmacist's perspective on the issues the white paper will most likely discuss.

Lauren Rowley (PCMA) said the PCMA, along with a variety of interested parties, including representatives of pharmacies and consumer representatives, actively participated in the Subgroup's work on the draft PBM model. She acknowledged the Subgroup's work was a deliberative and thoughtful discussion of the comments received, and it worked to reach a compromise on some of the draft PBM model's provisions. She said that while the compromises in the draft do not necessarily reflect the PCMA's ideal public policy, it does reflect a reasonable set of compromises across all interested parties. Ms. Rowley said PBMs are not insurers and do not collect premium from beneficiaries. She outlined what services PBMs provide to insurers to deliver safe, cost-effective prescription drug benefits. Ms. Rowley discussed the PCMA's interpretation of the *Rutledge* decision, which it believes was a narrow decision. She also said that like AHIP, if there are further discussions related to the decision, the ERISA (B) Working Group would be the appropriate NAIC group to conduct such discussions. Ms. Rowley said the PCMA suggests the Task Force adopt the draft PBM model as drafted by the Subgroup.

Mr. Beatty questioned why discussions of the *Rutledge* decision should not be discussed by the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. Ms. Rowley said the PCMA believes the ERISA (B) Working Group's membership includes those who are well-versed in ERISA and ERISA preemption issues. She said the Court's decision in *Rutledge* did not invalidate its previous decisions related to ERISA preemption. She suggested that as such, the ERISA preemption issues should, perhaps, be looked at more broadly to discuss what the Court actually said in the decision and its implications for the states with respect to PBM regulation. Commissioner Conway suggested that there was a role for both the ERISA (B) Working Group and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup concerning any discussions of the *Rutledge* decision.

Mr. Keen discussed the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's drafting process, including the Subgroup's early work to ensure everyone was equally educated on these issues before it started drafting a model. He explained that the current draft PBM model reflects the differing viewpoints from the Subgroup members with respect to PBM regulation. He said some states currently have robust PBM regulatory schemes, while other states do not currently regulate them. He said this dichotomy of state PBM regulation was evident in the Subgroup's discussions, with some Subgroup members at the beginning of the drafting process advocating for establishing an elaborate regulatory scheme in the draft with other Subgroup members advocating for a more incremental approach. Mr. Keen said that in developing the model, given this dichotomy, the Subgroup tried to come up with a draft that would be helpful for every state. He said the Subgroup also was mindful that the states wanted an NAIC model on this topic as soon as possible because their legislatures are asking for information and some sort of general framework for regulating PBMs.

Ms. Arp expressed support for Mr. Keen's comments. She said the Subgroup ultimately ended up with the Section 8 drafting note because of the lack of a consensus among the states on the topics described in the drafting note—not because of concerns with ERISA preemption. As such, the *Rutledge* decision does not mean the NAIC should restart its work on the draft PBM model. The decision means that a state can consider adding provisions in its laws related to maximum allowable cost (MAC) pricing and not be vulnerable to ERISA preemption. Ms. Arp discussed the uncertainty of other provisions listed in the drafting note on the cost of prescription drugs and the importance of obtaining such information as states move forward with implementing some of them. She also discussed the importance of understanding what the motive or end goal is of regulating PBMs rather than making public policy on Court dicta in a decision.

Mr. Keen said the Subgroup would be supportive of developing a white paper, as has been discussed, if that is what the Task Force decides should be the next step after adoption of the PBM model.

Commissioner Conway said NAIC staff will schedule a meeting prior to its already scheduled March 25 meeting to consider adoption of the draft PBM model. He requested comments from Task Force members. Commissioner Schmidt suggested that the draft PBM model should include a reference to the *Rutledge* decision. Commissioner Conway acknowledged her suggestion, but he questioned whether the NAIC has included such references in other NAIC models. Mr. Beatty expressed support for Commissioner Schmidt's suggestion. Commissioner Conway agreed that there needs to be further discussion of the *Rutledge* decision, but he suggested that the better setting for such a discussion would be in the proposed white paper.

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

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Draft: 3/16/21

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group  
Virtual Meeting  
January 28, 2021

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met Jan. 28, 2021. The following Working Group members participated: Katie Dzurec, Chair, Shannen Logue and Frank Callihan (PA); Jane Beyer, Vice Chair, Jeanette Plitt, Paul Dubois and John Haworth (WA); Jimmy Harris, Donna Lambert, Crystal Phelps and Chantel Allbritton (AR); Mary Boatright, Leannette Henagan, Erin Klug and Vanessa Darrah (AZ); Pam O'Connell, Jessica Ryan, Doris Walker, Sheirin Ghoddoucy and Christopher Citko (CA); Cara Cheevers, Kate Harris and Damion Hughes (CO); Kurt Swan, Courtney Miner, Paul Lombardo and Robert Chester (CT); Howard Liebers and Mary Beth Senkewicz (DC); Sarah Crittenden (GA); Cynthia Banks Radke, Sonya Sellmeyer, Angela Burke Boston, Lindsay Bates, Andria Seip and Jan Jones (IA); Ryan Gillespie, Sara Stanberry, Kate Morthland and Erica Weyhenmeyer (IL); Shannon Lloyd, Chris Hollenbeck, Craig VanAalst, Brenda Johnson, Barbara Torkelson, Tate Flott, Julie Holmes and Mark McClafflin (KS); Erica Bailey (MD); Peter Brickwedde and Andrew Kleinendorst (MN); Jeannie Keller (MT); Ted Hamby, Rosemary Gillespie, Shane Quinlan, Kathy Shortt, Tracy Biehn and Cheryl Bivens (NC); Sara Gerving, Colton Storseth, Chrystal Bartuska and Ross Hartley (ND); Ingrid Marsh, Michelle Heaton, and Tyler Brannen (NH); Ralph Boeckman, Gale Simon, Erin Porter and Chanell McDevitt (NJ); Sherri Mortensen-Brown, Viara Ianakieva, Diane Bilodeau, Julie Weinberg and Sarah Grisham (NM); Laura Miller, Guy Self, Kyla Dembowski, Todd Oberholtzer, Molly Mottram and Marjorie Ellis (OH); Alyssa Metivier, Victor Woods, Emily Maranjian and John Garrett (RI); Kendall Buchanan and Michael Bailes (SC); Jill Kruger and Lisa Harmon (SD); Rachel Bowden and Angela Melina Raab (TX); Tanji J. Northrup, Carrie Backus, Heidi Clausen, and Jaakob Sundberg (UT); Brant Lyons, Melissa Gerachis, Heather Webb, Ansley Fitzpatrick, Bryan Wachter, Jarod Mentzer, Julie Fairbanks and Tiffany Toney (VA); Barbara Belling, Jody Ullman, Diane Dambach and Mark Prodoehl (WI); Joylynn Fix (WV); and Denise Burke, Tana Howard and Mavis Earnshaw (WY).

1. Heard a Presentation on Consumer Experiences with MHP

Andrew Sperling (National Alliance on Mental Illness—NAMI) provided an overview of federal mental health parity (MHP) legislation and its interaction with state laws. He characterized the law as a success for consumers, but he said challenges remain, including enforcement and a lack of clarity on non-quantitative treatment limits (NQTLs). He said state insurance regulators should ensure compliance when behavioral health benefits are carved-out, tackle the difficulties of network adequacy in mental health, and work toward a recognized accreditation process, such as through URAC. He said the prospective medical management of inpatient hospitalization remains a big challenge and a difference from the way medical/surgical (MS) benefits are treated.

Ms. Beyer asked whether there is concern with insurers approving a lower level of care than requested by a provider. Mr. Sperling said plans insist on a lower level of care, even calling the provider every day to ask for discharge from an inpatient setting. Ms. Beyer asked about experiences consumers have in appealing determinations that a lower level of care is all that will be paid. Mr. Sperling said it is a large challenge for families, especially when the patient is in crisis. Ms. Dzurec asked whether there are different definitions of emergency services for psychiatric care versus MS services. Mr. Sperling said there are different legal standards, particularly for involuntary confinement. He said these legal considerations complicate health plan determinations because these are legal proceedings where law enforcement may be involved. Ms. Harris asked whether there is an opportunity to use criteria from the American Society of Addiction Medicine (ASAM) to guide coverage decisions. Mr. Sperling said this is a hot topic and the challenge is that treatment guidelines are different for each condition.

2. Heard a Presentation on Provider Experiences with MHP

Tim Clement (American Psychiatric Association—APA) described health care providers' experiences with MHP. He said utilization reviews for behavioral health often involve second-level review and peer-to-peer reviews in which the reviewer strongly encourages the provider to seek a lower level of care. He said smaller practices are at a disadvantage in negotiating with insurers, regardless of the scarcity of providers in a market. He outlined a number of prescription drug and formulary issues providers face. He urged state insurance regulators to look to medical experts in their states as well as state insurance regulators in other states who are performing parity market conduct exams.

3. Heard a Presentation on Health Plan Experiences with MHP

Lisa Campbell and Ryan Temme (Groom Law Group) presented on health plans' perspectives on MHP. Ms. Campbell noted that their remarks represent the views of America's Health Insurance Plans (AHIP), the Association for Behavioral Health and Wellness (ABHW), and the Blue Cross Blue Shield Association (BCBSA). Ms. Campbell described federal laws, noting the complexity of the tests for parity compliance. She referenced existing federal compliance tools. Mr. Temme emphasized the need for plans to better understand what would be considered compliant, particularly with regard to NQTLs. He described three levels of complexity with parity requirements: 1) a wide variety of covered plans; 2) the variety of approaches that are permissible; and 3) the different levels of analysis that a state insurance regulator could request. He said workforce shortages and the reluctance of providers to join networks contribute to the way plans offer and pay for mental health benefits and add to the complexity of compliance analysis. He said the rule is focused on the process, so different outcomes are not determinative of compliance. Ms. Campbell said federal guidance under recent legislation to require comparative analyses will provide a uniform standard for plans to report on their NQTLs.

Pamela Greenberg (ABHW) said her organization's main goal is to have a uniform implementation process and certainty for plans regarding what is compliant and non-compliant. Randi Chapman (BCBSA) said her organization seeks clarity and wants the new federal law to lead to consistent and transparent guidance. She said the new law provides an opportunity for a uniform approach. Miranda Motter (AHIP) recommended that the Working Group work with stakeholders to implement the new federal law, and she said work outside the framework of the new law could add confusion.

Ms. Beyer asked what role issuers have in making it easier for behavioral health providers to be part of plan networks. Ms. Greenberg said some providers do not have the means to offer telehealth and plans have helped there. She said plans have worked to reduce the administrative burden and provider partnerships can be more complex than working in a solo practice without taking insurance. Ms. Motter said another potential consideration is providers operating at the top of their licenses. Ms. Greenberg said collaborative care models are a good example of psychiatrists practicing at the top of their licenses, and it can help for plans to encourage and reimburse such models.

Ms. Dzurec asked about using provider ratios in measuring network adequacy. Mr. Clement said whether providers are taking new patients is an important consideration in addition to provider ratio. Ms. Greenberg said the variety of provider types in behavioral health must also be considered. Ms. Motter said telehealth should also be considered with regard to satisfying provider ratios.

Ms. Dzurec asked about federal guidelines for comparative analyses and how states can ask plans for them. Amber Rivers (U.S. Department of Labor—DOL) said it is a transitional time and guidance will come later. She added that much of the language in the new law is borrowed from existing statutes and regulations, so the concepts are not new. Mary Nugent (Center for Consumer Information and Insurance Oversight—CCIIO) said guidance has not yet been released, but there is nothing in federal law that prevents state insurance regulators from requesting analyses from state-regulated plans.

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

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