HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Aug. 15, 2024, Minutes
- Health Insurance and Managed Care (B) Committee July 26, 2024, Minutes (Attachment One)
- Health Insurance and Managed Care (B) Committee June 13, 2024, Minutes (Attachment Two)
  - Health Actuarial (B) Task Force Memorandum to the Committee on Cost-Sharing Reduction Referral (Attachment Two-A)
- Consumer Information (B) Subgroup July 29, 2024, Minutes (Attachment Three)
  - Prior Authorization Consumer Guide (Attachment Three-A)
- Consumer Information (B) Subgroup June 18, 2024, Minutes (Attachment Four)

Draft Pending Adoption

Draft: 8/21/24

Health Insurance and Managed Care (B) Committee
Chicago, Illinois
August 15, 2024

The Health Insurance and Managed Care (B) Committee met in Chicago, IL, Aug. 15, 2024. The following Committee members participated: Anita G. Fox, Chair (MI); Grace Arnold, Co-Vice Chair (MN); Glen Mulready, Co-Vice Chair (OK); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron (ID); D.J. Bettencourt (NH); Alice T. Kane represented by Viara Ianakieva (NM); Andrew R. Stolfi represented by Alex Cheng and Cassie Soucy (OR); Michael Humphreys (PA); Alexander S. Adams Vega represented by Maria Morcelo (PR); Jon Pike (UT); Mike Kreidler represented by Ned Gaines (WA); and Allan L. McVey (WV). Also participating were: Paul Lombardo (CT); Andria Seip (IA); Joanna Coll (IL); Vicki Schmidt (KS); Kevin P. Beagan (MA); Mary Kwei (MD); Chrystal Bartuska and John Arnold (ND); and Maggie Reinert (NE).

1. Adopted its July 26, June 13, and Spring National Meeting Minutes

The Committee met July 26. During this meeting, the Committee adopted the Regulatory Framework (B) Task Force's revised 2024 charges, which revised the 2024 charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup.

The Committee also met June 13. During this meeting, the Committee took the following action: 1) adopted revisions to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51); 2) adopted revisions to Valuation Manual (VM)-26, Section 3B—Contract Reserves for Credit Disability Insurance; 3) adopted the Health Actuarial (B) Task Force's revised 2024 charges; 4) discussed the Health Actuarial (B) Task Force's findings from its review and discussion of an issue the Committee referred to the Task Force late last year on how possible changes to the cost sharing reduction (CSR) subsidy, like changes to silver loading, could impact plan options and costs to consumers; and 5) heard a presentation from the Center for Insurance Policy and Research (CIPR) on findings from a case study the CIPR completed as part of its Network Adequacy Project: Compensation of Travel Costs for In-Network Care in Mississippi.

Commissioner McVey made a motion, seconded by Commissioner King, to adopt the Committee's July 26 (Attachment One), June 13 (Attachment Two), and March 18 (*see NAIC Proceedings – Spring 2024, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

3. Adopted its Subgroup, Working Group, and Task Force Reports

Commissioner Arnold made a motion, seconded by Commissioner Mulready, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its July 29 (Attachment Three) and June 18 (Attachment Four) minutes; 2) the Health Innovations (B) Working Group; 3) the Health Actuarial (B) Task Force; 4) the Long-Term Care Insurance (B) Task Force; 5) the Regulatory Framework (B) Task Force; and 6) the Senior Issues (B) Task Force. The motion passed unanimously.

4. Heard a Federal Update

Brian R. Webb (NAIC) provided a federal update on issues of interest to the Committee, beginning with congressional legislative activities. He said the funding for the mental health parity grants to the states to assist them in enforcing the mental health parity requirements under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) remains elusive. He explained that the grant money, which is $10 million per year for five years, has been authorized but not appropriated. He noted that once

again, the Senate Committee on Appropriations put in its year-end report that it believes the federal Centers for Medicare & Medicaid Services (CMS) has sufficient funds in its budget to start the grant program without an additional appropriation of funds. He said NAIC Government Relations staff will continue to work to get CMS to fund and start the grant program. Webb said that this year, both the U.S. House of Representatives (House) and the U.S. Senate have maintained the same level of State Health Insurance Assistance Program (SHIP) funding in their respective budget bills. He said that, typically, one chamber zeros out the funding, and the other one funds it. This year, both have included full funding for SHIP in their committee appropriation bills.

Webb said the NAIC recently sent a letter to Congress regarding the enhanced advance premium tax credits (APTCs) under the federal Affordable Care Act (ACA). He explained that the APTCs are currently scheduled to end in 2025. The NAIC letter urges that they be extended past 2025 for many good reasons, the principal reason being that the increased size and availability of the premium tax credits that have been available since the passage of the American Rescue Plan Act of 2021 have resulted in greater enrollment in marketplace plans in state individual health insurance markets. The greater subsidies have enhanced the affordability of coverage for families of modest means as well as those who were previously denied help with coverage costs due to income limits, those above 400% of the federal poverty level. Webb also noted the APTCs on reinsurance programs in states with an ACA Section 1332 waiver.

Webb said Medicare Advantage plan marketing continues to be a big issue and the subject of much discussion. He said NAIC Government Relations staff are continuing to work with the relevant Senate and House committees to add language to year-end Congressional budget legislation to make it clear that CMS can work with states through a cooperative enforcement agreement to enforce the federal rules related to Medicare Advantage marketing. He said some states have requested such an arrangement to address consumer complaints directly.

Webb said that in July, the Federal Trade Commission (FTC) released an interim staff report, "Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies." The report is highly critical of pharmacy benefit managers (PBMs), their funding, and their effect on consumers. He said the NAIC Government Relations staff will continue to follow this issue and see if it triggers any additional Congressional legislative activity on PBMs.

Regarding federal rules, Webb said it is anticipated that the new federal rule revamping provisions implementing the MHPAEA and establishing new requirements regarding non-quantitative treatment limitation (NQTL) requirements will be finalized soon. He said the NAIC also continues to look for clarity on the co-payment accumulator issue since the U.S. District Court for the District of Columbia's Sept. 29, 2023, decision vacating the 2021 U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters (NBPP) rule to the extent it permitted health plans to use a co-payment accumulator policy and HHS' decision not to enforce the 2020 NBPP rule, which prohibited copay accumulators except where a medically appropriate generic alternative is available. He said it has been rumored that such clarity could be included in the 2026 NBPP rule. He said he is aware of two states enforcing the 2020 NBPP rule, but other states need guidance on the issue.

Webb said the last federal rule he wanted to discuss was the ACA's Section 1557 final rule. He said there continue to be issues related to the final rule's language prohibiting discrimination based on a disability or age and Medicare supplement insurance (Medigap) plans. He said NAIC Government Relations staff have been seeking clarity on this issue from the HHS Office for Civil Rights (OCR) since May, right after the rule was finalized in April. To date, the OCR has not been responsive. He said NAIC Government Relations staff will continue to reach out to the OCR for a meeting to discuss the issue.

Webb next discussed recent court rulings, beginning with *Loper Bright Enterprises v. Raimondo* and *Relentless v. Department of Commerce* (collectively referred to as *Loper Bright*) rulings, which overturned the so-called "Chevron Doctrine." He said it is too early to tell what impact the ruling will have on federal health rules and

federal rulemaking, but he has already seen the *Loper Bright* ruling mentioned in some court cases related to the ACA Section 1557 rule. Webb said NAIC Government Relations staff continue to track both the *Braidwood v. Becerra* case, which challenged the ACA's preventive service requirements, and the *Pharmaceutical Care Management Association (PCMA) v. Mulready* case, which challenges state insurance regulators' right to regulate PBMs. He said both cases are continuing to make their way through the federal courts, which could have major implications for state insurance regulators.

5. Heard an Update from a Consumer Perspective on Recent State Activity on the Prior Authorization Process

Carl Schmid (HIV+Hepatitis Policy Institute), Stephani Becker (Shriver Center on Poverty Law), and Lucy Culp (Leukemia & Lymphoma Society—LLS) provided an update from a consumer perspective on recent state activity improving the prior authorization process.

Schmid discussed how the prior authorization process impacts patients and providers. He said that according to a 2023 American Medical Association (AMA) survey on prior authorization, 94% of providers said the prior authorization process delays patients' accessing necessary care. He provided additional statistics highlighting the effect of the prior authorization process on providers. He discussed the recommendations from two reports—the Center on Health Insurance Reforms (CHIR) report, "The Good, The Bad, The Costly," and the Network for Excellence in Health Innovation (NEHI) report, "Improving the Prior Authorization Process Recommendations for California," prepared for the California Health Care Foundation (CHCF)—suggesting potential reforms to improve the prior authorization process.

Schmid and Becker discussed prior authorization reform legislation in several states, including California, Illinois, Minnesota, New York, Vermont, and Rhode Island. Becker explained that the Rhode Island law signed in 2023 required the Office of the Health Insurance Commissioner (OHIC) to convene the Administrative Simplification Task Force to make prior authorization recommendations. She said that in its June 28 final report, the OHIC committed to: 1) ensuring uniform interpretation of a reduction in the volume of prior authorization; 2) collecting data in new ways to measure volume reductions; and 3) creating a new public body to serve as a forum for ongoing dialogue between payers and providers to inform prior authorization process improvements. Becker also noted new or strengthened prior authorization laws in Colorado, Maine, Maryland, Minnesota, Mississippi, Oklahoma, Vermont, Virginia, and Wyoming.

Culp discussed CMS's Interoperability and Prior Authorization Final Rule. She explained that the federal rule applies to Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP), and qualified health plans (QHPs) on the federal marketplaces. The final rule's requirements include: 1) a specific reason for denial; 2) shortened prior authorization response times; 3) public reporting; and 4) automation. Culp noted that the federal final rule does not include prior authorization changes for prescription drugs, but she anticipates CMS issuing a proposed rule for prescription drugs later this year.

Culp also discussed CMS's 2024 Medicare Advantage and Part D Final Rule. She explained that although it applies only to Medicare Advantage plans, she believes its provisions include meaningful changes to the prior authorization process that states can borrow from. She said those changes include: 1) new limits on the use of prior authorization; 2) banning retroactive denials; and 3) continuing prior authorization approvals as long as they remain medically necessary. The final rule also includes limits on the use of artificial intelligence (AI) for prior authorization determinations.

Culp suggested the following next steps for the Committee to consider: 1) charging the Consumer Information (B) Subgroup to modify and use the Subgroup's new consumer prior authorization guide to educate consumers; 2) forming a new Committee working group to share information and work on implementation, best practices, and

enforcement; and 3) partnering with the Innovation, Cybersecurity, and Technology (H) Committee on the use of AI in the prior authorization process.

Commissioner Mulready said Schmid's remarks characterized the prior authorization process as a barrier to care. He said he thinks of the prior authorization process as more of a checkpoint. He noted that without such checkpoints, there would be no limits on the type and number of health care services provided, which would not help to reduce health care costs. He asked Schmid if he thought there was a role for prior authorization. Schmid said he believes there is a role, but he noted that insurers approve most prior authorization requests. Given this, he questioned why consumers and providers on their behalf are required to go through the prior authorization process if most are approved, which is why he believes the prior authorization process is a barrier to care. Schmid said there is a need to find the appropriate balance because the current prior authorization process appears to be tilted too far toward not providing access to care. Director Fox agreed with Schmid about the need to find a balance between access to care and controlling health care costs.

6. Heard Presentations from the CHIR and AHIP on Health Cost Transparency

Sabrina Corlette (CHIR) and Kelley Schultz (America's Health Insurance Plans—AHIP) presented on health cost transparency. Corlette discussed the importance of health cost transparency in identifying what is driving the growth in health care costs. She referenced *Health Affairs* and RAND Corporation studies suggesting that prices, not consumption, are driving up health care costs. She discussed the different policy options—price regulation, anti-trust oversight/enforcement, and transparency—identified in a September 2022 Congressional Budget Office (CBO) report to promote affordability.

Corlette discussed the federal price transparency rules and how states could use the transparency in coverage (TiC) data collected under federal TiC rules to improve health cost transparency. She said such data could be used: 1) to conduct market scans to identify price outliers and cost drivers; 2) to monitor compliance with anti-trust actions and enforcements; 3) to support employer purchasing efforts; 4) as an independent source of data on median in-network rates for purposes surprise billing; and 5) to conduct rate review. Corlette discussed current problems with the TiC data, such as difficulty finding the data, duplicative or irrelevant data, and lack of standardization. She discussed state-level options to improve TiC data, including: 1) requiring insurers to attest to the completeness or accuracy of the TiC files; 2) hosting a centralized website with links to all insurer TiC files; 3) requiring greater standardization; and 4) using TiC data to inform public-facing reports about health system cost drivers.

Schultz discussed the federal TiC rule requirements—machine-readable files (MRFs), a cost estimator tool, and advanced explanation of benefits (AEOB)—including their drawbacks and opportunities for improving health cost transparency. She also discussed the implementation timeline for the federal TiC rule. Schultz discussed what actions states can take to address health cost transparency, such as: 1) prioritizing solutions that provide direct consumer value; 2) considering approaches to expand consumer awareness and education of tools; 3) avoiding single-state solutions; and 4) engaging on the next iteration of review and updates to the federal MRF requirements.

7. Heard an Update from the CCIIO on its Recent Activities

Ellen Montz (federal Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO's recent activities of interest. Her update included a discussion of four main areas: 1) 2024 open enrollment; 2) continued focus on affordability of coverage; 3) improving coverage options; and 4) not losing momentum from the Medicaid unwinding.

Montz discussed a few recent trends the CCIIO has been seeing: 1) the lower quality of QHP plan enrollment (e.g., more bronze plan enrollment versus silver plan enrollment) despite the availability of APTCs to help lower the cost of premium; and 2) the increase in consumer complaints. To address the increase in consumer complaints, many of which relate to the unauthorized switching of consumers to other plans, she said the CCIIO has taken a number of steps, including: 1) improving agent and broker training and technical assistance; 2) creating data specific to agents and brokers to track enrollment outcomes; 3) leveraging partnerships with stakeholders, like state insurance regulators, to identify fraud and eliminate bad actors; and 4) updating and making technical system changes to block unwanted changes and plan switches. She noted that to date, the CCIIO has suspended 450 agents from participating in the federal marketplace enrollments because of suspected fraudulent activity.

Montz also highlighted CMS' recently launched anti-fraud campaign designed to protect consumers in the marketplace from fraud and provide partners, such as state insurance regulators, with the latest information, tips, and resources to help prevent fraud and educate consumers on what they can do if they suspect fraud.

Montz said the CCIIO is working to finalize the MHPAEA rule. She said the CCIIO plans to begin work soon on the proposed 2026 NBPP rule.

Director Cameron asked Montz if the data the CCIIO is collecting about agents and brokers focuses strictly on federal marketplaces or if it also includes state-based marketplaces. He also asked if the CCIIO is sharing the names of any bad actors with the states based on the data. Montz said state-based marketplaces are responsible for overseeing agents and brokers who enroll consumers through the state-based marketplaces. She said that given that state insurance regulators license agents, the CCIIO is working to ensure data-sharing is in place to inform the states of any bad actors. She acknowledged that such communication is improving and that the CCIIO is working to be able to share not only agent suspensions from enrollment on the federal marketplace but also any complaints the CCIIO receives.

8. Discussed Addressed Priorities and Priorities to be Addressed in Future Meetings

Director Fox said that the Committee member survey conducted at the beginning of 2024 identified several key priorities to address this year. She said that to date, the Committee has discussed network adequacy, ground ambulance, and senior issues, such as long-term care insurance (LTCI). The Committee has also addressed issues related to the improper marketing of Medicare Advantage plans during NAIC staff weekly meetings and meetings with CMS.

Director Fox said that some of the remaining identified priorities were addressed during today's meeting-- health cost transparency and the prior authorization process. Other outstanding priorities identified include: 1) claim denials, which the Committee discussed in 2023; 2) plan benefit design; and 3) issues facing the small group market. She explained that a few of the remaining identified priorities, such as PBMs and mental health parity, are the focus of the Committee's task forces and working groups. She said that as the Committee prepares for its final meeting at the Fall National Meeting, anyone with thoughts or recommendations on any specific topics or presenters that align with any of these remaining priorities should reach out to her or NAIC staff.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Health Insurance and Managed Care (B) Committee
E-Vote
July 26, 2024

The Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded July 26, 2024. The following Committee members participated: Anita G. Fox, Chair (MI); Glen Mulready, Co-Vice Chair (OK); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron represented by Shannon Hohl (ID); Joy Y. Hatchette represented by David Cooney (MD); D.J. Bettencourt (NH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Alexander S. Adams Vega (PR); Jon Pike (UT); Mike Kreidler (WA); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted the Regulatory Framework (B) Task Force's 2024 Revised Charges

The Committee conducted an e-vote to consider adoption of the Regulatory Framework (B) Task Force's 2024 revised charges, which amend the 2024 charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup (*see NAIC Proceedings – Summer 2024, Regulatory Framework (B) Task Force, Attachment One-A*). The motion passed unanimously.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Draft: 7/10/24

Health Insurance and Managed Care (B) Committee
Virtual Meeting
June 13, 2024

The Health Insurance and Managed Care (B) Committee met June 13, 2024. The following Committee members participated: Anita G. Fox, Chair, Kevin Dyke, and Tina Nacy (MI); Grace Arnold, Co-Vice Chair (MN); Glen Mulready, Co-Vice Chair (OK); Trinidad Navarro represented by Susan Jennette (DE); John F. King represented by Teresa Winer (GA); Dean L. Cameron represented by Weston Trexler and Shannon Hohl (ID); Kathleen A. Birrane represented by Jamie Sexton and David Cooney (MD); D.J. Bettencourt represented by Michelle Heaton (NH); Alice T. Kane represented by Viara Ianakieva (NM); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Sandra L. Ykema (PA); Alexander S. Adams Vega represented by Carlos Valles (PR); Jon Pike represented by Tanji J. Northrup (UT); Mike Kreidler represented by Ned Gaines (WA); and Allan L. McVey represented by Joylynn Fix (WV).

1. Received an Update on Health Actuarial (B) Task Force Activities

Dyke said the Health Actuarial (B) Task Force has three items it is presenting for the Committee's adoption: 1) proposed revisions to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51); 2) proposed revisions to Valuation Manual (VM)-26, Section 3B—Contract Reserves for Credit Disability Insurance; and 3) proposed revisions to the Task Force's 2024 revised charges. He said two documents related to the AG 51 proposed revisions were included in the meeting materials: a memorandum to the Committee from the Long-Term Care Insurance (B) Task Force describing the proposed revisions and a document including the proposed revisions. Dyke explained that the AG 51 proposed revisions result from the work of the Health Test Ad Hoc Group of the Health Risk-Based Capital (E) Working Group, which reviewed the health test language within the *Annual Statement Instructions* due to inconsistencies in reporting of health business across the different blanks, as well as a significant amount of health business reported on the life and fraternal blank. Through its evaluation and discussion of changes to the health test, a question was raised regarding whether an entity would still be required to comply with the AG 51 requirements for long-term care insurance (LTCI) business if it moved from the life blank to the health blank. To address the issue, the Long-Term Care Actuarial (B) Working Group revised AG 51 to clarify that regardless of the blank the entity files, AG 51 filing is required by the entity if the criteria stated in the guideline are met. Dyke said the Health Actuarial (B) Task Force adopted the amendment Feb. 20. The Long-Term Care Insurance (B) Task Force adopted the amendment March 16.

Dyke said the next items for the Committee's consideration are the proposed revisions to VM-26, Section 3B—Contract Reserves for Credit Disability Insurance. He outlined the process of adopting *Valuation Manual* amendments and the Committee's role in the adoption before the package of *Valuation Manual* amendments is presented to the full NAIC Membership for adoption at each Summer National Meeting. He said the Health Actuarial (B) Task Force adopted this revision to VM-26, Section 3B, and is requesting Committee adoption because credit disability experience has gradually improved since the original 1997 credit disability study. The 2022 study indicates that the current valuation standard contains claim costs from 190%–276% of actual claim cost experience, based on the Society of Actuary's (SOA's) "2023 Credit Disability Study Report." The variations in the range shown above occur by elimination period and occupation class distributions observed over the period studied, 2014 through 2022. Dyke said the proposed changes to VM-26, Section 6B remove the 12% addition to the 1985 Commissioners Individual Disability Table A (85CIDA) incidence rates for newly issued contracts since the addition of the 12% constitutes a margin that is no longer needed or justified by experience. He said the Health

Actuarial (B) Task Force exposed the proposed versions for a 45-day public comment period ending March 22. No comments were received. The Health Actuarial (B) Task Force adopted the revisions May 13.

Dyke said the last items for the Committee's consideration are proposed amendments to the Task Force's 2024 charges (*see NAIC Proceedings – Spring 2024, Health Actuarial (B) Task Force, Attachment Two*). He said the amendments reflect that the Long-Term Care Actuarial (B) Working Group now reports to the Long-Term Care Insurance (B) Task Force instead of the Health Actuarial (B) Task Force.

Gaines made a motion, seconded by Heaton, to adopt the: 1) revisions to AG 51; 2) revisions to VM-26, Section 3B; and 3) Task Force's revised 2024 charges. The motion passed unanimously.

2. Discussed the Effects of Changes to CSRs

Director Fox said the next item was to hear the Health Actuarial (B) Task Force's findings from its review and discussion of an issue the Committee referred to the Task Force late last year on how possible changes to the cost-sharing reduction (CSR) subsidy, like changes to silver loading, could impact plan options and costs to consumers. In making that referral, it was the Committee's understanding that the Task Force had already heard from the American Academy of Actuaries (Academy) and other actuarial groups that silver loading has created odd incentives in the market. Because of this, the Committee felt it would be beneficial to know more about how changes in state silver loading policies or other changes, like the elimination of the enhanced subsidies in 2026, could impact consumer choices and the affordability of coverage.

Dyke said that included in the meeting materials is a memorandum from the Task Force to the Committee outlining its findings (Attachment Two-A). He explained that under the federal Affordable Care Act (ACA), CSRs are available for individuals and families purchasing health coverage in the health insurance marketplace with annual incomes below 250% of the federal poverty level (FPL). The federal government funded the cost of offering CSRs until 2017, when the U.S. Attorney General determined that funding was not appropriated by the U.S. Congress. Dyke said that when the funding was stopped, beginning in 2018, the federal Center for Consumer Information and Insurer Oversight (CCIIO) permitted states to allow insurers to increase plan premium rates to address the CSR shortfall. He said a variety of methods emerged to address the funding shortfall.

Dyke explained that the effect on consumer choices and affordability can vary based on the CSR funding methodology due to its resulting impact on premium subsidies or advanced premium tax credits (APTCs). He said that given the various methodologies that may be used to address the funding shortfall, the Task Force sought guidance and heard from the Academy, the CCIIO, and other stakeholders on the matter. He said the Task Force also updated its state survey of CSR loading approaches. Dyke summarized some of those discussions and the state survey results. He noted that the Task Force has never advocated for any particular approach states should take to address the funding shortfall.

Director Fox noted that enrollment in the ACA health insurance marketplace has increased because of the enhanced subsidies. She asked Dyke whether the next step to be considered if the enhanced subsidies end is whether there would be a corresponding decline in enrollment and whether state insurance regulators need to be vigilant and think about ways to get people enrolled in other coverage. Dyke said the Task Force did consider the impact of the enhanced subsidies ending as part of the referral. He noted that this is not a new issue for the Task Force, and there are many studies on it. He also noted that the NAIC is once again in the process of drafting a letter to Congress urging an extension of the enhanced subsidies or making them permanent. Dyke noted that all the things already discussed related to the enhanced subsidies' impact on enrollment in the ACA health insurance marketplace—increased enrollment and greater affordability—could potentially be reversed if they end. As a possible example, he pointed out the results of the Florida Office of Insurance Regulation's study on the

impact of the enhanced subsidies, which showed that enrollment increased by 51.4% overall from 2021 to 2023. The increase was 67.3% for those with incomes between 100% and 150% of the FPL and 86.9% for those over 400% of the FPL during the same period. He said these results would indicate the probability of a reversal in enrollment numbers if the enhanced subsidies end.

Director Fox said that despite asking for guidance from the CCIIO, the CCIIO has not dictated what methodology a state must use to address the CSR shortfall. As noted in the Task Force's memorandum to the Committee, there are many approaches the states can consider moving forward.

3. Heard a Presentation from the CIPR on Network Adequacy

Director Fox said the Committee would next hear a presentation from Kelly Edmiston (Center for Insurance Policy and Research—CIPR) on a case study the CIPR completed as part of its Network Adequacy Project: Compensation of Travel Costs for In-Network Care in Mississippi. Director Fox explained that she conducted a survey at the beginning of the year, asking Committee members which issues they were interested in learning more about. She said that network adequacy and its maximum time and distance requirements ranked as one of the issues. She said that before the CIPR presentation, Nacy would provide an overview of the network adequacy issue.

Nacy explained what a provider network is and how insurers establish provider networks, including defining and adjusting the number, quality, and type of providers in the network. She discussed the ACA's network adequacy goals and requirements, including maximum time and distance standards and maximum wait-time standards. Nacy explained that the federal Centers for Medicare & Medicaid Services (CMS) will conduct reviews to determine if an insurer satisfies the network adequacy requirements unless a state receives approval from the CMS to conduct its own reviews. To receive such approval, a state's criteria must be as stringent as CMS's network adequacy requirements.

Nacy noted that although her presentation seems to imply that network adequacy is simple and straightforward, state insurance regulators know that it is a challenging and complex issue. She said Edmiston will present a case study reflecting the CIPR's research on network distance issues, which would, hopefully, provide some insight and spark discussions on the issue.

Edmiston said the CIPR has been studying the issue of network adequacy for the past few years. During this meeting, he discussed the findings of a case study the CIPR conducted related to a new regulation in Mississippi requiring insurers to reimburse travel costs for patients who must travel 100 miles or more to access an in-network provider. The new regulations require an economic impact statement (EIS) that provides an estimate of the economic costs of the new regulation. He said the Mississippi Insurance Department requested the CIPR prepare an estimate of the costs to insurers of the regulation (or benefits to policyholders) to be used in the regulations' EIS. Edmiston discussed how the study was conducted. He provided results for one insurer for two provider specialties—allergy and immunology and reproductive endocrinology—from the 75 provider specialties surveyed as part of the study. He explained that the reimbursement costs to an insurer will vary based on whether the insurer has a broad or narrow provider network.

Director Fox asked Edmiston if requiring an insurer to reimburse consumers for travel costs could address an issue for states having insurer network adequacy compliance issues in rural areas. Edmiston said he does not know the impetus for Mississippi's new regulation requiring reimbursement for travel costs, but potentially such a requirement could address that issue for some states.

Nacy asked Edmiston how long it took the CIPR to complete the study, including the required analysis. Edmiston said excluding the time it took for the CIPR to obtain the necessary data, it took a couple of months to complete.

Nacy said that based on his discussion, it appears the CIPR is looking to obtain software to enable it to conduct more of these types of studies and analyses. She asked Edmiston if the CIPR had thought of other ways to assist the states with this issue. Edmiston said the CIPR is always happy to assist but noted that it seeks to obtain the software primarily to reduce the cost of conducting such studies and analyses to eliminate the need to rely on outside entities, such as Google, to perform the necessary millions of calculations. Commissioner Mulready asked if the CIPR conducted this analysis prior to or after the regulation's adoption. Edmiston answered that the CIPR conducted the analysis prior to its adoption because Mississippi law requires an EIS to be completed as part of the regulation adoption process.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MEMORANDUM

TO: Director Anita G. Fox, Chair of the Health Insurance and Managed Care (B) Committee

FROM: Kevin Dyke, Chair of the Health Actuarial (B) Task Force

DATE: June 3, 2024

RE: Cost Sharing Reduction (CSR) Referral to the Health Actuarial (B) Task Force Made at the 2023 Summer National Meeting

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In a September 15, 2023, memorandum, the Health Insurance and Managed Care (B) Committee asked the Health Actuarial (B) Task Force (HATF) to advise the Committee on how the impact of changes in CSR silver-loading policies or the elimination of enhanced subsidies could impact consumer choices and affordability. The Committee asked the HATF to review the issue and report its findings to the Committee.

Impact of Changes to CSR Loading Policies

Under the Affordable Care Act (ACA), cost sharing reductions are available for individuals (and families) purchasing health coverage on the Marketplace with annual incomes below 250% of the federal poverty level (FPL). The cost of offering the CSRs was funded by the federal government until 2017 when it was determined by the Attorney General that funding was not appropriated by Congress. When funding was stopped, the federal Center for Consumer Information and Insurer Oversight (CCIIO) instructed or permitted states to increase plan premiums to address the CSR shortfall. A variety of methods emerged to address the funding shortfall.

The effect on consumer choices and affordability can vary based on the CSR funding methodology due to its resulting impact on premium subsidies, or advanced premium tax credits ("APTCs"). Methods that result in higher silver, on-marketplace premiums produce higher premium subsidies as the subsidies are determined based on the relationship of the second-lowest priced silver plan to the individual's income. With greater subsidies, subsidy-eligible individuals may have a broader range of affordable plans, including low- or zero-cost plans. For example, when the CSR shortfall is applied only to silver, on-marketplace plans, the subsidies will be higher than if the CSR shortfall is recovered across all plans, or all silver on- and off-marketplace plans. The choice of method for determining the amount of CSR shortfall, such as those identified below in the Academy and Fann/Cruz discussions, can also affect the corresponding premiums and subsidies.

To understand the different CSR methodologies, HATF collected reports from interested parties and conducted conversations with regulators. This included guidance and feedback from the federal CCIIO, the American

Academy of Actuaries (Academy), and Greg Fann and Daniel Cruz, interested actuaries, as well as an updated state survey of CSR-loading approaches.

CCIIO

Since the loss of Federal funding, states have routinely asked CCIIO for specific or general guidance in determining the CSR load. In August 2018, CCIIO issued a bulletin encouraging states to consider offering plans outside of the Marketplace that do not include a CSR load. While the guidance focused on offering off-Marketplace plans without a load, it affirmed that CSR loads are permitted plan level variations for the actuarial value and cost-sharing design of the plan under 45 CFR 156.80(d)(2)(i). Over the years, HATF regulators have asked CCIIO if further guidance would be provided, and representatives indicated only that issuers can and should load for CSR amounts that the federal government will not reimburse and can do so by spreading all of the load across all plans within the single risk pool or applying the load only to the plans that generate CSR deficiencies. Further, they said whichever loading methodology is chosen, the total amount of the load should be actuarially justified, reasonable, and recover any deficiencies."[1]

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American Academy of Actuaries

In the fall of 2022, the Academy sent a letter to CCIIO offering comments and considerations relating to the CSR load. While the Academy did not advocate for a particular approach, they emphasized the importance of actuarial sound rates and suggested that CSR loads be "calibrated against actual experience to produce results consistent with anticipated incurred costs." They indicated other loading approaches not based on anticipated costs may not be actuarially sound and could produce cross-subsidies between plans not intended by federal regulations. Further, they explained that the choice of approach used in developing the CSR load could potentially lead to over- or under-accounting for the actual unfunded CSRs and recommended avoiding use of a method based on the federal AV calculator as outlined "whenever appropriate data for an actuarially sound methodology is available."

Fann/Cruz

Two actuaries, Greg Fann and Daniel Cruz, have advocated a different approach determining the CSR load on silver Marketplace plans and more broadly, the actuarial value and cost-sharing design plan level adjustments to rates. They suggest that with the elimination of Federal funding, silver level plans cover more paid claims than gold plans and significantly more than bronze plans and should be priced accordingly. Specifically, they believe silver plan level pricing should reflect maximum enrollment in 87 and 94 percent CSR plans as they believe all CSR-eligible individuals on the Marketplace would enroll in a CSR plan and that anyone who is not eligible for a CSR plan would not enroll in silver plans and instead enroll in gold or bronze plans. Fann and Cruz have shared their approach in various forums, including an April 2022 Families USA report and various posts on social media.

State Survey

To understand the various state approaches, HATF updated and enhanced a 2017 survey on CSR-loading guidance. Requested information included whether CSR loading occurs and certain characteristics of state guidance, such as requiring silver loading on or off the Marketplace and/or prescribing a factor for the CSR load. We also asked for a range of CSR factors if no factor was prescribed. Full or partial responses were received from 33 states. The survey showed that majority of states either require or expect funding to occur on silver level policies, either on or off the Marketplace. Nearly all responding states allow issuers to determine an appropriate CSR load, with a few states prescribing the CSR load. A summary of results and selected states who shared their public guidance separately are included in Appendix A. Due to the inclusion of informal guidance from several

[1] [1]CCIIO comments from the March 21, 2023 meeting of the Health Actuarial (B) Task Force

states in the survey, we will provide under separate cover the complete results of the survey in a regulator-only format.

Impact of Elimination of Enhanced Subsidies

Under the Affordable Care Act (ACA), premium tax credits are available to people purchasing health coverage on the Marketplaces with annual incomes between 100% and 400% of the federal poverty level (FPL). The American Rescue Plan Act of 2021 (ARPA) expands premium tax credits to those who are above 400% FPL and also increases subsidies for those making between 100% and 400% FPL for the 2021 and 2022 plan years. The enhanced subsidies were then extended for an additional three years, through the 2025 plan year, by the Inflation Reduction Act of 2022 (IRA).

As a result of these enhanced subsidies, enrollment in the ACA Marketplaces has increased substantially. According to the Florida Office of Insurance Regulation, enrollment increased by 51.4% overall from 2021 to 2023. The increase was 67.3% for those with incomes between 100% and 150% FPL, and by 86.9% for those over 400% FPL during the same period. The dramatic increases for these groups are attributed to the availability of $0 silver plans for those in the 100% to 150% FPL range, and to the provision of some subsidy to those over 400% FPL where previously there was none. As the silver loading for unfunded CSRs increases the premium for silver plans, and therefore the benchmark plan, the impact of the subsidy is greater in states with higher CSR loads.

If these subsidies are not extended beyond the 2025 plan year it will result in increased costs and reduced choices for consumers, including the return of the so-called “subsidy cliff” for those over 400% FPL. The Kaiser Family Foundation published an article in 2022 which analyzed the impact of the removal of the enhanced subsidies prior to the IRA being signed into law. This article highlights that the removal of the enhanced subsidies will have the greatest impact on older members, especially those over 400% FPL.

Appendix A - Survey Results and Selected State Guidance

Summary of Survey Results

50 states and the District of Columbia were surveyed, 33 responded with the following results:

- All 33 respondents indicated CSR loading occurs
- With respect to requiring CSR loading on silver plans:

Required	14 states (42%)
Not Required but Expected	9 states (27%)
Not Required	9 states (27%)

Selected State Guidance and Reports

(1) Nebraska

Nebraska Department of
Insurance Guidance
Document IGD - - B5

Title: Filing Guidance for Individual and Small Employer Major Medical Plans and Stand-Alone Dental Plans in Nebraska.

Sections: Guidelines for the Development of AV and Cost Share Design of each plan. Additional Requirement for What Needs to Be Provided as Rate Filing Support.

Issue Date: April 20, 2023

The following two sections were added to the final NE DOI Bulletin for filing 2024 ACA Plans.
These contain directions on developing CSR loads and benefit factors, as well as instructions on what should be reported in the SERFF rate filing.

Guidelines for the Development of "Actuarial Value and Cost Sharing Design" of Each Plan:

URRT Wksh 2, Sec. 3, line 3.3: "AV and Cost Sharing Design of the Plan"

- Each specific Plan has an "AV and Cost Sharing Design of the Plan" associated with it, more informally referred to as the plan's "Benefit Factor". This factor is one of the 5 Plan Level Adjustments allowed in CMS 45 CFR 156.80 rating development to adjust an issuer's MAIR (Market Adjusted Index Rate) to reflect the impact of the specific cost sharing of the plan, including Unit Cost and Utilization adjustments.

- The Benefit Factor for each plan must be developed to meet the "Single Risk Pool" rating requirements of the ACA. Benefit Factors must not reflect the differences in

morbidity between members expected to enroll in each plan, and each Benefit Factor should be developed assuming that the same standard population of members is enrolled on every Plan design.

- CMS has delegated to each state's effective rate review function the responsibility for determining how the Cost Sharing Reduction (CSR) benefit costs should be applied in ACA Individual rate setting within that state. The following guidelines are being posted to inform issuers as to what would be considered the acceptable standard for developing and filing Benefit Factors in plan year 2024 Nebraska ACA Individual rate filings.

    - Issuers may set their own CSR rating adjustments as long as they do not deviate from the standards below. The NDOI will no longer enforce the minimum 1.15 CSR load factor standard used in prior years and will not set a uniform CSR load factor for all issuers to use as some states have done. The NDOI has determined that applying such a uniform factor will likely never accurately reflect the correct value for any specific issuer. Issuers should utilize their own experience or other credible data when setting benefit factors, CSR Loads, Induced Demand Factors or other unit cost and utilization adjustments.

    - Issuers may apply formal Induced Demand Factors, or make appropriate utilization adjustments, as long as they meet the ACA Single Risk Pool rating requirements. Expected utilization differences due to member's health status, income levels, or other member case characteristics may NOT be reflected in Induced Demand Factors or other utilization adjustments used to develop the benefit factors.

    - Issuers may maintain Actuarial Soundness of their Index Rate by adjusting for the impacts of morbidity, reduced utilizations due to low-income members, and other causes by using the index rate adjustments listed below. As such, Silver Plan rates should not be adjusted independently to reflect lower utilizations due to more low-income members enrolling on 87% and 94% Silver Plan variants.

        - URRT Wksh 1, Sec. 2: "Morbidity Adjustment".
        - URRT Wksh 1, Sec. 2: "Other" Adjustment.

    - Issuers should assume expected distributions of members among their Silver Plan variants that reflects the most likely distribution that will occur. Simply assuming that all members will be enrolled on the 87% and 94% Silver Plan variants is not accepted as the standard method, though may be accepted if the issuer demonstrates it is the most likely distribution to

occur. Utilizing Nebraska PUF enrollment data from the recent plan year's enrollment among the standard Silver Plan, and the 73%, 87% and 94% variants, may provide a realistic distribution of membership to assume, given that the environment has not changed from the current year to the projected year (ARPA subsidies remain in place, etc.).

Additional Requirement for What Needs to Be Provided as Rate Filing Support:

Transparency of Benefit Factors.

The NDOI is requiring a Public Summary sheet of CSR Loads and Benefit Factors as outlined below. Additionally, the NDOI is requiring CSR Load and Benefit Factor development to be included in issuer's Individual Market rate filings.

(1) Required Individual Market Public Summary Sheet for CSR Loads and Benefit Factors.

This requirement applies to Individual On-Exchange Plans excluding Catastrophic Plans.

Issuers should provide a single Excel sheet in their annual SERFF rate filing containing the following columns of information which will be made Public when NE SERFF rate filings become Public on November 1st, 2023.

- HIOS Plan ID Number
- Metal Level
- AV Factor
- Benefit Factor (The AV Pricing & Cost Sharing Factor)
- Provider Network Adjustment
- CSR Load for Silver Plans, or 1.0 for all Non-Silver Plans
- Induced Demand Factor (plan aggregate for all services)

(2) Required Supporting Development of Benefit Factors and CSR Loads:

This requirement applies to Individual On-Exchange Plans and is not required to be made Public if the issuer submits a valid Trade-Secret Request within the rate filing.

(a) Issuers should provide a high-level summary of the data used for setting Benefit
Factors, including:

- Incurred claim dates

- Paid claim dates
- Lines of business, States, other Geographic factors
- Incurred Claims and Member Months by Calendar Year, summarized by each major service category (Similar to those used in URRT Worksheet 1, section 1).

Note this should summarize the data actually used to set benefit factors, whether it was from the company's own ACA Individual business, a consultant's health cost guidelines, National Group Business, etc…

(b) At the time of submitting the rate filing, Issuers should provide their complete detailed development of Benefit Factors for each of the following:
Plans with the lowest and highest Benefit Factor within each of the following Metal Levels:

- Bronze & Enhanced Bronze Plans
- Silver Plans
- Gold Plans
- Platinum Plans

(c) For each of the Plans indicated in (2b) above, the complete detailed Benefit Factor development should be included, showing the development from the underlying base experience by service category, including all adjustments or modeling applied to arrive at the final benefit factors. The level of service category included in the supporting development should reflect the level at which benefit factors are developed. This may be at a High-Level Service Category (Inpatient, Outpatient, Physician, Pharmacy,..) or at more refined levels if utilization and unit cost adjustments are applied at a more granular level.

(d) Identify all utilization and unit cost adjustments that have been applied at any step in the process to obtain the final estimated benefit cost factor in the new benefit period. A description and quantitative support should be provided for each adjustment.

Demonstrate how Induced Demand Factors (IDF) or other specific Utilization adjustments were determined and show how they are applied.

For provider contracting changes in the new plan year that result in adjustments to your unit cost assumptions, those adjustments should be documented and quantified.

(e) For On-Exchange Silver Plans the complete development of the CSR Load should be provided, and should include at least the following:

- Membership distribution assumptions used for enrollment in Base Silver, 73%, 87% and 94% Silver plan variants
- Data source used to determine the distribution (i.e. NE PUF Enrollment Data, Issuer's own experience, or other source)
- Membership adjustments made to the source data
- Utilization adjustments, including a description of any adjustments

(f) Issuers utilizing predictive models, such as GLMs, GAMs or other such predictive models, must provide the required support contained on the NDOI L&H webpage. Any other simulation models, or other models used in the process of setting benefit factors, need to be fully documented.

(2)Texas

Texas Association of Health Plans (axioshq.com)

(3) Washington

https://content.naic.org/sites/default/files/inline-files/cmte_b_ha_tf_related_state_cost_sharing_washington.pdf

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2024 Summer National Meeting/HATF CSR Memo B Committee Final.docx

Draft: 8/5/24

Consumer Information (B) Subgroup
Virtual Meeting
July 29, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met July 29, 2024. The following Subgroup members participated: David Buono, Chair (PA); T.J. Patton, Vice Chair, (MN); Michelle Baldock (IL); Alex Peck (IN); Terri Smith (MD); Jeana Thomas (MO); Hadiya Swann (NC); Jill Kruger (SD); Jennifer Ramcharan and Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keeley (WI).

1. Discussed a Consumer Guide on Prior Authorization

Buono discussed the work of a drafting group that developed a consumer guide on prior authorization. He thanked the drafting group for its work and said it intended the guide to cover important points while keeping the language clear and simple. He said the guide, once approved, may be modified by states to fit their needs.

The Subgroup reviewed the draft and discussed a number of changes. It added clarifying language about step therapy and a drafting note that points out where states can add additional information about their state laws. The Subgroup also discussed the document's reading level and was satisfied that it measured just below the ninth-grade level.

Patton made a motion, seconded by Keeley, to approve the guide with the changes added (Attachment Three-A). The motion passed unanimously. Joe Touschner (NAIC) said the guide would be shared with the Health Insurance and Managed Care (B) Committee for awareness, and the final version would be sent to Subgroup members and interested parties.

2. Discussed Other Matters

Buono said the Subgroup should expect to work on updates to the *Frequently Asked Questions About Health Care Reform* (FAQ) starting in September, so the document is ready for the beginning of open enrollment. He said the Subgroup has a list of potential projects to take up after that one, including guides on preventive services, limited benefit plans, mental health parity, and the balance billing protections of the federal No Surprises Act (NSA). He said the Subgroup could decide at a future meeting which topic to take up after the FAQ.

Having no further business, the Consumer Information (B) Subgroup adjourned.

NAIC Support Staff Hub/B CMTE/National Meetings/2024 Summer National Meeting/Cons Info 7.29.docx

Prior Authorization: What It Is, When It's Used, and Your Options

What Is Prior Authorization?

Prior authorization means your health plan requires your doctor or other healthcare provider to get approval *before* they provide health care services or prescribe prescription drugs. Without prior authorization, your health plan may not pay for your treatment or medication.

NOTE: Emergency services don't require prior authorization.

Why Do Health Plans Require Prior Authorization?

Prior authorization serves two purposes. First, it's a check that your plan covers the proposed care. It's also a way the health plan can decide if the care is medically necessary, safe, and cost effective.

What Is Medically Necessary?

A medically necessary service or prescription drug is one that's needed to diagnose or treat an illness, injury, condition, disease, or its symptoms. It must meet accepted standards of medicine. To decide what's medically necessary, your health plan must follow any state and federal laws that apply.

How Do Health Plans Decide What's Safe?

To be safe, procedures, treatments, and prescription drugs must meet the latest clinical standards and guidelines. They must avoid negative interactions between drugs you're already taking or treatments you're receiving.

What If My Health Plan Has Concerns with a Proposed Treatment or Medication?

The health plan may deny the request, ask for more information, recommend another approach, or talk with your provider to agree on the most appropriate care plan. Your health plan might suggest other tests based on clinical guidelines before it makes a decision.

Could My Health Plan Deny Prior Authorization Because of Cost?

Yes. Health plans may deny prior authorization when similar drugs or services are equally safe and effective but cost less. For example, a health plan may approve a drug only if you try a less expensive drug first and that drug isn't effective or causes side effects. This may be called step therapy.

Do I Need Prior Authorization to Continue a Treatment I'm Currently Receiving?

You may. Your health plan may require your provider to confirm that ongoing services or medications would continue to help you.

What Medications and Services Require Prior Authorization?

Your health plan has a list of medications and services that typically require prior authorization. You can find the list in printed plan documents and/or online.

Does Medicare Require Prior Authorization?

Original Medicare (Medicare Part A and Part B) generally does not require prior authorization.

Medicare Advantage and Medicare prescription drug plans (Part D) may require prior authorization.

How Long Do Prior Authorization Decisions Take?

How long it takes to get a prior authorization decision depends on how urgently you need the care. If your need is urgent, you or your provider can ask for an expedited (or quick) review. State or federal rules may limit the time a health plan can take to make decisions.

What Rules Must Plans Follow About Prior Authorization?

Health plans' prior authorization policies must follow federal and state laws. Depending on your state, these laws may address:

- How quickly health plans must respond to requests for prior authorization and appeals,
- What types of professionals may review and approve or deny a prior authorization request,
- What information a health plan must share with you and your provider when it denies a prior authorization request, and
- How long a prior authorization approval may last before you must ask for a new authorization.

How Do I Ask for Prior Authorization?

Your health care provider can make the prior authorization request. In some cases, your provider will request that you start the prior authorization process.

If your provider submits the request, they will send the required information to the health plan. You may need to fill out forms for your provider's office to use. A prior authorization form will include information about you, your medical conditions, and your health care needs. It's important to fill out the form completely and accurately. Missing or wrong information could delay your request or result in a denial.

If you submit the prior authorization request, ask your health plan how to do that. Make sure you meet the deadlines your health plan gives you. Keep copies of all documents and communications sent and received. Note dates and the names and titles of people you speak with. You may need this information if the request is denied. Keep a record of approved prior authorizations in case you need to ask for another one in the future.

Can I Appeal If I Think My Prior Authorization Was Incorrectly Denied?

You may appeal a health plan's prior authorization decision. Before starting the appeal process, call your health plan to learn why the prior authorization was denied. Check that all the requested information was received and was correct. If a simple error was the problem, such as missing information, correcting the error might be a quick fix.

If all information is correct and nothing is missing, you'll need to partner with your provider's office to start an appeal. Give the office the reason for the denial. Ask if there's other information that could support the prior authorization request. If so, you or your provider can follow your health plan's instructions to submit an appeal.

For more information about how to appeal a prior authorization decision, contact [your state Insurance Department] to help guide you through the process or help you file a complaint if appropriate.

Drafting Note: State laws or rules are referenced in three answers (What is Medically Necessary?, How Long Do Prior Authorization Decisions Take?, and What Rules Must Plans Follow About Prior Authorization?). States may wish to provide specific information on state laws or link to additional information. The final answer on appeals includes a reference to the state department of insurance, where it may be helpful to add contact information.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2024 Summer National Meeting/Prior Authorization Guide.docx

Draft: 6/26/24

Consumer Information (B) Subgroup
Virtual Meeting
June 18, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met June 18, 2024. The following Subgroup members participated: David Buono, Chair (PA); T.J. Patton, Vice Chair (MN); Michelle Baldock (IL); Terri Smith (MD); Jeana Thomas (MO); Hadiya Swann (NC); Jill Kruger (SD); Shelley Wiseman (UT); and Christina Keeley and Jody Ullman (WI). Also participating was: Susan Jeanette (DE).

1. Heard Introductory Remarks

Buono and Patton introduced themselves as the Subgroup's new chair and vice chair. Buono described his background with the Pennsylvania Insurance Department and his work on consumer issues. Patton shared his history with the Minnesota Department of Commerce and his work managing consumer assistance. Both said they are eager to develop materials for use by state insurance regulators with the Subgroup.

2. Discussed Guides on Prior Authorization

Buono discussed the work of a drafting group working on a consumer guide on prior authorization. He said the drafting group has made progress, and he hopes the drafting group will have a draft to share with the Subgroup after one or two additional meetings. He invited state insurance regulators and interested parties to join the drafting group's upcoming meetings.

Buono said that the drafting group had discussed developing two guides: one for consumers and one for state insurance regulators. He asked Subgroup members whether a guide for state insurance regulators would be useful. The Subgroup decided to defer to the drafting group on this question.

3. Discussed Other Matters

Buono said that in addition to the prior authorization guide and updates to the *Frequently Asked Questions about Health Care Reform*, the Subgroup should consider additional projects for the remainder of 2024 or 2025. He said two potential projects would produce consumer guides on the federal No Surprises Act (NSA) or mental health parity protections. He asked the Subgroup what additional topics should be considered.

Subgroup members and interested parties suggested a variety of potential topics for consumer materials, including coverage of preventive services, education on self-funded versus fully-insured plans, alternative payment models, making updates to the Subgroup's existing health insurance shopping tools, and limited benefit plans like short-term, limited duration (STLD), discount plans, and health care sharing ministries (HCSMs). Subgroup members also supported the idea of producing guides on the NSA and mental health parity. Buono said that he and Patton would discuss the suggestions and come back to the Subgroup with a proposal for its next project.

Having no further business, the Consumer Information (B) Subgroup adjourned.

