ROLL CALL

Jessica Altman, Chair
Pennsylvania
John Elias
New Hampshire

Lori K. Wing-Heier, Vice Chair
Alaska
Linda A. Lacewell
New York

Michael Conway
Colorado
Jon Godfread
North Dakota

Dean L. Cameron
Idaho
Andrew Stolfi
Oregon

Vicki Schmidt
Kansas
Hodgen Mainda
Tennessee

Nancy G. Atkins
Kentucky
Scott A. White
Virginia

Steve Kelley
Minnesota
Mike Kreidler
Washington

Mike Chaney
Mississippi

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

AGENDA

1. Consider Adoption of its Oct. 24 and Summer National Meeting Minutes
   —Commissioner Jessica Altman (PA)

2. Consider Adoption of its Subgroup, Working Group and Task Force Reports
   —Commissioner Jessica Altman (PA)
   • Consumer Information (B) Subgroup—Angela Nelson (MO)
   • Health Innovations (B) Working Group—Health Insurance Commissioner Marie Ganim (RI)
   • Health Actuarial (B) Task Force—Director Anita G. Fox (MI) and Kevin Dyke (MI)
   • Long-Term Care Insurance (E/B) Task Force
     —Commissioner David Altmaier (FL) and Commissioner Jessica Altman (PA)
   • Regulatory Framework (B) Task Force—Commissioner Michael Conway (CO)
   • Senior Issues (B) Task Force—Director Lori K. Wing-Heier (AK)

3. Hear an Update from the Federal Center for Consumer Information and Insurance Oversight (CCIIO)
   —Randy Pate (CCIIO)

4. Hear Presentation on “Overcharged: Why Americans Pay Too Much for Health Care”
   —Charles M. Silver (University of Texas at Austin, McDonald Endowed Chair in Civil Procedure, School of Law)

5. Hear a Panel Presentation on State Surprise Billing Laws: What Works and Impact on Networks and Reimbursement—Jane Beyer (WA) and Nancy Clark (TX)

6. Hear an Update on Legal Action Surrounding the Federal Affordable Care Act (ACA)
   —William G. Schiffbauer (Law Office of William G. Schiffbauer, Chartered)

7. Hear a Federal Legislative Update—Joseph Touschner (NAIC)
8. Discuss Any Other Matters Brought Before the Committee—Commissioner Jessica Altmann (PA)

9. Adjournment

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Agenda Item #1

Consider Adoption of its Oct. 24 and Summer National Meeting Minutes
—Commissioner Jessica Altman (PA)
Health Insurance and Managed Care (B) Committee
Conference Call
October 24, 2019

The Health Insurance and Managed Care (B) Committee met via conference call Oct. 24, 2019. The following Committee members participated: Jessica Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair, represented by Sarah Bailey (AK); Michael Conway (CO); Dean L. Cameron represented by Weston Trexler (ID); Vicki Schmidt represented by Julie Holmes (KS); Nancy G. Atkins (KY); Steve Kelley represented by Grace Arnold (MN); Jon Godfread (ND); Andrew Stolfi (OR); Hodgen Mainda (TN); Scott A. White (VA); and Mike Kreidler represented by Molly Nollette (WA). Also participating was: Kevin Dyke (MI).

1. **Adopted the Health Actuarial (B) Task Force’s 2020 Proposed Charges**

Mr. Dyke provided a brief overview of the Health Actuarial Task Force’s 2020 proposed charges. He said the Task Force’s proposed charges are similar to its 2019 charges. The Task Force will continue to focus on issues related to the federal Affordable Care Act (ACA) and long-term care insurance.

Commissioner Conway made a motion, seconded by Ms. Arnold, to adopt the Task Force’s 2020 proposed charges *(see NAIC Proceedings – Fall 2019, Health Actuarial (B) Task Force, Attachment ____)*. The motion passed unanimously.

2. **Adopted the Regulatory Framework (B) Task Force’s 2020 Proposed Charges**

Commissioner Conway said the Regulatory Framework’s 2020 proposed changes are straightforward, with only one completion date changed from 2019 to 2020. He said the Accident and Sickness Insurance Minimum Standards (B) Subgroup’s charge to revise the *Accident and Sickness Insurance Minimum Standards Model Act* (#170) was removed, as that work has been completed (including changing the title to the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*).

Ms. Nollette made a motion, seconded by Mr. Trexler, to adopt the Task Force’s 2020 proposed charges *(see NAIC Proceedings – Fall 2019, Regulatory Framework (B) Task Force, Attachment ____)*. The motion passed unanimously.

3. **Adopted the Senior Issues (B) Task Force’s 2020 Proposed Charges**

David Torian (NAIC) said the Senior Issues (B) Task Force’s 2020 proposed charges are basically the same as its 2019 charges, except for the following changes: Charge 2 and Charge 3 have been deleted because the subgroup and working group, respectively, have completed their work; and Charge 1F has been revised to add the *Limited Long-Term Care Insurance Model Act* (#642) and the *Limited Long-Term Care Insurance Model Regulation* (#643).

Commissioner Atkins made a motion, seconded by Commissioner Godfread, to adopt the Task Force’s 2020 proposed charges *(see NAIC Proceedings – Fall 2019, Senior Issues (B) Task Force, Attachment ____)*. The motion passed unanimously.

4. **Adopted its 2020 Proposed Charges**

Commissioner Altman stated that, prior to the call, NAIC staff distributed the Committee’s 2020 proposed charges and posted them on the Committee’s website, but—similar to many of the task force charges—there are not significant changes. The Committee will continue much of the important work that is already ongoing.

Commissioner Conway made a motion, seconded by Commissioner Stolfi, to adopt the Committee’s 2020 proposed charges *(Attachment ____)*. The motion passed unanimously.

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

Draft: 8/14/19

Health Insurance and Managed Care (B) Committee
New York, New York
August 4, 2019

The Health Insurance and Managed Care (B) Committee met in New York, NY, Aug. 4, 2019. The following Committee members participated: Jessica Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); Dean L. Cameron (ID); Vicki Schmidt (KS); Nancy G. Atkins (KY); Steve Kelley represented by Grace Arnold (MN); Jon Godfread (ND); Linda A. Lacewell represented by Troy Oechsner (NY); Andrew Stolfi (OR); Carter Lawrence (TN); Scott A. White represented by Julie Blauvelt (VA); and Mike Kreidler represented by Molly Nollette (WA). Also participating were: Steve Ostlund (AL); Ryan James (AR); Perry Kupferman (CA); Fleur McKendell (DE); Doug Ommen (IA); Alex Peck (IN); Rich Piazza (LA); Kevin Dyke (MI); Paige Duhamel (NM); Glen Mulready (OK); Todd E. Kiser (UT); Nathan Houdek (WI); and Joylynn Fix (WV).

1. Adopted its June 11 and Spring National Meeting Minutes

The Committee met June 11 and April 7. During its June 11 meeting, the Committee took the following action: 1) adopted the Regulatory Framework (B) Task Force’s 2019 charges, which added a charge for the HMO Issues (B) Subgroup to revise provisions in the Health Maintenance Organization Model Act (#430) to address conflicts and inconsistencies with the Life and Health Insurance Guaranty Association Model Act (#520); 2) adopted the Regulatory Framework (B) Task Force’s Request for NAIC Model Law Development for the HMO Issues (B) Subgroup to revise Model #430 consistent with its 2019 charge; and 3) adopted the Consumer Information (B) Subgroup’s consumer alert “What to Ask for When Shopping for Health Insurance.”

Ms. Nollette made a motion, seconded by Director Cameron, to adopt the Committee’s June 11 (Attachment One) and April 7 (see NAIC Proceedings – Spring 2019, Health Insurance and Managed Care (B) Committee) minutes. The motion passed unanimously.

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

Commissioner Godfread made a motion, seconded by Commissioner Atkins, to adopt the following reports: the Consumer Information (B) Subgroup, including its July 23 (Attachment Two), July 9 (Attachment Three), June 25 (Attachment Four), May 31 (Attachment Five), May 8 (Attachment Six) and May 1 (Attachment Seven) minutes; the Health Innovations (B) Working Group (Attachment Eight); the Health Actuarial (B) Task Force; the Long-Term Care Insurance (E/B) Task Force; and the Senior Issues (B) Task Force. The motion passed unanimously.

3. Heard an Update from the CCIIO

Randy Pate (federal Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO’s regulatory activities related to the federal Affordable Care Act (ACA) and other activities of interest to the Committee. He described the status of the current individual market and what actions the Trump Administration is taking to increase access and affordability. He discussed the average health risk, enrollment duration and costs across private insurance markets: the ACA individual market, the ACA small group market, and the large group market. He noted that enrollees in the ACA individual and small group markets tend to have shorter enrollment durations than enrollees in the large group market. In addition, individual market enrollees have 32% higher risk scores on average compared to large group enrollees.

Mr. Pate discussed enrollment patterns over the years for enrollment through state-based exchanges and HealthCare.gov. He noted that the federal Centers for Medicare & Medicaid Service’s (CMS) commitment to providing a seamless experience for consumers using HealthCare.gov. He said as reflected in consumer satisfaction rate surveys, CMS is achieving this goal.

Mr. Pate highlighted the decrease in premium for the second-lowest cost silver plan or benchmark plan from plan year 2018 to plan year 2019. He explained that this varies across the states, with some states experiencing increases in premium while others experience decreases in premium. He also discussed improvement in the states with respect to the number of insurers offering coverage. He discussed how state innovation using ACA Section 1332 waivers has played a big part in reducing premium. However, he said work still needs to be done to make the individual marketplace more attractive, particularly for those not receiving financial assistance. He discussed what actions the Trump Administration is taking to improve the individual market by encouraging more competition, state flexibility, new options and innovations.
Mr. Pate discussed how the recently finalized Health Reimbursement Account (HRA) rule will make it easier for small businesses to compete with larger businesses by creating another option for financing worker health insurance coverage. He said using an individual coverage HRA, employers will be able to provide their workers and their workers’ families with tax-preferred funds to pay all or a portion of the cost of health insurance for coverage that workers purchase through the individual market. As such, the HRA rule will significantly increase the number of Americans with private insurance coverage and thereby reduce the number of uninsured. He said the Trump Administration believes that by striking the right balance between employer flexibility and guardrails meant to protect the individual market against adverse selection, the HRA rule should significantly increase the size of the individual market, making it a more attractive option for insurers to enter and offer coverage.


The Committee heard a panel presentation on current parity implementation issues and outstanding parity issues state insurance regulators should be aware of regarding the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Varum Choudhary (Magellan Health—Magellan) provided an overview of state and federal policymaking with respect to parity in the provision of mental health and substance use disorder services. He outlined Magellan’s long-standing support of mental health parity and its policies aimed at achieving parity through its “Achieving the Triple Aim” initiative. He said the MHPAEA has improved the landscape of mental health and substance use disorder coverage, but challenges and opportunities remain. He discussed a few of those opportunities for policymakers, including state insurance regulators, to further improve parity, such as: 1) clarifying and standardizing compliance with non-quantitative treatment limits (NQTLs); 2) ensuring investment and accountability in the behavioral health system; 3) integrating behavioral and primary care; and 4) providing consumers with user-friendly information on how behavioral health benefits are developed on par with their medical/surgical benefits.

Andrew Sperling (National Alliance on Mental Illness—NAMI) explained that the MHPAEA does not mandate coverage of mental health or substance use disorder services. If a plan offers such coverage benefits, then the MHPAEA requires that the benefits must be “no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan…” and “there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits.” He said he believes the MHPAEA has been successful. However, he believes issues remain, particularly with respect to NQTLs; but even with respect to NQTLs, progress is being made. He discussed opportunities that he believes are available to state insurance regulators to improve access, including: 1) assuring compliance across both the plan managing medical-surgical benefits and the separate “carve out” plan managing behavioral health; and 2) ensuring parity for network adequacy. He also suggested a need for an independent accreditation process that insurers can use for compliance, particularly with respect to NQTLs.

Tim Clement (American Psychiatric Association—APA) expressed confidence that within the next few years, there will be full compliance with the MHPAEA given the work that is being done by state insurance regulators with insurers to improve compliance. He said, as Mr. Sperling noted, the MHPAEA has improved access and coverage, particularly with respect to quantitative treatment limits (QTLs), but more work needs to be done with respect to NQTLs. He noted that many insurers rely on checklists to achieve compliance, but some are not performing the necessary due diligence to ensure compliance “in operation.” He cited a few examples of such situations, such as prior authorization requirements or retrospective review requirements. He suggested that requiring enhanced attestation of compliance, not just attestation could address some of these issues. He said state insurance regulators, insurers, and consumers need to work as partners to resolve these issues and challenges.

Commissioner Altman asked Dr. Choudhary how Magellan works to ensure that there is “in operation” compliance with the MHPAEA’s requirements. He explained Magellan’s procedures. He said issues arise when the mental health or substance use disorder service does not translate to a comparable medical service. He said in such cases, Magellan works collaboratively to resolve the issue.

Director Wing-Heier asked about the use of telemedicine to address challenges for rural states, like Alaska, in having a sufficient number of network providers for the provision of mental health and substance use disorder services. Mr. Sperling said telemedicine is an option, but it is still challenging. Dr. Choudhary said he believes this problem with workforce and access can possibly be addressed by creating appropriate incentives.
Commissioner Kiser asked about addressing these issues through integrated care. Dr. Choudhary discussed how Magellan uses a fully integrated health model to equip primary care providers (PCPs) with what they need to treat mental health issues. Mr. Clement discussed the APA’s collaborative care model.

5. **Heard a Briefing from the CIPR on the Research Study “Rising Health Care Costs: Drivers, Challenges and Solutions”**

Dimitris Karapiperis (Center for Insurance Policy and Research—CIPR) discussed the provisions in the first installment of the research study “Rising Health Care Costs: Drivers, Challenges and Solutions,” which was released in December 2018. He said recently released installments of this study include the articles “Addressing High Care Cost Drivers—A Critical Role for Regulators” and “Prescription Drug Cost Drivers.” Jeff Czajkowski (CIPR) discussed the CIPR’s next steps regarding the study. He said the CIPR anticipates releasing three chapters prior to the Fall National Meeting, which would include articles on: 1) value-based reimbursement; 2) wasteful health spending; and 3) the use of big data to reduce health care costs. He also discussed the CIPR’s new initiatives such as its, “Regulator Insights” publication, highlighting two recent publications on long-term care insurance (LTCI) and air ambulances. He also discussed possible CIPR future projects of interest to the Committee, such as reference-pricing.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
Agenda Item #2

Consider Adoption of its Subgroup, Working Group and Task Force Reports
—Commissioner Jessica Altman (PA)
Summary Report

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Nov. 18, Oct. 21 and Oct. 7, 2019. During these calls, the Subgroup:

1. Developed a consumer guide entitled *Using Your Health Coverage*. The guide helps consumers better understand health coverage they are enrolled in by providing guidance on cost sharing, provider networks, referrals, coordination of benefits, life changes, and other topics. Readability review of the guide was recently completed and the Subgroup plans to meet to adopt the guide after the Fall National Meeting.

2. Distributed re-designed versions of the *Health Coverage Shopping Tool* and *What to Ask when Shopping for Health Coverage*. The NAIC’s Communications Department aided in updating the design of the two documents approved by the Subgroup in the past. The Subgroup reviewed the new designs and re-distributed the documents.

3. Approved revisions to the Frequently Asked Questions (FAQ) about Health Care Reform document. The Subgroup considered and approved changes to the FAQ to bring its content up to date for the 2020 plan year.

4. Began drafting a consumer guide on dealing with health insurance claims. The Subgroup began initial work to develop a guide to help consumers understand Explanation of Benefits (EOB) documents and how to deal with claims issues.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Nov. 18, 2019. The following Subgroup members participated: Angela Nelson, Chair, Jessica Schrimpf, Carrie Couch, Danielle McAfee-Thuinen and Camille Anderson-Weddle (MO); Michelle Baldock (IL); Alex Peck and Jennifer Groth (IN); Joy Hatchette (MD); Melinda Domzalski-Hansen (MN); Cuc Nguyen (OK); Katie Dzurec, David Buono and Elizabeth Hart (PA); Jill Kruger, Candy Holbrook and Gretchen Brodkorb (SD); Heidi Clausen and Jaakob Sundberg (UT); and Jennifer Stegall, Eric Corman, Julie Walsh, Mary Kay Rodriguez, Rebecca Rebholz and Sue Ezalarab (WI). Also participating were: Jacob Lauten and Chelsey Maller (AK); Julia Yee (CA); John Reilly (FL); Teresa Winer (GA); Cynthia Banks Radke and Sonya Sellmeyer (IA); Emily DeLaGarza (MI); Pam Koenig and Michelle Scaccia (MT); Jessica Baker, Monica Bryant and Patricia Trujillo (NM); Jana Jarrett (OH); Libby Camp Elliott and Markus Wilcox (TX); Yolanda Tennyson (VA); Dena Wildman, Ellen Potter and Vanessa George (WV); and Denise Burke (WY).

1. Discussed a Consumer Guide on Using Health Insurance

Ms. Nelson brought up the consumer guide, *Using Your Health Coverage*. She said that it had been sent to Brenda J. Cude (University of Georgia) to review for readability. She said that Ms. Cude had some questions overall and encouraged greater consistency in use of terms. Ms. Nelson said that the draft uses the terms “health insurance,” “health plan” “coverage,” and others and asked how the Subgroup would like to align these references.

The Subgroup discussed choosing one term and adding a definition of it early in the document. Harry Ting (Chester County Department of Aging Services – Apprise Program) said that the document references Medicare in some places and that “health plan” would be a better fit than “carrier” in the Medicare context. The Subgroup discussed the use of “health plan” further.

Ms. Nelson asked about a more consistent term to describe what health plans provide and suggested either “services” or “benefits” could be appropriate. The Subgroup discussed the question, and Ms. Hatchette said that services may or may not be benefits; only those that are covered by the plan are benefits. Candy Gallaher (America’s Health Insurance Plans—AHIP) said that insurers think of “benefits” as larger categories that contain many “services.” Ms Cude said that all these terms could be used, but the document should stick with consistent phrasing. She said that the conversation was helpful and that she would need to review the document again.

2. Discussed a Consumer Guide on Claims Issues

Ms. Nelson brought up the next item on the Subgroup’s work plan, a consumer guide related to claims. She said that this piece has a great deal of potential benefit for consumers. She said that many states have consumer information on appeals and grievances, but she would like to take a step back to the beginning of the process and provide better information on explanations of benefits (EOBs).

Ms. Nelson asked who the target audience for the guide should be. She asked whether the Subgroup had concerns with writing it in a broad-based way that applies to all private health coverage. Ms. Domzalski-Hansen asked whether it would cover Medicare, and Ms. Nelson responded that it should be focused on private coverage, not Medicare or Medicaid plans. The two discussed whether the document should include information on which government agency consumers should contact with a complaint, depending on the type of plan they have. Ms. Nelson said it should describe common elements in EOBs and present whom to call, but also help consumers be advocates for themselves.

Ms. Hatchette said that one concern is that the broader the application, the longer the document, and the fewer people who will read it. She said this piece could be something distributed in doctors’ offices, but if it is a multi-page document, that is difficult. Ms. Nelson said the Subgroup could consider a longer piece that consists of multiple one-pagers that could be used individually.

Ms. Nelson asked what topics should be covered in the guide. She mentioned several potential topics, including EOBs, claims denials, prior authorization, prescription drug exceptions, medical necessity determinations, mental health parity, provider access and external appeals. Ms. Baldock suggested focusing on appeals, complaints and external reviews, and the Subgroup...
discussed how to keep the document readable with a large number of potential topics. Mr. Ting suggested prioritizing the ones that come up the most often or are most important for consumers. Ms. Nelson stressed the importance of explaining EOBs.

Ms. Nelson asked about documents that could serve as models for the consumer guide. Ms. Hatchette said she likes a publication from Georgians for a Healthy Future, but it is still too long. Mr. Ting agreed that many existing pieces are too long and suggested that the guide include sample letters for different appeals. Ms. Cude questioned whether the guide should be split into multiple documents, and Ms. Nelson said it was an option and, in any case, the guide should be streamlined and easily digestible.

Ms. Nelson asked that the Subgroup send ideas for topics to cover in response to an initial list she would send.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Oct. 21, 2019. The following Subgroup members participated: Angela Nelson, Chair, and Jessica Schrimpf (MO); William Rodgers (AL); Weston Trexler (ID); Michelle Baldock and David Osborn (IL); Alex Peck (IN); Joy Hatchette and Mary Kwei (MD); Melinda Domzalski-Hansen (MN); Martin Swanson (NE); Cuc Nguyen (OK); Elizabeth Hart and Katie Dzurec (PA); Gretchen Brodkorb (SD); Heidi Clausen, Tanji Northrup and Jaakob Sundberg (UT); Todd Dixon (WA); Jennifer Stegall, Rebecca Rebholz and Julie Walsh (WI). Also participating were: Chelsey Maller (AK); Gerard O’Sullivan (CT); Fleur McKendell (DE); John Reilly (FL); Cynthia Banks Radke and Sonya Sellmeyer (IA); Emily DeLaGarza and Renee Campbell (MI); Bob Williams (MS); Pam Koenig (MT); Anna Howard (ACS CAN); Vickie Trice (TN); Angela Herron, Scott Helmcamp, Rachel Bowden and Marcus Wilcox (TX); and Yolanda Tennyson (VA); Joylynn Fix (WV); and Tana Howard (WY).

1. Reviewed an Updated Health Insurance Shopping Tool

Ms. Nelson described revisions that the NAIC’s Communications Division made to the Health Insurance Shopping Tool (Attachment 1) adopted by the Subgroup in 2018. She said that it looks better than before. In response to questions, she said that the text had not changed but the layout did. She said that states can use it to assist consumers. Subgroup members also inquired whether states are permitted to add their own branding so that the document shows both state and NAIC logos and whether an editable version would be available. Joe Touschner (NAIC) responded that he would bring these questions to the Communications Division and get back to the Subgroup.

2. Discussed a Consumer Guide on Using Health Insurance

Ms. Nelson brought up the consumer guide, Using Your Health Coverage. She reminded the Subgroup that it is intended for consumers enrolled in different kinds of coverage, including insurance in the individual market, as well as employer-sponsored coverage. She reviewed updates to the table of contents, and the Subgroup had no further edits.

Ms. Nelson said that Ms. Baldock and Candy Gallaher (America’s Health Insurance Plans—AHIP) collaborated on edits to the Life Changes section and asked them to review them. Ms. Gallaher said that they added subheadings and noted that Open Enrollment Period and Special Enrollment Period were not listed in the glossary, which they recommended be added.

The Subgroup discussed whether and how to reference transitions to Medicare. Ms. Gallaher noted that a note early in the document says that the guide is not applicable to Medicare, but that Medicare can be a more affordable option for eligible individuals than marketplace plans. She suggested that the guide recommend exploring Medicare options. Anna Howard (American Cancer Society Cancer Answer Network—ACS CAN) suggested a direction to contact a State Health Insurance Assistance Program (SHIP) with Medicare questions.

The Subgroup discussed how to deal with short-term health plans, which do not provide Summaries of Benefits and Coverage (SBC). Some suggested making reference to comprehensive coverage, which would exclude short-term plans. Others observed that existing language notes that the guides does not cover supplemental plans. Ms. Nelson said that the average consumer may not know what these terms mean. The Subgroup discussed adding text in the Getting to Know Your Health Plan section that urges consumers to identify the type of plan they are enrolled in and potentially saying that those in comprehensive coverage will receive an SBC. Some Subgroup members suggested a direction to check the policy.

Ms. Nelson asked whether the consumer guide is ready for a review for readability by Brenda J. Cude (University of Georgia). Ms. Cude said she is happy to review the document.

Ms. Nelson said the goal is to complete the guide by January 1 and then move on to a guide to help consumers deal with claims denials. She said that the Subgroup can still make edits after Ms. Cude’s review.
3. **Adopted Revisions to FAQ about Health Care Reform**

Ms. Nelson told the Subgroup that the Frequently Asked Questions (FAQ) document (Attachment 2) is for consumer services staff in state departments of insurance (DOI) to use when assisting consumers. She said the questions on the individual mandate and anti-discrimination provisions had been updated based on input from Subgroup members.

Ms. Dzurec made a motion, seconded by Mr. Swanson, to adopt the revised FAQ. The motion passed.

Ms. Nelson asked that the FAQ be posted to the Subgroup website and sent to the NAIC’s Health Reform email list.

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

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The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Oct. 7, 2019. The following Subgroup members participated: Angela Nelson, Chair, Amy Hoyt, Jessica Schrimpf and Mary Mealer (MO); Michelle Baldock and Mike Chrysler (IL); LeAnn Crow (KS); Mary Kwei (MD); Melinda Domzalski-Hansen (MN); Cuc Nguyen and Rebecca Ross (OK); David Buono and Katie Dzurec (PA); Candy Holbrook and Gretchen Brodkorb (SD); Heidi Clausen and Jaakob Sundberg (UT); and Jennifer Stegall and Sue Ezalarab (WI). Also participating were: Chelsey Maller and Jacob Lauten (AK); Erin Klug (AZ); Julia Yee (CA); Dayle Axman (CO); Howard Liebers (DC); John Reilly (FL); Teresa Winer (GA); Cynthia Banks Radke (IA); Emily DeLaGarza (MI); Jeannie Keller and Pam Koenig (MT); Chanell McDevitt (NJ); Mark Jordan (NM); Jana Jarrett (OH); Jennifer Ramcharan and Vickie Trice (TN); Marcus Willhouse and Rachel Bowden (TX); Jackie Myers and Yolanda Tennyson (VA); Dena Wildman and Joylynn Fix (WV); and Denise Burke and Tana Howard (WY).

1. Discussed a Consumer Guide on Using Health Insurance

Ms. Nelson reminded the Subgroup that the intended audience for the consumer guide, *Using Your Health Coverage*, is individuals who are already enrolled in health plans and would like help understanding their plans. She said her goal is to have a document ready for distribution by Jan. 1, 2020.

Ms. Nelson asked for comments on proposed changes to the listing of the document’s contents. Brenda J. Cude (University of Georgia) asked how readers with a hard copy could use internal links, and the Subgroup agreed to add page numbers to the table of contents.

Ms. Nelson asked the Subgroup for suggestions on how to provide direction to readers seeking information in languages other than English. Ms. Ramcharan said any information should be earlier in the document, since those with limited English proficiency will not make it far into the document. Ms. Baldock suggested that the states could translate the document or provide other assistance. Ms. Nelson said it was worth inquiring with the NAIC Communications Department about whether it could translate the document, at least into Spanish.

The Subgroup discussed the section on life changes. Ms. Cude said it need not mention every possible life change. Ms. Domzalski-Hansen said it should mention developing a disability. Mr. Buono urged the inclusion of information on the time limits associated with Special Enrollment Periods. Ms. Ezalarab suggested adding information on becoming eligible for Medicare. Candy Gallaher (America’s Health Insurance Plans—AHIP) said there should be some direction to readers as to what steps to take after a life change. Ms. Baldock suggested separate headings for each life event that show who to contact about a life change. Ms. Gallaher suggested starting with categories for each type of health coverage, employer, individual, etc. Ms. Baldock volunteered to start a draft of a table with this information.

Ms. Nelson reviewed the different sections in the document and explained that the next consumer guide would be focused on claims and denials.

Ms. Nelson discussed next steps for *Using Your Health Coverage* and encouraged members of the Subgroup and interested parties to focus on the content and the look of the document. She asked for ideas for info graphics and text boxes to highlight important points. She said after these ideas are incorporated, Ms. Cude can review the document for readability.

2. Discussed FAQ about Health Care Reform

Ms. Nelson brought up the need to update Frequently Asked Questions (FAQ) about Health Care Reform for the 2020 plan year. She explained that the document is intended for insurance department staff, not for consumers directly; though staff can use it in answering consumer questions. She reviewed edits to the document made by Joe Touschner (NAIC), highlighting one removed question on multi-state plans and one added question on health reimbursement arrangements.
Ms. Nelson asked about the existing question on protections against discrimination. She asked whether the existing answer should be changed in light of court decisions limiting enforcement of the protections and a proposed rule to change their application. Ms. Dzurec said the answer should point out the proposals to change the protections and encourage insurance department staff to check state laws that may offer similar protections. She said she would work on suggested edits to the answer.

Ms. Dzurec suggested that, rather than removing the question on multi-state plans, it be replaced with an explanation of the change in policy. She said it would be useful to clarify what happened to not just this policy, but others like co-ops. Ms. Nelson responded that staff can research elsewhere regarding policy changes and the document should not be unwieldy with these types of explanations. Ms. Gallaher suggested that the document could have an archive at the end with information about superseded policies.

Ms. Nelson asked when the document should be modified, as discussed, and posted or reviewed during the next conference call. The Subgroup decided to review it during the next call.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Health Innovations (B) Working Group met Dec. 7, 2019. During this meeting, the Working Group:

1. Adopted its Oct. 28 and Summer National Meeting minutes.

2. Heard two presentations on innovative insurer efforts to contain health care costs. A presentation from UnitedHealth Group (UHG) described the prevalence and causes of wasteful spending, the importance of incentives in driving changed health behaviors, and the benefits of more healthy choices on the part of consumers. A presentation from Medica showed the effects of Medica’s engagement with Accountable Care Organizations (ACOs), which resulted in risk-adjusted cost savings in five of six cases.

3. Heard a presentation on health care costs from the Health Care Cost Institute (HCCI) on trends in health spending. It pointed out that due to high prices, costs have increased even as utilization has decreased in recent years. It also noted that value-based care may be having an effect on the margins, but such care has only been rigorously studied in the Medicare context.

4. Heard a presentation from the Texas Medical Association (TMA) on providers’ reactions to insurer cost containment efforts. The presentation described the burden of prior authorization and other utilization management practices, and it recommended greater regulation of prior authorization.

5. Heard a presentation from Families USA on consumer priorities for cost containment efforts. It shared survey data on the difficulties paying for health care services related state efforts regarding the control of prescription drug costs, and it recommended surprise billing solutions that do not raise premiums.
The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met via conference call Oct. 28, 2019. The following Working Group members participated: Marie Ganim, Chair (RI); Martin Swanson, Vice Chair, and Michael Muldoon (NE); Andrew Stolfi, Vice Chair, Cassie Soucy, Jesse O’Brien, Tashaia Sizemore and Rick Barry (OR); Jacob Lauten (AK); Steve Ostlund and William Rodgers (AL); Andria Seip and Cynthia Banks-Radke (IA); Claire Szpara and Karl Knable (IN); Julie Holmes (KS); Amy Hoyt (MO); John Arnold (ND); Maureen Belanger (NH); Channell McDevitt and Diana Sherman (NJ); Paige Duhamel and Renee Blechener (NM); Katie Dzurec (PA); Douglas Danzeiser (TX); Heidi Clausen (UT); Molly Nollette, Jane Beyer and Jennifer Kreitler (WA); Nathan Houdek, Jennifer Stegall, Barbara Belling, Sue Ezalarab, Diane Dambach, Mary Kay Rodriguez and Julie Walsh (WI); and Joylynn Fix (WV). Also participating were: Mary Boatright (AZ); Christopher Citko (CA); Adam Boggess (CO); Fleur McKendell and Leslie Ledogar (DE); Chris Struk (FL); Kathy McGill (ID); Ryan Gillespie and Sara Stanberry (IL); Melinda Domzański-Hansen (MN); Bob Williams (MS); Ashley Perez, Michelle Scaccia, Pam Koenig and Tashia Sizemore (MO); Robert Croom, Ted Hamby and Mike Wells (NC); Laura Miller (OH); Kendall Buchanan (SC); Jill Kruger (SD); and Bob Grissom and Yolanda Tennyson (VA).

1. Discussed State Efforts to Address Prescription Drug Costs

Commissioner Stolfi and Ms. Soucy shared an overview of Oregon’s Prescription Drug Price Transparency program. Commissioner Stolfi described the requirements the program imposes on both prescription drug manufacturers and health insurers. He said health insurers must provide information on the top 25 highest cost drugs and the contributions of drug prices to premium increases. He reported that as of September, 300 manufacturers had filed 700 reports, which are available on a state website. The reports include price increases over the past five years and the prices the manufacturers charge in other countries. He said that Oregon plans to do more analysis of the reported data next year. He noted that fulfilling the consumer notice provisions of the law has been challenging, but his department has sent flyers to pharmacies. Ms. Soucy said that Oregon needed to identify the manufacturers that were required to report and that the Board of Pharmacy helped with a list. She said that education is needed to get the manufacturers to report correctly as many of them lack the specifics required to support their claims of trade secrets.

Joel Ario (Manatt Health) described activity in other states around drug pricing. He said 33 states have passed 59 laws on prescription drugs, many of them related to transparency and volume-based pricing. He explained California’s test of bulk pricing. He said California’s pool has 13 million people and includes Medicaid enrollees in the state. He noted that California’s experience will show how effective this strategy can be. He also mentioned California’s law on pay for delay. Mr. Ario also described Maryland’s drug price reforms. He said the first effort was stopped in the courts and warned that drug companies will look to litigation on all of these types of laws. He said that Maryland’s drug cost board will review the entire pharmaceutical supply chain and issue a report by December 2020. The report will consider direct price controls, a reverse auction and bulk purchasing as in California. He said that Maine has also enacted a drug affordability board with a 2021 start date, and it will consider spending targets and moving to more direct price controls over time.

2. Discussed State Laws and Regulations That Pertain to Telehealth

Health Insurance Commissioner Ganim said that telehealth is an innovative practice with the potential to reduce costs. She said that in Rhode Island, insurers are contracting with providers to provide telehealth services, but the providers may be from a national network and are not part of the patient’s medical home. She said that pediatricians in the state want to be the contracted entity to provide telehealth services to their patients to improve continuity of care. She said that in her state, state law is very general and only says that insurers must pay for telehealth.

Ms. Bartuska spoke about North Dakota’s laws. She said that the law defines facility and provider, and providers must meet the standards for medical professionals. Health insurance policies must cover telehealth and provide the same coverage for services delivered in person. However, she said that not all services are allowed via telehealth, and a carrier may define medical necessity. Ms. Sizemore said that Oregon grappled with the same questions about payment parity but that many of the questions have sorted themselves out without new laws or regulations. Ms. Bartuska added that North Dakota protects
consumers from disparate co-pays for telehealth but does not get involved in payment amounts between carriers and providers. Commissioner Ganim asked whether North Dakota requires any invested in infrastructure, and Ms. Bartuska responded that that was not necessarily something the department of insurance (DOI) would be aware of. Ms. Hoyt and Ms. Duhamel said Missouri and New Mexico have parity laws, as well. Ms. Duhamel said that New Mexico has Project ECHO, which allows providers to consult with other providers via telehealth.

Erika Melman (federal Centers for Medicare & Medicaid Services—CMS and Center for Consumer Information and Insurance Oversight—CCIIO) asked how states define telehealth and whether it can include communications like phone or email. Ms. Sizemore said Oregon law requires two-way synchronous communication; other states said they have similar requirements. Ms. Melman asked whether providers provide the site with the remote connection. Ms. Sizemore responded that providers might, but not issuers, and that senior centers or libraries can also provide sites. Runi Shukla (CMS–CCIIO) asked how telehealth affects network adequacy measures such as time and distance. Ms. Duhamel said it is hard to count telehealth providers as an addition to a plan’s network because providers already have full panels and cannot add more patients through telehealth. She said there is some advantage in provider-to-provider consultations, though. Ms. Sizemore said that in Oregon, insurers use telehealth to allow patients in areas with booked clinics to see providers in areas where clinics are not as busy. Ms. Melman asked where issuers provide access through telehealth to providers licensed in another state. Ms. Bartuska said some carriers allow for consultations with out-of-state providers, but only when the provider has a contract with an in-state hospital. Other states said they have similar arrangements.

Having no further business, the Health Innovations (B) Working Group adjourned.
The Health Actuarial (B) Task Force met Dec. 6, 2019. During this meeting, the Task Force:

1. Adopted the report of the Health Care Reform Actuarial (B) Working Group, which included the following action:
   a. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on the Risk Adjustment Data Validation (RADV) white paper released on Dec. 6.

2. Adopted its Sept. 17, Aug. 27, and Summer National Meeting minutes, which included the following action:
   a. Adopted its 2020 proposed charges.
   b. Received an update from the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) on progress on changes to the 2005 Group Term Life Waiver Mortality and Recovery Table (2005 Table).

3. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which included a summary of its Dec. 6 meeting. During its Dec. 6 meeting, the Working Group took the following action:
   a. Adopted its Summer National Meeting minutes.
   b. Adopted the report of the Long-Term Care Valuation (B) Subgroup.
   c. Adopted the report of the Long-Term Care Pricing (B) Subgroup.

4. Adopted the Long-Term Care Pricing (B) Subgroup’s Sept. 12 minutes, which included the following action:
   a. Discussed group long-term care insurance (LTCI) pricing.

5. Heard an update from the Academy Council on Professionalism.

6. Heard an update from the SOA on health insurance research.

7. Heard an update from the Academy Health Practice Council.
The Long-Term Care Actuarial (B) Working Group met Dec. 6, 2019. During this meeting, the Working Group:

1. Adopted its Oct. 24, Sept. 24, Aug. 28, Aug. 20, and Summer National Meeting minutes, which included the following action:
   b. Adopted the report of the Long-Term Care Pricing (B) Subgroup.
   c. Adopted the report of the Long-Term Care Valuation (B) Subgroup.

2. Adopted the report of the Long-Term Care Pricing (B) Subgroup, which included the following action:
   a. Adopted its Sept. 12 minutes, which included the following action:
      1. Discussed group long-term care insurance (LTCI) pricing.

3. Adopted the report of the Long-Term Care Valuation (B) Subgroup, which included the following action:

4. Heard an update from the American Academy of Actuaries (Academy) on LTCI Work Group activities.

5. Heard an update from the Society of Actuaries (SOA) on LTCI research.
REGULATORY FRAMEWORK (B) TASK FORCE
Saturday, December 7, 2019
11:30 a.m. – 1:00 p.m.

Meeting Summary Report

The Regulatory Framework (B) Task Force met Dec. 7, 2019. During this meeting, the Task Force:

1. Adopted its Oct. 2 and Summer National Meeting minutes. During its Oct. 2 meeting, the Task Force:
   a. Adopted its 2020 proposed charges.

2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, which included its Nov. 25, Nov. 19, Nov. 4, Oct. 28, Oct. 7 and Sept. 16 minutes. During these meetings, the Working Group:
   a. Discussed the comments received on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) (now known as the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170). The Subgroup plans to complete its review of the comments received via conference call after the Fall National Meeting.

3. Adopted the report of the ERISA (B) Working Group, which met Dec. 7 and took the following action:
   a. Adopted its Summer National Meeting minutes.
   b. Discussed association health plans (AHPs), including state legislative and regulatory activity addressing multiple employer welfare arrangements (MEWAs).
   c. Adjourned into regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

4. Adopted the report of the HMO Issues (B) Subgroup, which included its Nov. 21 and Sept. 16 minutes. During these meetings, the Subgroup:
   a. Exposed the Virginia Insurance Bureau’s recommendations for revising the Health Maintenance Organization Model Act (#430) for public a public comment period ending Oct. 15 to address inconsistencies and redundancies with the provisions in the Life and Health Insurance Guaranty Association Model Act (#520).
   b. Discussed the Virginia Insurance Bureau’s revised recommendations for revising Model #430 and the Maine Department of Insurance’s (DOI) comments on the revised recommendations.
   c. Adopted a motion to accept the Maine DOI’s approach for revising Model #430. The Subgroup plans to review and discuss an initial draft of revisions to Model #430 reflecting the Maine DOI’s approach via conference call after the Fall National Meeting.

5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which included its Dec. 2, Oct. 3, Aug. 29, Aug. 22, and Aug. 15 minutes. During these meetings, the Subgroup:
   a. Heard presentations from various stakeholders, including representatives from health insurers, pharmaceutical manufactures, pharmacy benefit managers (PBMs), academia, and consumers. The Subgroup conducted these information-gathering sessions to help inform its discussions on next steps to carry out its 2019 charge to consider developing a new NAIC model to establish a licensing or registration process for PBMs. As part of its 2019 charge, the Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.
   b. Discussed its next steps in making progress on its 2019 charge during a regulator-to-regulator session pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

6. Heard an update from the Center on Health Insurance Reforms’ (CHIR) work related to federal Affordable Care Act (ACA) implementation and other issues of interest to state insurance regulators. The update included a discussion of a forthcoming publication discussing state oversight of health care sharing ministries. There was also discussion of the CHIR’s work related to MEWAs. The CHIR recently published thousands of pages of U.S. Department of Labor (DOL) investigative records regarding MEWAs. The CHIR is continuing to track and analyze state regulatory approaches to MEWAs and short-term, limited-duration plans (STLDPs) in the wake of federal rule changes. The CHIR is also continuing its work to
track state reforms affecting the individual market. The presentation also highlighted the CHIR’s future research projects, including projects related to reinsurance and standardized health plans.

7. Heard a presentation on the implementation of the Consumer Purchasing Model in Summit County, CO.

8. Heard a panel presentation from America’s Health Insurance Plans (AHIP) on health care cost trends. The presentation also included affordability recommendations for state insurance regulators to consider.
The ERISA (B) Working Group met Dec. 7, 2019. During this meeting, the Working Group:

1. Adopted its Summer National Meeting minutes.

2. Discussed state legislative and regulatory activity addressing association health plans (AHPs) and multiple employer welfare arrangements (MEWAs).

3. Heard that the MEWA Association of America will be holding its first Annual Meeting in Austin on Monday Dec. 10 at the Hyatt Place, and invited state insurance regulators and interested parties to register and attend.

4. Heard from the U.S. Department of Labor (DOL) about its reorganization and continuing willingness to coordinate with the NAIC and the states on issues of mutual interest.

5. Heard from the Georgetown University Center on Health Insurance Reforms about its Freedom of Information Act (FOIA) request to the DOL for information on MEWA investigations.

6. Adjourned into a regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.
The Senior Issues (B) Task Force met Dec. 7, 2019. During this meeting, the Task Force:

1. Adopted its Oct. 16, Sept. 24 and Summer National Meeting minutes, which included the following action:
   a. Adopted a letter to the federal Centers for Medicare & Medicaid Services.
   b. Adopted its 2020 proposed charges.

2. Heard an update on federal funding for the State Health Insurance Assistance Program (SHIP).

3. Heard about a legislative proposal drafted by U.S. Senator Pat Toomey (PA), which is based upon one of the long-term care (LTC) policy option recommendations adopted by the Task Force that would allow for retirement account dollars to be used to buy long-term care insurance (LTCI) so families can better plan for long-term services and supports (LTSS) needs.

4. Heard an issue raised by Bonnie Burns (California Health Advocates—CHA) about conflicts between Medicare, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), and the Coordination of Benefits Model Regulation (#120).
Agenda Item #3

Hear an Update from the Federal Center for Consumer Information and Insurance Oversight (CCIIO)—*Randy Pate (CCIIO)*
Agenda Item #4

Hear a Presentation on “Overcharged: Why Americans Pay Too Much for Health Care”—
Charles M. Silver (University of Texas at Austin, McDonald Endowed Chair in Civil Procedure, School of Law)
TO FIX OUR HEALTH CARE SYSTEM, RESERVE INSURANCE FOR CATASTROPHES

CHARLES SILVER

SCHOOL OF LAW
UNIVERSITY OF TEXAS AT AUSTIN
&
CATO INSTITUTE

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
DECEMBER 8, 2019
Explains the big problems with our health care system.
- Fraud, waste, and abuse = $1T/year.
- Uncontrollable spending.
- Opaque prices.
- Surprise bills.
- Quality that is highly variable and often mediocre.
- Absurd prices for prescription drugs.

Offers solutions.
- Eliminate tax exemptions and coverage mandates.
- Promote competition and encourage medical tourism.
- Let the insurance-driven spending cycle burn itself out.
- Turn Medicare, Medicaid, and other programs into cash-transfer programs along the lines of Social Security and the Earned Income Tax Credit.
A Supercenter for Medicine

Pols talk of reducing health costs. Walmart and CVS are doing something about it.

By Charles Silver and David A. Hyman
Oct. 3, 2019 6:50 pm ET

No, Medicare for All Won’t Save Money

Blame Washington: it can't get the lobbies under control. Here's a better idea.

By CHARLES SILVER and DAVID A. HYMAN
11/25/2019 05:08 AM EST
EXCESSIVE RELIANCE ON 3RD PARTY PAYMENT—A FUNDAMENTAL DRIVER OF HEALTH CARE SPENDING
THE PROBLEM

1. Coverage of health care costs stimulates demand for more and more expensive medical treatments.
2. Heightened demand drives up prices and encourages the proliferation of services.
3. Rising prices and expanded health care needs scare consumers, who demand more protection.
4. Insurers and government agencies respond by offering more comprehensive coverage.
5. Return to Step 1.
THE SOLUTION: LET THE CYCLE BURN OUT

1. As spending increases, insurance becomes more expensive.

2. As insurance becomes pricier, people react by going bare.

3. The pool of insured people becomes less healthy on average, making insurance more expensive still and causing more people to go bare.

4. As people go bare or carry higher deductibles and copays, the army of self-paying consumers grows.

5. The retail health sector responds to the increase in demand by offering options for obtaining medical care that are cheaper and more convenient.
THE RETAIL REVOLUTION—TRANSPARENT PRICES; NO SURPRISE BILLS

https://surgerycenterok.com/
THE RETAIL REVOLUTION—LOW PRICES, CONVENIENT LOCATIONS

Welcome! What type of appointment would you like to schedule?
Location: 3615 CHARLES HARDY PKWY STE 200, Dallas, GA

- Medical
- Immunizations
- Dental
- Optometry
- Hearing
- Counseling
Agenda Item #5

Hear a Panel Presentation on State Surprise Billing Laws: What Works and Impact on Networks and Reimbursement—Jane Beyer (WA) and Nancy Clark (TX)
New York’s Out-of-Network (OON) Legislation

Part H of Chapter 60 of the Laws of 2014 (S.6914/A.9205)

Troy J. Oechsner
Deputy Superintendent for Health Insurance
New York State Department of Financial Services
For NAIC Conference
Sunday, December 8, 2019
Surprise Out-of-Network Protection Law

Issues

- **OON Surprise Bills** when consumer does everything possible to use in-network providers and still receives a bill from a provider who, unknown to the consumer, is OON.

- **OON Emergency Bills** that are excessive.

Solution: Chapter 60 of the Laws of 2014

- **Consumers have no liability** for OON Surprise and Emergency provider bills, aside from usual in-network cost share.

- **Independent Dispute Resolution (IDR)** between the provider and insurer for OON Surprise and Emergency Bills.
Disclosure

Issues

- **Comparison shopping is difficult** when consumers are trying to compare OON benefits.

- **When using services** consumers should know which providers are OON, how much those providers expect to charge, and how much their health plan expects to cover.

Solution: Chapter 60 of the Laws of 2014

- **Improved disclosure** on behalf of health plans, providers and hospitals.
Network Adequacy

Issues

- **Missing protections for inadequate networks.** Consumers receive surprise OON bills when in-network providers are not available and the consumer cannot go OON at no additional cost.

Solution: Chapter 60 of the Laws of 2014

- **Extended network adequacy review** to all plans, to ensure networks meet minimum adequacy standards.
- **Access to out-of-network care** at the in-network cost share, when there is no appropriate in-network provider. Also expanded external appeal rights.
NY IDR Process

- **Agent** uses billing expert with physician consult.
- **30 Day Timeframe.**
- **LOBA:** Last offer before arbitration. Agent chooses either (1) provider bill or (2) insurer payment.
- **Must Consider:** (1) any gross disparity between provider charge and other similar OON providers and (2) provider’s training, experience, usual charge, complexity and circumstances of case, patient characteristics, UCR, and any other information.
- **Review Binding.** Parties can still sue, but IDR admissible.
- **Loser pays** IDR cost. If settled, divide cost.
How Has IDR Worked In NY?

- Saved Consumers Over $400 Million.
- Reduced OON Billing in NY by 34%.
- Lowered In-Network Emergency Physician Payments by 9%.
- No discernable impact on premiums.
- No discernable impact on networks.
### IDR Results for Bills for Emergency Services 2015-2018

<table>
<thead>
<tr>
<th>Total Received</th>
<th>Not Eligible</th>
<th>Still in Process</th>
<th>Decision Rendered</th>
<th>Decided in Favor of Health Plan</th>
<th>Decided in Favor of Provider</th>
<th>Split Decision</th>
<th>Settlement Reached</th>
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<tr>
<td>2,250</td>
<td>577</td>
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<td>1,623</td>
<td>582</td>
<td>334</td>
<td>444</td>
<td>263</td>
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### IDR Results for Bills for Surprise Bills 2015-2018

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<th>Not Eligible</th>
<th>Still in Process</th>
<th>Decision Rendered</th>
<th>Decided in Favor of Health Plan</th>
<th>Decided in Favor of Provider</th>
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<th>Settlement Reached</th>
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</thead>
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<tr>
<td>1,486</td>
<td>457</td>
<td>57</td>
<td>972</td>
<td>106</td>
<td>391</td>
<td>318</td>
<td>157</td>
</tr>
</tbody>
</table>

- Decision rendered in favor of Health Plan
- Decision rendered in favor of Provider
- Split decision
- Settlement reached
Total IDR Award Amounts: Health Plan Payment More Reasonable for Emergency Services & Surprise Bills

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<thead>
<tr>
<th>Year</th>
<th>$200 or less</th>
<th>$200-500</th>
<th>$500-1,000</th>
<th>$1,000-5,000</th>
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<td>21</td>
<td>37</td>
<td>77</td>
<td>39</td>
<td>13</td>
<td>8</td>
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</table>
Total IDR Award Amounts: Provider Change More Reasonable for Emergency Services & Surprise Bills

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>$30,000 or greater</td>
<td>1</td>
<td>4</td>
<td>9</td>
<td>19</td>
</tr>
</tbody>
</table>
IDR Awards: Dollar Amounts as Compared to UCR

- DFS sampled IDR decisions to see how prevailing party’s payment/charge compares to UCR.

- Health plan’s payment more reasonable: payment 20%-100% lower than UCR.

- Provider’s charge more reasonable: payment 0%-50% higher than UCR.
### Independent Dispute Resolutions for Emergency Services Top Provider Specialties 2015-2018

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number Independent Dispute Resolution Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery</td>
<td>643</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>358</td>
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<tr>
<td>Orthopedic Surgery</td>
<td>311</td>
</tr>
<tr>
<td>General Surgery</td>
<td>163</td>
</tr>
</tbody>
</table>

### Independent Dispute Resolutions for Surprise Bills Top Provider Specialties 2015-2018

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number Independent Dispute Resolution Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>305</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>247</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>148</td>
</tr>
<tr>
<td>Neurology</td>
<td>116</td>
</tr>
</tbody>
</table>
Is IDR Best Approach?

**Pros**
- Viable alternative that does not appear inflationary.
- Avoids fee schedule conflict.
- Fair process engenders stakeholder buy-in.
- Limits likelihood of provider access issues.

**Cons**
- May not lower OON provider bills as much as fee schedule.
- Administrative costs higher.
- Theoretically inflationary (but see above).
Washington Balanced Billing Protection Act

NAIC Health Insurance and Managed Care Committee
Jane Beyer, Senior Health Policy Advisor
December 8, 2019
Scope of Balance Billing Protection Act

On May 21, Governor Inslee signed 2SHB 1065 into law. Codified at Chap. 48.49 RCW

As of January 1, 2020, surprise/balance billing is prohibited for:

• All emergency services at in-network and out-of-network (OON) hospitals, and

• Non-emergency “surgical or ancillary services” provided by an OON provider at an in-network hospital or ambulatory surgical center. Surgical or ancillary services include surgery, anesthesiology, pathology, radiology, laboratory or hospitalist services
Scope of Balance Billing Protection Act

Emergency Services received out-of-state:

• For emergency services provided to an enrollee in an out-of-network hospital located and licensed in Oregon or Idaho, the carrier must hold an enrollee harmless from balance billing

• Federal law needed in order to prevent hospitals from balance billing consumers for emergency services regardless of where the consumer lives
BBPA Application

BBPA applies to:

• All fully-insured health plans sold in Washington State (as defined in RCW 48.43.005)
• Washington State employee health plans
• New Washington State school employee health plans
• Self-funded group health plans that “opt-in” to the balance billing prohibition, consumer protections and arbitration
  • Simple online “opt-in” process. OIC will maintain list of plans
Consumer Protections

When surprise billing is **not** allowed, the following protections also apply:

- Carriers must pay out-of-network providers and facilities directly
- Consumer cost-sharing based on “median in-network contracted rate for the same or similar service in the same or similar geographic area”
- Any amount the consumer pays must be applied to their deductible and out-of-pocket limit
- OON provider must refund any amount the patient overpaid an out-of-network provider
- No provider, hospital or outpatient surgical facility can ask a patient to limit or give up these rights
- Notice regarding rights by provider when scheduling procedures, and by carrier via EOB
Out-of-Network Provider Payment

The OON provider will be paid a “commercially reasonable amount based on payments for the same or similar services provided in a similar geographic area”

If provider and health carrier cannot agree on this amount, after a 30 day informal negotiation period, they can proceed to arbitration:

• OIC provides parties with list of arbitrators/arbitration entities
• Providers can “bundle” same or similar claims that occurred within 2 months of each other, if same carrier and same provider
• Arbitrator chooses one party’s “best final offer,” parties split the cost of arbitration, each pays its own attorney’s fees
APCD Data set

To inform negotiations and arbitration, providers, carriers and arbitrators have access to a data set from the state’s All Payer Claims Database:

• Data set based on 2018 commercial fee-for-service health insurance claims
• Provides median in-network, median out-of-network and median billed charged
• Updated annually based on medical CPI to avoid rate changes due to impact of Act
Enforcement

• A “pattern of unresolved violations” of the BBPA consumer protection provisions constitutes “unprofessional conduct” under the state’s provider Uniform Disciplinary Act and is a basis for discipline under hospital, ASF and laboratory licensing statutes.

• OIC will first give provider/facility opportunity to cure violations.

• If OIC determines a pattern of unresolved violations has occurred, can refer the provider/facility to DOH/disciplinary authority for further action.
Transparency

Facility/provider and carrier requirements designed to:

• Inform consumers of their rights under BBPA
• Give consumers information about in-network and OON providers, including associated costs
• Promote facility-based provider contracting by requiring hospitals/ASF’s to provide carriers with list of providers who have privileges to practice in, or contract with the facility in advance of signing a contract with the carrier
The Spokes of BBPA Implementation

- **Outreach**
  - CLE’s
  - Webinars

- **Consumer Notice Template**
  - Posted on OIC website
  - 12 languages

- **Self-Funded Opt In**
  - Opt in via OIC website, as of 11/15/19

- **Complaints & DOH Referral**
  - Complaint & referral process developed

- **Arbitration**
  - Arbitrator application and list posted on OIC website

- **APCD Data Set**
  - Posted on OIC website: 11/15/19

- **Rules**
  - Final rule adopted 11/19/19

- **Communications & OIC Website**
  - New Website, as of 12/6/19

BBPA
January 1, 2020
Questions?

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Senior Health Policy Advisor
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(360) 725-7043

Connect with us!
• OIC BBPA website: Surprise medical billing
• Twitter: https://twitter.com/WA_OIC
• www.insurance.wa.gov
Resources


- OIC BBPA website: [https://www.insurance.wa.gov/surprise-medical-billing](https://www.insurance.wa.gov/surprise-medical-billing) (being revised as components added)

- Table summarizing BBPA: [https://www.insurance.wa.gov/sites/default/files/documents/Chart%20of%20%202019%20surprise%20billing%20law.pdf](https://www.insurance.wa.gov/sites/default/files/documents/Chart%20of%20%202019%20surprise%20billing%20law.pdf)

Agenda Item #6

Hear an Update on Legal Action Surrounding the Federal Affordable Care Act (ACA)
—William G. Schiffbauer (Law Office of William G. Schiffbauer, Chartered)
A BRIEF AND DISPASSIONATE UPDATE ON THE STATUS OF FEDERAL AFFORDABLE CARE ACT LITIGATION

National Association of Insurance Commissioners
Fall National Meeting
Austin, Texas
December 8, 2019
By
William G. Schiffbauer, Esq.
Major Pending Litigation

I.  *Texas et al v. United States of America et al*, U.S. District Court, Northern District of Texas; pending in the U.S. Court of Appeals for the Fifth Circuit.

Major Pending Litigation

III. Association for Community Affiliated Plans et al v. United States Department of the Treasury et al, U.S. District Court, District of Columbia; pending in the U.S. Court of Appeals for the D.C. Circuit.

IV. Maine Community Health Options v. United States, U.S. Court of Claims, U.S. Court of Appeals for the Federal Circuit, pending Supreme Court of the United States.
THE INDIVIDUAL MANDATE CASE

I. Texas et al v. United States of America et al
I. *Texas v. US*

A. TIMELINE


3. January 7, 2019, Blue States file appeal and case is docketed at Fifth Circuit Court of Appeals.
I. Texas v. US

A. TIMELINE

4. July 9, 2019, oral argument was heard by a three judge panel: Engelhardt (Trump); Elrod (G.W. Bush); and King (Carter).

5. After December 16, 2019, Fifth Circuit likely to issue its order and decision – ACA open enrollment ends.

6. Parties will file Petition for Certiorari to SCOTUS for review during this October 2019 Term.
I. Texas v. US

B. DISTRICT COURT’S OPINION

1. Individual mandate may no longer be upheld under the Tax Power of the Congress or the Commerce Clause.

2. Relies upon CJ Roberts NFIB v. Sebelius that the penalty no longer produces revenue in present tense.

3. Congress did not just suspend or delay the penalty, it eliminated the individual mandate penalty.
I. Texas v. US

B. DISTRICT COURT’S OPINION

4. Individual mandate is “essential” to the ACA and cannot be severed from the ACA’s remaining provisions.

5. Relies upon joint dissent severability rationale of four conservative Justices in NFIB v. Sebelius.

6. Cites six statutory references in ACA text and “findings” stating individual mandate is “essential” to the Act.
I. Texas v. US

B. DISTRICT COURT’S OPINION

7. Court’s attempt to “sever” interdependent provisions would “rewrite” the statute violating Separation of Powers.

8. The 2017 amendment did not remove the requirement to purchase insurance or the “findings” that the mandate is “essential” to the Act.
I. Texas v. US

C. BLUE STATES ARGUMENTS

1. The Coverage Provision is a “condition” or choice with no legal obligation and so remains Constitutional.

2. If Unconstitutional the Coverage Mandate is severable from the rest of the ACA.
I. *Texas v. US*

C. FIFTH CIRCUIT COURT OF APPEALS BACKGROUND

1. Maintains a reputation as the most politically conservative circuit court of appeals.

2. Six of the Fifth Circuit’s seventeen judges have been appointed by President Trump.

3. Twelve of the seventeen active judges were appointed by a Republican President.
I. Texas v. US

D. NOTE ON SEVERABILITY JURISPRUDENCE: 
   ALASKA AIRLINES v. BROCK (1987)

1. First, court determines if remainder of statute will 
   operate in the manner Congress intended; if not 
   remainder is invalidated?

2. Second, if remainder can operate as intended, would 
   Congress have enacted remainder standing alone and 
   without the invalid provision?
ASSOCIATION HEALTH PLANS CASE

II. State of New York et al v. United States Department of Labor et al
II. New York v. US DOL

A. TIMELINE


2. March 28, 2019, District Court issues order and opinion granting New York motion.

3. May 1, 2019, Federal Defendants filed an appeal with the D.C. Circuit Court of Appeals.
II. New York v. US DOL

A. TIMELINE

5. November 14, 2019, oral argument was heard before three judge panel: Henderson (G.H.W. Bush); Tatel (Clinton); and Katsas (Trump).


7. Parties will file Petition for Certiorari to SCOTUS for review during the October 2019 Term.
II. New York v. US DOL

B. DISTRICT COURT’S OPINION

1. The Final Rule is clearly an end-run around the ACA to avoid the most stringent requirements of the Act.

2. The Final Rule does violence to ERISA’s careful statutory scheme that is based on employment relationships.

3. The Final Rule extends ERISA to cover commercial insurance transactions between unrelated parties.
II. New York v. US DOL

B. DISTRICT COURT'S OPINION

4. The AHP is an entrepreneurial venture selling insurance outside of ERISA’s “employment relationship”.

5. The Final Rule has no meaningful limit on associations having a commonality of interest or control to be ERISA “employers”.
II. New York v. US DOL

B. DISTRICT COURT’S OPINION

6. The inclusion of “working owners” in contrary to the text of ERISA that requires an “employment relationship”.

7. ERISA defines an “employee” to be an individual employed by an employer and so anticipates two parties.

8. The bona fide association and working owner provisions are unlawful and vacated.
II. *New York v. US DOL*

C. FEDERAL DEFENDANTS’ REPLY

1. ERISA statutory term “employer” includes a group or association of employers acting in relation to an employee benefit plan.

2. AHP final rule is a reasonable interpretation of ERISA term “employer” because it is ambiguous and “group or association” is undefined.
II. *New York v. US DOL*

C. FEDERAL DEFENDANTS’ REPLY

3. Federal agencies may permissibly modify long-held sub-regulatory guidance and not foreclosed by other statutory provisions.

4. Statutory definition of “employer” is silent with respect to number of “employees” and final rule is a “reasonable” interpretation.
II. New York v. US DOL

D. U.S. COURT OF APPEALS FOR THE D.C. CIRCUIT – Background

1. Maintains a reputation as the nation’s expert court on administrative law and the Federal Administrative Procedures Act (“APA”).

2. The court has 12 (twelve) active judges – 5 appointed by a Republican President (3 by President Trump), and 7 by a Democrat President (4 by President Obama).
II. New York v. US DOL

D. U.S. COURT OF APPEALS FOR THE D.C. CIRCUIT

Background

3. Four of the current nine Justices on the Supreme Court are alumni of the court – John Roberts, Clarence Thomas, Ruth Bader Ginsberg, and Brett Kavanaugh.

4. The late Justice Antonin Scalia also served on this court.
SHORT-TERM LIMITED DURATION INSURANCE CASE

III. Association for Community Affiliated Plans et al v. United States Department of the Treasury et al
III. **ACAP v. US TREASURY**

A. TIMELINE

1. August 3, 2018, ACA Tri-Agencies publish final rule for Short-Term, Limited-Duration Health Insurance.

2. July 19, 2019, District Court issued its order and ruling upholding the final STLDI rule.

3. July 30, 2019, ACAP filed its appeal to the D.C. Circuit Court of Appeals.
III. ACAP v. US TREASURY

A. TIMELINE


5. February 11, 2020, ACAP brief is due.
III. ACAP v. US TREASURY

B. DISTRICT COURT’S OPINION

1. No serious question that Congress delegated to the Departments the authority to define STLDI and made no attempt to dictate the characteristics of such plans.

2. To succeed on their claim ACAP must show that the Departments overstepped bounds of their authority to an “extraordinary” extent.
III. **ACAP v. US TREASURY**

B. **DISTRICT COURT’S OPINION**

3. Prior to the ACA’s enactment the original definition of STLDI was in place in regulation for over a decade and Congress chose not to amend it in the ACA.

4. The 2018 final rule largely restored the long-standing and substantially similar regulatory definition and the statutory text remains silent on the meaning.
III. *ACAP v. US TREASURY*

**B. DISTRICT COURT’S OPINION**

5. Court must look to ordinary meaning of “short term”; a period of time that is “short” by comparison to another term – one-year for major medical, and multiple states define STLDI as “less than 12 months”.

6. Ordinary meaning of “duration” means the time during which something exists or lasts; the final rule provides a defined limit of up to 36 months.
III. *ACAP v. US TREASURY*

B. DISTRICT COURT’S OPINION

7. Court notes that from 1997 to 2016 the regulation permitted unlimited issuer-consented renewals of STLDI coverage; 2016 rule altered and limited to 3-months.

8. Congress did not intend for the ACA’s various reforms to apply to all “species” of individual health insurance and maintained the exemption for STLDI
III. ACAP v. US TREASURY

B. DISTRICT COURT’S OPINION

9. Because Congress did not define the term STLDI and so did not require a certain interpretation.

10. The Departments’ interpretation was reasonable and based on ordinary meaning.
C. PLAINTIFF ACAP’S ARGUMENTS

1. Final rule exceeded agencies authority and discretion and circumvents the purposes of the Affordable Care Act.

2. Final rule interprets “limited duration” to unreasonably encompass a renewal for up to three years.
III. *ACAP* v. *US TREASURY*

C. PLAINTIFF’S ARGUMENT

3. “Short-term” should be based on the 3 month “short coverage gap” exemption from the mandate penalty.

4. Final rule does not provide a reasoned explanation for changing prior law and arbitrary and capricious.
IV. *Maine Community Health Options v. United States*
IV. MAINE COMMUNITY v. US

A. TIMELINE


2. June 24, 2019, SCOTUS grants consolidated health plan petition for certiorari.

B. COURT OF APPEALS DECISION

1. Section 1342 of the ACA created an obligation of the government to pay participants for full risk corridor amounts.

2. Subsequent Congressional Appropriations Act restricting payments had the effect of repealing or altering the obligation and sources of funding.

3. No breach of an implied contract and no intention of government to bind itself in a contract.
IV. MAINE COMMUNITY v. US

C. HEALTH PLAN ARGUMENTS

1. The Federal Circuit’s “implied repeal” holding defies plain text and precedent and did not repeal or amend ACA section 1342.

2. The statutory text of ACA section 1342 unambiguously states the government “shall pay” in full and is mandatory payment obligation.

3. Government’s evasion of obligations under ACA section 1342 would have untenable consequences.
IV. MAINE COMMUNITY v. US

D. NAIC AMICUS BRIEF ARGUMENTS

1. Federal default on payments unraveled rate approvals and required states to maintain coverage.

2. Delinquent Federal payments accelerated financial problems of new ACA induced insurers.

3. Federal Government breached its obligations but demands to be made whole in event of insolvencies.
Summation


Summation

III. STLDI Final Rule: *Association for Community Affiliated Plans et al v. United States Department of the Treasury et al* – District of Columbia Circuit Oral Arguments March or April 2020; opinion May or June 2020; *unlikely* SCOTUS opinion on or before July 31, 2020.

THE END
Agenda Item #7

Hear a Federal Legislative Update—*Joseph Touschner (NAIC)*
Agenda Item #8

Discuss Any Other Matters Brought Before the Committee

—Commissioner Jessica Altman (PA)