

Revised: 7/22/20

2020 Summer National Meeting  
Virtual Meeting

**HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE**

**Tuesday, August 11, 2020**

**1:00 – 3:00 p.m. ET/12:00 – 2:00 p.m. CT/ 11:00 a.m. – 1:00 p.m. MT/10:00 a.m. – 12:00 p.m. PT**  
**CHIME Live**

**ROLL CALL**

|                                |              |                   |              |
|--------------------------------|--------------|-------------------|--------------|
| Jessica K. Altman, Chair       | Pennsylvania | Linda A. Lacewell | New York     |
| Lori K. Wing-Heier, Vice Chair | Alaska       | Jon Godfread      | North Dakota |
| Michael Conway                 | Colorado     | Glen Mulready     | Oklahoma     |
| John F. King                   | Georgia      | Andrew R. Stolfi  | Oregon       |
| Vicki Schmidt                  | Kansas       | Hodgen Mainda     | Tennessee    |
| Kathleen A. Birrane            | Maryland     | Todd E. Kiser     | Utah         |
| 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 April 28 and Feb. 26, 2020, and 2019 Fall National Meeting Minutes  
—*Commissioner Jessica K. Altman (PA)*
2. Consider Adoption of its Subgroup, Working Group and Task Force Reports  
—*Commissioner Jessica K. Altman (PA)*
  - Consumer Information (B) Subgroup—*Mary Kwei (MD)*
  - Health Innovations (B) Working Group—*Health Insurance Commissioner Marie Ganim (RI)*
  - Health Actuarial (B) Task Force—*Commissioner Todd E. Kiser (UT) and Jaakob Sundberg (UT)*
  - Regulatory Framework (B) Task Force—*Commissioner Michael Conway (CO)*
  - Senior Issues (B) Task Force—*Commissioner Marlene Caride (NJ)*
3. Hear a Presentation on Health Equity and Disparities in Health Care and Coverage  
—*Samantha Artiga (Kaiser Family Foundation—KFF)*
4. Hear a Presentation on COVID-19: Lessons Learned—*Daniel J. Meuse (State Health and Value Strategies [SHVS], Princeton School of Public and International Affairs, Princeton University)*
5. Hear a Presentation on COVID-19 Costs—*Jeanette Thornton (America's Health Insurance Plans—AHIP)*
6. Hear an Update on Federal Affordable Care Act (ACA) Court Cases—*Katie Keith (Out2Enroll)*
7. Receive an Update on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's Work—*TK Keen (OR)*
8. Hear a Federal Legislative Update—*Brian Webb (NAIC)*
9. Discuss Any Other Matters Brought Before the Committee—*Commissioner Jessica K. Altman (PA)*
10. Adjournment

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**Agenda Item #1**

**Consider Adoption of its April 28 and Feb. 26, 2020, and 2019 Fall National Meeting Minutes  
—Commissioner Jessica K. Altman (PA)**

Draft: 6/1/20

Health Insurance and Managed Care (B) Committee  
Conference Call  
April 28, 2020

The Health Insurance and Managed Care (B) Committee met via conference call April 28, 2020. The following Committee members participated: Jessica Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); John F. King represented by Teresa Winer (GA); Vicki Schmidt (KS); Al Redmer Jr. (MD); Steve Kelley represented by Grace Arnold and Sherri Mortensen Brown (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); Linda A. Lacewell represented by John Powell and Frank Horn (NY); Glen Mulready (OK); Andrew R. Stolfi represented by TK Keen (OR); Hodgen Mainda (TN); Todd E. Kiser represented by Jaakob Sundberg (UT); and Mike Kreidler represented by Molly Nollette and Jane Beyer (WA). Also participating were: David Altmaier (FL); Chlora Lindley-Myers (MO); Russell Toal (NM); Barbara D. Richardson (NV); and Marie Ganim (RI).

1. Received a Report from the Health Actuarial (B) Task Force

Mr. Sundberg provided a brief overview of the Health Actuarial (B) Task Force's April 23 meeting. He said the Task Force heard presentations from the American Academy of Actuaries (Academy), America's Health Insurance Plans (AHIP), Blue Cross and Blue Shield Association (BCBSA), and the Society of Actuaries (SOA) on COVID-19's potential effects on health care spending and the health insurance system, particularly with respect to the federal Affordable Care Act (ACA) 2021 premium rate assumptions. He said each presenter emphasized the uncertainty in 2021 pricing assumptions due to COVID-19 because of several factors, including 1) the rate of COVID-19 testing; 2) treatment rate, including treatment setting and treatment services provided; 3) treatment cost; 4) rate of services deferred from 2020; and 5) cost of services deferred from 2020. Mr. Sundberg said some presenters also suggested that the states assess their current rate filing deadlines and delay them if possible. Specifically, they recommended that the states target July 22 to give issuers time to incorporate the most recent data on the impact of COVID-19 when finalizing 2021 rates and strongly encouraged the states to allow issuers to revise their rate filings using the latest information available prior to states finalizing rates. He said presenters also stressed the importance of state insurance regulators working collaboratively with the industry to address these issues.

Mr. Sundberg said that among its next steps, the Task Force is meeting May 1 via conference call in regulator-to-regulator session to begin development of an outline and eventual 2021 rate pricing resource and guidance document for the states to consider when reviewing initial 2021 rates. He said the Task Force also will be discussing potential impact on risk corridors, particularly in light of the recent U.S. Supreme Court decision in *Maine Community Health Options v. United States*, which ruled that, in accordance with the ACA, the federal government illegally withheld full risk corridor payment amounts to insurers for significant losses to their health plans incurred during the first three years of the ACA's health marketplaces and that the insurers could sue for nonpayment of approximately \$12 billion in the U.S. Court of Federal Claims.

Commissioner Altman asked Mr. Sundberg about the Task Force's timeline for completing the resource and guidance document. Mr. Sundberg said he anticipates the Task Force completing this work and sending out a draft of the document within the next few weeks for comment given that some states have initial filing deadlines in May.

2. Discussed and Heard Comments from Stakeholders on Regulatory Flexibility Requests Due to COVID-19

Brian R. Webb (NAIC) said the NAIC has received letters from various stakeholders requesting state insurance regulatory relief due to COVID-19 in a number of categories, including: 1) telehealth and telebehavioral health access expansion and flexibility, including parity in payment and not limited to COVID-19; 2) administrative flexibility related to grace periods and continuity of coverage policies and requirements; 3) filing requirement flexibility; and 4) reducing administrative barriers, particularly related to prior authorization, provider credentialing, timely claim and payment requirements. He said many of these requests have already been addressed by the states, the federal government and industry itself. He noted that AHIP and the BCBSA recently submitted a letter to the Committee recommending that the states assess their current rate filing deadlines and delay them if possible to July 22 to give carriers time to incorporate the most recent data on the impact of COVID-19 when finalizing 2021 rates. Specifically, AHIP and the BCBSA are encouraging the states to allow issuers to revise their rate filings using the latest information available prior to states finalizing rates in the Health Insurance and Oversight System (HIOS).

Mr. Webb said another outstanding issue some stakeholders have raised is the creation of a new special enrollment period (SEP) for individuals who obtained their health insurance coverage through the individual market, but lose income and become

eligible for subsidized individual market coverage through the health insurance marketplaces. He said there is no existing SEP that addresses this situation. Mr. Webb said the federal Center for Consumer Information and Insurance Oversight (CCIIO) is relying on its existing SEPs to address loss of health insurance coverage issues due to COVID-19.

Commissioner Altman said NAIC staff prepared a summary compilation chart of the stakeholder letters submitted to the NAIC (Attachment ?), which she will go through section-by-section to provide each stakeholder the opportunity to provide any additional comments. Allison Ivie (Eating Disorders Coalition for Research, Policy & Action—EDC), on behalf of the Mental Health Liaison Group (MHLG), said that, as stated in its letter to the NAIC, the MHLG's most pressing concern is ensuring the continuity of care for its stakeholders via telehealth due to COVID-19. She said it is important that the states provide access to this benefit regardless of the type of insurance and ensure that consumers can receive this benefit from out-of-network providers, including providers across state lines, if the consumer's health benefit plan does not have an in-network specialty provider to treat the covered person.

Kate Gilliard (American Physical Therapy Association—APTA) said the APTA realizes that most states have already expanded telehealth to provide physical therapy-related services. She said, however, that this benefit has been provided with respect to established patients, not for new patients requiring an initial evaluation. She said that unless this issue is addressed, it could be problematic moving forward.

Emily Carroll (American Medical Association—AMA) said that as state insurance regulators continue to debate how best and responsibly to address the myriad of health insurance issues that have arisen due to COVID-19, the AMA urges the states to examine current policies that establish or fail to remove roadblocks between patients and their physicians that could threaten continuity of care or access to care, such as policies involving prior authorization and step therapy. She suggested that the states consider suspending such policies during the COVID-19 emergency because physicians are: 1) caring for COVID-19 patients; and 2) physician support staff are not in the office to process these requirements. Kim Horvath (AMA) stressed the need for plan flexibility for telehealth benefits, particularly for consumers with chronic health conditions. She noted the new requirements the U.S. Department of Health and Human Services (HHS) issued expanding telehealth services for Medicare enrollees. She said the AMA encourages all states to adopt telehealth policies that reflect those now being required under Medicare.

Justine Handelman (BCBSA) stressed the importance of extending the final rate filing deadline for plan 2021 rates, at least until August, because of the uncertainty insurers have in determining rates due to COVID-19. She urged state insurance regulators to use their influence with the CCIIO to move the date. Kristin Hathaway (AHIP) discussed the work the health insurance industry has done to date related to COVID-19, such as COVID-19 testing and fast-tracking providing credentialing and audits. She said AHIP appreciates the NAIC's and state insurance regulators' work providing flexibility in financial filing requirements and collaboration among the states in data requests.

Jessica Adams (American Society for Radiation Oncology—ASTRO) said the ASTRO has similar issues and concerns as those discussed by the AMA, particularly with respect to prior authorization requirements. She urged state insurance regulators to direct insurers to suspend prior authorization requirements for radiation therapy services for the duration of the COVID-19 health emergency because non-treating provider staff members, who would be processing these requests, are working remotely and treating provider staff members are being diverted to COVID-19 response activities, reducing staff manpower to process prior authorization requests. Molly Collins Offner (American Hospital Association—AHA) said the AHA's comments are similar to those already expressed. She said the AHA is working with its members to discuss additional operational challenges and areas where state insurance regulatory flexibility would be helpful. Robert Still (Radiology Business Management Association—RBMA) said the RBMA's comments are similar to the ASTRO's, the AMA's and the AHA's comments.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) said that as state insurance regulators encounter challenges in their states and continue to advocate for policy changes to federal law due to the COVID-19 emergency, the NAIC consumer representatives urge state insurance regulators to: 1) maximize access to comprehensive health coverage so people can access the care they need. More limited coverage or coverage that triggers only if a person becomes ill will be less successful at achieving the goals of getting people to proactively seek testing and treatment; 2) find ways to ease financial strain and support people's ability to comply with social distancing measures, such as ensuring easier access to prescription drug refills, telehealth services and mental health services—especially as the crisis continues; 3) ensure coverage of important health benefits, as well as cost protections, related to treatment and detection of the virus, including protection from surprise medical bills; and 4) continue to protect consumers from fraud and scams.

Katie Morgan (National Infusion Center Association—NICA) said the NICA supports patients' access to non-hospital non-oncology infusion centers, where they can receive provider-administered medical benefit drugs for the treatment of autoimmune diseases, immunodeficiency disorders, rare and genetic disorders, and other chronic, complex conditions. She said these patient populations are at high risk of severe COVID-19 disease should they be exposed. She said the NICA urges state insurance regulators to provide needed insurance flexibility and consider policy options that proactively facilitate continuity of care for these patients, such as: 1) allowing patients to use an out-of-network site of care at the in-network benefit level in the event they are unable to get treatment in their usual care setting due to a drug shortage or closure related to COVID-19; 2) waiving prior authorization requirements for established patients currently on therapy that are switching site of care; and 3) waiving step therapy policies and formulary restrictions in the event of drug shortages.

Rodney Peele (American Optometric Association—AOA) said the AOA urges state insurance regulators to provide the same regulatory flexibility for vision plans that is being provided for health benefit plans. He said the AOA suggestions for regulatory flexibility include: 1) extending contract renewal deadlines; 2) delaying claims audits and recoupments; 3) extending deadlines for filing claims and appeals; and 4) expanding access to telehealth services. He said state insurance regulators also should promote and respect the role of optometrists in the COVID-19 health emergency, including acknowledging that optometrists: 1) may order or perform COVID-19 testing; 2) provide essential eye health and vision care; and 3) have the autonomy to follow the advice of local, state and public health authorities, and best meet the needs of patients. Mr. Peele said optometrists take a leading role in patient care with respect to eye health and vision care, as well as general health and well-being. As primary health care providers, optometrists have extensive, ongoing training to examine, diagnose, treat and manage ocular disorders, diseases and injuries, and many of these treatments are essential. He said studies show that the same groups burdened by COVID-19 complications, such as those with hypertension and respiratory conditions, also suffer more vision problems. He said ensuring patient access to urgent and emergency eye care provided by optometrists is critical to ensuring that patients, particularly from at-risk populations, do not needlessly end up in an emergency room and potentially exposed to COVID-19 during this current public health emergency.

Commissioner Altman requested comments from Committee members. Director Lindley-Myers said she could support the NAIC requesting the federal Centers for Medicare & Medicaid Services (CMS) to push the final 2021 rate filing back to sometime in September to provide additional time for insurers to factor in any changes related to COVID-19. Superintendent Toal expressed support for Director Lindley-Myers' comments. The Committee members discussed whether to make such a request to the CMS. Some Committee members explained that they are maintaining their initial rate filing deadlines, but typically they permit carriers to revise their rate assumptions many times during the rate review process before the rates are final. After additional discussion, Commissioner Altman said the next step is for this issue to be discussed by the Government Relations (EX) Leadership Council. The Committee agreed.

Commissioner Godfread said the states have addressed on an individual basis the issues stakeholders raised in their letters to the NAIC. He said he thinks the next issue the state insurance regulators will have to address concerns payment for COVID-19 antibody testing. He said it would be nice if there could be some uniformity on how this issue is addressed across the states. Commissioner Mulready said he also is concerned and has reach out to Oklahoma's U.S. Senate delegation to obtain guidance on this issue and others. Commissioner Conway said it would be helpful to receive clarification from the CMS on the issue. Mr. Webb said the CMS anticipates providing additional guidance on the issue, but it has not set a time frame on when such guidance will be released.

### 3. Heard an Update from the CCIIO

Randy Pate (CCIIO) updated the Committee on the CCIIO's recent activities, particularly its activities related to the COVID-19 health emergency. He said the CCIIO recently released guidance related to the expansion of telehealth services in response to COVID-19. He said that as part of the Trump administration's efforts to combat the COVID-19, the CMS has postponed the 2019 benefit year HHS Risk Adjustment Data Validation (HHS-RADV) process in order for issuers and providers to focus on the health and safety threats currently faced by enrollees, participants and other impacted individuals due to the COVID-19 pandemic.

Mr. Pate said the CCIIO is working on establishing a new SEP for consumers enrolled in individual health insurance plans off the health insurance marketplace, but due to reduction of income because of job loss or some other event become eligible for subsidized individual health insurance coverage on the health insurance marketplace. He said the CCIIO is working quickly to operationalize this new SEP, but, currently, it does not have a specific date when it will be operational. Mr. Pate said the CCIIO also is considering providing additional time for submission of final 2021 rates consistent with the Committee's discussion.

The CCIIO is helping to disseminate information to individuals and employees to assist them in taking advantage of SEPs they might be eligible for due to COVID-19 through the HealthCare.gov website.

Mr. Pate said the HHS, through the Health Resources and Services Administration (HRSA), has launched a new COVID-19 Uninsured Program Portal, allowing health care providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 individuals on or after Feb. 4 to submit claims for reimbursement. Providers can access the portal at <https://COVIDUninsuredClaim.HRSA.gov>.

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

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Draft: 3/6/20

Health Insurance and Managed Care (B) Committee  
E-Vote  
February 26, 2020

The Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Feb. 26, 2020. The following Committee members participated: Jessica K. Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); John F. King (GA); Vicki Schmidt (KS); Steve Kelley represented by Grace Arnold (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); Glen Mulready (OK); Andrew R. Stolfi (OR); Hodgen Mainda represented by Rachel Jade-Rice (TN); and Mike Kreidler represented by Molly Nollette (WA).

1. Adopted the Regulatory Framework (B) Task Force's 2020 Revised Charges

The Committee conducted an e-vote to consider adoption of the Regulatory Framework (B) Task Force's 2020 revised charges, which add 2020 charges for the newly appointed MHPAEA (B) Working Group (*see NAIC Proceedings – Spring 2020, Regulatory Framework (B) Task Force, Attachment One-A*). A majority of the Committee members voted in favor of adopting the Task Force's 2020 revised charges. The motion passed unanimously.

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

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## Draft Pending Adoption

Draft: 12/16/19

Health Insurance and Managed Care (B) Committee  
Austin, Texas  
December 8, 2019

The Health Insurance and Managed Care (B) Committee met in Austin, TX, Dec. 8, 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 represented by John Melvin (KY); Steve Kelley (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); John Elias represented by Maureen Belanger (NH); Linda A. Lacewell represented by Tom Dudek (NY); Andrew Stolfi (OR); Hodgen Mainda (TN); Scott A. White represented by Julie Blauvelt (VA); and Mike Kreidler and Jane Beyer (WA). Also participating were: Steve Ostlund (AL); Ryan James (AR); Fleur McKendell and Leslie Ledogar (DE); Doug Ommen and Andria Seip (IA); Alex Peck (IN); Frank Opelka (LA); Kevin Dyke (MI); Paige Duhamel (NM); Glen Mulready (OK); Marie Ganim (RI); Nancy Clark (TX); Todd E. Kiser and Tanji Northrup (UT); and Nathan Houdek and Jennifer Stegall (WI).

### 1. Adopted its Oct. 24 and Summer National Meeting Minutes

The Committee met Oct. 24 and Aug. 4. During its Oct. 24 meeting, the Committee took the following action: 1) adopted the Health Actuarial (B) Task Force's 2020 proposed charges, the Regulatory Framework (B) Task Force's 2020 proposed charges, and the Senior Issues (B) Task Force's 2020 proposed charges; and 2) adopted its 2020 proposed charges.

Director Wing-Heier made a motion, seconded by Commissioner Godfread, to adopt the Committee's Oct. 24 (Attachment One) and Aug. 4 (*see NAIC Proceedings – Summer 2019, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

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

Commissioner Conway made a motion, seconded by Commissioner Kreidler, to adopt the following reports: the Consumer Information (B) Subgroup, including its Nov. 18 (Attachment Two), Oct. 21 (Attachment Three) and Oct. 7 (Attachment Four) minutes; the Health Innovations (B) Working Group (Attachment Five); the Health Actuarial (B) Task Force; the Long-Term Care Insurance (E/B) Task Force; the Regulatory Framework (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 provided a snapshot of the current open enrollment period to date, including application and enrollment numbers. He highlighted the effect of the ACA Section 1332 waivers in reducing premium costs. He said that to date, the CCIIO has approved 13 waivers. Most of the approved waivers were for establishing a reinsurance program. He also highlighted the steps the Trump Administration has taken to improve price transparency in healthcare, which is one of the Trump Administration's key priorities, including the publication of a proposed rule on Nov. 15 to require issuers to provide information to consumers on projected out-of-pocket (OOP) costs and make price information available to third-party vendors. Mr. Pate also discussed the CCIIO's recently released Risk Adjustment Data Verification (RAD-V) white paper. The RAD-V white paper lays out options for potential modifications to several aspects of the U.S. Department of Health and Human Services (HHS)-RADV methodology. Mr. Pate urged state insurance regulators to submit comments on the RAD-V white paper.

### 4. Heard a Presentation on “Overcharged: Why Americans Pay Too Much for Health Care”

Charles Silver (University of Texas at Austin & CATO Institute), co-author of the book “Overcharged: Why Americans Pay Too Much for Health Care,” discussed the problems in the U.S. healthcare system, which have contributed to high health care costs. He said these problems include: 1) fraud, waste and abuse; 2) uncontrollable spending; 3) opaque prices; 4) surprise bills; 5) quality that is highly variable and often mediocre; and 6) absurd prices for prescription drugs. He suggested several potential solutions to address these problems, such as: 1) eliminating tax exemptions and coverage for mandates; 2) promoting competition and encouraging medical tourism; 3) letting the insurance-driven spending cycle burn itself out; and 4) turning Medicare, Medicaid and other programs into cash-transfer programs along the lines of social security and the earned income tax credit.

## Draft Pending Adoption

Professor Silver described the problems in the U.S. health care system and its high and increasing health care costs as a vicious cycle with its excessive reliance on third-party payment. He said coverage of health care costs stimulates demand for more and more expensive medical treatments. This heightened demand drives up prices and encourages the proliferation of services. He said with these rising prices and expanded health care needs, consumers become scared and demand more protection. Insurers and government agencies respond to this panic by offering more comprehensive coverage, circling back to the beginning of the problem.

Professor Silver said the solution to ending this vicious cycle is to let it burn out. He said that as spending increases, insurance becomes more expensive, which leads to more uninsured. As people go without insurance or carry higher deductible and copays, the army of self-paying consumers grows. He said the retail sector responds to this increase in demand by offering options for obtaining medical care that is cheaper and more convenient. He discussed a current example of this retail revolution, the Surgery Center of Oklahoma.

Commissioner Stolfi asked Professor Silver about the consequences of letting the system burn itself out, particularly with respect to the poor. Professor Silver said he believes consumers should use health insurance to insure against catastrophic events like other types of insurances. He said his idea for creating cash-transfer programs would address the needs of the poor. Commissioner Conway questioned one aspect of Professor Silver's theory of letting the system burn itself out with respect to consumers paying more in deductibles and copays leading to lower health care prices in light of the growth of high deductible health plans (HDHPs). Professor Silver said it takes time for the transition. He cited the example of CVS halting the sale of tobacco products and establishing walk-in health care clinics. He acknowledged the difficulty of such a change with respect to catastrophic health care services.

### 5. Heard a Panel Presentation on State Surprise Billing Laws

Ms. Beyer provided an overview of Washington's Balance Billing Protection Act (BBPA). She explained that as of Jan. 1, 2020, in Washington, surprise/balance billing is prohibited for: 1) all emergency services at in-network and out-of-network (OON) hospitals; and 2) non-emergency surgical or ancillary services provided by an OON provider at an in-network hospital or ambulatory surgical center. She discussed the scope of the BBPA, including how it applies to emergency services received out-of-state. She discussed the BBPA's application, including a provision that permits self-funded plans to opt-in to the BBPA's balance billing prohibition, consumer protections, and arbitration provisions. She said that self-funded plans that want to opt-in can use a simple on-line "opt-in" process to do so. She said the Washington Department of Insurance (DOI) will maintain a list of self-funded plans choosing to opt-in.

Ms. Beyer discussed the BBPA's OON payment provision. She said the BBPA provides that the OON provider be paid a "commercially reasonable amount based on payment for the same or similar services provided in a similar geographic area." If the provider and health carrier cannot agree on this amount, after a 30-day informal negotiation period, they can proceed to arbitration. Ms. Beyer explained that to inform negotiations and arbitration, providers, carriers and arbitrators have access to a data set from the state's all payer claims database (APCD). She also described the BBPA's transparency and enforcement provisions.

Ms. Taylor said Texas' surprise billing law is similar in many ways to Washington's BBPA. She said Texas' law is also effective Jan. 1, 2020. The Texas law's application to insured plans and state employee plans is similar to Washington's law, except Texas' law does not include provisions permitting self-funded plans to opt-in. Ms. Taylor said Texas' law is unique in that it includes both an arbitration process and a mediation process. She said Texas' arbitration process must conclude by day 51. Its mediation process may last up to 120 days. Ms. Taylor said the OON provider payment is based on 80% of billed charges and geographic area.

Commissioner Altman asked what advice Ms. Beyer and Ms. Taylor would provide to the states considering such legislation. Ms. Beyer said she believes that in order to get such legislation enacted, it must strike a balance where stakeholders are not completely happy with the legislation, but they can live with it. Ms. Taylor agreed. Commissioner Godfreed asked what services are not included in the scope of either law. Ms. Beyer said air ambulance and ground ambulance services are not included in the scope of Washington's law. Ms. Taylor said Texas' law is similar. Ms. Duhamel discussed New Mexico's surprise bill law and its challenge with setting the OON payment benchmark. She agreed with Washington and Texas that one key to getting such legislation enacted was involving stakeholders throughout the process. Commissioner Mulready discussed Oklahoma's struggle with such legislation concerning the lack of authority the DOI has over certain health care providers. Ms. Beyer said Washington worked through this issue and ultimately worked out an agreement to work collaboratively with its Department of Health (DOH) concerning any provider enforcement issues.

## Draft Pending Adoption

### 6. Heard an Update on Legal Action Surrounding the ACA

William Schiffbauer (Law Office of William G. Schiffbauer) gave an update from his presentation at the Spring National Meeting on the four major cases involving the ACA: 1) *Texas v. United States of America, et al.*, which challenges the constitutionality of the ACA's individual mandate and its potential impact on other key ACA provisions; 2) *State of New York v. U.S. Department of Labor*, which challenges the legality of the federal association health plan (AHP) regulation; 3) *Association of Community Affiliated Plans, et al. v. U.S. Department of Treasury, et al.*, which challenges the legality of the federal short-term, limited-duration (STLD) plan regulation; and 4) *Maine Community Health Options v. United States*, which challenges the legality of the federal government withholding full risk corridor payment amounts to participants.

Mr. Schiffbauer provided an overview of the timeline, current status, and main arguments for each of the cases. The *Texas v. United States of America, et al.* case is pending in the U.S. Court of Appeals for the Fifth Circuit. The *State of New York v. U.S. Department of Labor* and *Association of Community Affiliated Plans, et al. v. U.S. Department of Treasury, et al.*, cases are both pending in the U.S. Court of Appeals for the Washington, DC Circuit. The *Maine Community Health Options v. United States* case is pending before the U.S. Supreme Court. Oral arguments in this case are scheduled before the U.S. Supreme Court Dec. 10.

Mr. Schiffbauer explained that if these cases are not already before the U.S. Supreme Court, no matter the outcome at the U.S. Court of Appeals level, it is anticipated that the parties in these cases will file a Petition for Certiorari to the U.S. Supreme Court. He summarized the cases as follows: 1) the Fifth Circuit Court of Appeals decision in *Texas v. United States of America, et al.* is expected before the end of the year, most likely following the end of the current open enrollment period ending Dec. 15. A U.S. Supreme Court opinion would be issued on or before July 31, 2020; 2) the District of Columbia Court's opinion in *State of New York v. U.S. Department of Labor* is expected in by December 2019 or January 2020. A U.S. Supreme Court opinion would be issued on or before July 31, 2020; 3) The District of Columbia Court will hold oral arguments in the *Association of Community Affiliated Plans, et al. v. U.S. Department of Treasury, et al.* case in March or April 2020. The court would issue an opinion in May or June 2020. It is unlikely that the U.S. Supreme Court would issue an opinion on or before July 31, 2020; and 4) The U.S. Supreme Court is likely to issue an opinion in the *Maine Community Health Options v. United States* on or before July 31, 2020.

### 7. Heard a Federal Legislative Update

Joe Tuschner (NAIC) provided a federal legislative update on Congressional activity of interest to the Committee. He discussed the current status of surprise billing legislation, explaining that it appears that a bi-cameral agreement has been reached. He said he would provide more details on this agreement to the Committee and other state insurance regulators after the Fall National Meeting. He said the NAIC received a letter from the federal Centers for Medicare & Medicaid Services (CMS) Administrator seeking recommendations for creating interstate compacts for the sale of health insurance across state lines, as required by ACA section 1333 and in compliance with an Executive Order. He said the Government Relations (EX) Leadership Council considered a letter responding to the request Dec. 4. He also said there is strong bipartisan support for further delaying the health insurance tax (HIT), which was not paid in 2019. He said the difficulty that the U.S. Congress (Congress) is facing is how to pay for it. The HIT brings in over \$16 billion a year. Mr. Tuschner said delaying the HIT could be part of an end-of-the-year budget deal.

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

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**Agenda Item #2**

**Consider Adoption of its Subgroup, Working Group and Task Force Reports  
—Commissioner Jessica K. Altman (PA)**

*2020 Summer National Meeting  
Virtual Meeting*

**HEALTH INNOVATIONS (B) WORKING GROUP**

**Thursday, July 30, 2020**

**11:30 a.m. – 1:00 p.m. ET / 10:30 a.m. – 12:00 p.m. CT / 9:30 – 11:00 a.m. MT / 8:30 – 10:00 a.m. PT**

**Meeting Summary Report**

The Health Innovations (B) Working Group met July 30, 2020. During this meeting, the Working Group:

1. Adopted its June 23 minutes. During this meeting, the Working Group discussed the regulation of coverage for telehealth services and potential topics for the Working Group's meeting during the Summer National Meeting.
2. Heard a presentation on privacy requirements for telehealth communications under the Health Insurance Portability and Accountability Act (HIPAA). An attorney with Manatt Health reviewed which HIPAA standards were required versus addressable, the flexibility established under the COVID-19 pandemic, and other considerations for covered entities in complying with privacy requirements.
3. Heard a panel discussion on telemedicine from representatives of stakeholder groups. The National Alliance on Mental Illness (NAMI) shared poll results and concerns from patients and mental health providers. America's Health Insurance Plans (AHIP) reviewed the growth in telehealth services, ongoing challenges, and what states can do to further promote telehealth. The American Academy of Family Physicians (AAFP) discussed changes to provider workflows, regulatory flexibilities and ongoing challenges, including the lack of alignment across payers.
4. Heard a presentation from the Milbank Memorial Fund on strategies for cost control. It suggested five areas in which state insurance regulators can incentivize and encourage greater health care system affordability.

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**Agenda Item #3**

**Hear a Presentation on Health Equity and Disparities in Health Care and Coverage  
—*Samantha Artiga (Kaiser Family Foundation—KFF)***

# Disparities in Health and Health Care: An Overview

Samantha Artiga

Director, Disparities Policy Project and Associate Director,  
Kaiser Program on Medicaid and the Uninsured  
Kaiser Family Foundation



Filling the need for trusted information on national health issues.

# KFF (Kaiser Family Foundation)

- Non-profit organization focusing on national health issues, as well as the U.S. role in global health policy
- Develop and run our own policy analysis, journalism, and communications programs
- Provide basic education to increase awareness and understanding of disparities
- Conduct data analysis to provide greater insight into status of disparities
- Analyze implications of emerging policy issues on disparities and efforts to advance equity
- Inform broad range of stakeholders through reports, meetings, briefings, and media
- All materials available through our website at [www.kff.org](http://www.kff.org)

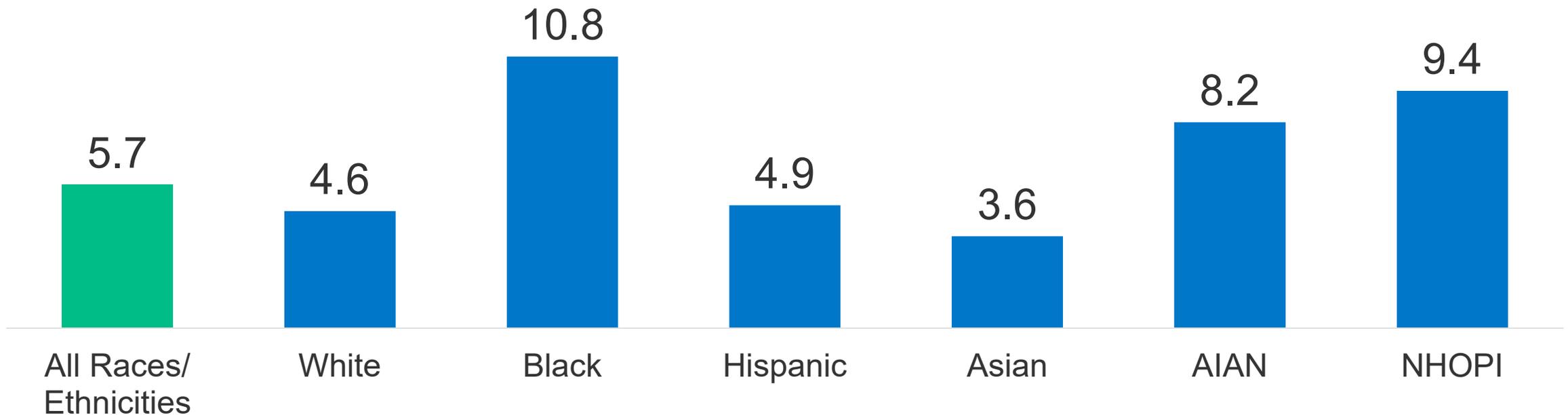
# What are health and health care disparities?

- Differences in health and health care between populations
  - Higher burden of illness, injury, disability, or mortality
  - Differences in insurance coverage, access to and use of care, and quality of care
- Arise from a complex and interrelated set of individual, provider, health system, societal, and economic factors
- Occur across a broad range of dimensions: race/ethnicity; socioeconomic status; gender; age; disability; sexual orientation or gender identity; geographic location, etc.
- Remain a longstanding and persistent issue

Figure 3

# Black, AIAN, and NHOPI people have higher infant mortality rates compared to other groups.

Infant Mortality per 1,000 Live Births, by Maternal Race/Ethnicity, 2018



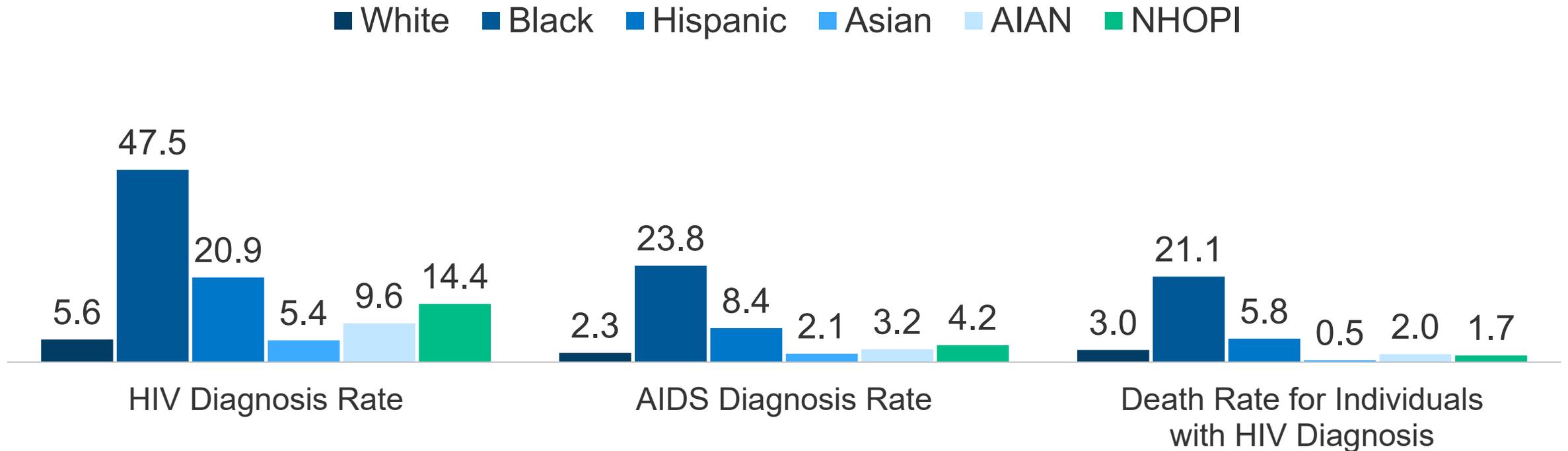
NOTE: AIAN refers to American Indian and Alaska Native people. NHOPI refers to Native Hawaiians and Other Pacific Islander people. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

SOURCE: CDC, National Center for Health Statistics, Division of Vital Statistics, Linked Birth/Infant Death Records, 2018.

Figure 4

# Black and Hispanic people face stark disparities in HIV and AIDS diagnoses and death rates among people with HIV.

HIV or AIDS Diagnosis and Death Rate per 100,000 among Teens and Adults by Race/Ethnicity, 2018



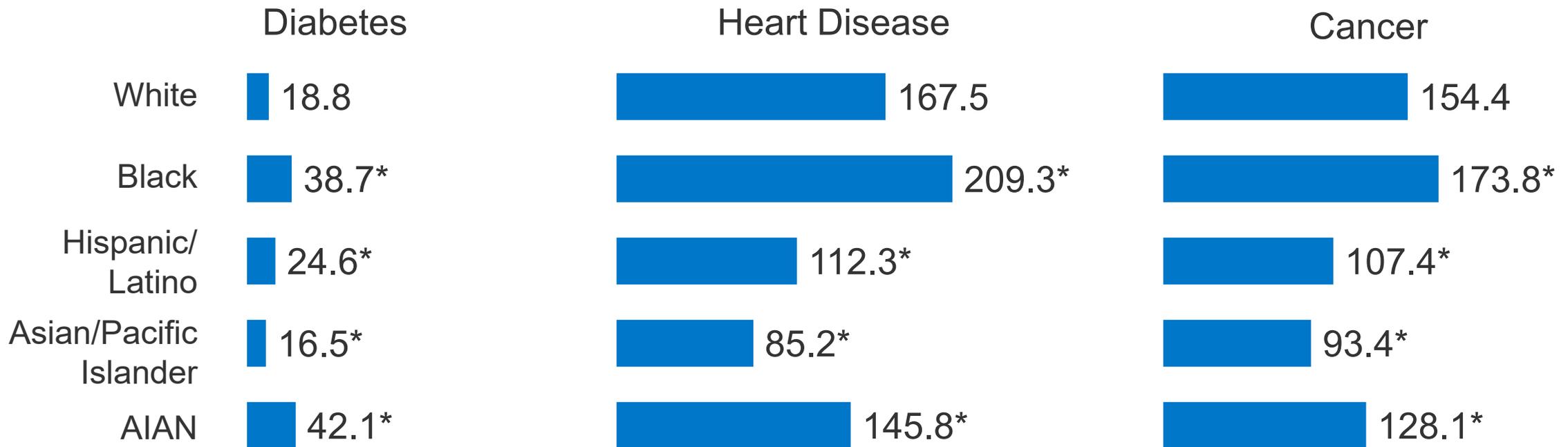
NOTE: Data based on surveillance data reported by states to the CDC. AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons categorized by race were not Hispanic or Latino. Individuals in each race category may, however, include persons whose ethnicity was not reported. Includes individuals age 13 and older. Data for HIV and AIDS diagnoses are as of 2018 and death rate data are as of 2017. Death rates for individuals with HIV are deaths due to any cause, not only from HIV-related illness.

SOURCE: CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2018.

Figure 5

# People of color have higher rates of death due to certain diseases.

Age-Adjusted Death Rates per 100,000 for Selected Diseases by Race/Ethnicity, 2018



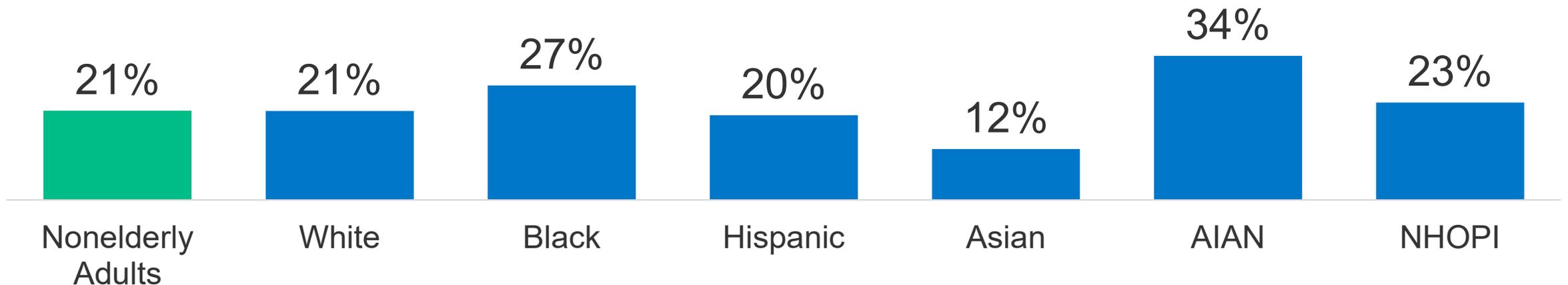
NOTE: \* Indicates statistically significant difference from White people at the  $p < 0.05$  level. AIAN refers to American Indian and Alaska Native people. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes individuals of all ages. Data for some groups should be interpreted with caution; see <http://wonder.cdc.gov/wonder/help/ucd.html#Racial>.

SOURCE: CDC, National Center for Health Statistics, WONDER Online Database, Underlying Cause of Death, 2018.

Figure 6

# The disparate impacts of COVID-19 mirror and compound underlying health disparities.

Share of Adults Ages 18-64 at Higher Risk of Serious Illness if Infected with Coronavirus by Race/Ethnicity



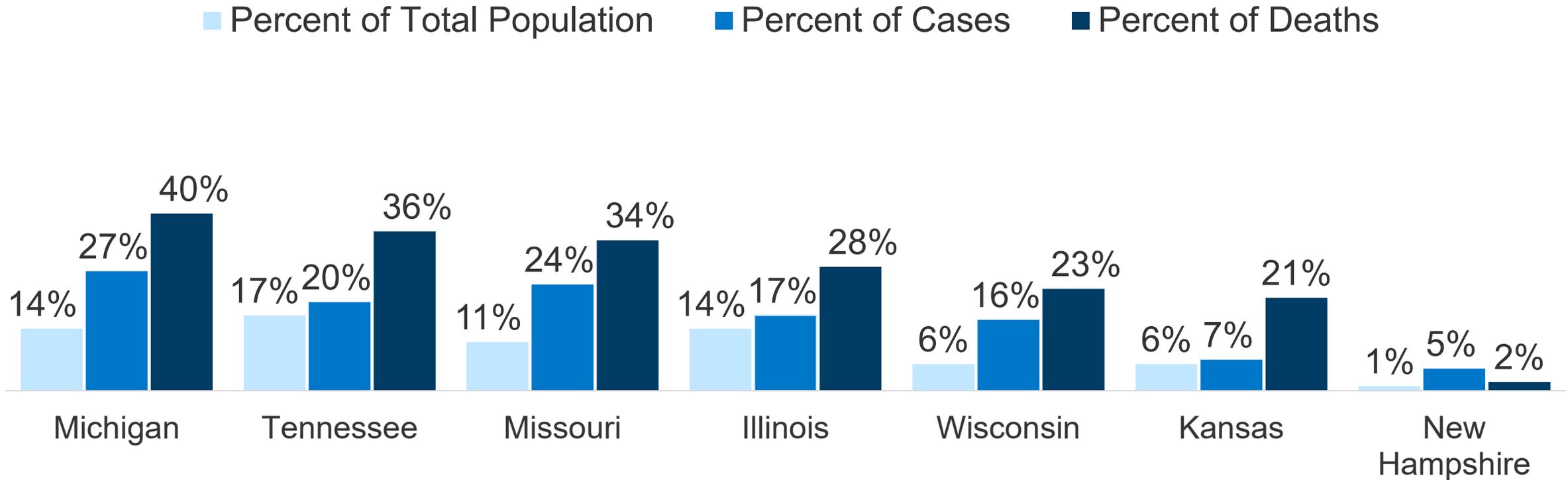
NOTE: Data includes adults ages 18-64; excludes adults living in nursing homes or other institutional settings. Persons of Hispanic origin may be of any race, but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

SOURCE: KFF analysis of 2018 Behavioral Risk Factor Surveillance System.

Figure 7

# Black people account for a disproportionate share of COVID-19 cases and deaths in most states reporting data.

Black People as a Share of Coronavirus Cases, Deaths, and Total Population in Select States, July 20, 2020

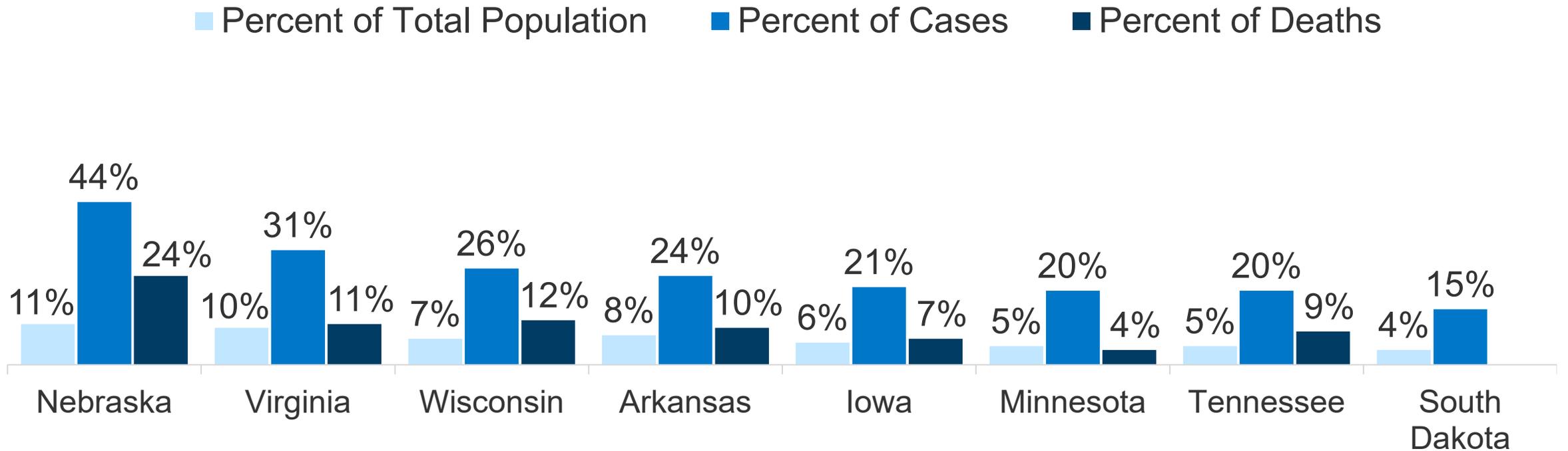


SOURCE: Distribution of Cases/Deaths by Race/Ethnicity based on KFF analysis of data from the COVID Tracking Project. Total State Population Distribution by Race/Ethnicity based on KFF analysis of 2018 American Community Survey.

Figure 8

# Hispanic people account for a disproportionate share of COVID-19 cases in most states reporting data.

Hispanic People as a Share of Coronavirus Cases, Deaths, and Total Population in Select States, July 20, 2020



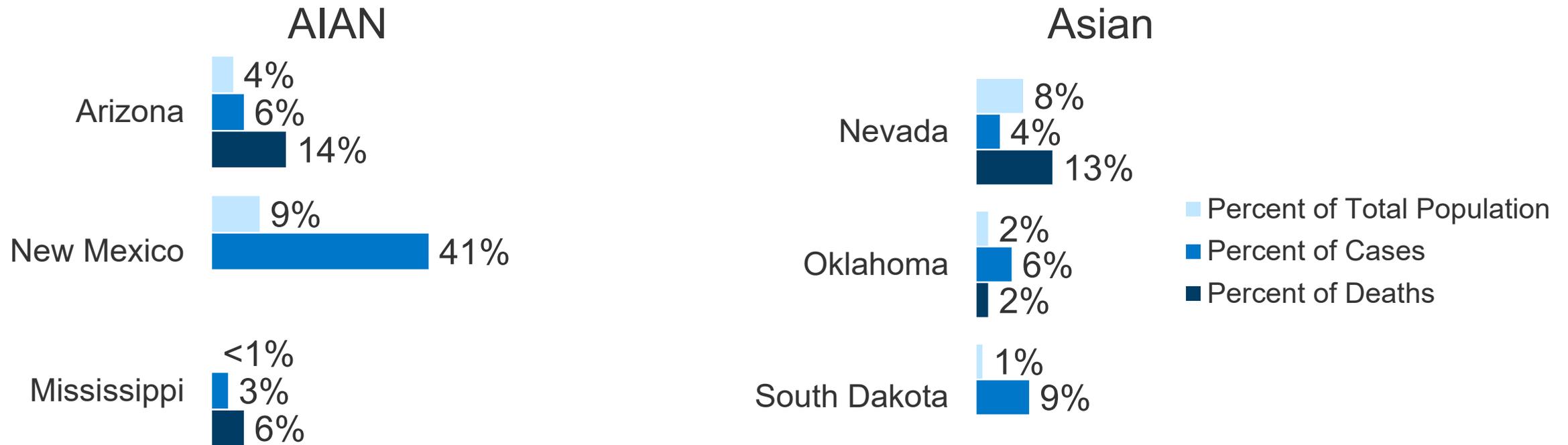
NOTE: As of July 20, 2020, South Dakota does not report coronavirus deaths by race/ethnicity.

SOURCE: Distribution of Cases/Deaths by Race/Ethnicity based on KFF analysis of data from the COVID Tracking Project. Total State Population Distribution by Race/Ethnicity based on KFF analysis of 2018 American Community Survey.

Figure 9

# COVID-19 is having stark impacts for American Indian and Alaska Native (AIAN) and Asian people in some states.

AIAN and Asian People as a Share of Coronavirus Cases, Deaths, and Total Population in Select States, July 20, 2020

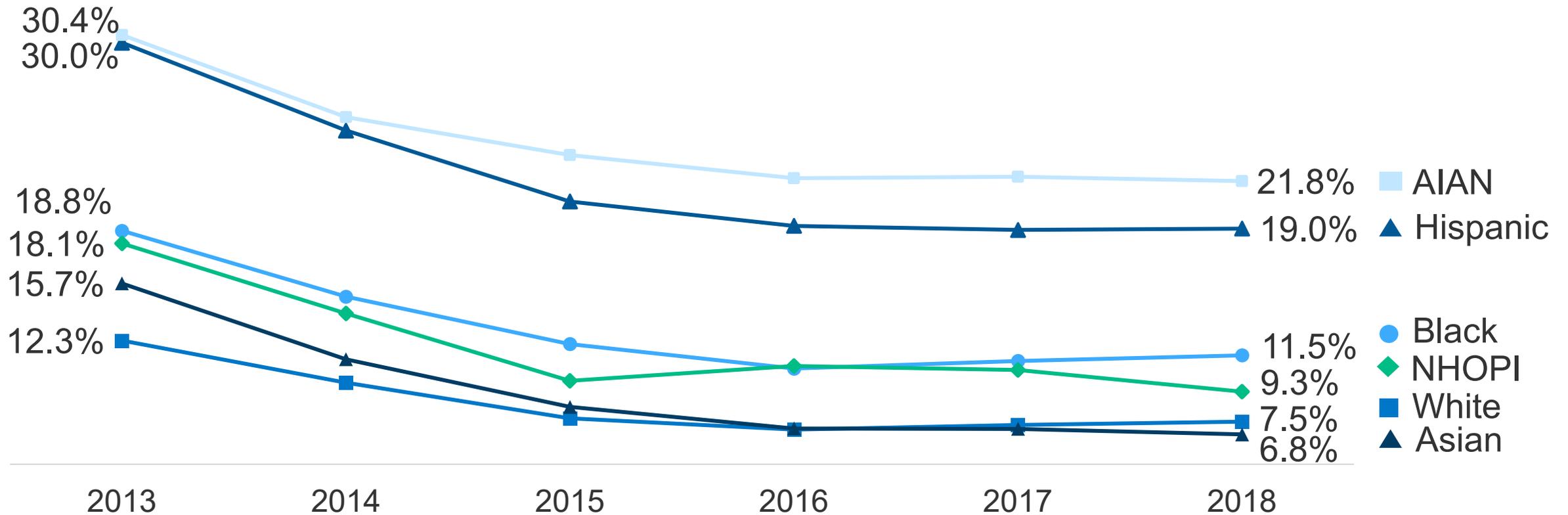


NOTE: As of July 20, 2020, New Mexico and South Dakota did not report coronavirus deaths by race/ethnicity.

SOURCE: Distribution of Cases/Deaths by Race/Ethnicity based on KFF analysis of data from the COVID Tracking Project. Total State Population Distribution by Race/Ethnicity based on KFF analysis of 2018 American Community Survey.

Figure 10

# Uninsured rates have declined since implementation of the Affordable Care Act, but disparities persist for some groups.



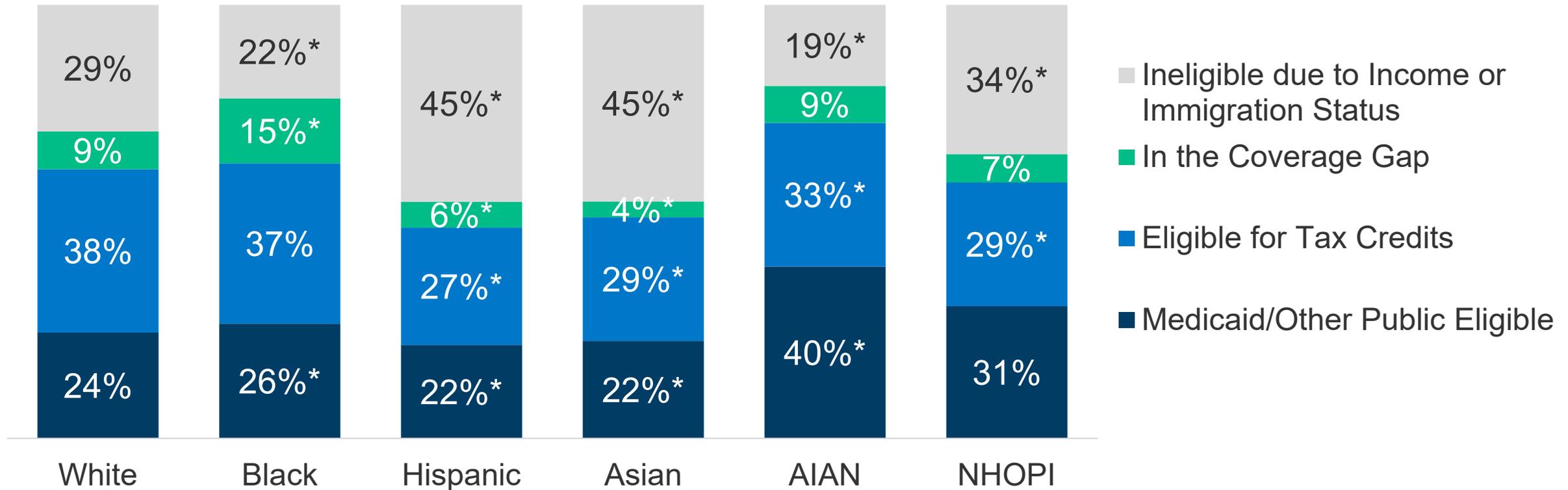
NOTE: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0-64 years.

SOURCE: KFF analysis of 2013-2018 American Community Survey.

Figure 11

# Uninsured Black individuals are more likely to fall in the coverage gap than their White counterparts.

Eligibility for ACA Coverage Among Nonelderly Uninsured by Race/Ethnicity, 2018



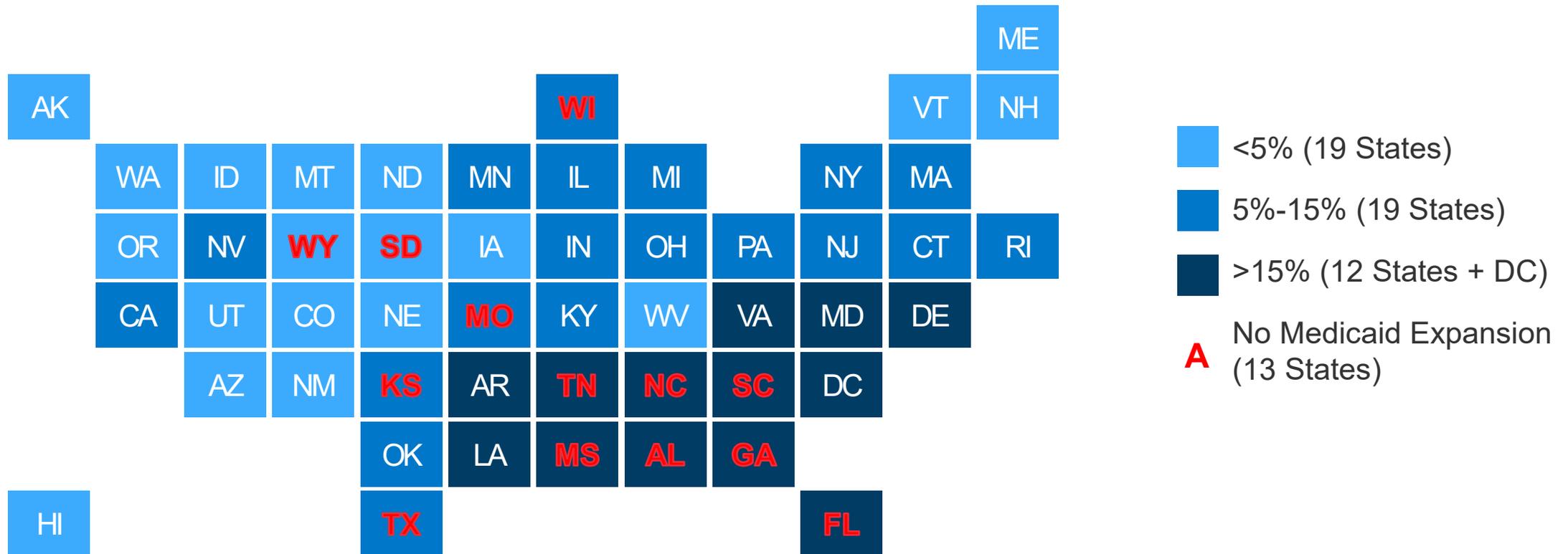
NOTE: \* Indicates statistically significant difference from Whites at the  $p < 0.05$  level. Totals may not sum due to rounding. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0-64 years of age. AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders.

SOURCE: KFF analysis based on 2019 Medicaid eligibility levels and 2018 American Community Survey.

Figure 12

# Black people make up a higher share of the population in the South, where many states have not expanded Medicaid.

Share of Total Nonelderly Population that is Black by State and Medicaid Expansion Status as of July 2020



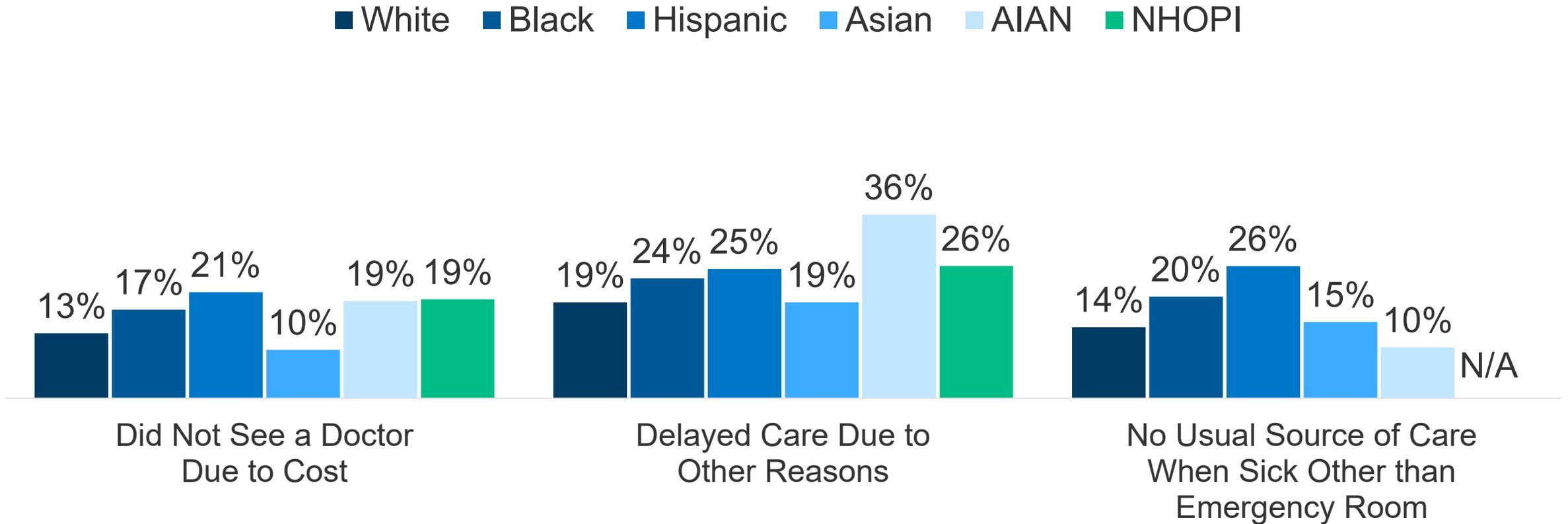
NOTE: Includes nonelderly individuals 0-64 years of age and non-Hispanic Blacks.

SOURCE: KFF analysis of 2018 American Community Survey and KFF Status of State Action on the Medicaid Expansion Decision, as of July 2020, <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

Figure 13

# People of color face increased barriers to accessing care.

Share of Nonelderly Adults Reporting Selected Barriers to Accessing Health Care by Race/Ethnicity, 2018



NOTE: AIAN refers to American Indian and Alaska Native people. NHOPI refers to Native Hawaiian and Other Pacific Islander people. N/A: data cannot be separately identified. Persons of Hispanic origin may be of any race, but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly adults 18-64 years of age.

SOURCE: KFF analysis of 2018 Behavioral Risk Factor Surveillance System and National Health Interview Survey data.

Figure 14

Health disparities are a symptom of social and economic inequities.

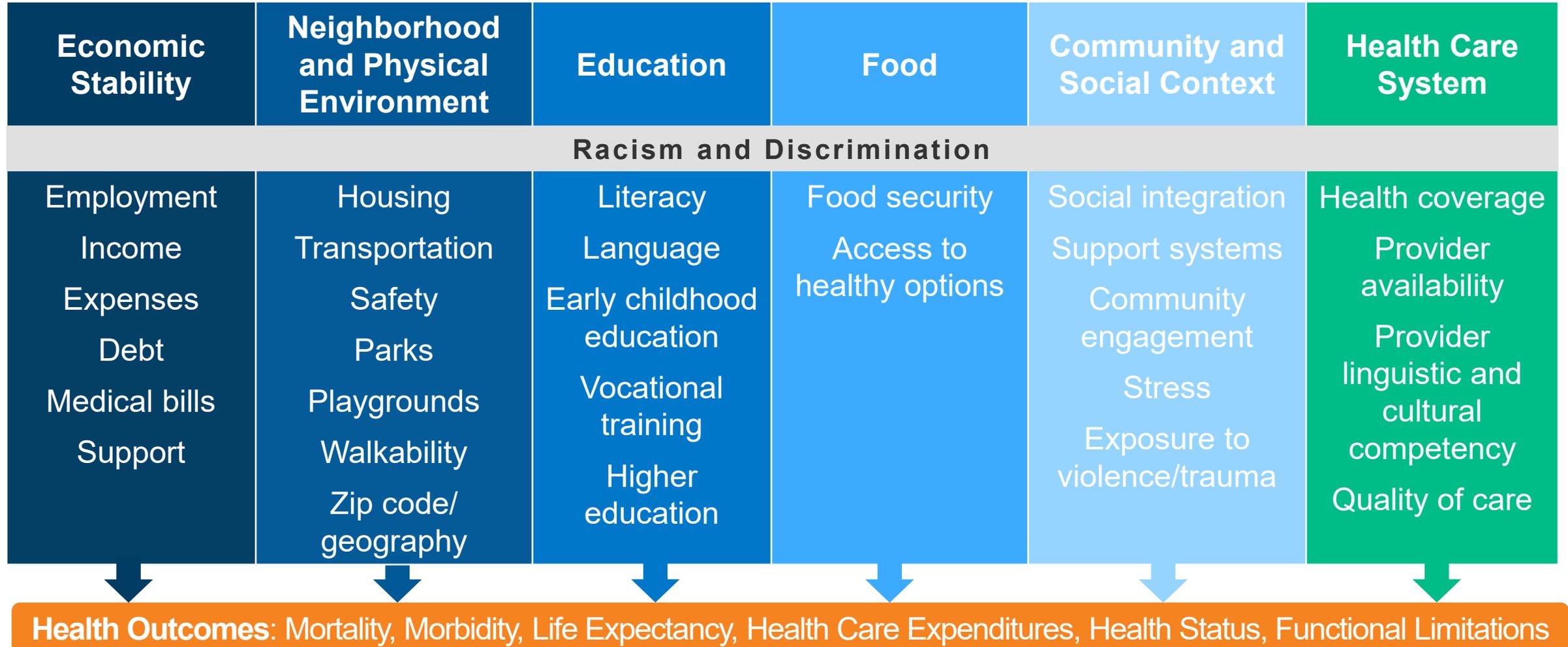
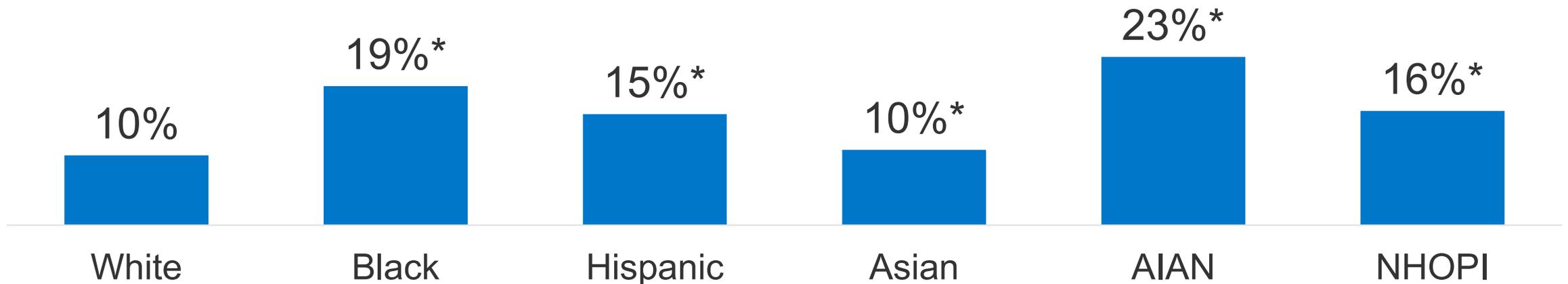


Figure 15

# People of color are more likely to have income below poverty compared to White people.

Percent of Nonelderly Population with Income Below Poverty by Race/Ethnicity, 2018



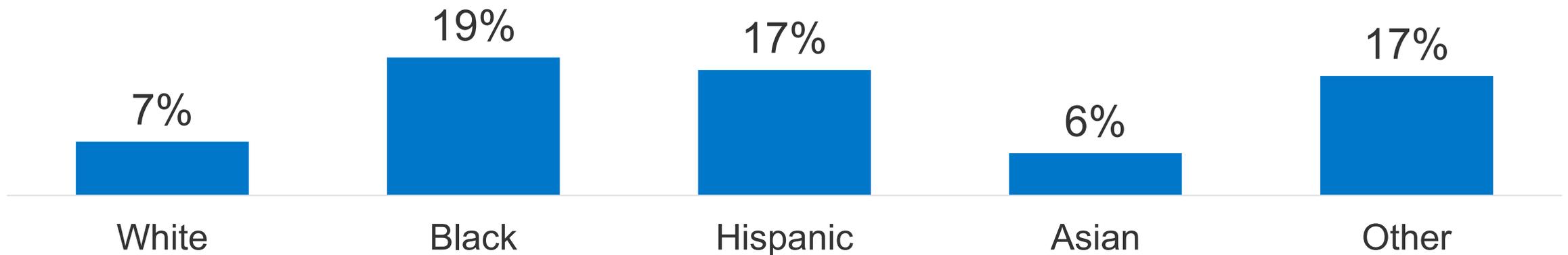
NOTE: \* Indicates statistically significant difference from the White population at the  $p < 0.05$  level. AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. N/A: data cannot be separately identified. Persons of Hispanic origin may be of any race, but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0-64 years of age.

SOURCE: KFF analysis of 2018 American Community Survey.

Figure 16

# Households of color are more likely to be facing food insecurity than White households.

Food Security among Reporting Households in the Last 7 Days by Race/Ethnicity, July 9 - July 14, 2020



SOURCE: KFF analysis of Census Week 9 Household Pulse Survey: July 9 - July 14, <https://www.census.gov/data/tables/2020/demo/hhp/hhp9.html>.

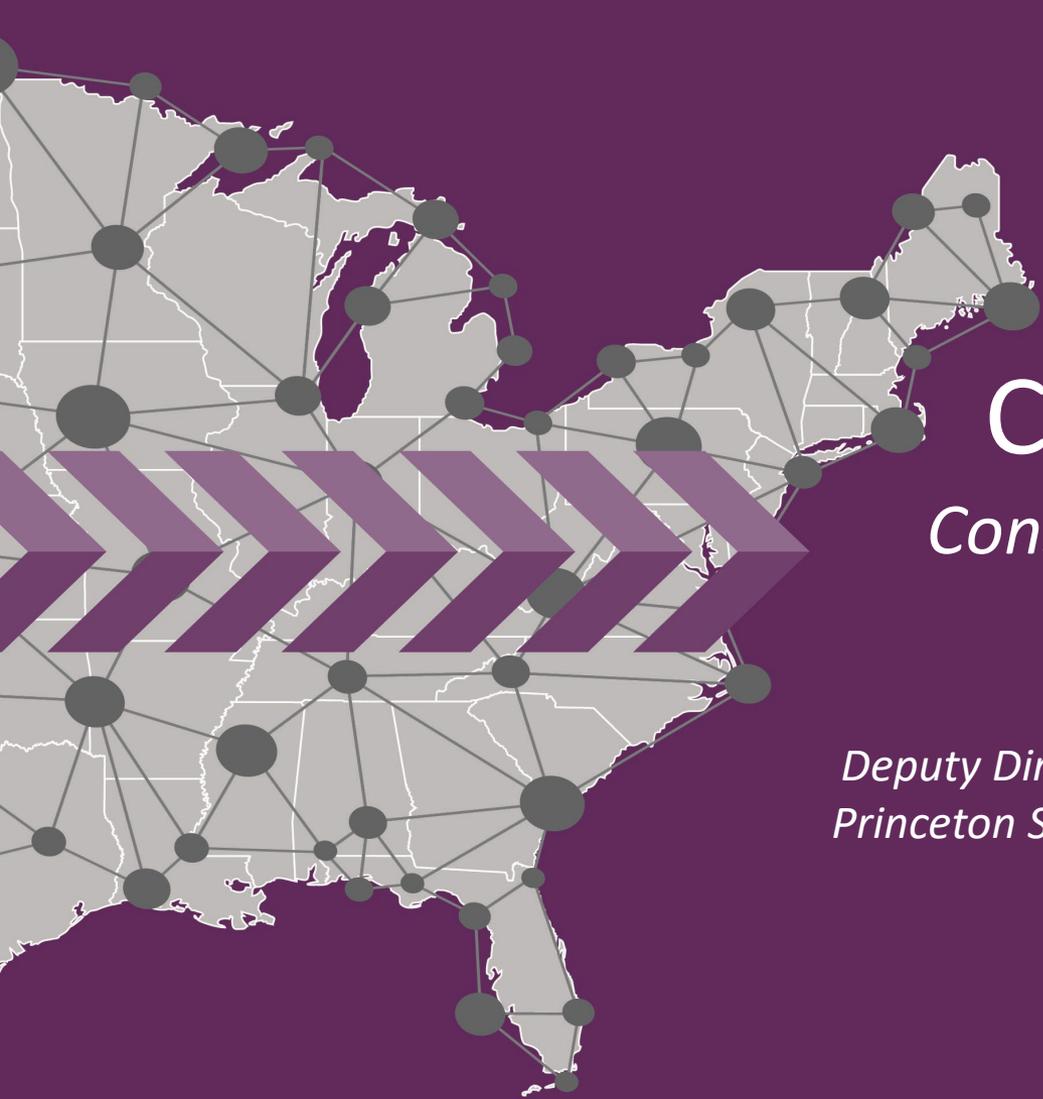
# Key Takeaways

- Health and health care disparities are a longstanding and persistent issue
- The COVID-19 pandemic has highlighted and exacerbated underlying disparities
- Health disparities are a symptom of broader social and economic inequities rooted in structural and systemic barriers that disadvantage people of color, including racism and discrimination
- Increased awareness and recognition of disparities provides an opportunity to advance equity
- Progress will require long-term efforts across sectors to prioritize equity and address systemic and structural barriers, including racism and discrimination

## **Agenda Item #4**

**Hear a Presentation on COVID-19: Lessons Learned**

**—Daniel J. Meuse (*State Health and Value Strategies [SHVS]*, Princeton School of Public and International Affairs, Princeton University)**



# COVID-19 and ESI

*Considerations for Regulators*

Daniel Meuse  
*Deputy Director, State Health and Value Strategies  
Princeton School of Public and International Affairs*

**STATE**  
Health & Value  
**STRATEGIES**  
**COVID-19**

*A grantee of the Robert Wood Johnson Foundation*

# About State Health and Value Strategies

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at [www.shvs.org](http://www.shvs.org).

**Questions?** Email Dan Meuse at [dmeuse@Princeton.edu](mailto:dmeuse@Princeton.edu).

Special thanks to Marissa Korn, Princeton School of Public and International Affairs, for research assistance.

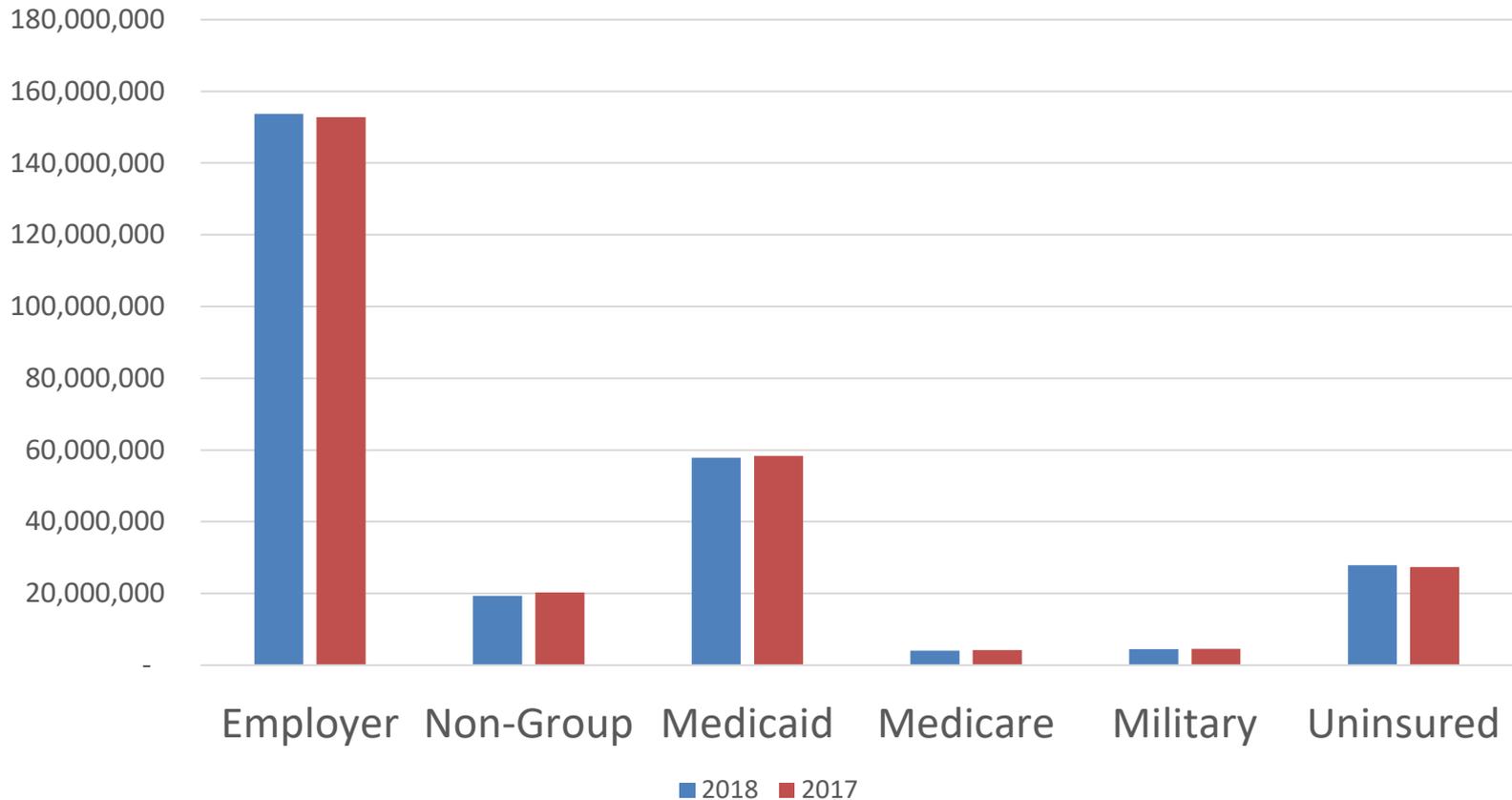
*Support for this presentation was provided by the Robert Wood Johnson Foundation.  
The views expressed here do not necessarily reflect the views of the Foundation.*

## Topics for Today

- What do we know about how the COVID-19 recession is affecting ESI?
- Where do people go if they lose ESI? What does it mean for consumers and providers?
- What are the larger policy considerations for regulators?

# Pre-COVID Coverage Landscape

## Source of Coverage for Non-Elderly (0-64)

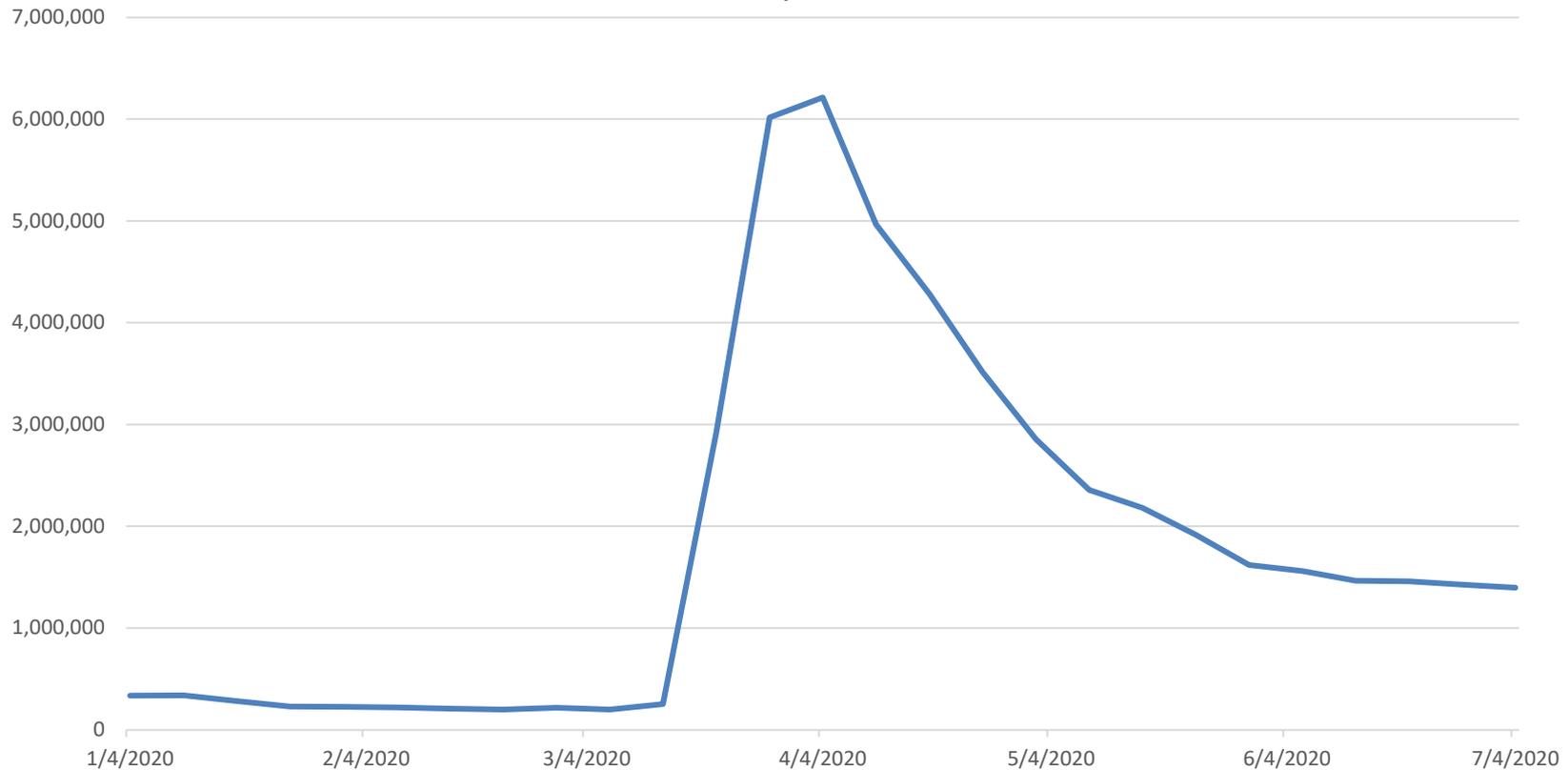


Date sourced from Kaiser Family Foundation / ACS –

<https://www.kff.org/other/state-indicator/nonelderly-0-64/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

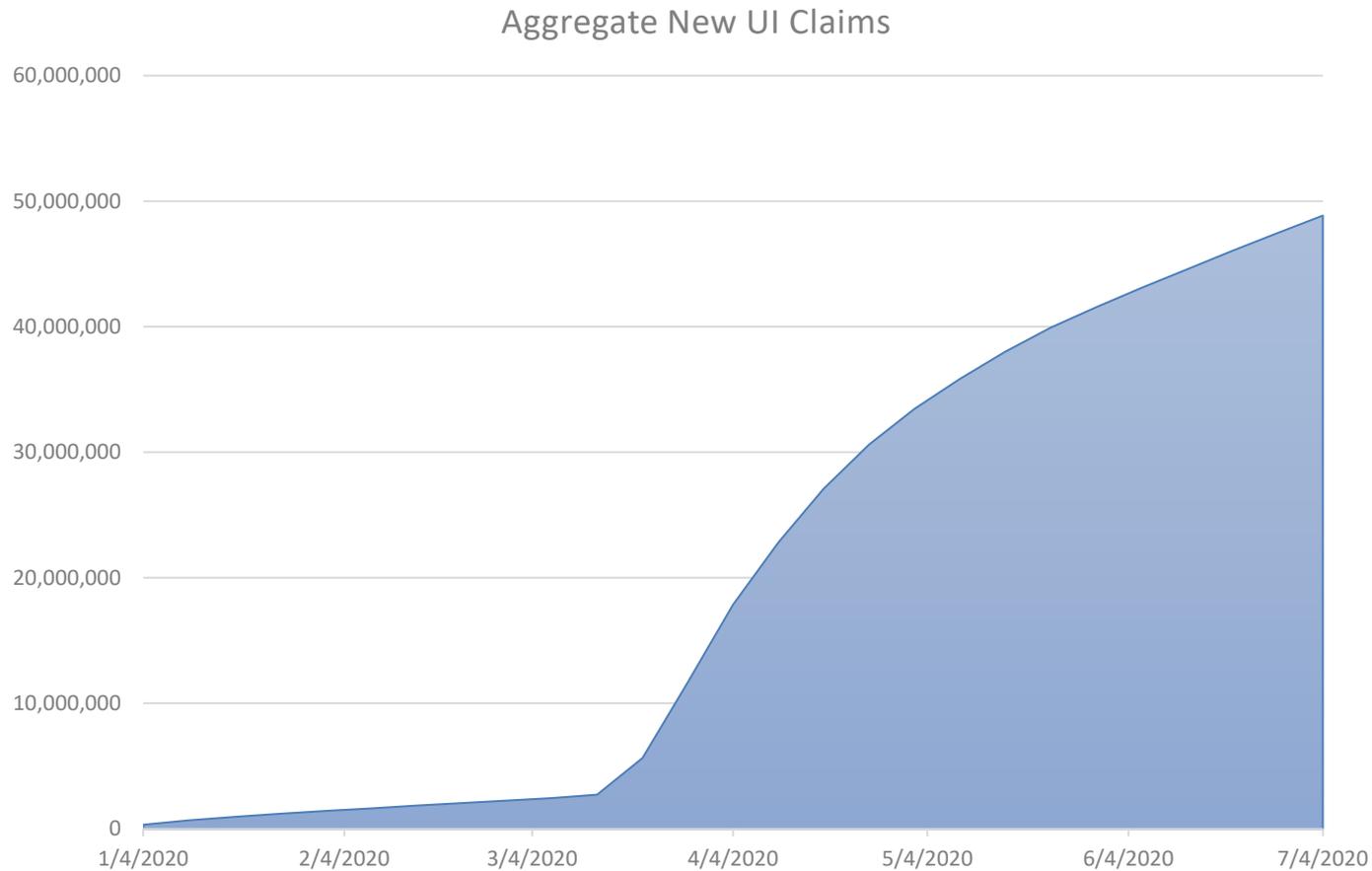
# The Recession's Effects

Weekly New UI Claims



From data retrieved from <https://oui.doleta.gov/unemploy/claims.asp>

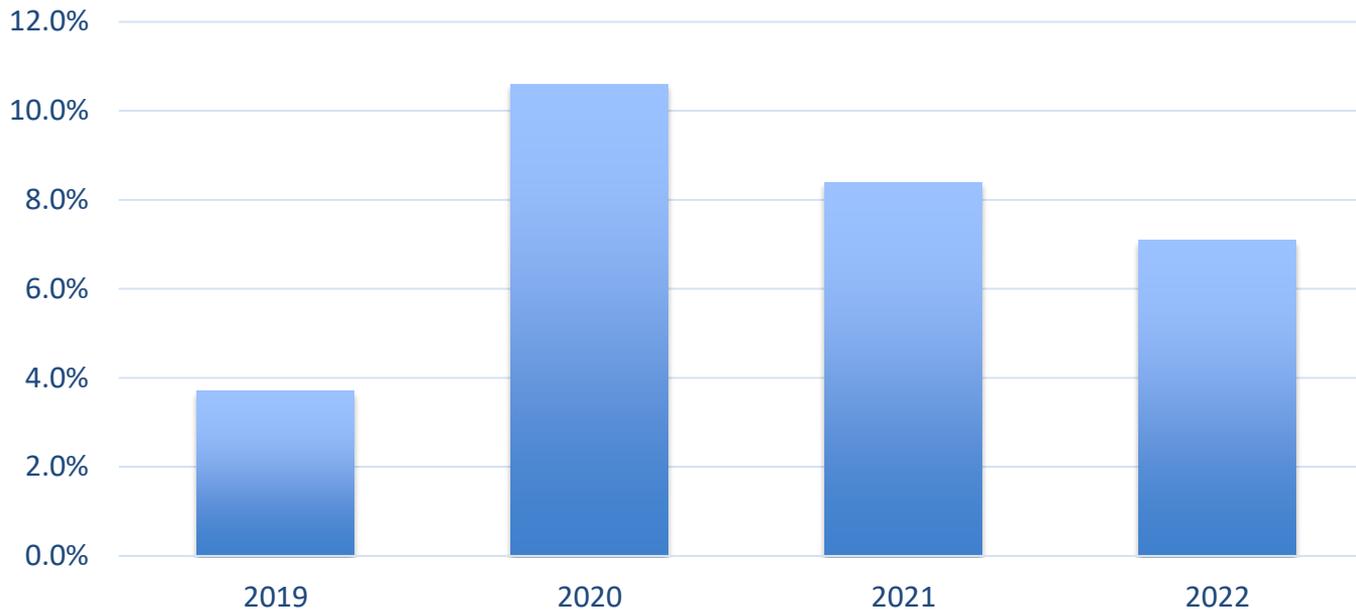
# The Recession's Effects



From data retrieved from <https://oui.doleta.gov/unemploy/claims.asp>

# The Recession's Effects

## Projected Unemployment Rate



<https://www.cbo.gov/publication/56465>

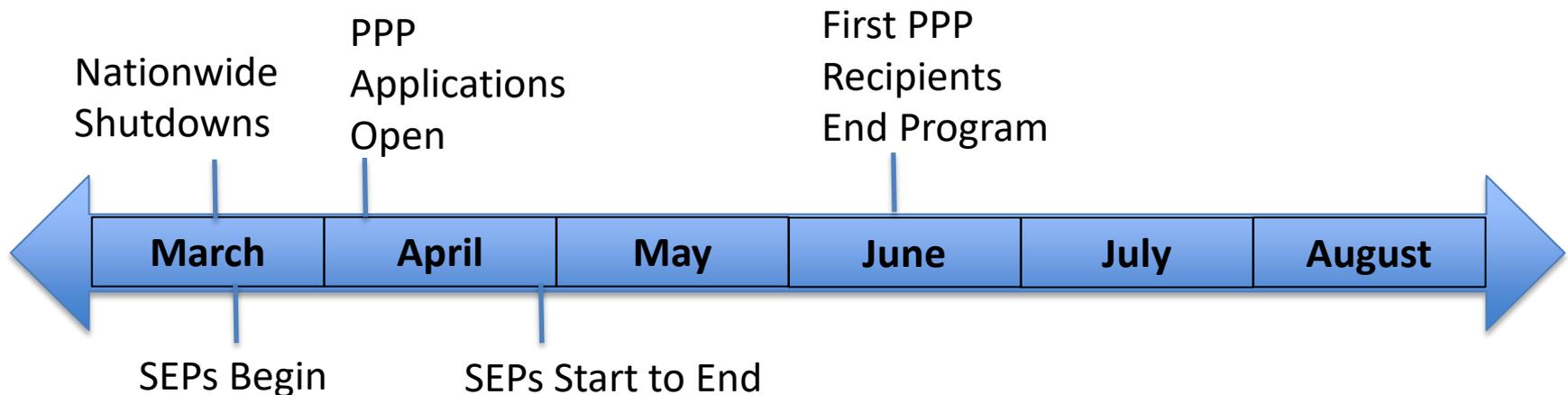
# The Recession's Effects

## Policy Responses

- Federal Legislation
  - FMAP Increase with Maintenance of Effort
  - Paycheck Protection Program
  - Economic Injury Disaster Loan
- State Reaction
  - Special Enrollment Periods for Marketplace
  - Premium Grace Periods

# The Recession's Effects

- New enrollments have been less than initially modeled
- Possible Causes:
  - Furloughs vs. Layoffs
  - Hierarchy of needs (income, food, ..., coverage)
  - Health care utilization decline
  - Federal program preserving ESI
  - Does job loss result in coverage loss?



# The Recession's Effects

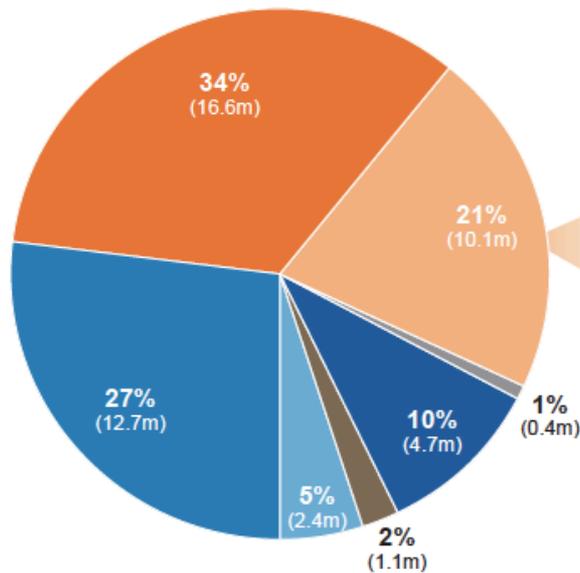
## What we don't know

- Who is actually losing job-based coverage?
- Where they are going to get coverage?
- Is the loss of coverage disproportionately impacting communities of color or patients at-risk for increased morbidity?

# The Recession's Effects

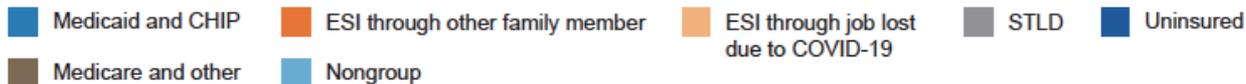
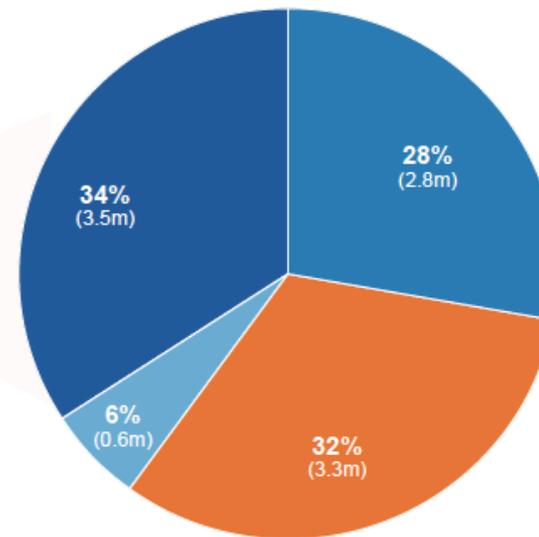
**Figure 1. Health Insurance Coverage Prior to Pandemic Among Those with Subsequent Job Loss in Family, 2020**

48 million nonelderly Americans



**Figure 2. Post Job Loss Coverage Among Workers and Family Members Losing ESI Due to COVID-19 Recession, 2020**

10.1 million nonelderly Americans



Source: Urban Institute's Health Insurance Policy Simulation Model

Notes: Estimates can be interpreted as applying to the average month in the last three quarters of 2020. ESI is employer-sponsored insurance, STL is short-term limited duration plans, CHIP is Children's Health Insurance Program

[https://www.urban.org/sites/default/files/publication/102552/changes-in-health-insurance-coverage-due-to-the-covid-19-recession\\_4.pdf](https://www.urban.org/sites/default/files/publication/102552/changes-in-health-insurance-coverage-due-to-the-covid-19-recession_4.pdf)

# Choices After ESI Loss

COBRA

Marketplace/QHP

Spouse/Family

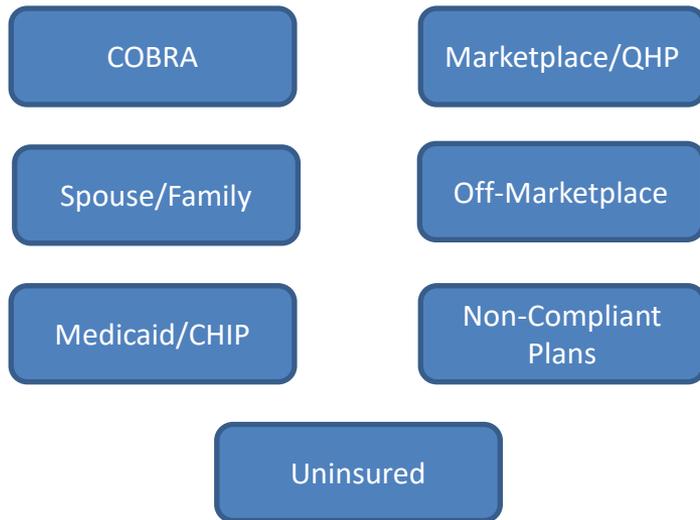
Off-Marketplace

Medicaid/CHIP

Non-Compliant  
Plans

Uninsured

# Choices After ESI Loss



## Consumer Considerations

- Premium Costs
- Deductibles
- Network of Providers
- Continuity of Care
- Administrative Burden
- Eligibility/Family Glitch

# Policy Opportunities and Lessons

- First widespread coverage loss since full ACA implementation
  - Impact of Medicaid expansion
  - Timing of enrollment & outreach
  - Outreach challenges

# Policy Opportunities and Lessons

- Lack of data hampers decision making
  - Potential to add coverage questions to UI applications
- Cost shifting due to lower ESI numbers
- Public Health directives and self-funded plans
  - Nursing Facility Testing Requirements

# Policy Opportunities and Lessons

- Churn
  - Income changes likely to drive enrollment from non-group to Medicaid
  - When Medicaid Maintenance of Effort requirements end, influx of enrollees to Marketplace may require increased enrollment efforts (SEP or extension of OEP)

# Policy Opportunities and Lessons

- Impact on non-group market risk pool
- Population health efforts
  - Vaccination rates (non-COVID vaccines)
  - Chronic disease care
  - Preventive services
- Opportunities for Alternative Payment Models (with self-funded participation!)

# Discussion



Thank You

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**Dan Meuse**  
Deputy Director  
State Health and Value Strategies  
dmeuse@Princeton.edu  
609-258-7389  
www.shvs.org

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**Agenda Item #5**

**Hear a Presentation on COVID-19 Testing and Costs**  
**—*Jeanette Thornton (America's Health Insurance Plans—AHIP)***

**Agenda Item #6**

**Hear an Update on Federal Affordable Care Act (ACA) Court Cases—*Katie Keith (Out2Enroll)***

# Update on Federal ACA Court Cases

Health Insurance and Managed Care (B) Committee

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Katie Keith, JD, MPH  
Georgetown University Law Center

# Supreme Court Cases

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## Taking Stock of the 2019 Term

- *Maine Community Health Options*: insurers are entitled to more than \$12.2 billion in unpaid risk corridors payments from 2014 to 2016  
**Next steps:** resolution of amounts owed, timing of payments, MLR
- *Little Sisters of the Poor*: government has the authority to create broad exemptions to the ACA's contraceptive mandate  
**Next steps:** employers can claim exemption under new rules, more litigation

## What to Expect in the 2020 Term

- *California v. Texas* (global challenge to the ACA) → briefing completed in mid-August, oral argument TBD, two severability cases in 2019 term
- *Rutledge v. PCMA* (state regulation of pharmacy benefit managers) → oral argument set for October 6, 2020
- *Gresham v. Azar* (validity of Medicaid work requirements) → *cert* not yet granted

# Decided/Pending ACA Lawsuits

| Topic                            | Court   | Result   |
|----------------------------------|---|--|
| <b>Short-term plans</b>          | D.C. Circuit                                  | Upheld 2018 rule on STLDI (request for <i>en banc</i> review)  |
| <b>Risk adjustment</b>           | Second Circuit                                | New York risk adjustment rule is preempted by the ACA  |
| <b>HIT</b>                       | Fifth Circuit                                 | States not entitled to recoup prior year HIT from MCOs   |
| <b>Plan design</b>               | Ninth Circuit                                 | Sec. 1557 prohibits discrimination in benefit design (exclusion was for all hearing loss treatment except cochlear implants) |
| <b>Multiple policy decisions</b> | MD district court                             | Claims advance under the APA but not the Take Care Clause of the Constitution  |
| <b>Double billing rule</b>       | CA, MD, WA district courts                    | Vacated the 2019 rule requiring double billing/payment for certain abortion services (on appeal to Fourth, Ninth Circuits)   |
| <b>AHPs</b>                      | D.C. Circuit                                  | Decision pending (oral argument in Nov. 2019)  |
| <b>Unpaid CSRs</b>               | Federal Circuit                               | Decision pending (oral argument in Jan. 2020)  |
| <b>Sec. 1557</b>                 | Fifth Circuit; CA, DC, MA, NY district courts | Briefing → effective date of Aug. 18th if not blocked  |
| <b>Forcing a SEP</b>             | DC district court                             | Briefing completed in early August   |

# Other Health Litigation Issues

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- Public charge rule (district courts in CA, MD, NY)
- Provider conscience rule (Second, Ninth Circuits)
- Prescription drug transparency rule (D.C. Circuit)
- Hospital transparency rule (D.C. Circuit)
- Site-neutral payments (D.C. Circuit)
- Title X domestic gag rule (Ninth Circuit)

# Thank you!

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Katie Keith, JD, MPH  
Georgetown University Law Center

[katie.keith@georgetown.edu](mailto:katie.keith@georgetown.edu)

More resources available at: [healthaffairs.org/blog](http://healthaffairs.org/blog)

**Agenda Item #7**

**Receive an Update on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's Work**

**—TK Keen (OR)**

*Conference Call*

**PHARMACY BENEFIT MANAGER REGULATORY ISSUES (B) SUBGROUP  
July 16, 2020**

**Summary Report**

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call July 16, 2020. During this call, the Subgroup:

1. Discussed the ad hoc drafting group's draft pharmacy benefit manager (PBM) model act.
2. Exposed the PBM draft for a public comment period ending Sept. 1. The Subgroup plans to meet via conference call to begin discussion of the comments received sometime in September after the public comment period ends.

**Agenda Item #8**

**Hear a Federal Legislative Update—*Brian Webb (NAIC)***

**Agenda Item #9**

**Discuss Any Other Matters Brought Before the Committee**

**—*Commissioner Jessica K. Altman (PA)***