2020 Fall National Meeting
Virtual Meeting

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
Monday, December 7, 2020
4:00 – 5:00 p.m. ET/3:00 – 4:00 p.m. CT/ 2:00 – 1:00 p.m. MT/1:00 – 12:00 p.m. PT

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

Carter Lawrence
Tennessee

Kathleen A. Birrane
Maryland

Tanji J. Northrup
Utah

Grace Arnold
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 Nov. 2 and Summer 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
     —Interim Commissioner Tanji J. Northrup (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 an Update on Federal Affordable Care Act (ACA)-Related Court Cases—Katie Keith (Out2Enroll)

4. Hear a Federal Legislative and Administrative Update and Outlook for 2021—Brian Webb (NAIC)

5. Receive an Update on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s Work—TK Keen (OR)

6. Discuss Any Other Matters Brought Before the Committee—Commissioner Jessica K. Altman (PA)

7. Adjournment

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Agenda Item #1

Consider Adoption of its Nov. 2 and Summer National Meeting Minutes
—Commissioner Jessica K. Altman (PA)
Draft: 11/10/20

Health Insurance and Managed Care (B) Committee
Conference Call
November 2, 2020

The Health Insurance and Managed Care (B) Committee met via conference call Nov. 2, 2020. The following Committee members participated: Jessica K. Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair, represented by Sarah Bailey (AK); Michael Conway (CO); John F. King represented by Teresa Winer (GA); Vicki Schmidt (KS); Kathleen A. Birrane and Mary Kwei (MD); Grace Arnold (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); Linda A. Lacewell represented by Tom Dudek (NY); Glen Mulready (OK); Andrew R. Stolfi (OR); Hodgen Mainda represented by Brian Hoffmeister (TN); Tanji J. Northrup (UT); and Mike Kreidler (WA). Also participating were: Barbara D. Richardson (NV); and Jeff Rude (WY).

1. **Adopted the Revisions to Model #430**

Jolie H. Matthews (NAIC) said the revisions to the *Health Maintenance Organization Model Act (#430)* represent the work of the Health Maintenance Organization (HMO) Issues (B) Subgroup to complete its charge to revise provisions in the model to address conflicts and redundancies with provisions in the revised *Life and Health Insurance Guaranty Association Model Act (#520)*, which added HMOs as members of the guaranty association. The Subgroup met in 2019 and early this year to discuss its work. Ms. Matthews said during these meetings, the Subgroup identified several provisions in Model #430 to delete to reconcile its provisions with the 2017 revisions to Model #520.

Ms. Matthews said the provisions identified include Section 14—Continuation of Benefits, Section 20—Uncovered Expenditures Deposit, and Section 3HH, the definition of “uncovered expenditures.” She said for reference, for the states not intending to adopt the revised Model #520, the Subgroup added an appendix to Model #430 that includes the deleted provisions. She said the Subgroup also deleted Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency because its provisions are obsolete due to the federal Affordable Care Act (ACA).

Ms. Matthews said the Subgroup unanimously adopted the revisions on July 13 via conference call. The Regulatory Framework (B) Task Force also unanimously adopted the revisions on Sept. 24 via conference call.

Commissioner Conway made a motion, seconded by Interim Commissioner Northrup, to adopt the revisions to Model #430 (see NAIC Proceedings – Summer 2020, Regulatory Framework (B) Task Force, Attachment Four-B). The motion passed unanimously.

2. **Adopted its Task Forces’ 2021 Proposed Charges**

Commissioner Altman said prior to the call, NAIC staff distributed the 2021 proposed charges for the Health Actuarial (B) Task Force, the Regulatory Framework (B) Task Force, and the Senior Issues (B) Task Force. Ms. Matthews said generally, the task forces’ 2021 proposed charges differ little from their 2020 charges. She explained that the Health Actuarial (B) Task Force disbanded the Health Reserves (B) Subgroup and, as such, deleted its charges. Similarly, the Regulatory Framework (B) Task Force disbanded the HMO Issues (B) Subgroup, so its charges were deleted. Ms. Matthews said the Health Actuarial (B) Task Force and the Senior Issues (B) Task Force adopted their 2021 proposed charges on Oct. 8 via conference call. The Regulatory Framework (B) Task Force adopted its charges on Oct. 23.

Commissioner Mulready made a motion, seconded by Commissioner Godfread, to adopt the 2021 proposed charges for the Health Actuarial (B) Task Force, the Regulatory Framework (B) Task Force, and the Senior Issues (B) Task Force. The motion passed unanimously.

3. **Adopted its 2021 Proposed Charges**

Commissioner Altman said prior to the call, NAIC staff distributed the Committee’s 2021 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 Altman said one change made from its 2020 charges is merging three charges related to the Committee’s work with the Market Regulation and Consumer Affairs (D) Committee into one charge.
Commissioner Mulready asked if the Committee’s charges include any activities related to health care sharing ministries (HCSMs). He said during the 2020 Commissioners’ Conference small group sessions, there was discussion of the Committee looking into these types of entities at some point. Commissioner Conway said the Regulatory Framework (B) Task Force heard presentations on HCSMs at the Summer National Meeting. He said at the conclusion of the presentations, there was no discussion among the Task Force members to take any additional action related to HCSMs. However, he said he would add a discussion on HCSMs to the Task Force’s agenda for its Nov. 19 meeting.

Commissioner Conway made a motion, seconded by Commissioner Mulready, to adopt the Committee’s 2021 proposed charges (Attachment One-A). The motion passed unanimously.

4. **Received a Report from the Consumer Information (B) Subgroup**

Ms. Kwei provided an update on the Consumer Information (B) Subgroup’s work related to its charge to develop information or resources that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance. She said the Subgroup recently adopted updates to its “Frequently Asked Questions (FAQ) About Health Reform” document in preparation for the 2021 open enrollment period. She said the Subgroup updates this document each year for state departments of insurance (DOIs) to use this document to answer questions from consumers as they consider their health plan enrollment options for the upcoming open enrollment period. She said the Subgroup also developed a new document for consumers to use when considering purchasing a short-term policy. She said this document generally alerts consumers and tries to assist them in making an informed choice to enroll in such coverage.

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

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The Health Insurance and Managed Care (B) Committee met via conference call Aug. 11, 2020. The following Committee members participated: Jessica K. Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); Vicki Schmidt (KS); Kathleen A. Birrane (MD); Steve Kelley represented by Grace Arnold and Peter Brickwedde (MN); Mike Chaney (MS); Jon Godfread (ND); Linda A. Lacewell represented by John Powell (NY); Glen Mulready (OK); Andrew R. Stolfi and TK Keen (OR); Hodgen Mainda (TN); Todd E. Kiser (UT); and Mike Kreidler (WA). Also participating were: David Altmaier (FL); Dean L. Cameron (ID); Sharon P. Clark (KY); Eric A. Cioppa (ME); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Bruce R. Ramge (NE); Marlene Caride (NJ); Russell Toal (NM); and Marie Ganim (RI).

1. **Adopted its April 28, Feb. 26, and 2019 Fall National Meeting Minutes**

The Committee met April 28, Feb. 26, and Dec. 8, 2019. During its April 28 and Feb. 26 meetings, the Committee took the following action: 1) received a report from the Health Actuarial (B) Task Force on its work to develop an outline and eventual 2021 rate pricing resource and guidance document for the states to consider when reviewing initial 2021 rates in light of the COVID-19 pandemic; 2) discussed and heard comments from stakeholders on areas, such as telehealth requirements and form filing requirements, in which state insurance regulators can provide regulatory flexibility due to the COVID-19 pandemic; and 3) adopted the Regulatory Framework (B) Task Force’s revised 2020 charges, which added a charge for the newly appointed MHPAEA (B) Working Group.

Commissioner Godfread made a motion, seconded by Commissioner Conway, to adopt the Committee’s April 28 (Attachment One), Feb. 26 (Attachment Two) and Dec. 8, 2019, (see NAIC Proceedings – Fall 2019, Health Insurance and Managed Care (B) Committee) minutes. The motion passed unanimously.

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

Commissioner Schmidt made a motion, seconded by Ms. Arnold, to adopt the following reports: the Consumer Information (B) Subgroup, including its July 9 (Attachment Three), Jan. 21 (Attachment Four) and Jan. 7 (Attachment Five) minutes; the Health Innovations (B) Working Group (Attachment Six); the Health Actuarial (B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force.

3. **Heard a Presentation on Health Equity and Disparities in Health Care and Coverage**

Samantha Artiga (Kaiser Family Foundation—KFF) provided an overview of disparities in health and health care. She defined health and health care disparities as: 1) differences in health and health care between populations; 2) arising from a complex and interrelated set of individual, provider, health system, societal and economic factors; and 4) occurring across a broad range of dimensions—race/ethnicity, socioeconomic status, gender, age, disability, sexual orientation or gender identity, geographic location and more. She discussed the implications of such disparities for black and Hispanic populations, including higher infant mortality rates, higher mortality rates due to certain diseases, and a disproportionate share of COVID-19 cases. She described health disparities as a symptom of social and economic inequities.

Ms. Artiga said uninsured rates have declined since the implementation of the federal Affordable Care Act (ACA); but despite that, disparities in health care persist for some populations, such as African Americans and other people of color. She discussed some of the reasons for this occurrence, such as coverage gaps and geography. African Americans make up a larger share of the population in the South, where many states have not expanded Medicaid.

Ms. Artiga ended her presentation with five key takeaways for the Committee to consider: 1) health and health care disparities are a longstanding and persistent issue; 2) the COVID-19 pandemic has highlighted and exacerbated underlying disparities; 3) 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; 4) increased awareness and recognition of disparities provides an opportunity to advance equity; and 5) progress will require long-term efforts across sectors to prioritize equity and address systemic and structural barriers, including racism and discrimination.
Commissioner Altman said Pennsylvania expanded Medicaid under the ACA as an approach to alleviate the disparities in health and health care. She asked Ms. Artiga if such actions actually make a difference. Ms. Artiga said research has shown that states that have opted to expand Medicaid eligibility under the ACA have improved disparities in health and health care. However, she noted that coverage is one piece of the puzzle because improving access to coverage does not necessarily improve other factors that lead to these disparities, such as access to certain types of foods and reliable transportation to get to health care providers. Director Wing-Heier asked for additional information about disparities in health and health care for Alaska Natives. Ms. Artiga said there is limited data on this population because of the way states report it. She said states report aggregate data on Alaska Natives that includes other populations, such as American Indians. She said this is an ongoing issue, that affects the ability of researchers to understand what is happening, specifically to these populations.

Commissioner Mainda asked Ms. Artiga what types of stakeholders she believed could come together to address disparities in health care and coverage. Ms. Artiga said she envisions the states coordinating across multiple agencies and sectors to address not only health and health care disparities, but other issues that underlie them, such as housing and transportation. She said this also includes more data collection to better understand the problems and setting certain outcomes. Commissioner Birrane asked Ms. Artiga whether expanded access to telehealth services has had an impact on health and health care disparities. Ms. Artiga said the KFF has data on telehealth services and its use, but it has not analyzed it specifically with respect to health and health care disparities. However, she said anecdotally, given the unequal access to telehealth service coverage and attitudes on using such services, in addition to probable issues with having access to compatible equipment and broadband for certain populations, in the short-term, telehealth most likely has not improved health and health care disparities.


4. **Heard a Presentation on COVID-19 and Employer-Sponsored Insurance**

Daniel Meuse (State Health and Value Strategies (SHVS), Princeton School of Public and International Affairs) discussed COVID-19 and the resulting recession’s effect on employer-sponsored insurance (ESI) coverage. He raised the following questions for the Committee’s consideration: 1) what do we know about how the COVID-19 recession is affecting ESI; 2) where do people go if they lose ESI, and what does that mean for consumers and providers; and 3) what are the larger policy considerations for state insurance regulators. He walked the Committee through these issues, describing the differences in ESI coverage pre-COVID-19 and post-COVID-19 because of the COVID-19 driven recession. He discussed federal and state policymakers’ responses to the recession, such as enacting the federal Paycheck Protection Program (PPP) and new special enrollment periods (SEPs) established by state health insurance exchanges. He also highlighted what policymakers do not know with respect to ESI coverage, such as who is actually losing ESI coverage, where consumers go to get coverage, and whether the loss of ESI coverage disproportionally affects people of color or patients at risk for increased morbidity.

Mr. Meuse touched on the options consumers have after losing ESI coverage, such as Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Medicaid/Children’s Health Insurance Plan (CHIP), non-compliant plans like short-term, limited-duration (STLD) plans, or becoming uninsured. He also discussed what consumers consider in choosing what option to take after losing ESI coverage, including premium costs, deductibles and provider networks. He discussed the policy opportunities and lessons to be learned. He said because this is the first widespread coverage loss since full ACA implementation, it provides an opportunity for policymakers to consider existing and new options to address it. Those options include: 1) Medicaid expansion; 2) reconsidering the timing of enrollment and outreach; and 3) alternative payment models.

Commissioner Altman asked Mr. Meuse for any best practices he would suggest to assist people in moving from ESI coverage to other coverage, particularly with assisting consumers in obtaining sufficient information to make informed decisions. Mr. Meuse said the states should partner with community-based organizations that may already have a relationship with certain populations to assist in providing outreach and distributing information. Commissioner Conway asked Mr. Meuse if he has any recommendations on what state insurance regulators could use to assist consumers in transitioning to other coverage in addition to SEPs. Mr. Meuse suggested additional marketing campaigns particularly targeted at individuals transitioning on and off Medicaid coverage. Health Insurance Commissioner Ganim asked Mr. Meuse if any states that have an individual mandate are considering changes to that mandate, considering the COVID-19 driven recession resulting in consumers losing ESI coverage. Mr. Meuse said he is not aware of any such activity, but he anticipates that the states would relax their hardship exemption documentation requirements in order for consumers to meet the requirements of a state’s hardship exemption from having to have health insurance coverage.
5. **Heard a Presentation on COVID-19 Testing and Costs**

Mr. Eyles (America’s Health Insurance Plans—AHIP) discussed expanding access to COVID-19 testing and the need for additional federal funding for such testing. He discussed the purposes of COVID-19 testing—guiding care and treatment, public health surveillance, and occupational health—and its essential components. He explained that with respect to COVID-19 testing, federal agencies have a critical responsibility to ensure quality, support appropriate use, and prioritize affordable solutions. He also outlined the role that insurers, governmental and public health agencies, and employers play in the COVID-19 testing framework.

Mr. Eyles said AHIP and 48 other organizations believe that COVID-19 testing is one of the most important tools the U.S. has to combat the pandemic, both for identifying the virus and for preventing its spread. He said it is vital that the federal government designate the resources to support expanded access to testing. He discussed AHIP’s recommendations related to COVID-19 testing: 1) ensure all Americans have access to testing regardless of coverage status; 2) ensure federal funding accounts for the magnitude of tests required to get the economy back on track and reduces the risk of transmission in different settings and the progression of the disease; 3) solidify comprehensive strategies that incorporate testing to achieve occupational and public health goals; 4) ensure that testing does not lead to premium spikes in 2021; and 5) protect against fraud.

6. **Heard an Update on ACA Federal Court Cases**

Katie Keith (Out2Enroll) gave an update on ACA federal court cases. She discussed U.S. Supreme Court (Court) decisions from its 2019 session, including the Court’s 8-1 decision in favor of insurers in *Maine Community Health Options v. United States*, which challenged the legality of the federal government withholding full risk corridor payment amounts to participants. She also discussed cases scheduled for oral arguments during the Court’s upcoming 2020 session, including the *California v. Texas* case, which challenges the constitutionality of the ACA’s individual mandate and its potential impact on other key ACA provisions, as well as the *Rutledge v. PCMA* case, which challenges the state regulation of pharmacy benefit managers (PBMs).

Ms. Keith also discussed other pending ACA cases in the federal circuit courts, including a case pending in the D.C. Circuit Court of Appeals, *Association of Community Affiliated Plans, et al. v. U.S. Department of Treasury, et al.*, which upheld the legality of the federal STLD plan regulation, and a case pending in the U.S. Court of Appeals for the Second Circuit, *UnitedHealthcare of New York, v. Lacewell*, which ruled that New York’s risk adjustment rule is preempted by the ACA.

7. **Received an Update on the Work of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup**

Mr. Keen updated the Committee on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s work to complete its charge to develop a new NAIC model establishing a registration or licensing process for PBMs. He said after the Subgroup was appointed in late 2018, the Subgroup decided during its first meetings in early 2019 that it wanted to obtain more information on the issues before beginning its work to draft the new model regulating PBMs and potentially including additional provisions related to PBM prescription drug pricing and cost transparency. The Subgroup held a series of conference calls throughout the summer and early fall of 2019 to hear from various stakeholders on the issues the Subgroup wanted to hear more about, such as rebating, discounts, prescription drug pricing, and how PBMs are currently regulated.

Mr. Keen said during these meetings, the Subgroup heard presentations from consumers, economists, the PBM industry, insurers, and the states on these issues and suggestions on how the Subgroup might address them. He said after finishing these information-gathering sessions, the Subgroup decided that it had obtained sufficient information to move forward with its charge. In November 2019, the Subgroup established an ad hoc technical drafting group to develop an initial draft for the full Subgroup’s review.

Mr. Keen said after a series of meetings late last year and early this year, the ad hoc group developed a draft for the Subgroup’s review. He said the ad hoc group based its draft on the National Council of Insurance Legislators (NCOIL) model and made changes based on the Subgroup’s charge to the ad hoc group.

Mr. Keen said the Subgroup met July 16 via conference call to discuss the ad hoc group’s draft. He said there was robust discussion among the Subgroup members about the draft, particularly about a proposed provision that lists potential provisions, such as PBM network adequacy requirements and rebates, that states could include in any regulations adopted to implement the proposed model’s provisions. At the end of the discussion, the Subgroup agreed that the draft was just the beginning of the drafting process, not the end of the process, and it exposed the draft for a public comment period ending Sept. 1. Mr. Keen said after the public comment period ends, the Subgroup will begin meeting via conference call to discuss and consider changes to the draft based on the comments received.
Draft Pending Adoption

8. **Heard a Federal Legislative Update**

Brian Webb (NAIC) provided a federal legislative update on Congressional activity of interest to the Committee. He discussed the current status of surprise billing legislation, saying that the NAIC sent yet another letter to Congressional leaders urging them to pass federal surprise bill legislation and extend protections to air ambulances. He explained that the COVID-19 health emergency has stymied a lot of action in Congress on this issue despite bi-partisan support and support from the Trump Administration to address the issue. NAIC staff will continue to monitor this issue.

Mr. Webb said the U.S. House of Representatives (House) Committee on Appropriations passed its package of fiscal year 2021 appropriations bills, which included additional funding in the U.S. Department of Labor (DOL)/U.S. Department of Health and Human Services (HHS) bill in the amount of $2.9 million for state health insurance assistance programs (SHIPS), bringing the total appropriation to $55 million. He said the U.S. Senate (Senate) Committee on Appropriations has not acted yet.

Mr. Webb said with respect to the administrative action, the NAIC has requested additional guidance on a number of issues, such as COVID-19 testing and the insurer payment responsibilities. He said the federal Centers for Medicare & Medicaid Services (CMS) did issue guidance on the issue, but state insurance regulators still have questions. NAIC staff are working with CMS representatives to seek answers to those questions. Mr. Webb said the NAIC also requested guidance on premium holidays, particularly with respect to the individual market and its potential impact on advance premium tax credit (APTC) payments. The CMS released additional guidance on that issue last week, as announced during the Regulatory Framework (B) Task Force’s meeting on Aug. 4. Mr. Webb said the guidance did not answer all the questions, and NAIC staff will be working with CMS staff to receive answers on the outstanding issues.

Mr. Webb said one issue still awaiting additional guidance concerns the risk corridor payments owed to insurers as a result of the 8-1 Court decision of the *Maine Community Health Options v. United States* case that Ms. Keith mentioned during her presentation. However, he said he recently learned that one state’s insurer has received its payment after completing the Court of Federal Claims process and receiving a final certification of payment from the Judgement Fund. Therefore, payments are being made, but the CMS has not provided guidance on how it will be accounted for for the purposes of medical loss ratio (MLR) refunds.

Mr. Webb said the NAIC sent a comment letter, like many other states, on the Internal Revenue Services’ (IRS’) proposed regulations on health reimbursement arrangements (HRAs) that would permit an individual to use an HRA to fund health care sharing ministry (HCSM) payments. He said the letter expressed concern with adverse selection and other potential issues that could affect the stability of the individual market. He said NAIC staff will be closely tracking what happens with this proposed regulation.

Mr. Webb said NAIC staff continues to work closely with the CMS and DOL on mental health parity implementation. He said NAIC staff also has been working with the CMS and its federal Center for Program Integrity (CPI) on improper marketing concerns. NAIC staff have also had numerous discussions with the CMS on its new requirement that the states annually submit a report to the CMS on state mandates. The states still have many questions on this new requirement.

Mr. Webb said a new issue has arisen concerning telehealth and the ability for the states and insurers to continue to provide access to this expanded coverage after the COVID-19 health emergency declaration ends because of Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy concerns. NAIC staff are working with the CMS and the federal Office of Civil Rights (OCR) to find a solution to address this concern. NAIC staff are also working with the CMS and state insurance regulators on issues related to outreach with the upcoming open enrollment for plan year 2021 during the COVID-19 health emergency and discussing alternatives to what the states have traditionally done to educate and inform consumers about open enrollment in lieu of face-to-face meetings and forums.

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)
Summary Report

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Oct. 29 and Oct. 20, 2020. During these meetings, the Subgroup:

1. Discussed and adopted the revisions to the Frequently Asked Questions on Health Care Reform document.

2. Discussed and adopted a new consumer guide “Before You Buy That ‘Low Cost’ Health Insurance.” The guide helps consumers better understand short-term plans and other non-federal Affordable Care Act (ACA) plans before they buy such coverage.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Oct. 29, 2020. The following Subgroup members participated: Mary Kwei, Chair (MD); Debra Judy, Vice Chair (CO); Anthony L. Williams (AL); Michele Baldock (IL); LeAnn Crow (KS); Judith Watters (ME); Carrie Couch (MO); Kathy Shortt (NC); Vickie Trice (TN); Tanji Northrup (UT); Todd Dixon (WA); and Jennifer Stegall (WI).

1. **Adopted Updates to FAQ Document**

The Subgroup conducted an e-vote to consider adoption of a revised and updated version of the “Frequently Asked Questions about Health Care Reform” document (Attachment -A). The motion passed unanimously.

2. **Adopted a Consumer Guide on Short-Term Plans**

The Subgroup conducted an e-vote to consider adoption of a consumer guide “Before You Buy That “Low Cost” Health Insurance” (Attachment -B). The motion passed unanimously.
Draft Pending Adoption

Health Insurance and Managed Care (B) Committee
12/7/20

Draft: 11/12/20

Consumer Information (B) Subgroup
Conference Call
October 20, 2020

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Oct. 20, 2020. The following Subgroup members participated: Mary Kwei, Chair (MD); Debra Judy, Vice Chair (CO); Weston Trexler (ID); Michelle Baldock (IL); Jenifer Groth (IN); LeAnn Crow, Brenda Johnson, Tate Flott, and Shannon Lloyd (KS); Judith Watters and Sherry Ingalls (ME); Candace Gergen (MN); Carrie Couch, Michelle Vickers, and Jessica Schrimpf (MO); Laura Arp and Martin Swanson (NE); Ingrid Marsh (NH); Kathy Shortt (NC); Cuc Nguyen (OK); Elizabeth Hart and Shannen Logue (PA); Gretchen Brodkorb, Candy Holbrook and Jill Kruger (SD); Jennifer Ramcharan and Vickie Trice (TN); Shelley Wiseman and Jaakob Sundberg (UT); Jennifer Stegall, Julie Walsh, Darcey Paskey, Rebecca Rebholz and Mary Kay Rodriguez (WI).

1. **Discussed Updates to FAQ about Health Care Reform**

   The Subgroup discussed updates to the Frequently Asked Questions (FAQ) about Health Care Reform document. Ms. Kwei pointed out questions in the FAQ document with unresolved comments. Brenda Cude (University of Georgia) asked about notices for transitional plans. Ms. Shortt said there is no harm in keeping it, even if it has outlived its usefulness. Ms. Cude suggested revised language, which the Subgroup agreed to accept. The Subgroup discussed whether to add a question on when Medicare is a primary or secondary payer to employer coverage. The Subgroup agreed to add one such a question. The Subgroup also agreed to add a question on the interaction between Medicare and health reimbursement arrangements (HRAs). The Subgroup discussed Question 91, which concerned Medicare inquiries. Bonnie Burns (California Health Advocates—CHA) agreed to work with other NAIC consumer representatives to develop revised language and forward the revised language for the Subgroup’s consideration.

   The Subgroup agreed to review an updated version of the FAQ document and vote on approval by e-mail in the week of Oct. 26.

2. **Discussed a Consumer Guide on Short-Term Plans**

   Ms. Judy brought up the consumer guide titled “Before You Buy That “Low Cost” Health Insurance.” The Subgroup discussed adding a reference to off-exchange plans being available during open enrollment and agreed to remove a reference to marketplace plans so that off-exchange are also included. Ms. Ramcharan said that many state insurance regulators cannot regulate health care sharing ministries (HCSMs) and Tennessee published information to say it cannot help consumers with them. Ms. Judy said that state authority concerning HCSMs vary. She recommends that the language remain unchanged and the states can edit the language to reflect their authority over such plans. The Subgroup discussed limiting the warning on phone and internet sales to outside open enrollment. After discussion, the Subgroup decided to retain the existing language because limited benefit plans are sometimes marketed during open enrollment as well. Ms. Rodriguez suggested adding a warning not to provide banking or social security numbers until a consumer has reviewed plan materials. The Subgroup accepted her suggestion.

   The Subgroup agreed to review an updated version of the guide and vote on approval by e-mail in the week of Oct. 26.

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

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Virtual Meeting  
(in lieu of meeting at 2020 Fall National Meeting)

HEALTH INNOVATIONS (B) WORKING GROUP  
Monday, November 9, 2020  
1:00 – 2:30 p.m. ET / 12:00 – 1:30 p.m. CT / 11:00 a.m. – 12:30 p.m. MT / 10:00 – 11:30 a.m. PT

Summary Report

The Health Innovations (B) Working Group met Nov. 9, 2020. During this meeting, the Working Group:

1. Approved its July 30 minutes.

2. Heard a presentation on hospital prices. A researcher with RAND Corporation presented data from the third round of the organization’s study on the prices paid by large private plans to hospitals. Since the last round, the study has been expanded to 49 states and cover both facility and professional fees. The presentation showed that commercial prices relative to Medicare have risen steadily, and they vary widely across states, within states, and within health systems. It showed that payer mix has little relation to prices, indicating that hospitals do not shift costs between Medicare and private payers.

3. Heard a presentation on a new hospital cost tool. A fellow with the National Academy for State Health Policy (NASHP) explained a resource that allows purchasers, policymakers, and state insurance regulators to better understand hospital costs and the expenses that hospitals must cover with revenue from insurers and other sources. The presentation showed the profit or loss that different types of hospitals generate from different payers. The tool allows for the comparison of hospital prices to their breakeven levels. It can be used for any hospitals that report certain data to Medicare.

4. Heard a presentation on prices for coronavirus tests. An expert with the Kaiser Family Foundation (KFF) presented on private insurance coverage of COVID-19 tests. She shared data on the prices that some hospitals post on their websites, gave examples of prices from other providers, and suggested questions for state insurance regulators to consider related to price transparency and requirements for insurers to cover tests.

5. Heard presentations from consumer representatives. A consumer representative with Consumer Checkbook outlined why current price transparency efforts are not working for consumers and suggested a number of steps that state insurance regulators can take to improve consumer understanding. A consumer representative with the National Association of State and Territorial AIDS Directors (NASTAD) explained how public health could be improved by using more appropriate definitions of “diagnostic” and “surveillance” testing for COVID-19. A third consumer representative shared a law review article he authored on opportunistic pricing in health care and suggestions for state insurance regulators in reducing costs.
Draft Pending Adoption

Health Innovations (B) Working Group
Virtual Meeting (in lieu of meeting at the 2020 Fall National Meeting)
November 9, 2020

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met Nov. 9, 2020. The following Working Group members participated: Marie Ganim, Chair (RI); Martin Swanson, Vice Chair, and Laura Arp (NE); Andrew R. Stolfi, Vice Chair, and TK Keen (OR); Anthony L. Williams and William Rodgers (AL); Sarah Bailey, Lori K. Wing-Heier and Jacob Lauten (AK); Howard Liebers (DC); Doug Ommen, Andria Seip and Cynthia Banks Radke (IA); Kim Collins, Claire Szpara and Karl Knable (IN); Brenda Johnson, Craig Van Aalst and Julie Holmes (KS); Robert Wake (ME); Camille Anderson-Weddle, Carrie Couch, Jessica Schrimpf, Michelle Vickers, Chlora Lindley-Myers and Amy Hoyt (MO); Jon Godfread, Colton Storseth and Chrystal Bartuska (ND); Tyler Brannen and Maureen Belanger (NH); Philip Gennace (NJ); Colin Bailio and Paige Duhamel (NM); Mark Garratt (NV); Jessica K. Altman and David D’Agostino (PA); Valerie Brown, Doug Danzeiser, Rachel Bowden, David Bolduc and Barbara Snyder (TX); Shelley Wiseman and Jaakob Sundberg (UT); Molly Nollette and Jane Beyer (WA).

1. **Adopted its July 30 Minutes**

Commissioner Stolfi made a motion, seconded by Ms. Arp, to adopt the Working Group’s July 30 minutes (see NAIC Proceedings – Summer 2020, Health Insurance and Managed Care (B) Committee, Attachment Six), which covered presentations related to telehealth and cost control. The motion passed unanimously.

2. **Heard a Presentation on Hospital Prices**

Christopher Whaley (RAND Corporation) gave a presentation on the RAND Corporation’s most recent study on the prices charged by hospitals to private health plans. He described the changes to the study since the last version, including that it now includes 49 states, six all-payer claims databases, professional fees, and facility fees. He said commercial prices relative to Medicare have increased steadily, and they were 247% of Medicare prices, on average, in 2018. He said hospital prices vary widely across the states, within the states, and within health systems. The study found some link between price and quality, but there are many high-quality hospitals with low prices. He suggested policy changes, such as support for all-payer claims databases, policies that promote competition and eliminate gag clauses, limits on out-of-network charges, and all-payer or global budget programs.

Commissioner Stolfi asked what resources might be available to help employers use the data from the study in their negotiations with health plans. Mr. Whaley said employers can form coalitions to rethink benefit designs in ways that take advantage of lower priced providers. He also said states can use their leverage as large employers to direct enrollees to lower priced providers and implement reference-based pricing. Commissioner Stolfi asked how the Medicare comparison rate was determined. Mr. Whaley said his study makes all of the same adjustments as Medicare does for payments, including geographic adjustments and teaching hospital adjustments.

Commissioner Godfread asked Mr. Whaley to respond to hospitals’ argument that they are rate takers, not rate setters. Mr. Whaley said different markets have different dynamics, so this may be true in some places, but rates of growth, like 10% per year above Medicare rates, do not seem to indicate rate taking.

3. **Heard Presentations on Hospital Costs**

Marilyn Bartlett (National Academy for State Health Policy—NASHP) explained a hospital cost tool that her organization developed. She said information on hospital prices is more available, but data on the costs that hospitals have is harder to find. She said using the tool does not take much work, just gathering a Medicare cost report for a hospital and entering information into a Microsoft Excel spreadsheet. She said the tool could be used in health insurance rate review, hospital merger evaluations, and discussions around global health care budgets. She showed how the tool can be used to compare hospitals in different categories, such as not-for-profit, for-profit health system, and university-based and by payer mix, showing how much profit hospitals make from Medicare and Medicaid patients. She said the tool also allows calculation of a hospital’s breakeven point for different payers.
4. **Heard a Presentation on Costs and Coverage Requirements for Coronavirus Tests**

Karen Pollitz (Kaiser Family Foundation—KFF) presented on prices for coronavirus tests and issues related to the federal requirement for insurers to cover the cost of tests. She described the different types of tests in the market and those under development. She explained federal law and guidance on insurer coverage, which says that testing for surveillance need not be covered and providers must post their cash prices online. She added that states may impose additional standards or requirements if they do not prevent the application of federal law. She discussed pricing information based on Medicare payment rates, the prices posted on hospital websites, and in advertising from retailers and test manufacturers. She shared media stories of the amounts insured and uninsured individuals have been charged for tests. She suggested ways for state insurance regulators to address testing prices, including enhancing price transparency; coordinating to report complaints; auditing a sample of claims; adapting surprise billing protections; and communicating with federal officials, other state agencies like attorneys general, and local public health departments.

Commissioner Stolfi asked how the states can clarify coverage for tests when an individual is notified by a contact tracer that there was a possible exposure. Ms. Pollitz said in her view, such a test would be diagnostic and not for surveillance.

5. **Heard Presentations from Consumer Representatives on Health Care Prices and Coronavirus Test Prices**

Eric Ellsworth (Consumer’s Checkbook) outlined ways in which price transparency efforts are not working for consumers. He noted that consumers are not aware of existing tools, the information they provide is not actionable, and providers often make care decisions, not consumers. He said consumers need accurate, real time information. He recommended that state insurance regulators push for public network data and standards for clarity in user experiences.

Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) spoke on coronavirus test prices. She suggested that there is no such thing as a purely surveillance test. She said for other diseases like hepatitis, insurers cover routine screening as well as diagnostic testing. She said public health funding should be more consistent, rather than increasing only when there is a public health emergency. She said given cuts to public health funding, insurers have a role to play in funding testing in the current emergency. She said state insurance regulators could more broadly define recent exposure to allow more coverage for testing.

Jackson Williams (Dialysis Patient Citizens) addressed the issue of hospital prices and the role of insurers and state insurance regulators in pushing back on high prices. He suggested that state insurance commissioners act as coordinators to facilitate more effective negotiation between payers, both insurers and employers, and providers. He said there is also a role for state attorneys general and consumer advocates. He suggested that state insurance regulators could withhold permission to increase rates and potentially impose a duty on insurers to get the best price for consumers. He shared a law review article he authored that further describes these ideas.

Having no further business, the Health Innovations (B) Working Group adjourned.
Summary Report

The Health Actuarial (B) Task Force met Nov. 19, 2020. During this meeting, the Task Force:

1. Adopted the report of the Health Care Reform Actuarial (B) Working Group, which has not met since the Summer National Meeting.

2. Adopted its Oct. 8 and Summer National Meeting minutes, which included the following action:
   a. Disbanded the Health Reserves (B) Subgroup.
   b. Adopted its 2021 proposed charges.
   c. Discussed educational opportunities.

3. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met Nov. 2 and took the following action:
   a. Adopted its Aug. 25 and Summer National Meeting minutes, which included the following action:
      1. Heard an update from the American Academy of Actuaries (Academy) on its long-term care work group activities.
   b. Adopted the report of the Long-Term Care Valuation (B) Subgroup. The Subgroup’s focus has been on implementation of Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51).
   c. Adopted the report of the Long-Term Care Pricing (B) Subgroup, including its Sept. 2 minutes. During this meeting, the Subgroup took the following action:
      1. Discussed long-term care insurance (LTCI) cash value buyouts.
      2. Heard presentations from interested parties on considerations regarding cash value buyouts.
Virtual Meeting
(in lieu of meeting at the 2020 Fall National Meeting)

REGULATORY FRAMEWORK (B) TASK FORCE
Thursday, November 19, 2020

Summary Report

The Regulatory Framework (B) Task Force met Nov. 19, 2020. During this meeting, the Task Force:

1. Adopted its Oct. 23, Sept. 24 and Summer National Meeting minutes, which included the following action:
   a. Adopted its 2021 proposed charges.
   b. Adopted revisions to the Health Maintenance Organization Model Act (#430) to address inconsistencies and redundancies in the model with the provisions of the recently revised Life and Health Insurance Guaranty Association Model Act (#520), which added health maintenance organizations (HMOs) as members of the guaranty association.
   c. Disbanded the Health Maintenance Organization (HMO) Issues (B) Subgroup.
   d. Discussed the work of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s work to develop and adopt a new NAIC model regulating pharmacy benefit managers (PBMs), the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model Act).

2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, which has not met since December 2019 due to the COVID-19 public health emergency and the resignation of one of its co-chairs.

3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group, which met Nov. 12 in 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 has not met since July 13 and June 24 because it has completed its work to adopt revisions to the Health Maintenance Organization Model Act (#430) to address inconsistencies and redundancies in the model with the provisions in the Life and Health Insurance Guaranty Association Model Act (#520), which added HMOs as members of the guaranty association. The Subgroup has been disbanded.

5. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, which met Oct. 6 in 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.

6. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which met Oct. 29, Oct. 22, Oct. 8, Oct. 1, Sept. 24 and Sept. 14, but did not include adopting the proposed PBM Model Act. During these meetings, the Subgroup took the following action:
   a. Discussed the Sept. 1 comments received on the draft proposed PBM Model Act.
   b. Adopted the proposed PBM Model Act.

7. Exposed the proposed PBM Model Act for an additional 30-day public comment period.

8. Heard a presentation on “Protect Consumers from Individual Health Insurance Marketing & Sales Abuses.” The presentation highlighted the seriousness of the issue of marketing and sales abuses related to non-federal Affordable Care Act (ACA) health benefit plans and the resulting harm to consumers. The presentation also discussed secret shopping experiences and how those experiences exposed the various deceptive sales practices, including high-pressure sales tactics, misleading use of insurer logos and names and the types and scope of plan benefits offered. The presentation also included specific actions state insurance regulators and the NAIC can take to address these concerns.

10. Discussed potential next steps regarding health care sharing ministries (HCSMs). The Task Force decided to defer making a decision and to revisit the discussion during its meeting at the 2021 Spring National Meeting.
Meeting Summary

The Senior Issues (B) Task Force held an electronic vote Oct. 20, 2020. During this meeting, the Task Force:

1. Adopted its Oct. 8 minutes, which included the following action:
   a. Adopted its 2021 proposed charges.
   b. Discussed Medicare and payment of the costs of administering a coronavirus vaccine if approved under an emergency-use authorization.

2. Adopted its Sept. 2 minutes, which included the following action:
   a. Heard a presentation from AlliedVirtualCare on its initiative to reduce long-term care insurance (LTCI) costs.
   b. Discussed deceptive COVID-19 marketing and sales practices targeting seniors.

3. Adopted its Summer National Meeting minutes.
The Senior Issues (B) Task Force conducted an e-vote that concluded Oct. 20, 2020. The following Committee members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair (AK); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods (DC); Trinidad Navarro represented by Fleur McKendell (DE); David Altmair (FL); John F. King represented by Geraldine Farr (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark (KY); James L. Donelon represented by Ron Henderson (LA); Gary Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane (MD); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Jon Godfread represented by Chrystral Bartuska (ND); Bruce R. Ramge (NE); Barbara D. Richardson represented by Jack Childress (NV); Tynesia Dorsey represented by Laura Miller (OH); Jessica K. Altman (PA); Hodgen Mainda represented by Brian Hoffmeister (TN); Tanji J. Northrup (UT); Mike Kreidler represented by Mike Bryant (WA); and Mark Afable represented by Jennifer Stegall (WI).

1. **Adopted the Task Force’s Oct. 8, Sept. 2 and Summer National Meeting Minutes**

The Task Force conducted an e-vote to consider the adoption of its Oct. 8 (Attachment ?-A), Sept. 2 (Attachment ?-B) and Aug. 3 (see NAIC Proceedings – Summer 2020, Senior Issues (B) Task Force) minutes.

Without objection, the Task Force adopted its minutes, with Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, Utah and Wisconsin voting in favor of adoption.

Having no further business, the Senior Issues (B) Task Force adjourned.
The Senior Issues (B) Task Force met via conference call Oct. 8, 2020. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair (AK); Jim L. Ridling represented by Steve Ostlund (AL); Alan McClain represented by William Lacy (AR); Elizabeth Petri (AS); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Mary Beth Senkewicz (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by John Reilley (FL); John F. King (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen (IA); Dean L. Cameron represented by Kathy McGill (ID); Stephen W. Robertson represented by Mary Ann Williams (IN); Vicki Schmidt represented by Julie Holmes (KS); Kathleen A. Birrane represented by Joy Hatchette (MD); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Fred Anderson (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Bruce R. Rame represented by Martin Swanson (NE); Russell Toal represented by Bogdanka Kurahovic (NM); Barbara D. Richardson represented by Jack Childress (NV); Tynesia Dorsey represented by Laura Miller (OH); Glen Mulready represented by Ron Kreiter (OK); Jessica K. Altman represented by Jim Laverty (PA); Larry D. Deiter represented by Jill Kruger (SD); Hodgen Mainda represented by Brian Hoffmeister (TN); Tanji J. Northrup represented by Jakob Sundberg (UT); Scott A. White represented by Bob Grissom (VA); Mike Kreidler represented by Michael Bryant (WA); and Mark Afaile represented by Jennifer Pegall (WI). Also participating were: Vanessa Darrah (AZ); Eric Anderson (IL); Bob Williams (MS); Martin Wojcik (NY); Christina Rouleau (VT); and Mavis Earnshaw (WY).

1. **Adopted its 2021 Proposed Charges**

   Director Wing-Heier made a motion, seconded by Mr. Swanson, to adopt the Task Force’s 2021 proposed charges (Attachment 1A). The motion passed unanimously.

2. **Discussed Medicare and a Possible Coronavirus Vaccine**

   Director Wing-Heier opened the discussion on the possibility that Medicare may not cover the costs of administering a coronavirus vaccine if approved under an emergency-use authorization. She felt it was important for the Task Force to address and discuss that several newspapers and online articles have written about the problem that Medicare would not cover the cost of administering any coronavirus vaccine approved for emergency use. Director Wing-Heier said the recently passed Coronavirus Aid, Relief, and Economic Security (CARES) Act ensures coronavirus vaccine coverage with no out-of-pocket costs for people on Medicare, but Medicare does not cover costs for drugs approved under the U.S. Food and Drug Administration’s (FDA’s) emergency use authorization (EUA) designations.

3. **Discussed Other Matters**

   Bonnie Burns (California Health Advocates—CHA) raised a couple issues. The first issue she raised was that persons with End-Stage Renal Disease (ESRD) will be able to enroll in Medicare Advantage, and most plans institute a 20% coinsurance for dialysis. She said these costs will be very high for ESRD patients because most do not know of these costs, and these costs will push many ESRD patients into Medicaid.

   Ms. Burns raised a second issue regarding possible confusion of notices pertaining to rate increases and premium reductions. She said there is a lawsuit moving towards settlement and, as part of the settlement, policyholders will be offered a number of options to reduce a previous premium increase. She said the notice will also include information related to future premium increases, if any. She said the notice generated by this settlement could come in addition to or in combination with any current rate increase filings. Ms. Burns said in California, 35,000 California Partnership policyholders may lose their Partnership status if they reduce their daily benefit below the minimum daily benefit allowed in California of $240 or reduce or drop their inflation protection below the minimum of 5% compounded.

Having no further business, the Senior Issues (B) Task Force adjourned.

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The Senior Issues (B) Task Force met via conference call Sept. 2, 2020. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair (AK); Jim L. Ridling represented by Steve Ostlund (AL); Alan McClain represented by William Lacy (AR); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Kim Latta (CO); Andrew N. Mais represented by Paul Lombardo (CT); Trinidad Navarro represented by Susan Jennette (DE); David Altmairer represented by Chris Struk (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen (IA); Dean L. Cameron represented by Kathy McGill (ID); Stephen W. Robertson represented by Rebecca Vaughan (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Stephanie McLaughey-Bowker (KY); James J. Donelon represented by Alecia Johnson (LA); Gary Anderson represented by Rebecca Butler (MA); Kathleen A. Birrane represented by Joy Hatchette (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Steve Kelley represented by Fred Andersen (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Bruce R. Range represented by Martin Swanson (NE); Chris Nicolopoulos represented by Roni Karnis (NH); Barbara D. Richardson represented by Jack Childress (NV); Tynesia Dorsey represented by Laura Miller (OH); Glen Mulready (OK); Andrew R. Stolli represented by Gayle L. Woods (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Hodgenvinanda represented by Brian Hoffmeister (TN); Todd E. Kiser represented by Tomasz Serbinowski (UT); Scott A. White represented by Bob Grissom (VA); Mike Kreidler represented by Michael Bryant (WA); Mark Afable (WI); and James A. Dodrill represented by Ellen Potter (WV). Also participating were: Vanessa Darrah (AZ); Eric Anderson (IL); Bob Williams (MS); Martin Wojcik (NY); Sarah Neil (RI); and Andrew Dvorine (SC).

1. **Heard a Presentation from AlliedVirtualCare on its Initiative to Reduce LTCI Costs**

Commissioner Caride asked Bob Bischoff (AlliedVirtualCare—AVC) to discuss an initiative to help reduce long-term care insurance (LTCI) costs. Mr. Bischoff said their initiative uses virtual tools to help reduce costs. He said they are looking at how long-term care (LTC) insurers can save on closed books of business. He said falls, cognitive decline, hearing loss and depression collectively contribute to a significant increase in costs and claims. He said by implementing programs and services that leverage therapeutic and preventative health programs, identify undiagnosed risks, and increase access to highly effective, lower-cost, virtual solutions for needed therapies, it is possible for these insurers to save on those closed books of business.

Mr. Bischoff said the AVC is a self-funded startup made up of three health care leaders committed to helping people remain healthy and independent as they age and partnering with leading virtual care solutions, seeking pilot populations and pursuing National Institutes of Health (NIH) grants to fund outcomes research to further support their business model. He said AVC brings together allied health professionals and state-of-the-art virtual care technologies to sustain independence and improve health outcomes. He highlighted the target populations as the “aging” population nearing or post-retirement, those experiencing slow progression through the care continuum (“Age in Place”), and those at risk for losing their ability to work and live independently. He highlighted the related conditions of Alzheimer's Disease and related dementias (ADRD), which he pointed out are estimated to cost about $290 billion in 2020, age-related hearing loss, depression and social isolation, and falls.

Mr. Bischoff said the current system is broken. He said risk assessment for ADRD, depression and social isolation, hearing care, and falls are often overlooked during regular health assessments, that clinic-based therapies exist independently and the care and experience are not readily coordinated, and that effective, proven, lower-cost virtual solutions exist but historically have been underused. He said within the last three months or so, there has been a huge upswing and increase in the use of telehealth. He said in 2019, there were approximately 36 million users, and 2020 is projected to be at about 1 billion. He said AVC has developed a program called Songbird to promote education, awareness and self-assessment to identify undiagnosed risks in these areas, to navigate members to a curated network of virtual care solutions to provide high-quality, economical interventions that increase use of needed therapies, and to integrate self-assessment and virtual care data to measure outcomes.

Mr. Bischoff said the time is ripe now for this initiative and program for a variety of reasons. He said there is a growing awareness of how these conditions have an impact on population independence and quality of life. He said virtual care is seeing a massive lift as a result of new Medicare and Medicare Advantage rules, improved reimbursement and licensing rules for virtual care, an increase demand for allied health providers, an acceptance of virtual care solutions as a viable treatment option, and a recognition of value-based enterprises within pending changes to Physician Self-Referral (Stark) and anti-kickback laws.
Commissioner Caride said she is seeing a large increase of the use of telehealth and that it is becoming more pervasive due to COVID-19. She said she is interested in seeing how this will work with LTCI. Director Wing-Heier asked Mr. Bischoff what the next steps are and what is he seeking from state insurance regulators. Mr. Bischoff said they are looking to identify blocks of members and would appreciate assistance in engaging with these blocks of members. Director Wing-Heier asked if they are looking at pre-claim or on-claim persons. Mr. Bischoff said either group but that pre-claim would be better.

Bonnie Burns (California Health Advocates—CHA) said that a benefit for LTCI insurers would be if fall prevention were part of the care or part of the benefits. She said half of nursing home visits are a result of falls, and insurers and state insurance regulators should think about how fall prevention could prevent nursing home care. Mr. Bischoff said different tests can work with the use of virtual care. He said different treatments can be tied together, such as strength training balance; a Fitbit could be useful for some individuals.

Commissioner Caride asked if physical training through virtual care is happening now. Mr. Bischoff said there are some providers doing just that, and the Centers for Disease Control and Prevention (CDC) has been taking a close look at the use of virtual care and physical training. Commissioner Caride said in relation to hearing loss, more physical treatments, such as training in walking and taking more steps, could help reduce falls. Mr. Bischoff added depression prevention as part of the hearing loss community. He said many individuals with hearing loss suffer from depression, and without treatment for the hearing loss, depression will worsen, and the individual will be less able to interact. He said this could lead to severe withdrawal, both physically and mentally.

Ms. Nakasone asked about the fall assessment and how virtual care can be useful when someone may need an in-person treatment of help to prevent falls. Mr. Bischoff agreed that at that point, a person needing such care and treatment where an in-person caretaker is needed, then virtual care could still be used but in a different manner. Mr. Serbinowski asked if they have approached insurance companies already and how long of a study they are anticipating because he feels that such a study will have to take quite some time. Mr. Bischoff said they have not asked insurance companies and they are prepared, including financially, for a long study time. He gave an example of the progress that currently exists to help those inflicted with hearing loss. He said the modern hearing aid can measure so many metrics now. He said modern aids can measure how long one talks, financially, for a long study time. Mr. Bischoff said they have not asked the insurance companies and they are prepared, including financially, for a long study time. He gave an example of the progress that currently exists to help those inflicted with hearing loss. He said the modern hearing aid can measure so many metrics now. He said modern aids can measure how long one talks, financially, for a long study time.

Ms. Neil asked about persons on claim and getting kicked off due to improvement and what about the activities of daily living (ADLs) and if a person is still paying for ADL and no longer need service due to improvement. Ms. Burns said if a person improves enough and gets off claim because they can do enough ADLs, there is a chance they would not improve enough and therefore would not get care. Mr. Bischoff said hearing loss is a domino effect and can lead to problems with or the inability to do ADLs. He said in the ideal world, it would be nice to get the person off claim, but it is more realistic to keep the person at home and continue to get services.

2. Discussed Insurance Sales, Seniors and COVID-19

Ms. Burns discussed COVID-19 fraud against seniors and said the Senior Medicare Patrol (SMP) program is seeing more cases. She introduced Rebecca Kinney (U.S. Administration for Community Living—ACL), Marissa Whitehouse (ACL) and Matthew Smith (Coalition Against Insurance Fraud—CAIF) to discuss this matter.

Ms. Kinney said her department manages the SMP program (SMP), along with State Health Insurance Assistance Program (SHIPs) and other similar programs. She said the SMP assists Medicare beneficiaries, their families and caregivers to prevent, detect and report health care fraud, errors and abuse through outreach, counseling and education. SMPs are grant-funded projects of the ACL. She said there are SMPs in every state and territory, and they work with the states’ Departments of Insurance (DOIs) and the Centers for Medicare and Medicaid Services (CMS).

Ms. Whitehouse discussed a special case the SMP in California had examined revolving around unsolicited in-person contact with seniors and offering COVID-19 prevention tests. She said there are concerning sales allegations from certain brokers and a pattern using the guise of delivering COVID-19 prevention kits to gain access to members that are not a part of their book of business and intentionally engaging in unsolicited contact with members in violation of the Medicare Communications and Marketing Guidelines. She said the California SMP referred the case to the investigation arm of the California Department of Managed Health Care, the California DOI, the CMS, and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).
Ms. Burns said these brokers are more aggressive and insistent on coming to the senior’s home, using the guise of COVID-19 prevention kits, and then changing the senior’s plan. She said these agents/brokers apply pressure, gain entry, begin to discuss COVID-19 and then switch to discussing the senior’s coverage. She said many times, these seniors are then changed from their current coverage. She gave an example of one senior who was switched to hospice and others who were switched from Medicare Supplement to Medicare Advantage.

Mr. Smith said COVID-19 scams have the largest spoke in history. He said a United Nations (UN) study showed 60% of phishing scams are related to COVID-19. He said many of the frauds and scams his organization is seeing are fake test kits, pre-signups for a vaccine, targeting seniors’ stimulus checks and staged auto accidents. He said in relation to the previous discussion on telehealth, that while it is great and he is supportive, there is a potential for fraud against seniors. He gave as an example of unlicensed physicians and physicians outside the U.S. pretending to be licensed in the U.S. He said his organization is seeing a rise in fraudulent marketing of pandemic riders to provide extra coverage for family members. He said his organization is ready to work with state insurance regulators and insurance professionals, and he provided his organization’s website, www.insurancefraud.org, as a starting point for regulators.

Ms. Burns said that each SMP has its own site or is included in the state’s SHIP program, and she encouraged state insurance regulators to coordinate with their state’s SMP as the best way to combat fraud against seniors.

3. Continued Discussion from the Summer National Meeting of Seniors and COVID-19

Director Wing-Heier said there is no need for further discussion considering the presentations the Task Force just heard. She asked if any states had other COVID-19 concerns. Mr. Swanson said Nebraska has ongoing COVID-19 investigations but specific to seniors. Commissioner Caride said there have been no cases elevated to her department, but she is aware of scams and frauds in other states that may have an impact in her state. Ms. Burns and Mr. Smith both said that it is difficult to get seniors to admit they have been scammed or to complain to an agency if they are aware of abuse and fraud. Ms. Burns said only a small percentage complain. Both Ms. Burns and Mr. Smith said the discovery of any fraudulent abuse or scams are found when the senior comes to a SMP or SHIP for an entirely different reason, and far too many seniors do not know who or what agency/department to bring their complaints.

Having no further business, the Senior Issues (B) Task Force adjourned.

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The Senior Issues (B) Task Force met via conference call Aug. 3, 2020. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair (AK); Jim L. Ridling represented by Steve Ostlund (AL); Alan McClain represented by William Lacy (AR); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Fleur McKendell (DE); David Altmaier (FL); John F. King (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Sonya Sellmeyer (IA); Dean L. Cameron represented by Weston Trexler (ID); Stephen W. Robertson represented by Rebecca Vaughan (IN); Vicki Schmidt represented Craig Van Aalst (KS); James J. Donelon represented by Ron Henderson (LA); Gary Anderson represented by Ruth Moritz (MA); Kathleen A. Birrane represented by Fern Thomas (MD); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Steve Kelley represented by Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Mary Jo Wegenast (NC); Jon Godfread represented by Chrystal Burtuska (ND); Bruce R. Ramge (NE); Chris Nicolopoulos represented by Maureen Belanger (NH); Russell Toal represented by Paige Duhamel (NM); Barbara D. Richardson represented by Jack Childress (NV); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Ron Kreiter (OK); Andrew R. Stolfi represented by Gayle L. Woods (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Hodgen Mainda represented by Vickie Trice (TN); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser represented by Jaakob Sundberg (UT); Scott A. White represented by Bob Grissom (VA); Mike Kreidler represented by Michael Bryant (WA); Mark Afable represented by Jennifer Steggall (WI); and James A. Dodrill (WV).

1. **Adopted its March 3 and 2019 Fall National Meeting Minutes**

   Director Lindley-Myers made a motion, seconded by Mr. Henderson, to adopt the Task Force’s March 3 (Attachment One) and Dec. 7, 2019, *(see NAIC Proceedings – Fall 2019, Senior Issues (B) Task Force)* minutes. The motion passed unanimously.

2. **Heard a Federal Legislative Update**

   David Torian (NAIC) provided a federal legislative update, including an update on funding for the State Health Insurance Assistance Program (SHIP) and the pending release of the Federal Interagency Task Force on Long-Term Care Insurance’s final report.

3. **Discussed Other Matters**

   Director Wing-Heier asked Task Force members about their experience with seniors and COVID-19 and any information that we might not be aware of in respect to the pandemic. She said there are some incidental and anecdotal stories that seniors may be putting off health care needs or the need to go into a long-term care (LTC) facility. She asked whether there is anything from an insurance perspective that we should be taking a look at this time.

   Commissioner Caride said New Jersey has managed to control the crisis somewhat, but it is watching as the numbers are beginning to come up again as so many states are seeing of resurgence of it. She said she has heard on numerous occasions about seniors who are refusing to go to nursing homes and not wanting to go to the hospital with the concern of getting COVID-19, even if their health requires them to see their doctors.

   Commissioner Caride said New Jersey and hospitals are doing a push in marketing and advertising to seniors that they are open for business outside of dealing with a pandemic. She said the numbers have gone down drastically, and it is time for these seniors to come back for either an elective procedure they put off or just for a regular checkup. She said there is a lot of work to be done to encourage seniors not to be afraid to go to their doctors or to go to the hospital. She said one area of promotion is telehealth and telemedicine.

   Bonnie Burns (California Health Advocates—CHA) highlighted fraud and COVID-19 among seniors, and she encouraged communication among all parties about any and all fraud circulating. She also said there is the problem with people who are getting home care under long-term care insurance (LTCI) policies. She said these people have family living in their homes who are able and available caregivers, but these family caregivers are excluded under almost all of the LTCI policies. She said the
Draft Pending Adoption

pandemic has increased the concern about an outside caregiver, and many are now going without care. She encouraged state insurance regulators and companies to look at the flexibility of having a family caregiver included on a month to month basis during this national emergency.

Director Wing-Heier asked Ms. Burns if there is anything state insurance regulators can do when they speak with carriers about these concerns. Ms. Burns replied that it is important for state insurance regulators to make carriers aware of this fraud and these problems and encourage them to make changes or alternatives during this national emergency.

Commissioner Caride said regarding fraud, she had heard about companies going and taking swabs of seniors and charging the seniors’ insurance. She said she knows the Task Force has talked about different things that are going on around the country regarding seniors. She said that is our watchlist, and it is interesting to hear how other states are handling different situations.

Ms. Burns raised the concern with a lot of emphasis on medical services that plans are able to provide, and while they may be valuable for people who qualify for it, it is not universally applicable to every senior. She said she is seeing a lot of evidence that agents are telling people to sign up for plans, telling them about medical events and home delivered meals, for instance. But only a very small percentage of people would qualify and actually get that benefit, and that information is not communicated. Ms. Burns said there are all kinds of ads running on TV right now that emphasize these non-medical benefits to the broad population.

Mr. Henderson said he has noticed an uptick in advertisements enticing seniors with plans that offer additional benefits. He said his department is receiving more and more calls from seniors who have called the number of the advertisement and find out that they have been switched to another plan without their knowledge or consent. He said his department is spending a lot of time correcting these changes. He cited as an example, a senior who, unbeknownst to her, was removed from her company retirement plan and put into a Medicare Advantage plan.

Ms. Brown said she is seeing these ads, and they are on many cable channels and often on some specific channels. She said she cannot recall the names of the specific ads that cater to seniors. She said these ads are not from Colorado, but they are being beamed into Colorado, and its department receives calls every day about these ads.

Commissioner Caride asked if there was anything else anyone wished to discuss.

Marcy Buckner (National Association of Health Underwriters—NAHU) raised the issue of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), and a senior may end up in a COBRA plan and then be penalized that 10% for life for going into COBRA when they should have been on Medicare. She said NAHU is working with Congressman Kurt Schrader of Oregon on a bill he has co-sponsored to allow seniors enrolled in COBRA coverage to transition to Medicare Part B without a penalty, the same as seniors who remain on similar employer-sponsored coverage, by providing for a one-time special enrollment period. She said there is hope that the bill could be brought into a larger Medicare bill later this year. She said she wanted to discuss this with the Task Force, and if anyone wants additional information about this bill and topic, she would be happy to share it with the Task Force.

Ms. Burns said she has been dealing with this issue of COBRA and Medicare for three years. She said there are conflicts that exist regarding Medicare eligible individuals who have COBRA protection and Medicare eligible individuals who work for small employers. She said these conflicts between Medicare and COBRA rules have led to confusion about which system and which set of rules governs eligibility for coverage and how responsibility for payment of health care benefits for eligible individuals is determined. She said these conflicts have led to some Medicare eligible individuals being subject to Medicare premium penalties and delays in coverage, mistakes in benefit payment, and claims for recovery of mistakenly paid COBRA benefits. She said the U.S. Department of Labor (DOL) has made efforts to address this matter through notices, but it is far from perfect. She also said the Schrader bill is in the right direction, but it does not deal with late enrollment. She said there needs to be a change in the Coordination of Benefits Model Regulation (#120) to address health benefits based upon the model. She has provided the Task Force with language for the model, and she hopes the Task Force will seriously consider this very complex issue.

Having no further business, the Senior Issues (B) Task Force adjourned.

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Agenda Item #3

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

Health Insurance and Managed Care (B) Committee

Katie Keith, JD, MPH
Georgetown University Law Center
CA v. TX: An Overview

18 Republican AGs/Govs
Two individuals in Texas
Department of Justice

vs.

21 Democratic AGs/Govs
House of Representatives

Argument
- In 2012, the Supreme Court upheld the mandate as a tax in *NFIB v. Sebelius*
- Now that Congress zeroed out the individual mandate penalty in the Tax Cuts and Jobs Act of 2017, it is no longer a tax and is unconstitutional
- The entire ACA relies on the mandate so should also be struck down

Timeline
- Oral argument on Nov. 10th
- No decision until 2021 – as early as spring or as late as summer 2021
CA v. TX: Potential Outcomes

Spectrum of decisions, each with its own implications

Status Quo
- No standing/subject matter jurisdiction
- Mandate is constitutional
- Mandate is unconstitutional but fully severable

Some Disruption
- Preexisting condition protections are struck down
- Title I of ACA is struck down

Severe Disruption
- Entire ACA is struck down
Observations from Oral Argument

- Significant focus on standing and constitutionality – but no clear consensus
- Seeming majority for severing the mandate from the rest of the ACA
  - “Here, Congress left the rest of the law intact when it lowered the penalty to zero. That seems to be compelling evidence on the question.” – Chief Justice Roberts to Texas
  - “I tend to agree with you that it's a very straightforward case for severability under our precedents, meaning that we would excise the mandate and leave the rest of the Act in place, reading our severability precedents.” - Justice Kavanaugh to House
  - “I think it's hard for you to argue that Congress intended the entire Act to fall if the mandate were struck down when the same Congress that lowered the penalty to zero did not even try to repeal the rest of the Act. I think, frankly, that they wanted the Court to do that. But that's not our job.” – Chief Justice Roberts to Texas
  - “In 2017, do you read Congress as having wanted to preserve protection for coverage for people with preexisting conditions? Because it sure seems that way from the -- the record and the text.” – Justice Kavanaugh to Texas

For a deeper dive, visit: https://www.healthaffairs.org/do/10.1377/hblog20201111.916623/full/
Supreme Court Cases

Other Cases to Watch in the 2020 Term

- *Rutledge v. PCMA* (state regulation of pharmacy benefit managers) → oral argument held on October 6, 2020

- *Gresham v. Azar* (validity of approval of Medicaid work requirements) → *cert* petitions under consideration

- *AMA v. Azar* (validity of restrictions on Title X family planning service providers) → *cert* petition under consideration

- Multiple lawsuits on the public charge rule → *cert* petitions under consideration
# Decided/Pending ACA Lawsuits

<table>
<thead>
<tr>
<th>Topic</th>
<th>Court</th>
<th>Result</th>
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<tbody>
<tr>
<td>Unpaid CSRs</td>
<td>Federal Circuit</td>
<td>Insurers entitled to unpaid CSRs but with damages offset by excess PTCs from premium loading (en banc review denied)</td>
</tr>
<tr>
<td>Data Marketing Partnership</td>
<td>Fifth Circuit</td>
<td>District court overturned Dept. of Labor advisory opinion ruling to conclude that a limited partnership arrangement qualifies as a single employer self-insured group health plan under ERISA</td>
</tr>
<tr>
<td>Section 1557</td>
<td>Second, Fifth, DC Circuits; MA, NY district courts</td>
<td>LGBT-specific changes to the 2020 rule vacated because HHS failed to consider the impact of Bostock; rest of rule in effect</td>
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<td>Contraceptive mandate</td>
<td>Fifth Circuit; CA, IN, MA, PA district courts</td>
<td>Litigation continues over new rules after Little Sisters of the Poor</td>
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<td>AHPs</td>
<td>D.C. Circuit</td>
<td>Decision pending (oral argument in Nov. 2019)</td>
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<td>Short-term plans</td>
<td>D.C. Circuit</td>
<td>Upheld 2018 rule on STLDI (awaiting decision on en banc review)</td>
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<tr>
<td>HIT</td>
<td>Fifth Circuit</td>
<td>States not entitled to recoup prior year HIT re: MCOs (awaiting decision on en banc review)</td>
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Other Pending Litigation Issues

• Other ACA cases
  • Double billing rule (Fourth, Ninth Circuits)
  • “Take Care” case (MD district court)
  • COVID-19 special enrollment period (DC district court)
• Provider conscience rule (Second, Ninth Circuits)
• Hospital transparency rule (D.C. Circuit)
Thank you!

Katie Keith, JD, MPH
Georgetown University Law Center
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More resources available at: healthaffairs.org/blog
Agenda Item #4

Hear a Federal Legislative and Administrative Update and Outlook for 2021

—Brian Webb (NAIC)
Federal Legislative and Administrative Update and Outlook for 2021

Health Insurance and Managed Care (B) Committee
Fall National Meeting 2020

Brian Webb
Assistant Director of Health Policy and Legislation
NAIC

December 7, 2020
What to Expect in 2021

Key Factors that Will Impact Health Actions in 2021:

- Supreme Court Decision in *California v. Texas*
  - Oral Arguments were November 10
  - Timing of final decision unclear
  - Decision unclear – Constitutional? Severable?

- Makeup of the Senate
  - Final Majority
  - Committee Leadership
Possible Activity Regardless

- Unfinished Business that is Not as Partisan:
  - Surprise Billing – including Air Ambulance?
    - Can a compromise on payment amount be found?
    - Could be change in attitude at Dept of Transportation on air ambulance
  - Prescription Drug Reform
    - Can common ground be found?
  - Telehealth Expansion
  - COVID-19 Relief
Possible Congressional Actions

- Health Insurance Reforms?
  - Subsidies
  - Outreach
  - Reinsurance
  - Network Adequacy
  - Short-Term, Limited Duration Plans
  - Public Option

- Other Health Reforms?
  - Mental Health Parity
  - Health Care Sharing Ministries
  - Medicare/Long-Term Care
Some Possible Actions by New Administration:

- Short-Term, Limited Duration Plans
- Association Health Plans
- Section 1557 (nondiscrimination) - restore protections
- Separate Payment for Abortion
- HRA payments for Health Care Sharing Ministries
- Cost-Sharing Reduction (CSR) Payments
- Section 1332 guidance
- Medicaid Work Requirements
- Exchange Flexibility
- Medicaid Work Requirements
Questions?

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Agenda Item #5

Receive an Update on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s Work
—TK Keen (OR)
PHARMACY BENEFIT MANAGER REGULATORY ISSUES (B) SUBGROUP
October 29, 2020 / October 22, 2020 / October 8, 2020 / October 1, 2020 / September 24, 2020 / September 14, 2020

Summary Report

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 29, Oct. 22, Oct. 8, Oct. 1, Sept. 24 and Sept. 14, 2020. During these meetings, the Subgroup:

1. Discussed the Sept. 1 comments received on the proposed new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model).

2. Adopted the PBM model and forwarded it to the Regulatory Framework (B) Task Force for its consideration.
Agenda Item #6

Discuss Any Other Matters Brought Before the Committee

—Commissioner Jessica K. Altman (PA)