ROLL CALL

Jon Godfread, Chair  
Jessica K. Altman, Vice Chair  
Lori K. Wing-Heier  
Michael Conway  
John F. King  
Dean L. Cameron  
Kathleen A. Birrane  
Anita G. Fox  
Grace Arnold  
Russell Toal  
Glen Mulready  
Andrew R. Stolfi  
Jonathan T. Pike  
Mike Kreidler  
Allan L. McVey

North Dakota  
Pennsylvania  
Alaska  
Colorado  
Georgia  
Idaho  
Maryland  
Michigan  
Minnesota  
New Mexico  
Oklahoma  
Oregon  
Utah  
Washington  
West Virginia

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

AGENDA

1. Consider Adoption of its Summer National Meeting Minutes  
   — Commissioner Jon Godfread (ND)

2. Consider Adoption of its Subgroup, Working Group, and Task Force Reports  
   — Commissioner Jon Godfread (ND)
   A. Consumer Information (B) Subgroup—Mary Kwei (MD)
   B. Health Innovations (B) Working Group—Commissioner Andrew R. Stolfi (OR)
   C. Health Actuarial (B) Task Force—Superintendent Eric A. Cioppa (ME) and Marti Hooper (ME)
   D. Regulatory Framework (B) Task Force—Commissioner Michael Conway (CO)
   E. Senior Issues (B) Task Force—Commissioner Marlene Caride (NJ)

3. Consider Adoption of its 2022 Proposed Charges—Commissioner Jon Godfread (ND)

4. Consider Adoption of its Task Forces’ 2022 Proposed Charges—  
   Commissioner Jon Godfread (ND)

5. Hear an Update from the Federal Centers for Medicare & Medicaid Services’ (CMS’) Center for Consumer Information and Insurance Oversight (CCIIO)—Jeff Wu (CCIIO)

6. Discuss Committee Federal No Surprises Act (NSA) Consumer, Provider, and Insurer Outreach Materials—Commissioner Jon Godfread (ND)
7. Hear a Summary of Findings from the Kaiser Family Foundation’s (KFF’s) 2021 Employer Health Benefits Survey (EHBS)—Gary Claxton (KFF) and Matthew Rae (KFF)

8. Receive an Update on the Special (EX) Committee on Race and Insurance Workstream Five’s Work—Commissioner Jessica K. Altman (PA) and Commissioner Ricardo Lara (CA)

9. Discuss Any Other Matters Brought Before the Committee—Commissioner Jon Godfread (ND)

10. Adjournment
Agenda Item #1

Consider Adoption of its Summer National Meeting Minutes
—Commissioner Jon Godfread (ND)
The Health Insurance and Managed Care (B) Committee met in Columbus, OH, Aug. 16, 2021. The following Committee members participated: Jon Godfrey, Chair (ND); Jessica K. Altman, Vice Chair (PA); Lori K. Wing-Heiter (AK); Michael Conway (CO); Dean L. Cameron (ID); Kathleen A. Birrane (MD); Anita G. Fox (MI); Grace Arnold (MN); Russell Toal (NM); Glen Mulready (OK); Andrew R. Stolfi (OR); Jonathan T. Pike (UT); Mike Kreidler (WA); and James A. Dodrill represented by Ellen Potter (WV). Also participating were: Alan McClain (AR); David Altmaier (FL); Doug Ommen (IA); Mike Chaney (MS); Troy Downing (MT); Eric Dunning (NE); Barbara D. Richardson (NV); Elizabeth Kelleher Dwyer (RI); Carter Lawrence (TN); Doug Slape (TX); Don Beatty (VA); and Tregenza A. Roach (VI).

1. **Adopted its June 22 and Spring National Meeting Minutes**

The Committee met June 22 to adopt the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model).

Director Cameron made a motion, seconded by Commissioner Mulready, to adopt the Committee’s June 22 (Attachment One) and April 12 (see NAIC Proceedings – Spring 2021, Health Insurance and Managed Care (B) Committee) minutes. The motion passed unanimously.

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

Commissioner Pike made a motion, seconded by Commissioner Kreidler, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its July 1 minutes (Attachment Two) minutes; 2) the Health Innovations (B) Working Group, including its July 27 minutes (Attachment Three); and 3) the Senior Issues (B) Task Force.

3. **Heard a Discussion from the Biden Administration on the Implementation and Enforcement of the NSA Provider Requirements**

Jeff Wu (Center for Consumer Information and Insurance Oversight—CCIIO) discussed the Biden Administration’s current and future efforts related to the implementation and enforcement of the federal No Surprises Act (NSA) provider requirements. He focused his remarks on how the federal agencies charged with implementing the NSA can work together to address any implementation and enforcement issues. He said the CCIIO recognizes that the states are in different positions as far as enforcement when the NSA becomes effective Jan. 1, 2022.

Mr. Wu discussed the major provisions in the interim final rule (IFR) issued July 1 with an effective date of Sept. 13. The IFR was issued jointly by the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), the U.S. Department of the Treasury (Treasury Department), and the U.S. Office of Personnel Management (OPM). He said the IFR focused on the NSA’s consumer protection provisions, such as calculating patient cost-sharing, outlining notice and consent waiver provisions, and establishing a consolidated complaints process.

Mr. Wu said the states have primary enforcement authority with respect to insured plans, including the provider provisions. He said the federal Centers for Medicare & Medicaid Services (CMS) will only enforce these provisions if a state does not or cannot substantially enforce them. However, he explained that even under those circumstances, the CMS would seek to enter into a collaborative enforcement agreement with the state. He said the CMS has sent each state a written survey in its effort to assess which states plan to enforce the NSA’s provisions and their ability to do so. He said following the survey response deadline, the CMS plans to hold meetings with each state concerning their survey responses, including which state agency will enforce the NSA provisions, particularly provisions in the NSA concerning providers. Following these conversations, he said the CMS will send a final determination letter to the state’s governor outlining an NSA enforcement scheme.

Director Cameron asked if the CMS plans to send a copy of the letter sent to state governors to state insurance regulators. Mr. Wu confirmed the CMS’s intention to do so. Director Cameron asked for additional clarification on the collaborative enforcement agreements. Mr. Wu said each such agreement would be specific and tailored to a state’s circumstances as to the role the CMS will take, given that the states are the primary enforcers. However, he noted that the CMS recognizes that the
**Draft Pending Adoption**

NSA includes a different set of stakeholders, which generally are not subject to state insurance regulation and over which state insurance regulators have no enforcement authority. He said the CMS also recognizes that some states may have resource issues that could affect their direct enforcement capacities. He said given this, there will most likely be different approaches and different collaborative models. He emphasized that the CMS prefers that the states be the primary enforcers of the NSA requirements.

Commissioner Altman asked about the CMS’s plans to educate the consumers and providers on the NSA’s provisions and the possibility of partnering with the states on such education campaigns. Mr. Wu said the CMS is currently thinking about ways to educate stakeholders on the NSA’s provisions. He said the CMS would be very interested in partnering with states in NSA awareness education campaigns. He said he believes that given the nature of the NSA, engaging consumers in such campaigns may be more challenging because consumers most likely will not be paying attention until they need to pay attention, such as after receiving a surprise bill. Commissioner Conway said Colorado has an existing comprehensive state law on surprise bills. He said he is concerned about aligning Colorado’s law and the NSA with respect to enforcement and Employee Retirement Income Security Act of 1974 (ERISA) plans. He asked if the CMS has contemplated or is contemplating the use of collaborative enforcement agreements with the states to address this issue. He said this issue is complex, particularly with respect to self-insured ERISA plans. He said the CMS anticipates additional federal rulemaking to address these types of jurisdictional issues, but the CMS wants to work with the states.

Commissioner Godfread also noted similar complexities regarding enforcement related to air ambulances and the interplay of the NSA and the Airline Deregulation Act (ADA). Mr. Wu agreed. He said the CMS is hoping to address this in future federal rulemaking.

Mr. Wu said the public comment deadline on the IFR ends Sept. 7. He said the federal agencies charged with implementing the NSA plan to issue additional federal rules on the independent dispute resolution (IDR) process. He said he believes that the IDR process in the IFR tries to strike the right balance, but the CMS is certainly aware of trying not to have an overly burdensome and costly administrative process. He said additional federal rulemaking will concern: 1) air ambulance services; 2) direct and indirect compensation to agents and brokers; 3) accuracy of provider directories; and 4) gag clauses.

4.  **Heard a Panel Discussion of NSA Provider Compliance and Enforcement Issues**

Molly Smith (American Hospital Association—AHA) presented on “No Surprises Act: Provider Compliance and Enforcement Issues.” She said hospitals and health systems strongly support patient protections against surprise medical bills, and they will work diligently to comply with the NSA as of its Jan. 1, 2022, effective date. However, she noted that the NSA is a large comprehensive piece of legislation with several different independent policies. Given this, stakeholders will need time to implement its various components and need adequate and comprehensive guidance from both federal and state governments to assist in this effort. Ms. Smith said oversight will be critical; but, to date, the role of the federal government and the states remains unclear on several key NSA provisions. She discussed the AHA’s primary NSA implementation issues, including issues related to: 1) its scope and application; 2) notice/consent and disclosure documents and policies; and 3) training. She also discussed what the AHA believes are priority areas for oversight and enforcement for both providers and plans and insurers. She discussed from a provider perspective specific NSA oversight and enforcement challenges, such as the complexity of the rules and timeline and standards for implementation. She made several recommendations for Committee members to consider moving forward with NSA implementation, including: 1) clear articulation of which components of the NSA will be overseen by the federal government and which by the states; 2) development of a crosswalk between the federal and state laws and clear assessment of which states meet the standards for compliance on relevant provisions; and 3) development of a data submission process with standards for the states to report complaints and outcomes to the federal government for tracking and oversight.

Emily Carroll (American Medical Association—AMA) discussed the challenges and opportunities the NSA provides from the AMA’s perspective. She highlighted potential issues with the IDR process, including its timelines. In addition, like Ms. Smith’s comments, Ms. Carroll also discussed and urged more clarity on: 1) the scope of federal law and the interaction between federal and state laws; and 2) which laws apply for patients and providers. With respect to the NSA’s notice and consent and disclosure requirements, she urged federal and state insurance regulators to ensure that meaningful information is provided to consumers and noted the need for standard automated transactions. Ms. Carroll also discussed NSA enforcement.

Melanie de Leon (Federation of State Medical Boards—FSMB) presented on “The No Surprises Act: A Process for Collaboration in Compliance.” She described the FSMB, including its role and functions, which is to support state medical boards through education, assessment, research, and advocacy as well as promoting regulator best practices across the states. She discussed how the NSA presents an opportunity for collaboration between stakeholders in complying with its requirements. In focusing on this, Ms. de Leon highlighted Washington’s balance billing law. She discussed how Washington is enforcing its
Draft Pending Adoption

law with a goal of giving providers and facilities a chance to correct or cure any violations. She also discussed how the Washington Department of Insurance (DOI) has established a partnership with state agencies with provider oversight to share information regarding any violations of the Washington law. The Washington DOI has signed a memorandum of understanding (MOU) regarding data sharing to assist in this partnership effort. Ms. de Leon noted that, to date, the Washington DOI has not received any complaints involving provider violations.

5. Received an Update on the Special (EX) Committee on Race and Insurance Workstream Five’s Work

Commissioner Altman, co-chair of the Special (EX) Committee on Race and Insurance Workstream Five, provided an update to the Committee on Workstream Five’s work to date. She said since the Workstream last updated the Committee at the Spring National Meeting, the Workstream met July 8 and June 10. She said during its June 10 meeting, the Workstream heard responses from a panel of industry representatives and a panel of consumer representatives on several key questions related to data collection. Those questions asked about the benefits of insurer collection of disaggregated demographic data, the risks of collecting such data and regulatory barriers to the collection of such data. She said the Workstream also asked the panelists to discuss what role state insurance regulators should have in collecting this type of data and whether there is a specific deliverable the NAIC should work towards in addressing this issue.

Commissioner Altman said Workstream Five’s July 8 meeting focused on issues related to provider networks, provider directories, and cultural competency. The Workstream asked panelists representing consumers, industry, and providers to respond to several key questions related to these issues, including: 1) whether there are ways state insurance regulators can incentivize more diverse, inclusive, and culturally competent provider networks; and 2) how provider directories can be used as a tool to connect patients to culturally competent providers. The Workstream also asked if there are specific deliverables the NAIC should work towards to address these issues.

Commissioner Altman said following these meetings, the Workstream prepared and distributed a draft data collection best practices document reflecting the discussion during the June 10 meeting for a public comment period ending Aug. 19. She said the Workstream plans to discuss any comments on the draft document during its Aug. 26 meeting.

Commissioner Altman said in looking ahead, the Workstream plans to continue meeting at least once a month to work on best practices documents and collect additional information on issues it identified in its report to the Special (EX) Committee on Race and Insurance. She said the Workstream anticipates finishing work on the data collection best practices document before the Fall National Meeting; and sometime in the Fall, the Workstream plans to begin work on a similar best practices document on provider network, provider directory, and cultural competency issues. She said during its November meeting, the Workstream plans to focus on health equity and COVID-19.

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 Jon Godfread (ND)
Virtual Meetings

CONSUMER INFORMATION (B) SUBGROUP

Meeting Summary Report

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Dec. 2, Oct. 20, Oct. 14, and Aug. 24, 2021. During these meetings, the Subgroup:

1. Discussed and adopted revisions to the Frequently Asked Questions (FAQs) about Health Care Reform.
2. Discussed and adopted consumer-facing claims process guides--appeals process, medical necessity, explanation of benefits (EOBs), claims filing and billing codes and claims.
3. Discussed and adopted a consumer-facing issue brief on balance billing.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Oct. 20, 2021. The following Subgroup members participated: Mary Kwei, Chair (MD); Debra Judy, Vice Chair (CO); Anthony L. Williams (AL); Michelle Baldock (IL); LeAnn Crow (KS); Judith Watters (ME); Carrie Couch (MO); Laura Arp (NE); Cuc Nguyen (OK); Jill Kruger (SD); Vickie Trice (TN); and Jennifer Steagall (WI).

1. **Adopted Updates to “Frequently Asked Questions About Health Care Reform”**

The Subgroup conducted an e-vote to consider adoption of a revised and updated version of “Frequently Asked Questions about Health Care Reform” (Attachment 1). The motion passed unanimously.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met October 14, 2021. The following Subgroup members participated: Mary Kwei, Chair, and Paul Meyer (MD); Debra Judy, Vice Chair (CO); William Rodgers (AL); Kristen Finau, Kathy McGill, Randy Pipal, Weston Trexler, and Fernanda Vallejo (ID); Michelle Baldock (IL); Alex Peck (IN); LeAnn Crow, Chris Hollenbeck, Tate Flott, and Brenda Johnson (KS); Judith Watters (ME); Candace Gergen, Gregory Maus, and Sherri Mortensen-Brown (MN); Carrie Couch, Amy Hoyt, and Jo LeDuc, (MO); Cuc Nguyen, Mike Rhoads, and Rebecca Ross (OK); Gretchen Brodkorb and Jill Kruger (SD); Brian Hoffmeister, Bill Huddleston, Scott McAnally, Jennifer Ramcharan, and Vickie Trice (TN); and Eric Corman, Darcy Paskey, Jennifer Stegall, and Julie Walsh (WI). Also participating was: Patrick Smock (RI).

1. **Discussed “Frequently Asked Questions About Health Care Reform”**

Ms. Kwei said the NAIC’s Communications Department created branded versions of the claims guides the Subgroup previously approved, and they are available on the NAIC website. She thanked the Subgroup members who contributed edits to “Frequently Asked Questions About Health Care Reform,” as well as Brenda J. Cude (University of Georgia) for reviewing the document. She said Ms. Cude had two outstanding questions about the document. The Subgroup discussed whether the use of the term “excepted benefits” was clear, and it decided it is an appropriate term because the document is intended for state insurance regulators. The second question was regarding the term “applicable large employer.” The Subgroup discussed whether all large employers are applicable large employers and how often department of insurance (DOI) staff are called to respond to questions about them. It considered adding a link to Internal Revenue Service (IRS) information or adding an additional question to the document that defines “applicable large employer.”

Ms. Kwei asked whether Subgroup members or interested parties had other comments or edits on “Frequently Asked Questions About Health Care Reform,” and no one offered any. The Subgroup decided to conduct a vote to approve “Frequently Asked Questions About Health Care Reform” by email.

2. **Discussed a Consumer Brief on Balance Billing**

Ms. Kwei brought up balance billing and the federal No Surprises Act (NSA). She said previous Subgroup discussions have concluded that there is not yet enough information available to develop a useful document for consumers. She said the Health Insurance and Managed Care (B) Committee discussed overall education on the NSA, including materials targeted at consumers, insurers, and providers.

Ms. Kwei asked if any states have been working on consumer information on either state or federal balance billing protections and whether the Subgroup could offer any helpful assistance. No members or interested parties made suggestions.

Ms. Kwei said the Committee is working on a template that state DOIs could use to educate providers on the coming effective date of the NSA. She suggested that the Subgroup could develop a similar template that states could use for consumers. Ms. Cude said consumers are expected to have many questions about the NSA protections, so materials would be helpful.

Ms. Kwei suggested that the Subgroup develop a very simple document on balance billing, including scenarios of what could happen and what consumers can do to respond to certain situations. Ms. Cude said documents should help consumers apply knowledge, not just provide definitions. Subgroup members agreed that a scenario-based approach would be helpful. Kris Hathaway (American Association of Health Insurance Plans—AHIP) said AHIP has developed a one-pager on balance billing protections, and she said she would share it.

The Subgroup decided that it should develop draft materials by late November, circulate them, and aim to finalize materials by mid-December. The materials would be for consumer use, not targeted to insurance department staff.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Aug. 24, 2021. The following Subgroup members participated: Mary Kwei, Chair, and Paul Meyer (MD); Debra Judy, Vice Chair (CO); Yada Horace, William Rodgers, and Anthony L. Williams (AL); Kathy McGill, Randy Pipal, and Weston Trexler (ID); Ryan Gillespie (IL); Jenifer Groth (IN); LeAnn Crow, Tate Flott, and Tom Treacy (KS); Judith Watters (ME); Carrie Couch, Amy Hoyt, Jo LeDuc, Jessica Schrimpf, and Michelle Vickers (MO); Tracy Biehn and Kathy Shortt (NC); Martin Swanson (NE); Landon Hubbart and Rebecca Ross (OK); David Buono and Elizabeth Hart (PA); Candy Holbrook and Jill Kruger (SD); Bill Huddleston and Scott McAnally (TN); Heidi Clausen and Jaakob Sundberg (UT); and Diane Dambach, Christina Keely, Darcy Paskey, and Jennifer Stegall (WI). Also participating was: Jana Jarret (OH).

1. **Adopted Consumer Guides on the Claims Process**

Ms. Kwei said the consumer guides are intended to stand on their own, but they also cover the entire claims process from filing a claim to external appeals. She said edits had been incorporated from Brenda J. Cude (University of Georgia) and Subgroup members.

Ms. Watters made a motion, seconded by Ms. Kruger, to adopt the consumer guides. The motion passed unanimously.

Ms. Kwei said that the guides would be emailed and posted to the Subgroup’s website and that states are free to add their own content.

2. **Heard a Presentation on Consumer Group Perspectives on Barriers to Insurance**

Ms. Kwei said consumer representatives had requested time to share the results of a survey.

Ms. Cude said the survey was conducted due to the NAIC’s attention to diversity and to inform the work of state insurance regulators. She said it was funded by the Robert Wood Johnson Foundation (RWJF), and its purpose was to gather information on challenges to access and identify any systemic discrimination. She said it was an online survey of state, local, and regional grassroots, nonprofit, and community organizations with information across different lines of insurance, including health.

Harry Ting (Health Care Consumer Advocate) explained survey results that show the most pressing health insurance issues for constituents of the surveyed organizations, including unaffordability and difficulty of understanding coverage and costs. He also shared results on where consumers get information about insurance, which included family and friends, as well as community organizations at the top, followed by internet searches, agents and brokers, and TV and radio. He said consumer groups reported little interaction with state insurance departments. He said it would be more impactful for state insurance departments to distribute information through community organizations in addition to the departments’ websites and social media. He said the Subgroup should consider adding to its 2022 charges completion of a survey on best practices by state insurance departments in communicating with consumers. Ms. Cude added that information could also be distributed via programs like income tax assistance. She said insurance department public information officers (PIOs) and other stakeholders may not be aware of materials on the Subgroup’s website.

Ms. Judy asked about what difficulties consumers have in understanding coverage. Ms. Cude said further conversations with community organizations would be helpful since they perceive that information is not understandable. Mr. Ting said few organizations felt their constituents check insurance department websites and that presentations to the groups would be beneficial. Ms. Kwei said Maryland had made or planned presentations to groups representing communities like LGBTQ individuals or rural residents.

Bonnie Burns (California Health Advocates) said consumer understanding of insurance terms is low. Mr. Ting said community organizations can be helpful in walking through concepts and definitions, and Ms. Cude said prepared content can help in
Ms. Burns and Mr. Ting discussed the value of using employers, State Health Insurance Assistance Program (SHIP) counselors, and unemployment assistance staff in reaching consumers who need health insurance information.

Mr. Ting asked for reactions to the suggestion of new charges for a survey of best practices in consumer information. Ms. Watters suggested looking at entities external to state insurance departments as well. Ms. Cude said part of surveying state insurance departments could be asking about other agencies in their states or outside groups that do consumer communication well.

Ms. Ross said the Oklahoma Insurance Department has a section on its website with health options for the unemployed, including videos and updated information.

3. Discussed Future Work Products for the Subgroup

Ms. Kwei said the Subgroup has been waiting for further federal guidance on the federal No Surprises Act (NSA) before producing a guide on balance billing and asked for input on whether to move forward or continue to wait. Ms. Kruger said she is concerned that too little information is available. Ms. Judy said any document would have to be high-level because of differing state laws. Ms. Cude said a basic document with definitions and examples would be helpful. Ms. Judy said states with balance billing laws may already have that information available, so the Subgroup should build on what exists.

Ms. Kwei said the Subgroup traditionally updates its Frequently Asked Questions About Health Care Reform document by the beginning of Open Enrollment, coming on Nov. 1. She asked how the Subgroup should proceed this year, given the frequently asked questions (FAQ) addendum produced earlier in the year. Ms. Watters said the Beyond the Basics website has some updated information. The Subgroup discussed the extent of updates that are needed. Ms. Judy said the FAQ updates should take precedence over a guide on balance billing. Ms. Kwei suggested that Subgroup members could take sections of the FAQ, review them, and make suggested updates.

Ms. Cude said some links on the Subgroup website do not work and asked whether content on the NAIC’s consumer website is compatible with the Subgroup’s work.

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

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Virtual Meeting
(in lieu of meeting at the 2021 Fall National Meeting)

HEALTH ACTUARIAL (B) TASK FORCE
Monday, November 29, 2021

Meeting Summary Report

The Health Actuarial (B) Task Force met Nov. 29, 2021. During this meeting, the Task Force:

1. Adopted its Sept. 14 minutes, which included the following action:
   A. Adopted its April 23 and April 6 minutes, and the May 17 and March 29 minutes of the Long-Term Care Actuarial (B) Working Group, which included the following action:
      i. Exposed a proposal to revise the instructions for the health Statement of Actuarial Opinion (SAO) for a public comment period ending May 7.
      ii. Discussed a long-term care insurance (LTCI) data call.
      iii. Heard a presentation from the Society of Actuaries (SOA) on COVID-19 impacts on LTCI.
   B. Adopted a motion to disband the Health Care Reform Actuarial (B) Working Group and the State Rate Review (B) Subgroup.
   C. Adopted its 2022 proposed charges.
   D. Discussed its proposal to revise instructions for the Health Annual Statement SAO.

2. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on a system connection between the System for Electronic Rates & Forms Filing (SERFF) and the Health Insurance Oversight System Unified Rate Review (HIOS URR) module

3. Heard an update on SOA health care trend research.


5. Heard an update from the Academy and the SOA Research Institute on an LTCI mortality and lapse study.

6. Discussed the impact of legislation adding dental, hearing, and vision benefits to Medicare Part B on Medicare supplement plans.


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REGULATORY FRAMEWORK (B) TASK FORCE
Tuesday, November 30, 2021

Meeting Summary Report

The Regulatory Framework (B) Task Force met Nov. 30, 2021. During this meeting, the Task Force:

1. Adopted its Nov. 9 and Summer National Meeting minutes, which included the following action:
   A. Adopted its 2022 proposed charges.

2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Nov. 1, Oct. 4, Sept. 20, Aug. 23, Aug. 9, and July 26 minutes. During these meetings, the Subgroup took the following action:
   A. Continued discussion of revisions to Sections 1–7 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) based on the comments received by the July 2 public comment deadline.
   B. Heard presentations on the products covered under Model #171. The presentations specifically discussed: a) the different types of products covered under Model #171; b) how they pay benefits; c) what they are designed to do; d) how they are marketed; and e) how they are sold. The Subgroup also heard a consumer perspective on these products.

3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group, including its Oct. 8 and July 30 minutes. During these meetings, the Working Group took the following action:
   A. Discussed potential updates to the Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation (ERISA Handbook) related to the U.S. Supreme Court’s decision in Rutledge vs. the Pharmaceutical Care Management Association (PCMA) with respect to any ERISA preemption. The Working Group also discussed the Rutledge decision in relation to the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s new 2021 charge to develop a white paper discussing state laws regulating pharmacy benefit manager (PBM) business practices. Following these discussions, the Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
   B. Reviewed and discussed an initial draft summary of the Rutledge v. Pharmaceutical Care Management Association decision. The Working Group agreed that the initial draft summary needed to be revised. The Working Group plans to review and discuss a revised draft summary in early 2022.

4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Aug. 5 minutes. During this meeting, the Working Group took the following action:
   A. Heard presentations discussing the provider perspective on mental health parity.

5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which has not held an open meeting since October 2020 because it completed its initial work to develop a new NAIC model regulating PBMs. The proposed new NAIC model did not receive sufficient votes for adoption during the Executive (EX) Committee and Plenary meeting at the Summer National Meeting. The
Subgroup met Nov. 8 and Sept. 5, 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. Heard a presentation on the federal No Surprises Act’s (NSA’s) interim final rules and implications for the states. The presentation provided an overview of the NSA and detailed the provisions included in the interim final rules and proposed rules issued to date implementing the NSA. The interim final rules issued July 1 include provisions focused on both patients and regulated entities. The interim final rules confirm that state departments of insurance (DOIs) are the primary enforcers of provisions that apply to insurers and fully insured health products. The U.S. Department of Health and Human Services (HHS) will enforce the NSA’s requirements in states that fail to substantially enforce the law. The DOL will enforce the NSA’s provisions for self-funded group health plans. The same enforcement framework is established with respect to providers, including air ambulances. The federal agencies charged with implementing the NSA issued proposed rules Sept. 10 concerning air ambulance providers. The federal agencies implementing the NSA issued another set of interim final rules Sept. 30 focusing on the independent dispute resolution (IDR) process. Other provisions of this rule include provisions on good-faith cost estimates for uninsured patients and a patient-provider dispute resolution process when cost estimates are wrong. The presentation also discussed the federal method for determining the out-of-network provider payment amount and the various state out-of-network provider payment determination methods. The presentation highlighted various NSA reporting provisions intended to try to determine the NSA’s effect on various health care-related factors, such as its effect on health care costs, provider networks, and provider consolidation. The presenters noted that for the states having balance billing protection laws prior to the enactment of the NSA, analyses trying to determine those laws’ effect on similar health care-related factors is limited. Depending on the state approach taken to determine payment amount, some studies of these state laws indicate little impact, while others indicate mixed impacts.

7. Discussed the expanded scope of external review under the NSA, the implications of this expanded scope on the Uniform Health Carrier External Review Model Act (#76), and possible steps the Task Force can take to address the issue. The Task Force decided to set up an ad hoc group to work with NAIC staff to discuss the possible steps to address the issue and make recommendations to the Task Force sometime in late January or early February 2022.
Virtual Meeting
(in lieu of meeting at the 2021 Fall National Meeting)

SENIOR ISSUES (B) TASK FORCE
Tuesday, November 30, 2021

Meeting Summary Report

The Senior Issues (B) Task Force met November 30, 2021. During this meeting, the Task Force:

1. Adopted its Oct. 6 minutes, which included the following action:
   A. Adopted its 2022 proposed charges.
   B. Heard a presentation on the WA Cares Fund.

2. Adopted the report of the Long-Term Care Insurance Model Update (B) Subgroup, which included its Nov. 3 and Oct. 13 minutes. During these meetings, the Subgroup took the following action:
   A. Reviewed Sections 7–12 of the Long-Term Care Insurance Model Regulation (#641) to determine their flexibility to remain compatible with the evolving delivery of long-term care (LTC) services and the evolving long-term care insurance (LTCI) marketplace.
   B. Reviewed Sections 1–6 of Model #641 to determine their flexibility to remain compatible with the evolving delivery of LTC services and the evolving LTCI marketplace.

3. Heard a discussion about Medigap and durable medical equipment (DME), which focused on excessive charges.

4. Heard a federal legislative update regarding funding for the State Health Insurance Assistance Program (SHIP) and the hearing benefit to be added to Medicare Part B.

SITF Summary
Agenda Item #3

Consider Adoption of its 2022 Proposed Charges—Commissioner Jon Godfread (ND)
HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

The mission of the Health Insurance and Managed Care (B) Committee is to consider issues relating to all aspects of health insurance.

Ongoing Support of NAIC Programs, Products or Services

1. The Health Insurance and Managed Care (B) Committee will:
   A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC’s position through letters and testimony, when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   C. Monitor the activities of the Regulatory Framework (B) Task Force.
   D. Monitor the activities of the Senior Issues (B) Task Force.
   E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
   F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
   G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.

2. The Consumer Information (B) Subgroup will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.

3. The Health Innovations (B) Working Group will:
   A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
   B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision-making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.
   C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
   D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to utilize the information gathered by the Working Group.
   E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook
Agenda Item #4

Consider Adoption of its Task Forces’ 2022 Proposed Charges
—Commissioner Jon Godfread (ND)
The mission of the Health Actuarial (B) Task Force is to identify, investigate, and develop solutions to actuarial problems in the health insurance industry.

Ongoing Support of NAIC Programs, Products or Services

1. The **Health Actuarial (B) Task Force** will:
   A. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
   B. Provide support for issues related to implementation of, and/or changes to, the federal Affordable Care Act (ACA).
   C. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
   D. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
   E. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary to other NAIC groups relative to their work on health actuarial matters.

2. The **Long-Term Care Actuarial (B) Working Group** will:
   A. Assist the Health Actuarial (B) Task Force in completing the following charges:
      1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.
      2. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
      3. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.

3. The **Long-Term Care Pricing (B) Subgroup** will:
   A. Assist the Long-Term Care Actuarial (B) Working Group in completing the following charge:
      1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.

4. The **Long-Term Care Valuation (B) Subgroup** will:
   A. Assist the Long-Term Care Actuarial (B) Working Group in completing the following charges:
      1. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
      2. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.

NAIC Support Staff: Eric King

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2022 PROPOSED CHARGES

REGULATORY FRAMEWORK (B) TASK FORCE

The mission of the Regulatory Framework (B) Task Force is to: 1) develop NAIC model acts and regulations for state health care initiatives; and 2) consider policy issues affecting state health insurance regulation.

Ongoing Support of NAIC Programs, Products and Services

1. The Regulatory Framework (B) Task Force will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2022.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to association health plans (AHPs).
   F. Monitor, analyze, and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

2. The Accident and Sickness Insurance Minimum Standards (B) Subgroup will:
   A. Review and consider revisions to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171).

3. The ERISA (B) Working Group will:
   A. Monitor, report, and analyze developments related to the federal ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
   C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.

4. The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group will:
   A. Monitor, report, and analyze developments related to the federal Paul Wellstone and Pete Domenici MHPAEA of 2008, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate best practices with the states, the DOL, and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
   C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to the MHPAEA.
   D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook.
   E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.
5. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will:
   A. Develop a white paper to: 1) analyze and assess the role PBMs, pharmacy services administrative organizations (PSAOs), and other supply chain entities play in the provision of prescription drug benefits; 2) identify, examine, and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating, and spread pricing, including the implications of the Rutledge v. Pharmaceutical Care Management Association (PCMA) decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.
   B. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). Based on issues identified in the white paper, the Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.

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

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2022 Proposed Charges

SENIOR ISSUES (B) TASK FORCE

The mission of the Senior Issues (B) Task Force is to: 1) consider policy issues; 2) develop appropriate regulatory standards; and 3) revise, as necessary, the NAIC models, consumer guides, and training material on Medicare supplement insurance, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

Ongoing Support of NAIC Programs, Products or Services

1. The Senior Issues (B) Task Force will:
   A. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. Work with federal agencies to advance appropriate regulatory standards for Medicare supplement and other forms of health insurance applicable to older Americans. Review the *Medicare Supplement Insurance Minimum Standards Model Act (#650)* and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)* to determine if amendments are required based on changes to federal law. Work with the federal Centers for Medicare & Medicaid Services (CMS) to revise the annual joint publication, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
   B. Monitor the Medicare Advantage and Medicare Part D marketplace. Assist the states, as necessary, with regulatory issues. Maintain a dialogue and coordinate with the CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Assist the states and serve as a clearinghouse for information on Medicare Advantage plan activity.
   C. Provide the perspective of state insurance regulators to the U.S. Congress (Congress), as appropriate, and the CMS on insurance issues, including those concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme. Review and monitor state and federal relations with respect to senior health care initiatives and other impacts on the states.
   D. Monitor developments concerning State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Assist the states with issues relating to SHIPs and support a strong partnership between SHIPs and the CMS. Provide the perspective of state insurance regulators to federal officials, as appropriate, on issues concerning SHIPs.
   E. Monitor, maintain, and review, in accordance with changes to Model #651, a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by state insurance regulators and others. Review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in Model #651.
   F. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on LTCI, including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Review the existing *Long-Term Care Insurance Model Act (#640)*, the *Long-Term Care Insurance Model Regulation (#641)*, the Limited *Long-Term Care Insurance Model Act (#642)*, and the Limited *Long-Term Care Insurance Model Regulation (#643)* to determine their flexibility to remain compatible with the evolving delivery of long-term care (LTC) services and the evolving LTCI marketplace. Work with federal agencies, as appropriate.
   G. Examine examples of health-related financial exploitation of seniors and work with other NAIC committees, task forces, and working groups on possible solutions.
   H. Examine the effects of structural racism and the COVID-19 pandemic on access, affordability, and outcomes for older insurance consumers.
2. The **Long-Term Care Insurance (LTCI) Model Update (B) Subgroup** will:
   
   A. Review and update Model #640 and Model #641 to determine their flexibility to remain compatible with the evolving delivery of LTC services and the evolving LTCI marketplace.
   
   B. Update Model #642 and Model #643 to correlate with Model #640 and Model #641.
   
   C. Consider recommendations referred from the Long-Term Care Insurance (EX) Task Force and/or its subgroups.

NAIC Support Staff: David Torian

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Agenda Item #5

Hear an Update from the Federal Centers for Medicare & Medicaid Services’ (CMS) Center for Consumer Information and Insurance Oversight (CCIIO)—Jeff Wu (CCIIO)
Agenda Item #6

Discuss Committee Federal No Surprises Act (NSA) Consumer, Provider, and Insurer Outreach Materials—Commissioner Jon Godfread (ND)
New Protections from Surprise Medical Bills

You may have heard stories from friends or in the news about balance bills or surprise bills from health care providers. Starting in 2022, a new law will protect you from many types of surprise bills. Here are the basics about the new protections and some examples of how they can protect consumers.

What is balance billing?
Balance billing happens when a health care provider (a doctor, for example) bills a patient after the patient’s health insurance company has paid its share of the bill. The balance bill is for the difference between the provider’s charge and the price the insurance company set, after the patient has paid any copays, coinsurance, or deductibles.

Balance billing can happen when a patient receives covered health care services from an out-of-network provider or an out-of-network facility (a hospital, for example).

In-network providers agree with an insurance company to accept the insurance payment in full, and don’t balance bill. Out-of-network providers don’t have this same agreement with insurers. Some health plans, such as Preferred Provider Organization (PPO) or Point of Service (POS) plans, include some coverage for out-of-network care, but the provider may still balance bill the patient if state or federal protections don’t apply. Other plans don’t include coverage for out-of-network services and the patient is responsible for all of the costs of out-of-network care. Medicare and Medicaid have their own protections against balance billing.

What is surprise billing?
Surprise billing happens when a patient receives an unexpected balance bill after they receive care from an out-of-network provider or at an out-of-network facility, such as a hospital. It can happen for both emergency and non-emergency care. Typically, patients don’t know the provider or facility is out-of-network until they receive the bill.

Some states have laws or regulations that protect patients against surprise billing. However, state laws generally don’t apply to self-insured health plans, and most people who get coverage through an employer are in self-insured health plans. Now, a new federal law protects consumers in self-insured health plans as well as consumers in states that don’t have their own protections.

What protections are in place?
A new federal law, the No Surprises Act, protects you from:

- Surprise bills for covered emergency out-of-network services, including air ambulance services (but not ground ambulance services), and
- Surprise bills for covered non-emergency services at an in-network facility.

The law applies to health insurance plans starting in 2022. It applies to the self-insured health plans that employers offer as well as plans from health insurance companies.
• A facility (such as a hospital or freestanding emergency room (ER)) or a provider (such as a doctor) may not bill you more than your in-network coinsurance, copays, or deductibles for emergency services, even if the facility or provider is out-of-network.

• If your health plan requires you to pay copays, coinsurance, and/or deductibles for in-network care, you’re responsible for those.

• The new law also protects you when you receive non-emergency services from out-of-network providers (such as an anesthesiologist) at in-network facilities. An out-of-network provider may not bill you more than your in-network copays, coinsurance, or deductibles for covered services performed at an in-network facility.
  o You can never be asked to waive your protections and agree to pay more for out-of-network care at an in-network facility for care related to emergency medicine, anesthesia, pathology, radiology, or neonatology—or for services provided by assistant surgeons, hospitalists (doctors who focus on care of hospitalized patients), and intensivists (doctors who care for patients needing intensive care), or for diagnostic services including radiology and lab services.
  o You still can agree in advance to be treated by an out-of-network provider in some situations, such as when you choose an out-of-network surgeon knowing the cost will be higher. The provider must give you information in advance about what your share of the costs will be. If you did that, you’d be expected to pay the balance bill as well as your out-of-network coinsurance, deductibles, and copays.

What else should I know?

• Your health plan and the facilities and providers that serve you must send you a notice of your rights under the new law.

• If you’ve received a surprise bill that you think isn’t allowed under the new law, you can file an appeal with your insurance company or ask for an external review of the company’s decision. You also can file a complaint with the [State Insurance Commissioner] or the federal Department of Health and Human Services.

• An independent dispute resolution (IDR) process, or another process your state sets up, is available to settle bills. Providers and insurance companies can use this process to settle disputes about your bill without putting you in the middle. A similar dispute resolution process is available for individuals who are uninsured, in certain circumstances, such as when the actual charges are much higher than the estimated charges.

• Other protections in the new law require insurance companies to keep their provider directories updated. They also must limit your copays, coinsurance, or deductibles to in-network amounts if you rely on inaccurate information in a provider directory.

• You can get more information and make complaints to federal agencies by calling 1-800-985-3059.

See the next page for examples of how the No Surprises Act protections apply.
Examples of Surprise Bill Protections

Q. Deion fell off a ladder, hitting his head and breaking his arm. He was taken to the nearest emergency room. He needed covered imaging and radiology services as well as surgery. Now bills are starting to come in. What is he responsible for paying? How can he get help if he's receiving bills that don't match the explanation of benefits (EOB) from his health insurance plan?

A. For emergency care he received, Deion is only responsible for paying his in-network deductibles, copays, and coinsurance, even if health care providers who were not in his plan network treated him or he was taken to a facility that was out-of-network. If the bills don’t match his explanation of benefits (EOB), Deion can call his health insurer first. If he isn’t satisfied with the insurer’s response, he can contact [insert state agency].

If Deion is admitted to the hospital after he receives care in the emergency room, he should know that any out-of-network health care providers at the facility may ask him to consent to continuing care and to agree to pay higher amounts. They can only ask for his consent to receive out-of-network care once he is stabilized, able to understand the information about his care and out-of-pocket costs, and it is safe to travel to an in-network facility using non-emergency transportation. If those conditions are met, Deion can decide if he wants to continue with the out-of-network provider, or travel to a provider who participates in his health plan’s network. If he stays with the out-of-network provider and consents to out-of-network billing, he’ll be responsible for any out-of-network deductibles, copays, or coinsurance. He’ll also be responsible for the amount the provider charges that is more than what the insurance company pays (the balance bill).

Q. Bill had chest pains and went to his local hospital's emergency room. The doctors there said he had to be transported to a hospital in a major city for full treatment and he had to go by air ambulance to make it in time. Bill was flown to the larger hospital and is now doing well. Bill's wife, Nancy, has heard scary stories about air ambulance costs and is starting to worry. Are there any protections for someone who is transported by air ambulance in an emergency?

A. If the air ambulance company has an in-network contract with Bill’s health insurance plan, then Bill will only have to pay the in-network deductibles, coinsurance, or copays. The air ambulance company will accept their contracted amount as payment in full.

Starting in 2022, the new federal No Surprises Act protects patients even if the air ambulance company doesn’t have an in-network contract with their health insurance plan. Bill will only have to pay the deductibles, copays, or coinsurance that he would have to pay if the air ambulance were in-network. Federal law will help the air ambulance and the health insurance companies determine how to pay the rest of the bill.
Q. Elena is scheduled for a biopsy, a service that her health plan covers. Her hospital and surgeon are in-network with her health plan, but the hospital uses anesthesiologists and pathologists that are not in-network. Does this mean everything will be covered as in-network, or could Elena have some unexpected charges?

A. Surgery for a biopsy can involve health care providers that you don’t get to choose, such as an anesthesiologist and a pathologist. Starting in 2022, when Elena chooses an in-network facility and surgeon for her procedure, all of her out-of-pocket costs will be at the in-network rate. That includes the costs for any out-of-network providers she didn’t choose who participate in her care.

Q. Hannah changes jobs and her family is covered under a new employer health plan. Hannah and her husband’s doctors are in-network with the new company, but their child’s pediatrician is not. How can they find an in-network pediatrician? Can they rely on the online provider directory for accurate information?

A. Hannah can review her new health plan’s online provider directory or call the insurance company to get information. An insurance company may have different networks for different health plans. It’s important to look at the directory for your specific health plan.

Most people rely on their health plan to give them accurate information about in-network health care providers. [States may insert protections in their laws.]

Starting in 2022, federal law requires health care providers to update their information with insurance companies when there is a change. In turn, insurance companies must verify that the information in their provider directories is complete.

If Hannah calls the insurance company to ask for a list of in-network pediatricians, the insurance company has one business day to give her a list. If Hannah relies on inaccurate information from the insurance company that a provider is in-network, then Hannah will be responsible only for the in-network deductibles, copays, or coinsurance.
[ADVISORY] [BULLETIN] TO
HEALTH CARE PROVIDERS AND FACILITIES
ON REQUIREMENTS UNDER THE FEDERAL NO SURPRISES ACT

To: Health Care Providers and Facilities

From: [State] Insurance Commissioner

Date: [December 2021]

Subject: Federal No Surprises Act (NSA) Health Care Provider, Health Care Facility and Provider of Air Ambulance Services Requirements

The purpose of this [Advisory] [Bulletin] is to provide information on requirements in the federal No Surprises Act (NSA) that apply to health care providers and facilities and providers of air ambulance services for plans starting in 2022.

[State Insurance Commissioner] provides this information to educate stakeholders about new protections applicable to health insurance enrollees in [State]. Depending on circumstances, enforcement of these federal law provisions and similar state laws may come from one of several federal and state regulatory entities, including but not limited to the [State Insurance Department]. Under this framework, [State Insurance Department] intends to continue its responsibilities and commitment to protect consumers, including receiving complaints from consumers on issues related to the NSA. These complaints may concern health care providers and facilities and may be referred, as appropriate, to other state or federal agencies for investigation and enforcement.

Background

As part of the Consolidated Appropriations Act of 2021, on Dec. 27, 2020, the U.S. Congress enacted legislation, the federal No Surprises Act (NSA), which contains many provisions to help protect consumers from surprise bills for plans starting in 2022. The provisions in the NSA create requirements that apply to health care providers and facilities and providers of air ambulance services, such as cost-sharing rules, prohibitions on balance billing for certain items and services, notice and consent requirements and requirements related to disclosures about balance billing protections.

These health care provider and facility and provider of air ambulance services requirements generally apply to items and services provided to individuals enrolled in group health plans or group or individual health insurance coverage, including Federal Employees Health Benefits (FEHB) plans. The NSA’s requirements related to the good faith estimates and patient-provider dispute resolution process also apply to individuals with no health insurance coverage and individuals choosing not to use their health insurance coverage.
Health Care Provider and Facility and Provider of Air Ambulance Services Requirements that Apply to Plans Starting in 2022

Health care providers and facilities and providers of air ambulance services:

- May not balance bill for out-of-network emergency services (Public Health Service Act (PHS Act) section 2799B-1; 45 C.F.R. section 149.410).
- May not balance bill for non-emergency services by nonparticipating providers at certain participating health care facilities, unless notice and consent was given in some circumstances (PHS Act section 2799B-2; 45 C.F.R. section 149.420).
- Shall disclose patient protections against balance billing (PHS Act section 2799B-3; 45 C.F.R. section 149.430)
- May not balance bill for air ambulance services by nonparticipating air ambulance providers (PHS Act section 2799B-5; 45 C.F.R. section 149.440)
- Shall provide a good faith estimate in advance of scheduled services, or upon request (PHS Act section 2799B-6; 45 C.F.R. section 149.610 (for uninsured or self-pay individuals)
- Shall submit accurate information for provider directories and reimburse enrollees for errors (PHS Act section 2799B-9)

**Summary of Major NSA Health Care Provider and Facility and Provider of Air Ambulance Services Requirements**

1) No balance billing for out-of-network emergency services

*Nonparticipating providers and nonparticipating emergency facilities:*

- Cannot bill or hold liable enrollees in group health plans or group or individual health insurance coverage who received emergency services at an emergency department of a hospital or an independent freestanding emergency department for a payment amount greater than the in-network cost-sharing requirement for such services.

- Post-stabilization services are considered emergency services, and are therefore subject to this prohibition, unless notice and consent requirements are met.

2) Exceptions to no balance billing for out-of-network emergency services—notice and consent

*Nonparticipating providers and facilities may balance bill for post-stabilization services only if the following conditions have been met:*

- The attending emergency physician or treating provider determines the enrollee: 1) can travel using nonmedical transportation to an available participating provider or participating health care facility located within a reasonable travel distance, taking into account the individual's medical condition; and 2) is in a condition to receive notice and provide informed consent;
• The nonparticipating provider or non-participating facility provides the beneficiary, enrollee or participant with a written notice and obtains consent as outlined in the NSA’s regulation and guidance; and

• The provider or facility satisfies any additional state law requirements.

Even if all of the conditions above are met:

• With respect to both emergency and non-emergency services, a provider or facility cannot balance bill for items or services furnished because of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider or facility previously satisfied the notice and consent criteria.

3) No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities

Nonparticipating providers of non-emergency services at a participating health care facility:

• Cannot bill or hold liable enrollees in group health plans or group or individual health insurance coverage, including FEHB plans, who received covered non-emergency services with respect to a visit at a participating health care facility from a nonparticipating provider for a payment amount greater than the in-network cost-sharing requirement for such services, unless notice and consent requirements are met.

• **Note:** The exception for notice and consent requirements does not apply to the following list of ancillary services, for which the prohibition against balance billing remains applicable:
  a. Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology;
  b. Items and services provided by assistant surgeons, hospitalists, and intensivists;
  c. Diagnostic services, including radiology and laboratory services; and
  d. Items and services provided by a nonparticipating provider if there is no participating provider who can provide such item or service at such facility.

4) Disclose patient protections against balance billing

• A provider or facility must disclose to an enrollee information regarding federal and, if applicable, state balance billing protections and how to report violations.

• Providers or facilities must post this information prominently at the location of the facility, post it on a public website, if applicable, and provide it to the enrollee in a timeframe and manner consistent with state and federal regulations.

5) No balance billing for air ambulance services by nonparticipating air ambulance providers
• Providers of air ambulance services cannot bill or hold liable enrollees who received covered air ambulance services from a nonparticipating air ambulance provider for a payment amount greater than the in-network cost-sharing requirement for such services.

6) **Provide a good faith estimate of the expected charges in advance of scheduled services, or upon request, to uninsured or self-pay individuals.**

• Upon an individual’s scheduling of items or services, or upon request, a provider or facility must ask if the individual is enrolled in a health benefit plan or health insurance coverage.

• For individuals without health insurance coverage or individuals who do not plan to file a claim for the item or service, starting Jan. 1, 2022, the provider or facility must give the individual a good faith estimate of the expected charges for furnishing the scheduled item or service and any items or services reasonably expected to be provided in conjunction with those items and services, including those provided by another provider or facility. In addition, the good faith estimate provided directly to these individuals must include information related to the patient-provider dispute resolution process that is used to determine the appropriate payment amount when the difference between the good faith estimate provided and a bill the individual receives following the provision of the item or service satisfies the dollar threshold [established in federal regulation or for those states that have a balance billing law, the dollar threshold amount and payment methodology found in that state law or regulation] to be eligible to use the process.

• For individuals with health insurance coverage and who plan to submit a claim for the item or service to the plan or issuer, once federal regulations are finalized, the provider or facility must provide to the individual’s plan or issuer a good faith estimate of the expected charges for furnishing the scheduled item or service and any items or services reasonably expected to be provided in conjunction with those items and services, including those provided by another provider or facility, with the expected billing and diagnostic codes for these items and services.

7) **Submit accurate information for provider directories and reimburse enrollees for errors**

Any health care provider or health care facility that has or has had a contractual relationship with a health benefit plan or health insurance issuer to provide items or services under such plan or insurance coverage must:

• Submit provider directory information to a plan or issuer, at a minimum: a) at the beginning of the network agreement with a plan or issuer, b) at the time of termination of a network agreement with a plan or issuer; c) when there are material changes to the content of the provider directory information of the provider or facility; d) upon request by the plan or issuer; and e) at any other time determined appropriate by the provider, facility or the U.S. Department of Health and Human Services (HHS).
- Reimburse beneficiaries, enrollees or participants who relied on an incorrect provider directory and paid a provider bill in excess of the in-network cost-sharing amount (i.e., the difference between the patient’s in-network cost-sharing and the amount that the patient paid the provider previously).

8) **Use independent dispute resolution or other available methods to resolve out-of-network bills**

- [In State, some health care items and services are subject to balance billing protections established under state law. When such laws apply, providers and facilities will continue to use State’s process for resolving disputes with payers related to out-of-network payment amounts.]

- For items and services to which state law does not apply, the NSA establishes an independent dispute resolution process that providers, facilities, and air ambulance providers can use in the case of certain out-of-network claims when open negotiations do not result in an agreed-upon payment amount.

- Providers, facilities and air ambulance providers will be required to meet deadlines, attest to no conflicts of interest, choose a certified independent dispute resolution entity, submit a payment offer and provide additional information if needed. More information on the federal independent dispute resolution process is expected to be added to the [Centers for Medicare & Medicaid Services No Surprises Act home page](https://www.cms.gov/nosurprises).

**Guidance and Technical Resources**

- [Centers for Medicare & Medicaid Services No Surprises Act Home Page](https://www.cms.gov/nosurprises)
  - Provider Requirements and Resources Page
- [Overview of NSA Rules and Fact Sheets](https://www.cms.gov/nosurprises)
- Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under No Surprises ([Download Fee Information](#))
- Standard notice & consent forms for nonparticipating providers & emergency facilities regarding consumer consent on balance billing protections ([Download Surprise Billing Protection Form](#))
- Model disclosure notice on patient protections against surprise billing for providers, facilities, health plans and insurers ([Download Patient Rights & Protections Against Surprise Medical Bills](#))
- Paperwork Reduction Act (PRA) model notices and information collection requirements for the Federal Independent Dispute Resolution Process ([Download Model Notices and Information Requirements](#))
- Paperwork Reduction Act (PRA) model notices and information collection requirements for the good-faith estimate and patient-provider payment dispute resolution ([Download Model Notices and Information Requirements](#))
- Requirements for including federal agency contact information and website URL on certain documents ([Download Memo of Requirements for Plans, Providers and Facilities](#))
Agenda Item #7

Hear a Summary of Findings from the Kaiser Family Foundation’s (KFF’s) 2021 Employer Health Benefits Survey (EHBS)—Gary Claxton (KFF) and Matthew Rae (KFF)
Figure 1
Average Annual Premiums for Single and Family Coverage, 2000-2021

<table>
<thead>
<tr>
<th>Year</th>
<th>Single Coverage</th>
<th>Family Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>$2,471</td>
<td>$6,438</td>
</tr>
<tr>
<td>2003</td>
<td>$3,383</td>
<td>$9,068</td>
</tr>
<tr>
<td>2006</td>
<td>$4,242</td>
<td>$11,480</td>
</tr>
<tr>
<td>2009</td>
<td>$4,824</td>
<td>$13,375</td>
</tr>
<tr>
<td>2012</td>
<td>$5,615</td>
<td>$15,745</td>
</tr>
<tr>
<td>2015</td>
<td>$6,251</td>
<td>$17,545</td>
</tr>
<tr>
<td>2018</td>
<td>$6,896</td>
<td>$19,616</td>
</tr>
<tr>
<td>2021</td>
<td>$7,739</td>
<td>$22,221</td>
</tr>
</tbody>
</table>

Figure 2
Average Annual Increases in Premiums for Family Coverage Compared to Other Indicators, 2000-2021

Overall Inflation  Workers' Earnings  Family Premiums

* Family Premiums Estimate is statistically different from estimate for the previous year shown (p < .05).

Figure 3
Average General Annual Deductibles for Single Coverage, 2006-2021

* Estimate is statistically different from estimate for the previous year shown (p < .05).

NOTE: Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

Figure 4
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2021

NOTE: Information was not obtained for POS plans in 1988 or for HDHP/SO plans until 2006. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey and the 2021 KFF Survey for a discussion of weighting changes.

Figure 5
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 1999-2021

- 3-199 Workers
- 200-999 Workers
- 1,000 or More Workers
- ALL FIRMS

* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. Overall, 64% of covered workers are in a self-funded plan in 2021. Due to a change in the survey questionnaire, funding status was not asked of firms with conventional plans in 2006; therefore, conventional plan funding status is not included in the averages in this figure for 2006. See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.

Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Insured Plan, by Firm Size, 2021

- **3-49 Workers**
  - Self-Funded or Level-Funded: 42%
  - Fully-Insured: 58%

- **50-199 Workers**
  - Self-Funded or Level-Funded: 48%
  - Fully-Insured: 52%

- **All Small Firms**
  - Self-Funded or Level-Funded: 45%
  - Fully-Insured: 55%

Tests found no statistical difference from estimate for all other firms not in the indicated size category (p < .05).

NOTE: See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.

SOURCE: KFF Employer Health Benefits Survey, 2021
Figure 7
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Funded Plan, 2021

Among Covered Workers, Percentage in a Self-Funded Plan: 21%
Among Covered Workers, Percentage in a Level-Funded Plan: 38%
Among Covered Workers, Percentage in a Self-Funded or Level-Funded Plan: 45%

NOTE: See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 3-199 workers. This figure shows the percentage of covered workers; in 2021, 42% of small firms reported that they had a level-funded plan. This includes respondents who indicated both that their plan was level-funded and fully insured.

SOURCE: KFF Employer Health Benefits Survey, 2021
Figure 8
Among Firms with 50 or More Employees Offering Health Benefits, Changes the Firm Made Since the Beginning of the COVID-19 Pandemic to Meet the Mental Health Needs of Employees, 2021

- Increased coverage for out-of-network MHSA services: 3%
- Waived or reduced cost-sharing for MHSA services: 4%
- Expanded the number of MHSA providers in-network: 6%
- Developed new resources such as an EAP: 16%
- Expanded ways in which enrollees can get MHSA services, such as telemedicine: 31%
- Any of these changes: 39%

NOTE: MHSA refers to Mental Health and/or Substance Abuse. EAP refers to Employee Assistance Programs. We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.

SOURCE: KFF Employer Health Benefits Survey, 2021
Figure 9
Among Firms Offering Health Benefits, How Important Firm Considers Telemedicine in Providing Access to Enrollees in The Coming Years, by Firm Size, 2021

<table>
<thead>
<tr>
<th>Firm Size</th>
<th>Very Important</th>
<th>Important</th>
<th>Slightly Important</th>
<th>Not Important</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Small Firms (50-199 Workers)</td>
<td>45%</td>
<td>31%</td>
<td>18%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>All Large Firms (200 or More Workers)</td>
<td>52%</td>
<td>33%</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>All Firms (50 or More Workers)</td>
<td>47%</td>
<td>31%</td>
<td>17%</td>
<td>17%</td>
<td>17%</td>
</tr>
</tbody>
</table>

NOTE: Telemedicine is health care services provided to a patient from a provider who is at a different location, including video chat and remote monitoring. We do not include email, exclusively web-based non-interactive resources, or online information a plan may make available unless a health professional provides information specific to the enrollee's condition.

SOURCE: KFF Employer Health Benefits Survey, 2021
Among Firms Offering Telemedicine Benefits, Changes the Firm Made to Telemedicine Benefits During the COVID-19 Pandemic, 2021

- Contracted with a new telemedicine service provider: 5%
- Eliminated or reduced cost-sharing for telemedicine services: 18%
- Expanded the number of services covered through telemedicine: 23%
- Expanded the number or types of providers that provide telemedicine services: 23%
- Expanded the settings or locations where enrollees may use telemedicine services: 24%
- Expanded coverage for additional modes of delivering telemedicine: 31%
- Increased promotion or employee communication of telemedicine resources: 51%
- Any of these changes to telemedicine benefits: 65%

NOTE: We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.

SOURCE: KFF Employer Health Benefits Survey, 2021
Thank you.
Agenda Item #8

Receive an Update on the Special (EX) Committee on Race and Insurance Workstream Five’s Work—Commissioner Jessica K. Altman (PA) and Commissioner Ricardo Lara (CA)
Agenda Item #9

Discuss Any Other Matters Brought Before the Committee
—Commissioner Jon Godfread (ND)