



HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Monday, April 12, 2021

4:00 – 5:00 p.m. ET/3:00 – 4:00 p.m. CT/ 2:00 – 3:00 p.m. MT/1:00 – 2:00 p.m. PT

ROLL CALL

Table listing committee members by state: Jon Godfread (Chair, North Dakota), Jessica K. Altman (Vice Chair, Pennsylvania), Lori K. Wing-Heier (Alaska), Michael Conway (Colorado), John F. King (Georgia), Dean L. Cameron (Idaho), Kathleen A. Birrane (Maryland), Anita G. Fox (Michigan), Grace Arnold (Minnesota), Russell Toal (New Mexico), Glen Mulready (Oklahoma), Andrew R. Stolfi (Oregon), Jonathan T. Pike (Utah), Mike Kreidler (Washington), James A. Dodrill (West Virginia).

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

AGENDA

- 1. Hear a Discussion from the Biden Administration on its Federal Legislative and Administrative Initiatives and Priorities—Jeff Wu (Center for Consumer Information & Insurance Oversight—CCIIO)
2. Consider Adoption of its 2020 Fall National Meeting Minutes—Commissioner Jon Godfread (ND)
3. Consider Adoption of its Subgroup, Working Group and Task Force Reports—Commissioner Jon Godfread (ND)
4. Consider Adoption of the Regulatory Framework (B) Task Force Report and the Proposed Pharmacy Benefit Manager (PBM) Model Act—Commissioner Michael Conway (CO)
5. 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)
6. Hear a Discussion on the 2021 Work of the Committee’s Subgroup, Working Group and Task Forces—Commissioner Jon Godfread (ND)
7. Discuss Any Other Matters Brought Before the Committee—Commissioner Jon Godfread (ND)
8. Adjournment

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## **Agenda Item #1**

**Hear a Discussion from the Biden Administration on its Federal Legislative and Administrative Initiatives and Priorities—*Jeff Wu (Center for Consumer Information and Insurance Oversight—CCIO)***

**Agenda Item #2**

**Consider Adoption of its 2020 Fall National Meeting Minutes**  
**—Commissioner Jon Godfread (ND)**

## Draft Pending Adoption

Draft: 12/14/20

### Health Insurance and Managed Care (B) Committee Virtual 2020 Fall National Meeting December 7, 2020

The Health Insurance and Managed Care (B) Committee met Dec. 7, 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); Grace Arnold (MN); Mike Chaney represented by Mark Haire (MS); Jon Godfread (ND); Linda A. Lacewell represented by John Powell (NY); Glen Mulready (OK); Andrew R. Stolfi represented by TK Keen (OR); Carter Lawrence (TN); Tanji J. Northrup (UT); and Mike Kreidler (WA). Also participating were: Jim L. Ridling (AL); Elizabeth Perri (AS); David Altmaier (FL); Dean L. Cameron (ID); Sharon P. Clark (KY); Eric A. Cioppa (ME); Anita G. Fox (MI); Bruce R. Ramge (NE); Tynesia Dorsey (OH); and Elizabeth Kelleher Dwyer and Marie Ganim (RI).

#### 1. Adopted its Nov. 2 and Summer National Meeting Minutes

The Committee met Nov. 2 and Aug. 11. During its Nov. 2 meeting, the Committee took the following action: 1) adopted the 2021 proposed charges of the Health Actuarial (B) Task Force, the Regulatory Framework (B) Task Force, and the Senior Issues (B) Task Force; 2) adopted its 2021 proposed charges; 3) adopted revisions to the *Health Maintenance Organization Model Act* (#430). The revisions address conflicts and redundancies in Model #430 with provisions in the revised *Life and Health Insurance Guaranty Association Model Act* (#520), which added health maintenance organizations (HMOs) as members of the guaranty association; and 4) received 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. The Subgroup recently adopted updates to its "Frequently Asked Questions (FAQ) About Health Reform" (FAQ) document in preparation for the 2021 open enrollment period. The Subgroup also developed a new document for consumers to use when considering purchasing a short-term policy; i.e., a policy that is not subject to the requirements of the federal Affordable Care Act (ACA).

Commissioner Conway made a motion, seconded by Commissioner Birrane, to adopt the Committee's Nov. 2 (Attachment One) and Aug. 11 (*see NAIC Proceedings – Summer 2020, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

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

Interim Commissioner Northrup made a motion, seconded by Commissioner Schmidt, to adopt the following reports: the Consumer Information (B) Subgroup, including its Oct. 29 (Attachment Two) and Oct. 20 (Attachment Three) minutes; the Health Innovations (B) Working Group (Attachment Four); the Health Actuarial (B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force.

#### 3. Heard an Update on ACA Federal Court Cases

Katie Keith (Out2Enroll) gave an update on ACA federal court cases. She discussed her observations from the recent oral arguments before the U.S. Supreme Court (Court) in the case of *California v. Texas*, which challenges the constitutionality of the individual mandate and the potential impact of the decision on other key ACA provisions. She said the Court seemed to focus its questions about the case on standing and constitutionality, but she could not discern any consensus as to how the Court might decide the case based on the questions.

Ms. Keith also discussed the potential spectrum decisions that the Court could make in the case and its implications: 1) status quo—no standing/subject matter jurisdiction mandate is constitutional or mandate is unconstitutional but fully severable; 2) some disruption—preexisting condition protections are struck down or Title I of the ACA is struck down; or 3) severe disruption—entire ACA is struck down. It is anticipated that any decision in the case will not be released until 2021, possibly as early as spring 2021 or as late as summer 2021.

Ms. Keith also noted the recent oral arguments before the Court on Oct. 6 in the *Rutledge v. Pharmaceutical Care Management Association* case. This case challenges the authority of the states to regulate pharmacy benefit managers (PBMs).

Ms. Keith discussed other cases that the Committee might want to keep track of that have petitions for *certiorari* currently pending before the Court, including *American Medical Association v. Azar*—validity of restrictions on Title X family planning

## Draft Pending Adoption

service providers. She said the Court granted a writ of *certiorari* on Dec. 4 in the *Gresham v. Azar* case, which challenges the validity of approval of Medicaid work requirements. She also highlighted a number of cases still pending in other courts, such as two cases still pending in the Washington, DC 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 short-term limited-duration (STLD) plan regulation, and *State of New York v. U.S. Department of Labor* (DOL), which concerns the regulation of association health plans (AHPs).

Commissioner Altman asked Ms. Keith if she knows why the Washington, DC Circuit Court of Appeals has yet to issue a decision in the case concerning the regulation of AHPs, given that the case was heard over a year ago. Ms. Keith said she has no insights on the delay, but one possibility could be the case's complexity resulting in the court having trouble reaching any sort of consensus on a decision.

Commissioner Altman said she received a question asking Ms. Keith about what options the states might have if the Court overturned the ACA. Ms. Keith said the options that states would have to address and fill-in any gaps left if the ACA is overturned depends on whether the Court overturns the ACA in its entirety or if the decision is more narrowly tailored by overturning certain ACA provisions. For example, she said if Title I of the ACA, which includes the individual and group market reform requirements and other major health insurance reform components, is overturned, it would be a challenge for a state to address by itself. However, if the Court decides that the individual mandate is unconstitutional but retains the remainder of the ACA, the states could address this.

#### 4. Heard a Federal Legislative and Administrative Update and Outlook for 2021

Brian R. Webb (NAIC) provided an outlook for 2021, including a federal legislative and administrative update on Congressional and Trump Administration activity of interest to the Committee. He said Ms. Keith explained in her presentation that one key factor that will determine health activity in 2021 is the Court's decision in *California v. Texas*. The other key factor is the final makeup of the U.S. Senate (Senate).

Mr. Webb also discussed Congressional activity that could happen in the meantime that possibly has bipartisan support, such as passing legislation related to surprise billing. He noted that the NAIC continues to urge the U.S. Congress (Congress) to include protections related to air ambulances in such legislation. Other legislation could include prescription drug reform, telehealth expansion, and a COVID-19 relief package.

Mr. Webb said keeping in mind the key factors affecting what could happen in Congress in 2021, he said there is the possibility that Congress could look at health insurance reform legislation that would include provisions related to STLD plans, reinsurance, network adequacy, and the public option. He said other health reforms could include reforms related to mental health parity, long-term care (LTC), and health care sharing ministries (HSCMs). He also outlined potential administrative action by the incoming Biden Administration, such as new administrative rulemaking on: 1) STLD plans; 2) AHPs; 3) cost-sharing reduction (CSR) payments; 4) ACA Section 1332 guidance; and 5) health reimbursement arrangement (HRA) payments for HSCMs. These new rules could potentially overturn the Trump Administration's rules on these issues.

#### 5. 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 "consider developing a new NAIC model to establish a licensing registration process for pharmacy benefit managers (PBMs)" and "consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency."

Mr. Keen discussed the Subgroup's drafting process. He said after the Subgroup was appointed in late 2018, it decided during its first meetings in early 2019 that it wanted to obtain more information before drafting the new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model). He said the Subgroup met 12 times 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. He said because the Subgroup included over 25 members, the goal was to have the Subgroup members all equally educated on these issues before it started drafting a model.

Mr. Keen said following the conclusion of these informational meetings, the Subgroup established an ad hoc drafting group to develop an initial draft based on the Subgroup's discussions. He said after a series of meetings late last year and early this year, the ad hoc drafting group developed a draft for the Subgroup's review. He said the Subgroup met July 16 to discuss the ad hoc drafting group's draft and expose the draft for a public comment period ending Sept. 1. The Subgroup received 19 comment letters, which it discussed during its Oct. 29, Oct. 22, Oct. 8, Sept. 24 and Sept. 14 meetings. After these discussions, the

## Draft Pending Adoption

Subgroup adopted the proposed new PBM model on Oct. 29 and forwarded it to the Regulatory Framework (B) Task Force for its consideration.

Mr. Keen described some provisions in the proposed PBM model. He explained that at its core, the model is a PBM licensing model. He said given the lack of national consensus on some issues, particularly issues related to PBM pricing and cost transparency, the Subgroup decided on this framework. He said Sections 1 through 4 of the proposed PBM model set out the model's purpose, scope and definitions. He noted that the Subgroup wanted to avoid any issues currently pending in the *Rutledge v. Pharmaceutical Care Management Association* case, and it carefully crafted these provisions to avoid such issues. Section 5 provides the PBM licensing provisions, including provisions related to approving initial PBM licenses and renewals.

Mr. Keen said the Subgroup had a lot of discussion concerning Section 6—Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices. He said the Subgroup received comments from a wide range of stakeholders on this section in terms of the language related to gag clauses and information-sharing for the purposes of enforcement. He noted how beneficial it was to have a member of the Subgroup that could provide a pharmacist's perspective when discussing this section. Section 7 of the proposed PBM model provides enforcement language and penalties for any violations of the model.

Mr. Keen said the Subgroup spent the bulk of its time discussing the framework for Section 8—Regulations. He explained that the Subgroup decided to add a drafting note to Section 8 to provide state statutory citations for 15 topic areas that some states might want to consider when developing their state legislation regulating PBMs. He said the 15 topic areas are those areas where the Subgroup found, at this time, a lack of national consensus to include in the proposed PBM model. He said Section 9 and Section 10 provide, respectively, for the severability of the PBM model's provisions and an effective date.

Mr. Keen said the Subgroup presented the proposed PBM model to the Regulatory Framework (B) Task Force during its Nov. 19 meeting. He said the Task Force deferred action on the proposed PBM model and exposed it for a 30-day public comment period ending Dec. 22. He said it is anticipated that the Task Force will meet sometime in January 2021 to discuss any comments received.

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

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**Agenda Item #3**

**Consider Adoption of its Subgroup, Working Group and Task Force Reports  
—*Commissioner Jon Godfread (ND)***



*Virtual Meeting*

**CONSUMER INFORMATION (B) SUBGROUP**

Thursday, April 1, 2021

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

**Summary Report**

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met April 1, 2021. During this meeting, the Subgroup:

1. Discussed potential topics for the Subgroup to address in 2021, such as the federal American Rescue Plan Act (ARPA), the claims process and the federal No Surprises Act (NSA).
2. Discussed potential products for the Subgroup to develop in 2021, such as a series of briefs on claims, updating the Frequently Asked Questions (FAQ) on Health Care Reform document and developing new products related to the NSA.

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*Virtual Meeting  
(in lieu of the 2020 Fall National Meeting)*

**HEALTH ACTUARIAL (B) TASK FORCE  
Thursday, November 19, 2020**

**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.

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*Adopted by the Executive (EX) Committee and Plenary, 12/9/20*  
*Adopted by the Health Insurance and Managed Care (B) Committee, 11/2/20*  
*Adopted by the Health Actuarial (B) Task Force, 10/8/20*  
*Amended to include Subgroup Charges, 1/21/21*  
*Adopted by the Health Actuarial (B) Task Force 1/22/21*

## AMENDMENTS TO 2021 ADOPTED CHARGES

### HEALTH ACTUARIAL (B) TASK FORCE

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 **Health Care Reform Actuarial (B) Working Group** will:
  - A. Assist the Health Actuarial (B) Task Force in completing its charge to provide support for issues related to implementation of, and/or changes to, the ACA.
3. The **State Rate Review (B) Subgroup** will:
  - A. Assist the Health Care Reform Actuarial (B) Working Group in completing its charge to provide support for issues related to implementation of, and/or changes to, the ACA.
4. 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*.
5. 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.
6. 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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*Virtual Meeting*

*(in lieu of meeting at the 2021 Spring National Meeting)*

**Health Innovations (B) Working Group**

Friday, March 26, 2021

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

**Summary Report**

The Health Innovations (B) Working Group met March 26, 2021. During this meeting, the Working Group:

1. Heard presentations on telehealth coverage issues from the Center for Connected Health Policy (CCHP), the American Psychiatric Association (APA) and Regence.
2. Heard a presentation from Washington regarding changes to its providers network review policies resulting from greater demand for telehealth services during the COVID-19 pandemic.
3. Discussed the effects of increased premium tax credit payments on federal funding for state reinsurance programs.

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## Draft Pending Adoption

Attachment **XX**  
Health Insurance and Managed Care (B) Committee  
4/12/21

Draft: 4/5/21

Health Innovations (B) Working Group  
Virtual Meeting (*in lieu of meeting at the 2021 Spring National Meeting*)  
March 26, 2021

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met March 26, 2021. The following Working Group members participated: Andrew R. Stolfi, Chair (OR); Laura Arp, Co-Vice Chair (NE); Nathan Houdek, Co-Vice Chair, Barbara Belling, Diane Dambach, Darcy Paskey, Mark Prodoehl, Rebecca Rebholz and Richard Wicka (WI); Philip Barlow and Howard Liebers (DC); Angela Burke Boston, Andria Seip and Cynthia Banks Radke (IA); Claire Szpara (IN); Craig Van Aalst, Julie Holmes and Tate Flott (KS); Robert Wake and Marti Hooper (ME); Renee Campbell and Karen Dennis (MI); Grace Arnold, Helen Bassett, Galen Benshoof and Peter Brickwedde (MN); Camille Anderson-Weddle, Carrie Couch, Chlora Lindley-Myers, Jo LeDuc and Amy Hoyt (MO); Chrystal Bartuska, Angie Voegelé and Karri Volk (ND); Michelle Heaton and Maureen Belanger (NH); Christine Machnowsky (NJ); Paige Duhamel (NM); Mark Garratt (NV); Jessica K. Altman and Katie Dzurec (PA); Doug Danzeiser, Essi Eargle, R. Michael Markham, Ryan Jaffe, Debra Diaz-Lara and Angelica Garza (TX); Shelly Wiseman, Tanji Northrup and Jaakob Sundberg (UT); Jane Beyer, Jennifer Kreitler and Molly Nollette (WA); and Joylynn Fix (WV).

### 1. Heard Presentations on Regulations Regarding Coverage for Telehealth Services

Mei Wa Kwong (Center for Connected Health Policy—CCHP) gave a presentation on recent activity by the federal government and states to regulate coverage for telehealth services. She described changes made to allow and encourage greater use of telehealth in Medicare, Medicaid and by private payers. She identified state trends in 2021, including activity related to mental health and substance use disorder services, allowing telephone-only connections, requirements on regulatory boards to consider telehealth, and discussions on what to make permanent. She shared resources available from CCHP that continue to track changes in telehealth policy. Commissioner Stolfi asked about lists of state legislative activity. Ms. Kwong said the CCHP website has a section devoted to state COVID-19 responses, as well an annual legislative roundup. Commissioner Stolfi asked what states might see from the federal level going forward. Ms. Kwong said federal programs have significant influence, but they are in the same position of a lot of states, deciding which changes to make permanent. She said her expectation is that some but not all of the federal telehealth changes will be extended.

Tim Clement (American Psychiatric Association—APA) provided a presentation on the use of telehealth by psychiatrists. He noted the sharp increase in telehealth services provided during the pandemic and shared study results that he said indicate the quality of telehealth services matches that of in-person services. He said the APA has supported state insurance regulators' efforts to expand access to telehealth. He said even though APA members strongly prefer in-person services, they recognize some patients prefer or need telehealth services, both during the pandemic and after. He cited the APA's model legislation on telehealth, which requires payment parity, allows telephone-only connections in limited circumstances, and prohibits insurers from employing utilization review that is not used for in-person services. He noted that physicians' overhead costs are not lower because of telehealth unless they completely shut down their offices and only offer telehealth. He said the APA is open to payment parity requirements that might require a provider to maintain an office location.

Dr. Drew Oliveira (Regence BlueShield) presented on his plan's experience with telehealth, as well as virtual and digital care. He said telehealth had previously been focused on urgent care visits and provider-to-provider consultations in rural areas. He said the majority of patients who used telehealth during the pandemic would do so again, and about 20% prefer virtual over in-person services. He said up to half of primary care and 85% of behavioral health care could potentially be delivered virtually. He described digital and in-home care as treatment methods in addition to synchronous telecommunication. He gave examples of physical therapy visits and orthopedic exams as new types of care that are starting to be delivered by telehealth. He said telehealth can support better access to care in rural and underserved areas, but it may require audio-only services until gaps in broadband access can be closed. He said he worries about fragmentation in care due to telehealth and said information sharing is important. He said there is also some worry about high-frequency, low-value care—like texting back and forth—that may not be beneficial. He said payment parity can perpetuate fee for service payments, and it would be helpful to put telehealth into a prospective payment system. He said a federal Health Insurance Portability and Accessibility Act (HIPAA)-compliant system would be preferable to audio-only, but it may take a while to get there.

Commissioner Stolfi asked whether there is any difference in effectiveness in telehealth for first visits and also about health equity. Mr. Clement said studies he is aware of did not break out first versus subsequent visits. He said research shows telehealth can increase access to underserved communities and that more research is ongoing. Dr. Oliveira said behavioral health services have been underused in the past and that telehealth can encourage more appropriate use. Ms. Kwong said there has been a lack of studies on the impact of telehealth on communities of color. She said impacts are likely to vary from place to place.

Mr. Houdek asked how the payment parity issue has worked in other states and what state insurance regulators should think about. Mr. Clement said alternative payment models should be developed specifically for telehealth and that providers are willing to compromise on pure payment parity. Ms. Kwong said quality levels are comparable and questioned whether lower payments for telehealth would discourage its use after the pandemic. She said telehealth utilization dropped as states opened up. Dr. Oliveira said Medicare's relative value calculation took overhead costs into account, and they should be considered with telehealth going forward, but closer to 80% of in-person costs than one-third. He said some telehealth visits are replacements for in-person, and others are in addition.

Commissioner Stolfi asked how health plan thinking about telehealth has shifted due to the pandemic. Dr. Oliveira said access to trained practitioners needs to be expanded. He said there can be cost savings if a practitioner can monitor someone who gets better faster because they complete physical therapy at home rather than waiting for an office visit. He said the biggest concern is connecting back to the practitioners who are providing care in person.

## 2. Discussed State Responses to the COVID-19 Pandemic

Commissioner Stolfi asked state insurance regulators how they have innovated and changed how they do business in the last 13 months due to the pandemic. Ms. Nolette and Ms. Kreitler responded for Washington. They described how the provider network access program responded to a proposal from an issuer to offer a product with a telemedicine-only network tier. Ms. Kreitler described the questions state insurance regulators asked the carrier and said the network was approved when the carrier agreed to the same cost-sharing for the telemedicine-only tier and the second tier of in-person providers. Commissioner Stolfi asked about the scope of Washington's provider contract reviews and the staff resources devoted to it. Ms. Kreitler said four staff members work on the reviews for about 8,000 contracts per year, and it takes approximately two hours per contract. Contracts are reviewed for the protection of the enrollee, including hold harmless, clean claim and grievance provisions.

Ms. Arp said Nebraska received many complaints from the behavioral health community regarding telehealth near the beginning of the pandemic. The state surveyed carriers on their policies and posted the answers on its website.

The Working Group discussed payment parity laws in their states.

## 3. Discussed Other Matters

Commissioner Arnold raised the impacts of increased premium tax credits on state reinsurance programs run with Section 1332 waivers. She said Minnesota and other states with reinsurance programs sent a letter to the federal Centers for Medicare & Medicaid Services (CMS) asking it to revise the pass through amounts it will pay states for 2021. She said insurers' rates have already been set, but tax credits are changing, so the federal government will save more and should recalculate to share savings with states. She said there are other complex issues for 2022, but the letter was focused on 2021. Commissioner Stolfi asked how much movement there could be and whether states might adjust their reinsurance parameters. Commissioner Arnold said Minnesota is likely at the high end of how much additional funds it would receive because it has a lower percentage of subsidized enrollees compared to other states. She said states will likely have to provide additional information to CMS to justify revised amounts.

Wayne Turner (National Health Law Program—NHeLP) pointed out two resources for the Working Group. One was an article in *Health Affairs* on disproportionately low use of telehealth by patients with limited English proficiency. The second was a set of principles from a consortium of citizens with disabilities on how best to serve persons with disabilities with telehealth.

Kris Hathaway (America's Health Insurance Plans—AHIP) noted that AHIP and the Blue Cross and Blue Shield Association (BCBSA) have initiated a vaccine community connector program to enhance vaccinations among vulnerable groups. She said state insurance regulators with questions could reach out to her or to the BCBSA through Randi Chapman or Clay McClure.

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

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## NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

*Virtual Meeting*

*(in lieu of meeting at the 2021 Spring National Meeting)*

### **SENIOR ISSUES (B) TASK FORCE**

Tuesday, February 23, 2021

3:00 – 4:00 p.m. ET / 2:00 – 3:00 p.m. CT / 1:00 – 2:00 p.m. MT / 12:00 – 1:00 p.m. PT

### **Meeting Summary Report**

The Senior Issues (B) Task Force met Feb. 23, 2021. During this meeting, the Task Force:

1. Discussed its 2021 agenda and possible issues.

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**Agenda Item #4**

**Consider Adoption of the Regulatory Framework (B) Task Force Report and the Proposed Pharmacy Benefit Manager (PBM) Model Act—*Commissioner Michael Conway (CO)***



*Virtual Meeting*

*(in lieu of meeting at the 2021 Spring National Meeting)*

**REGULATORY FRAMEWORK (B) TASK FORCE**

Thursday, March 25, 2021

4:00 – 5:00 p.m. ET / 3:00 – 4:00 p.m. CT / 2:00 – 3:00 p.m. MT / 1:00 – 2:00 p.m. PT

**Summary Report**

The Regulatory Framework (B) Task Force met March 25, 2021. During this meeting, the Task Force:

1. Adopted its March 18, 2021; March 1, 2021; and 2020 Fall National Meeting minutes, which included the following action:
  - a. Discussed comments received on the draft the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model Act).
  - b. Adopted the 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. Due to the recent appointment of a new co-chair, it is anticipated the Subgroup will resume its meetings in late April.
3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group, which has not met since the 2020 Fall National Meeting. It is anticipated the Working Group will likely next meet sometime following the Spring National Meeting to discuss any updates regarding association health plans (AHPs), including the status of the appeal in *State of New York et al. v. U.S. Department of Labor et al.* The Working Group also could discuss the U.S. Supreme Court’s decision in *Rutledge v. the Pharmaceutical Care Management Association (PCMA)* with respect to any ERISA preemption issues. It then plans to adjourn into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, which met March 10 and Jan. 28. During these meetings, the Working Group took the following action:
  - a. Heard from stakeholders—consumers, providers and plans—on their experiences with the implementation of and compliance with the MHPAEA’s mental health parity requirements.
  - b. Met 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.
5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which has not met since October 2020 because it completed its work. The Subgroup could resume meeting to start work on a new 2021 charge to develop a white paper on issues related to the state regulation of certain pharmacy benefit manager (PBM) business practices.
6. Heard an update from the Center on Health Insurance Reforms’ (CHIR’s) work related to federal Affordable Care Act (ACA) implementation, recently enacted federal laws such as the federal No Surprises Act (NSA) and the federal American Rescue Plan Act (ARPA), and other issues of interest to state insurance regulators. The update included a discussion of the CHIR’s efforts to assess the impact of the extended special enrollment periods (SEPs) into the federal health insurance exchanges, as



provided in the ARPA, on access and affordability of coverage and how it will be implemented. The CHIR is continuing its work to track state regulatory reforms affecting the individual market, such as the ACA's Section 1332 waiver program, including whether the states are looking at other options, in addition to reinsurance programs, in light of the ARPA that could positively affect the affordability of comprehensive coverage. The CHIR is also continuing its work of tracking state regulatory approaches to the COVID-19 pandemic. The presentation also highlighted some of the CHIR's future work on network adequacy and standardized health plans and non-comprehensive coverage arrangements.

7. Heard a presentation on the NSA. The presentation highlighted the NSA's scope, including what types of plans it covers and where its protections apply. The NSA does not apply to short-term plans and excepted benefits plans. It also does not apply to ground ambulance services, but it does apply to air ambulance services. The presentation described how the NSA protects patients from balance bills by requiring that patients be held responsible for in-network cost sharing only and barring providers from sending or collecting a bill for amounts other than in-network cost sharing. The presentation also discussed a key component of the NSA—determining the payment amount for out-of-network care when there is a payment dispute. The presentation highlighted the NSA's enforcement mechanisms and the role that the states will have. Lastly, the presentation discussed what questions remain with the NSA with respect to states that currently have balance billing laws and those that do not. The presentation also discussed next steps regarding the NSA, including the anticipated federal regulations.
8. Heard a discussion of the recent decision in *Rutledge v. the Pharmaceutical Care Management Association (PCMA)* and its potential effect on the ability of state insurance regulators to regulate certain PBM business practices. The Task Force anticipates more discussion of the Rutledge case as part of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's future work to develop a white paper on state options with respect to regulating PBM business practices and the ERISA (B) Working Group's discussion of the case's potential impact with respect to ERISA preemption.

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*Adopted by the Health Insurance and Managed Care (B) Committee - TBD*  
*Adopted by the Regulatory Framework (B) Task Force – March 18, 2021*  
*Adopted by the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup – Oct. 29, 2020*

Draft: 3/12/21  
A new model

## [STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

### Table of Contents

Section 1.	Short Title
Section 2.	Purpose
Section 3.	Definitions
Section 4.	Applicability
Section 5.	Licensing Requirement
Section 6.	Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices
Section 7.	Enforcement
Section 8.	Regulations
Section 9.	Severability
Section 10.	Effective Date

### Section 1. Short Title

This Act shall be known and may be cited as the [State] Pharmacy Benefit Manager Licensure and Regulation Act.

### Section 2. Purpose

- A. This Act establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.
- B. The purpose of this Act is to:
  - (1) Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;
  - (2) Promote the solvency of the commercial health insurance industry, the regulation of which is reserved to the states by the McCarran-Ferguson Act (15 U.S.C. §§ 1011 – 1015), as well as provide for consumer savings, and fairness in prescription drug benefits;
  - (3) Provide for powers and duties of the commissioner; and
  - (4) Prescribe penalties and fines for violations of this Act.

### Section 3. Definitions

For purposes of this Act:

- A. “Claims processing services” means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:
  - (1) Receiving payments for pharmacist services;
  - (2) Making payments to pharmacists or pharmacies for pharmacist services; or
  - (3) Both paragraphs (1) and (2).

- B. “Commissioner” means the insurance commissioner of this state.

**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.

- C. “Covered person” means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.
- D. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.
- E. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

**Drafting Note:** States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

- F. “Other prescription drug or device services” means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:
- (1) Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;
  - (2) Disbursing or distributing rebates;
  - (3) Managing or participating in incentive programs or arrangements for pharmacist services;
  - (4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;
  - (5) Developing and maintaining formularies;
  - (6) Designing prescription benefit programs; or
  - (7) Advertising or promoting services.
- G. “Pharmacist” means an individual licensed as a pharmacist by the [state] Board of Pharmacy.
- H. “Pharmacist services” means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.
- I. “Pharmacy” means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.
- J. (1) “Pharmacy benefit manager” means a person, business or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to covered persons who are residents of this state, for health benefit plans.
- (2) “Pharmacy benefit manager” does not include:

- (a) A health care facility licensed in this state;
- (b) A health care professional licensed in this state;
- (c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager; or
- (d) A health carrier to the extent that it performs any claims processing and other prescription drug or device services exclusively for its enrollees.

**Section 4. Applicability**

- A. This Act shall apply to a contract or health benefit plan issued, renewed, recredentialed, amended or extended on or after the effective date of this Act, including any health carrier that performs claims processing or other prescription drug or device services through a third party.

**Drafting Note:** States may want to consider adding language to Subsection A above or Section 10—Effective Date providing additional time for pharmacy benefit managers to come into compliance with the requirements of this Act.

- B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the requirements of this Act.
- C. Nothing in this Act is intended or shall be construed to conflict with existing relevant federal law.

**Section 5. Licensing Requirement**

- A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without first obtaining a license from the commissioner under this Act.
- B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers under this Act.

**Drafting Note:** States that are restricted in their rulemaking to only what is prescribed in statute may want to consider including in this section specific financial standards required for a person or organization to obtain a license to operate as a pharmacy benefit manager in this state.

- C. A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the commissioner.

**Drafting Note:** States may want to consider reviewing their third party administrator statute if a state wishes to specify what documents must be provided to the commissioner to obtain a pharmacy benefit manager license in the state.

- D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee of \$[X].
- E. The commissioner may refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.
- F. (1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations,

including the payment of an annual license renewal fee of \$[X] and completion of a renewal application on a form prescribed by the commissioner.

- (2) Such renewal fee and application shall be received by the commissioner on or before [x] days prior to the anniversary of the effective date of the pharmacy benefit manager's initial or most recent license.

**Section 6. Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices**

- A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:
  - (1) The nature of treatment, risks or alternative thereto;
  - (2) The availability of alternate therapies, consultations, or tests;
  - (3) The decision of utilization reviewers or similar persons to authorize or deny services;
  - (4) The process that is used to authorize or deny healthcare services or benefits; or
  - (5) Information on financial incentives and structures used by the insurer.
- B. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.
- C. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:
  - (1) The recipient of the information represents it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and
  - (2) Prior to disclosure of information designated as confidential the pharmacist or pharmacy:
    - (a) Marks as confidential any document in which the information appears; or
    - (b) Requests confidential treatment for any oral communication of the information.
- D. A pharmacy benefit manager may not terminate the contract of or penalize a pharmacist or pharmacy due to pharmacist or pharmacy:
  - (1) Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by state law or the commissioner; or
  - (2) Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance with this Act.
- E. (1) A pharmacy benefit manager may not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person's cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price.

- (2) Any amount paid by a covered person under paragraph (1) of this subsection shall be attributable toward any deductible or, to the extent consistent with section 2707 of the Public Health Service Act, the annual out-of-pocket maximums under the covered person's health benefit plan.

**Section 7. Enforcement**

- A. The commissioner shall enforce compliance with the requirements of this Act.
- B. (1) The commissioner may examine or audit the books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine compliance with this Act.

**Drafting Note:** States may want to consider including a reference to the cost of examinations in the *Model Law on Examinations* (#390).

**Drafting Note:** States may want to consider incorporating their existing market conduct examination statutes into this Act rather than relying on the examination authority provided under this section.

- (2) The information or data acquired during an examination under paragraph (1) is:
  - (a) Considered proprietary and confidential;
  - (b) Not subject to the [Freedom of Information Act] of this state;
  - (c) Not subject to subpoena; and
  - (d) Not subject to discovery or admissible in evidence in any private civil action.
- C. The commissioner may use any document or information provided pursuant to Section 6C of this Act or Section 6D of this Act in the performance of the commissioner's duties to determine compliance with this Act.
- D. The commissioner may impose a penalty on a pharmacy benefit manager or the health carrier with which it is contracted, or both, for a violation of this Act. The penalty may not exceed [insert appropriate state penalty] per entity for each violation of this Act.

**Drafting Note:** If an appeals process is not otherwise provided, a state should consider adding such a provision to this section.

**Section 8. Regulations**

The commissioner may adopt regulations regulating pharmacy benefit managers that are not inconsistent with this Act.

**Drafting Note:** This Act is primarily intended to establish licensing standards for pharmacy benefit managers (PBMs). A number of states have enacted statutes or made suggestions that extend into the regulation of PBM business practices. The provisions below, which are followed by citations to state law where applicable, provide topic areas that states pursuing this Act may wish to consider in their proposed legislation:

- (1) PBM network adequacy (Ark. Code 23-92-505 and Okla. Stat. 36-6961) (Also, see provisions in the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) and the *Health Benefit Plan Network Access and Adequacy Model Act* (#74));
- (2) Prohibited market conduct practices (Ark. Code 23-92-506; MD. ANN. CODE § 15-1642; N.M. Stat. 59A-61-5 and 59A-61-7; Oregon Rev. Stat. §§ 735.534 through 735.552; and South Carolina Code §38-71-2230(A)(1));
- (3) Data reporting requirements under state price-gouging laws;

- (4) Rebates (O.C.G.A. §33-64-10(b) (Georgia); 24-A Maine Rev. Stat. Ann. Chapter 56-C; MD. ANN. CODE § 15-1624 and Texas Insurance Code §1369.502);
- (5) Prohibitions and limitations on the corporate practice of medicine (CPOM) (O.C.G.A. §33-64-4 (Georgia));
- (6) Compensation (Ark. Code 23-92-506(b)(5)(A) and N.J.S.A. 17B:27F-8 (New Jersey));
- (7) Procedures for pharmacy audits conducted by or on behalf of a PBM (Del. Ins. Code Chapter 33A §§ 3301A – 3310A; MD. ANN. CODE § 15-1629; Oregon Rev. Stat. §§ 735.540 through 735.552; and 40 PA. CONS. STAT. §§ 4511-4514);
- (8) Medical loss ratio (MLR) compliance;
- (9) Affiliate information-sharing (Ga. Code § 26-4-119 and § 33-64-11(a)(8));
- (10) Lists of health benefit plans administered by a PBM in this state (New Hampshire Rev Stat § 402-N:6)
- (11) Reimbursement lists or payment methodology used by PBMs (Ark. Code § 17-92-507; Colo. Rev Stat. § 25-37-103.5; Del. Ins. Code Chapter 33A §§ 3321A – 3324A; Kansas Rev Stat §§ 40-3829 - 40-3830; 24-A Maine Rev. Stat. Ann. Chapter 56-C; MD. ANN. CODE § 15-1628.1 and §15-1628.2; N.J.S.A. §17B:27F-2 (New Jersey); and Oregon Rev. Stat. § 735.534 and § 735.536);
- (12) Prohibiting clawbacks (Ala. Code § 27-45A-5; MD. ANN. CODE § 15-1628.3; Minn. Stat. 62W.13; N.J.S.A. 17B:27-7 (New Jersey); and Oregon Rev. Stat. § 735.534);
- (13) Affiliate compensation (Colo. Rev. Stat. § 10-16-122.3 and Ga. Code § 26-4-119 and § 33-64-11(a)(7));
- (14) Prohibiting spread pricing (LA. REV. STAT. ANN § 22:1867 and Va. Code § 38.2-3467(D)); and
- (15) Transparency provisions (24-A Maine Rev. Stat. Ann. Chapter 56-C; Texas Insurance Code § 1369.502; and RCW 43.71C.030 (Washington)).

**Section 9. Severability**

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of this Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

**Section 10. Effective Date**

This Act shall be effective [insert date]. A person doing business in this state as a pharmacy benefit manager on or before the effective date of this Act shall have [six (6)] months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.

## **Agenda Item #5**

**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)***

## 2021 Proposed Charges

### SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

The **Special (EX) Committee on Race and Insurance** will:

- A. Serve as the NAIC's coordinating body on issues related to (i) diversity and inclusion within the insurance sector; (ii) race, diversity, and inclusion in access to the insurance sector and insurance products; and (iii) practices within the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups.
- B. Coordinate with existing groups such as the Big Data and Artificial Intelligence (EX) Working Group and the Casualty Actuarial and Statistical (C) Task Force and encourage those groups to continue their work in predictive modeling, price algorithms and artificial intelligence (AI), with a particular focus on how race is impacted.
- C. (Workstream One) Continue research and analysis to develop specific recommendations on action steps that state insurance regulators and companies can take to improve the level of diversity and inclusion in the industry, including:
  1. Seek additional engagement from stakeholders to understand the efficacy of diversity-related programs, how companies measure their progress and what state insurance regulators can do to support these efforts.
  2. Collect input on existing gaps in available industry diversity-related data.
- D. (Workstream Two) In coordination with the Executive (EX) Committee, receive reports on NAIC diversity, equity and inclusion (DE&I) efforts. Serve as the coordinating body for state requests for assistance from the NAIC related to DE&I efforts.
- E. (Workstream Three) Research best practices among state insurance departments on DE&I efforts and develop forums for sharing relevant information among states.
- F. Continue research and analysis of insurance, legal and regulatory approaches to addressing unfair discrimination, specifically proxy discrimination and disparate impact, by defining the terms and determining appropriate steps to address, including:
  1. (Workstream Four) The impact of traditional life insurance underwriting on minority populations, considering the relationship between mortality risk and disparate impact.
  2. (Workstream Three) Developing analytical and regulatory tools to assist state insurance regulators in determining unfair discrimination including issues related to:
    - a. The used of socioeconomic variables.
    - b. Identifying proxy variables for race.
    - c. Correlation vs. causation.
    - d. Disparate impact considerations.
    - e. Use of third-party data.
    - f. Appropriateness of data such as criminal history.
- G. (Workstreams Three, Four and Five) Consider enhanced data reporting and record-keeping requirements across product lines to identify race and other sociodemographic factors of insureds. Consider a data call to identify resources and products sold in specific ZIP codes to identify barriers to access.
- H. Continue research and analysis related to insurance access and affordability issues, including:
  1. (Workstream Four) The marketing, distribution and access to life insurance products in minority communities, including the role that financial literacy plays.
  2. (Workstream Four) Disparities in the number of cancellations/rescissions among minority policyholders.
  3. (Workstream Five) Measures to advance equity through lowering the cost of health care and promoting access to care and coverage, with specific focus on measures to remedy impacts on people of color, low income and rural populations, and historically marginalized groups, such as the LGBTQ+ community, individuals with disabilities, and Alaska Native and other Native and Indigenous people.
  4. (Workstream Five) Examination of the use of network adequacy and provider directory measures (such as provider diversity, language and cultural competence) to promote equitable access to culturally competent care.
  5. (Workstream Five) Conduct additional outreach to educate consumers and collect information on health and health care complaints related to discrimination and inequities in accessing care.
  6. (Workstream Three) Steps that can be taken to mitigate the impact of residual markets, premium financing and nonstandard markets on disadvantaged groups.
  7. Make referrals for the development of consumer education and outreach materials as appropriate.

- I. Direct NAIC and Center for Insurance Policy and Research (CIPR) staff to conduct necessary research and analysis, including:
  1. (Workstream Three) The status of studies concerning the affordability of auto and homeowner's insurance, including a gap analysis of what has not been studied.
  2. (Workstream Three) The availability of producer licensing exams in foreign languages, steps exam vendors have taken to mitigate cultural bias, and the number and locations of producers by company compared to demographics in the same area.
  3. (Workstream Five) Aggregation of existing research on health care disparities and collection of insurance responses to the COVID-19 pandemic and its impact across demographic populations.

#### **LIFE INSURANCE AND ANNUITIES (A) COMMITTEE – NEW CHARGES**

The **Accelerated Underwriting (A) Working Group**, as part of its ongoing work to consider the use of external data and data analytics in accelerated life underwriting, will include an assessment of and recommendations, as necessary, regarding the impact of accelerated underwriting on minority populations.

#### **HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE – NEW CHARGES**

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 the effect on the states of proposed and enacted federal legislation and regulations, **including, where appropriate, an emphasis on equity considerations and the differential impact on underserved populations**; and communicate the NAIC's position through letters and testimony, when requested.

The **Mental Health Parity and Addition Equity Act (MHPAEA) (B) Working Group** of the Regulatory Framework (B) Task Force will develop model educational material for state departments of insurance (DOIs) and research disparities in and interplay between mental health parity and access to culturally competent care for people of color and other underrepresented groups.

The **Health Innovations (B) Working Group** will evaluate mechanisms to resolve disparities through improving access to care, including the efficacy of telehealth as a mechanism for addressing access issues; the use of alternative payment models and value-based payments and their impact on exacerbating or ameliorating disparities and social determinants of health; and programs to improve access to historically underserved communities.

#### **MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE – NEW CHARGES**

The **Producer Licensing (D) Task Force** will receive a report from on the availability of producer licensing exams in foreign languages, the steps exam vendors have taken to mitigate cultural bias, and the number and location of producers by company compared to demographics in the area.

## **Agenda Item #6**

**Hear a Discussion on the 2021 Work of the Committee's Subgroup, Working Group and Task Forces—*Commissioner Jon Godfread (ND)***

**Health Insurance and Managed Care (B) Committee**  
**Task Forces, Working Groups and Subgroups**

**Health Insurance and Managed Care (B) Committee**

**2021 Charges:**

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 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.

**NAIC Staff:** Jolie H. Matthews ([jmatthews@naic.org](mailto:jmatthews@naic.org))/Brian R. Webb ([bwebb@naic.org](mailto:bwebb@naic.org))/Jennifer R. Cook ([jcook@naic.org](mailto:jcook@naic.org))

• **Consumer Information (B) Subgroup:**

**Subgroup Chair:** Mary Kwei (MD); **Subgroup Vice Chair:** Debra Judy (CO)

**2021 Charges:**

- 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.

**NAIC Staff:** Joe Touschner ([jtouschner@naic.org](mailto:jtouschner@naic.org))

• **Health Innovations (B) Working Group:**

**Working Group Chair:** Andrew Stolfi (OR); **Working Group Co-Vice Chairs:** Martin Swanson (NE)/Laura Arp (NE)

**2021 Charges:**

- 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 Staff:** Joe Touschner ([jtouschner@naic.org](mailto:jtouschner@naic.org))

**Health Actuarial (B) Task Force**  
*NAIC Staff:* Eric King ([eking@naic.org](mailto:eking@naic.org))

*Task Force Chair:* Eric A. Cioppa (ME)/Marti Hooper (ME)

*Task Force Co-Vice Chair:* Andrew N. Mais (CT)/Paul Lombardo (CT)

*Task Force Co-Vice Chair:* Jonathan T. Pike (UT)/Jaakob (Jaak) Sundberg (UT)

**2021 Charges:**

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.

*NAIC Staff:* Eric King

- **Health Care Reform Actuarial (B) Working Group**

*Working Group Chair:* David Shea (VA)

**2021 Charge:** Assist the Health Actuarial (B) Task Force in completing its charge to provide support for issues related to implementation of, and/or changes to, the ACA.

*NAIC Staff:* Eric King

- **State Rate Review (B) Subgroup**

*Subgroup Chair:* David Shea (VA)

**2021 Charge:** Assist the Health Care Reform Actuarial (B) Working Group in completing its charge to provide support for issues related to implementation of, and/or changes to, the ACA.

*NAIC Staff:* Eric King

- **Long-Term Care Actuarial (B) Working Group**

*Working Group Chair:* Perry Kupferman (CA)

**2021 Charges:** 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; and 3) Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.

*NAIC Staff:* Eric King

- ***Long-Term Care Pricing (B) Subgroup***

***Subgroup Chair:*** Paul Lombardo (CT)

***2021 Charge:*** 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.

***NAIC Staff:*** Eric King

- ***Long-Term Care Valuation (B) Subgroup***

***Subgroup Chair:*** Fred Andersen (MN)

***2021 Charge:*** 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; and 2) Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.

***NAIC Staff:*** Eric King

## **Regulatory Framework (B) Task Force**

*NAIC Staff:* Jolie Matthews/Jennifer Cook

**Task Force Chair:** Michael Conway (CO)

**Task Force Vice Chair:** Bruce R. Ramge (NE)

### **2021 Charges:**

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 2021.
- 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.

- ***Accident and Sickness Insurance Minimum Standards (B) Subgroup***

**Subgroup Co-Chair:** Commissioner Glen Mulready (OK) and **Subgroup Co-Chair:** Laura Arp (NE)

**2021 Charge:** Review and consider revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

*NAIC Staff:* Jolie Matthews

- ***ERISA (B) Working Group***

**Working Group Chair:** Bob Wake (ME)

### **2021 Charges:**

- Monitor, report and analyze developments related to the federal Employee Retirement Income Security Act of 1974 (ERISA), and make recommendations regarding NAIC strategy and policy with respect to those developments.
- Monitor, facilitate and coordinate with the states and the U.S. Department of Labor (DOL) related to sham health plans.
- Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the federal Affordable Care Act (ACA) that relate to ERISA.
- Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) and modify it, as necessary, to reflect developments related to ERISA.

*NAIC Staff:* Jennifer Cook

- ***Mental Health Parity and Addition Equity Act (MHPAEA) (B) Working Group***

***Working Group Chair:*** Katie Dzurec (PA); ***Working Group Vice Chair:*** Jane Beyer (WA)

***2021 Charges:***

- A. Monitor, report and analyze developments related to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and make recommendations regarding NAIC strategy and policy with respect to those developments.
- B. Monitor, facilitate and coordinate best practices with the states, the U.S. Department of Labor (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.

***NAIC Staff:*** Jolie Matthews/Joe Tuschner

- ***Pharmacy Benefit Manager Regulatory Issues (B) Subgroup***

***Subgroup Chair:*** TK Keen (OR); ***Subgroup Vice Chairs:*** Martin Swanson (NE) and Laura Arp (NE)

***2021 Charge:*** Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including provisions on PBM prescription drug pricing and cost transparency in the new NAIC model.

***NAIC Staff:*** Jolie Matthews

## **Senior Issues (B) Task Force**

*NAIC Staff:* David Torian (dtorian@naic.org)

**Task Force Chair:** Marlene Caride (NJ)

**Task Force Vice Chair:** Lori K. Wing-Heier (AK)

### **2021 Charges:**

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 the State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Provide assistance to 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.

### • **Long-Term Care Insurance (LTCI) Model Update (B) Subgroup**

**Subgroup Chair:** Philip Gennace (NJ)

**Subgroup Vice Chair:** Laura Arp (NE)

**2021 Charges:** 1) 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; 2) Update Model #642 and Model #643 to correlate with Model #640 and Model #641; and 3) Consider recommendations referred from the Long-Term Care Insurance (EX) Task Force and/or its subgroups.

**NAIC Staff:** David Torian

**Agenda Item #7**

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