

Revised: 8/12/21

2021 Summer National Meeting

Columbus, Ohio

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Monday, August 16, 2021

2:00 – 3:30 p.m.

Convention Center—Union Station Ballroom—Level 1

ROLL CALL

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

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

AGENDA

1. Consider Adoption of its June 22 and Spring 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. Hear a Discussion from the Biden Administration on the Implementation and Enforcement of Federal No Surprises Act (NSA) Provider Requirements
—*Jeff Wu (Center for Consumer Information and Insurance Oversight—CCIIO)*
4. Hear a Panel Discussion of NSA Provider Compliance and Enforcement Issues
—*Molly Smith (American Hospital Association—AHA), Emily Carroll (American Medical Association—AMA), and Melanie de Leon (Federation of State Medical Boards—FSMB)*
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. Discuss Any Other Matters Brought Before the Committee
—*Commissioner Jon Godfread (ND)*
7. Adjournment

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Agenda Item #1

**Consider Adoption of its June 22 and Spring National Meeting Minutes
—Commissioner Jon Godfread (ND)**

Draft: 7/8/21

Health Insurance and Managed Care (B) Committee
Virtual Meeting
June 22, 2021

The Health Insurance and Managed Care (B) Committee met June 22, 2021. The following Committee members participated: Jon Godfread, Chair (ND); Jessica K. Altman, Vice Chair (PA); Lori K. Wing-Heier (AK); Michael Conway (CO); John F. King represented by Elizabeth Nunes (GA); Dean L. Cameron (ID); Kathleen A. Birrane (MD); Anita G. Fox represented by Sarah Wohlford and Chad Arnold (MI); Grace Arnold represented by Galen Benshoof and Sherri Mortensen-Brown (MN); Russell Toal (NM); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi (OR); Jonathan T. Pike (UT); Mike Kreidler (WA); and James A. Dodrill represented by Tonya Gillespie (WV). Also participating were: Vicki Schmidt (KS); Eric Dunning (NE); and Barbara D. Richardson (NV).

1. Adopted Revised Regulatory Framework (B) Task Force Charges

Commissioner Godfread said that during its June 15 meeting, the Regulatory Framework (B) Task Force adopted a new 2021 charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper (*see NAIC Proceedings – Summer 2021, Regulatory Framework (B) Task Force, Attachment One-A*). He said the proposed charge was included in the Committee’s meeting materials. He asked if anyone had any questions about the charge. There were no questions.

Superintendent Toal made a motion, seconded by Commissioner Conway, to adopt the Regulatory Framework (B) Task Force’s revised 2021 charges, adding a new charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper. The motion passed unanimously.

2. Adopted the PBM Model

Commissioner Godfread said that during the Committee’s meeting at the Spring National Meeting, the Committee deferred adoption of the proposed [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model) in order to have more time to discuss it, particularly to discuss concerns expressed about the proposed drafting note for Section 8—Regulations. He explained that the proposed drafting note provides options to the states to add additional provisions to the pharmacy benefit manager (PBM) model regarding certain pharmacy benefit manager (PBM) business practices.

Commissioner Godfread explained his thoughts regarding the proposed PBM model and whether state departments of insurance (DOIs) are the appropriate state agency to regulate PBMs. He said North Dakota has such concerns, but North Dakota also recognizes that some states may have different thoughts on the issue. He requested comments. Commissioner Birrane acknowledged Commissioner Godfread’s concerns, but she noted that Maryland has enacted extensive legislation related to PBMs and that her concerns with the proposed PBM model related to the proposed Section 8 drafting note. She expressed concern about the approach taken in the drafting note and its impact on the uniform adoption of the PBM model, which is a key goal of NAIC models. Commissioner Birrane suggested that because of the newly adopted charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper that would explore the PBM business practices in the drafting note, including current and emerging state laws on these practices, the white paper would be the better approach to take rather than the drafting note.

Commissioner Conway also acknowledged Commissioner Godfread’s comments on whether state DOIs are the appropriate state agency to regulate PBMs. He noted, however, that many states have already moved forward with having the state DOI be responsible for regulating PBMs. He also explained that in discussing the proposed PBM model with other NAIC members, some members expressed support for moving forward with a NAIC model regulating PBMs in order to have an NAIC model to support their ongoing efforts on this issue. Commissioner Conway noted Commissioner Birrane’s comments regarding the Section 8 drafting note and its possible deletion, particularly given the adoption of the white paper charge.

Commissioner Conway made a motion, seconded by Commissioner Birrane, to adopt the PBM model without the Section 8 drafting note. Commissioner Godfread asked if there was any discussion.

Carl Schmid (HIV+Hepatitis Policy Institute) said the NAIC consumer representatives submitted a comment letter to the Committee expressing support for adoption of the white paper charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup and support for adoption of the PBM model. He said the NAIC consumer representatives support moving forward

with the PBM model with the Section 8 drafting note because it provides examples to those states that would like to move beyond PBM licensure or registration to include other provisions regulating PBM business practices. He acknowledged the concerns that some have raised related to the Section 8 drafting note and reiterated the NAIC consumer representatives' support for moving forward with the PBM model.

The Committee discussed the background related to the Section 8 drafting note, including noting that the drafting note was a compromise between those states that wanted to add substantive provisions to the PBM model concerning some of these PBM business practices and those states that did not want to move beyond PBM licensure and registration. The Committee also discussed the importance of moving forward with the PBM model because it does set out structure for PBM licensure and registration for those states that wish to move forward with having that authority in the state DOI. The Committee also noted the importance of the work the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will be doing in support of the PBM model with respect to the development of the white paper.

The motion to adopt the PBM model without the Section 8 drafting note (Attachment One-A) passed based on those Committee members present and voting.

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

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Draft: 4/15/21

Health Insurance and Managed Care (B) Committee
Virtual 2021 Spring National Meeting
April 12, 2021

The Health Insurance and Managed Care (B) Committee met April 12, 2021. The following Committee members participated: Jon Godfread, Chair (ND); Jessica K. Altman, Vice Chair (PA); Lori K. Wing-Heier (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 represented by Molly Nollette (WA); and James A. Dodrill (WV). Also participating were: Jim L. Ridling (AL); Ricardo Lara (CA); David Altmaier (FL); Doug Ommen (IA); Dana Popish Severinghaus (IL); Vicki Schmidt (KS); Sharon P. Clark (KY); Eric A. Cioppa (ME); Mike Chaney (MS); Mariano A. Mier Romeu (PR); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Mark Afable (WI); and Jeff Rude (WY).

1. Heard a Presentation from the Biden Administration on its Federal Legislative and Administrative Initiatives and Priorities

Jeff Wu (federal Centers for Medicare & Medicaid Services—CMS) updated the Committee on the Biden Administration's legislative and administrative priorities. He discussed the history of health insurance marketplaces with respect to the number of uninsured, enrollment and insurer participation. He said there was a sharp decrease in the uninsured after 2010, followed by an increase since 2016. He also pointed out that minority rates of the uninsured were persistently higher in 2019 than for whites. He discussed the effects of the COVID-19 pandemic on the number of uninsured. He explained that the Biden Administration's initial fears of increases in the uninsured was driven by the high unemployment rate during the beginning months of the COVID-19 pandemic. However, he noted that pre-pandemic research suggests that the federal Affordable Care Act (ACA) plays a critical role in helping people maintain coverage after job losses, which may have mitigated coverage changes due to unemployment. In addition, he said the uninsured rate did not increase dramatically because many individuals who lost some form of employment had low incomes or were in jobs without health benefits, and some were either enrolled in Medicaid or were already uninsured before their job loss. He said economic relief and other COVID-19 measures provided in the federal Families First Coronavirus Response Act (FFCRA) and the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act were contributing factors in stabilizing the number of uninsured.

Mr. Wu said enrollment in the health insurance marketplaces has steadied over time and insurer participation in the marketplaces has improved, but premium cost remains a challenge. He discussed how provisions in the federal American Rescue Plan Act of 2021 (ARPA) could address some of the marketplace premium cost issues. President Biden signed the ARPA into law on March 11. He said the ARPA makes major improvements in access to and affordability of health coverage through the marketplace by increasing eligibility for financial assistance to help pay for marketplace coverage. The ARPA also lowers premiums for most people who currently have a marketplace health plan and expands access to financial assistance for more consumers because of the increased tax credits to reduce their premiums. Mr. Wu also described other provisions in the ARPA, including: 1) subsidies to cover 100% of the cost of premiums for Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage; and 2) funding for grants to states to assist state-based marketplaces (SBMs) with implementation, covering information technology (IT) changes, and outreach.

Mr. Wu provided an update on the number of individuals who have enrolled to date in the marketplaces using the current special enrollment period (SEP), which has been extended to Aug. 31. He discussed the Biden Administration's National Consumer Outreach Campaign to increase awareness among the uninsured about the existence of the SEP and the affordability and availability of assistance to pay for premiums. He announced that the CMS is making approximately \$2.3 million in additional funding available to current navigator grantees in federally facilitated marketplace (FFM) states to support the outreach, education and enrollment efforts around the 2021 SEP.

Mr. Wu briefly discussed the federal No Surprises Act (NSA) and provisions in the NSA that provide consumer protections regarding surprise bills. He also touched on the Biden Administration's efforts to address the COVID-19 pandemic through provisions in the FFCRA, the CARES Act, and other policy initiatives, including releasing additional guidance and toolkits on COVID-19 vaccine and testing coverage.

Commissioner Altman asked Mr. Wu about any initiatives the CMS might be pursuing to address the gap in the number of uninsured among minority groups versus the number of uninsured among whites and whether there would be opportunities for the NAIC to partner with the CMS to address the issue. She also asked how the CMS plans to coordinate with SBMs if it is working on this issue. Mr. Wu acknowledged the issue of health equity in health insurance coverage. He explained that one way the Biden Administration is working to initially address this gap is through significant investment in the navigator program.

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Commissioner Godfreed said state insurance regulators have reached out to the CMS for clarification on how the ARPA and reinsurance programs that states have implemented through the ACA's Section 1332 waiver program are to work together with respect to pass through payment calculations moving forward. Mr. Wu said the CMS is aware of this issue and is working to provide answers on this issue to the states soon.

2. Adopted its 2020 Fall National Meeting Minutes

Superintendent Toal made a motion, seconded by Director Cameron, to adopt the Committee's Dec. 7, 2020, minutes (*see NAIC Proceedings – Fall 2020, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

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

Commissioner Conway made a motion, seconded by Director Cameron, to adopt the following reports: the Consumer Information (B) Subgroup, including its April 1 minutes (Attachment One); the Health Innovations (B) Working Group, including its March 26 minutes (Attachment Two); the Health Actuarial (B) Task Force, including its 2021 revised charges; and the Senior Issues (B) Task Force.

3. Adopted the Regulatory Framework (B) Task Force Report and Received the Draft PBM Model Act

Commissioner Conway said the Regulatory Framework (B) Task Force met March 25 and took the following action: 1) adopted its March 18, March 1, and 2020 Fall National Meeting minutes; 2) received an update from Georgetown University's Center on Health Insurance Reforms (CHIR) on its work related to the ACA and two recently enacted federal laws; i.e., the NSA and the ARPA; 3) heard a presentation on the NSA; and 4) heard a discussion of the recent U.S. Supreme Court decision in *Rutledge vs. Pharmaceutical Care Management Association (PCMA)*.

Commissioner Conway said the Task Force met March 18 and adopted the draft NAIC [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model). He said after an almost year-long drafting process, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adopted the proposed new NAIC model in late October 2020, completing its charge to "consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs)" and "consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency." During its meeting at the 2020 Fall National Meeting, the Task Force deferred immediate adoption of the draft PBM model and exposed it for an additional public comment period ending Dec. 22, 2020.

Commissioner Conway said the Task Force discussed the comments received on the draft PBM model during its March 1 meeting and adopted it during its March 18 meeting with non-substantive changes based on the comments received. He explained that at its core, the draft PBM model is a PBM licensing model. He said after a lot of discussion and given the lack of national consensus on some issues, particularly issues related to PBM pricing and cost transparency, the Subgroup decided on this framework. As a compromise, to address those topics that it felt there was not a national consensus to include in the substantive provisions of the draft PBM model, Commissioner Conway said the Subgroup decided to add a drafting note to Section 8—Regulations. The drafting note includes state statutory citations for 15 topic areas involving certain PBM business practices that some states might want to consider when developing their state legislation regulating PBMs.

Commissioner Conway said there has been a lot of debate and discussion, including during the Task Force's March 18 meeting, on the appropriateness of including such options in an NAIC model, given the potential for the lack of uniform adoption by the states. However, the Task Force decided to move forward with adoption and forward the draft PBM model to the Committee for its consideration and additional discussion, as the Committee deems appropriate. Commissioner Conway explained that during its March 18 meeting, the Task Force discussed and decided to move forward with developing a new 2021 charge directing the Subgroup to develop a white paper to further detail state options in regulating PBM business practices with respect to some of the 15 topic areas included in the proposed Section 8 drafting note. He said the white paper also is to touch on how the *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* decision may or may not affect state options in this area.

Director Cameron made a motion, seconded by Director Wing-Heier, to adopt the Regulatory Framework (B) Task Force's report. The motion did not include adoption of the draft PBM model. After discussion, the Committee decided to defer adoption of the draft PBM model until it could further discuss the issues Commissioner Conway highlighted in his report, particularly the issues related to the Section 8 drafting note. The Committee will meet sometime after the Spring National Meeting to continue the discussion.

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

Commissioner Altman and Commissioner Lara, co-chairs of the Special (EX) Committee on Race and Insurance (Special Committee) Workstream Five, provided an update to the Committee on Workstream Five's work to date. Commissioner Lara said since the Special Committee created Workstream Five last year, the Workstream has been meeting in open and regulator-to-regulator sessions to work on its charge to "examine and to determine which practices or barriers exist in the insurance sector that potentially disadvantage people color and/or historically underrepresented groups in the health insurance line of business" and "make recommendations on action steps." He said one of the first actions the Workstream took was to meet Dec. 2, 2020, to hear from various stakeholders to help the Workstream members identify and understand more fully disparities in health insurance affecting racial and historically underrepresented groups and what questions the Workstream members should be asking themselves and considering as it moves forward.

Commissioner Lara said the testimony provided during that Dec. 2, 2020, meeting confirmed the Workstream's initial thoughts that access to care and network adequacy is an ongoing and persistent issue for people of color and/or historically underrepresented population groups. He said Workstream Five also believes the other issues it has identified merit discussion and examination as well, including affordability.

Commissioner Altman said as reported during the Special Committee's meeting April 12, following its Dec. 2, 2020, meeting, Workstream Five met in regulator-to-regulator sessions to develop and finalize its initial report and recommendations to the Special Committee for its consideration. She said the Special Committee discussed 2021 proposed charges that included Workstream Five's recommendations included in its initial report and exposed them for a 30-day public comment period ending May 14.

Commissioner Altman said the 2021 proposed charges include charges to the Committee and two of its groups; i.e., the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group and the Health Innovations (B) Working Group. She said the 2021 proposed charges also direct Workstream Five to continue its work in various areas the Workstream identified in its initial report as areas for more discussion, including network adequacy and consumer education.

Commissioner Altman said as the Workstream moves forward with its work related to network adequacy, the Workstream plans to focus its research on measures to remedy impacts on historically marginalized groups, as well as examination of the use of network adequacy and provider directory measures to promote equitable access to culturally competent care. She said as the Workstream continues its work related to consumer education targeted toward people of color and/or historically underrepresented population groups, Workstream Five plans to monitor opportunities and identify strategies for consumer education to address equity issues. The Workstream will make referrals, as appropriate, to the Consumer Information (B) Subgroup to develop educational materials after identifying areas and strategies believed to help increase awareness in communities of color and among other underrepresented groups.

Commissioner Altman said during the NAIC/Consumer Liaison Committee's April 8 meeting, there were two presentations that reflected core areas Workstream Five is discussing with respect to health equity and communities of color and/or historically underrepresented groups; i.e., maternal health outcomes and coverage for children. She said the Workstream plans to continue to act as a forum for discussion of these issues as it continues its work.

6. Heard a Discussion on the 2021 Work of the Committee's Subgroup, Working Group and Task Forces

Jolie H. Matthews (NAIC) discussed the 2021 work of the Committee's subgroup, working group and task forces. She said included in the Committee meeting materials is a document that summarizes the 2021 charges for each of the groups that report to the Committee. The document also lists each group's chair and, as appropriate, vice chair and NAIC staff support.

Ms. Matthews highlighted a few of the additional projects some of the groups, including the Committee itself, most likely will have to take on in addition to the work in their 2021 ongoing charges. She said the Consumer Information (B) Subgroup most likely will be tasked with preparing new consumer-facing materials related to health equity and diversity based on recommendations from Workstream Five. She said the Subgroup also anticipates completing additional work related to the NSA and the ARPA as it discussed during its April 1 meeting.

Ms. Matthews said the Health Innovations (B) Working Group will continue its work to gather and share information, best practices, experience and data to inform and support health innovation at the state and national levels with respect to the ACA and other health policy initiatives. She said over the last year, in part, because of the COVID-19 pandemic and how the federal

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government and the states have used telehealth to address issues with access, the Working Group has been focusing on telehealth issues. She said based on a new 2021 charge from the Special Committee, as recommended by Workstream Five, it is anticipated that the Working Group will continue its focus on telehealth, but with respect to health equity and diversity issues.

Ms. Matthews said the Health Actuarial (B) Task Force will continue its work related to the ACA; but in addition to that work, the Task Force could take on additional work related to recently enacted federal legislation, such as the NSA and the ARPA. She said the Task Force recently submitted its recommendations to the CMS for the definition of “Geographic Regions” in the NSA.

Ms. Matthews said the Regulatory Framework (B) Task Force will continue to supervise the work of its working groups and subgroups. She said as Commissioner Conway discussed during this report to the Committee, the Task Force will be meeting soon to finalize a new charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup for it to begin work on a white paper that will discuss options for the states to regulate certain PBM business practices and the effect, if any, the decision the *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* case may have on those options. She said the Employee Retirement Income Security Act (ERISA) (B) Working Group is also anticipated to meet to discuss the *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* decision from the ERISA preemption perspective and consider revising the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook), as appropriate, to include a discussion of the case. The MHPAEA (B) Working Group will begin work related to its anticipated new charge from the Special Committee to examine health equity and diversity in the mental health and substance use disorder (MH/SUD) treatment context during a meeting on April 21.

Ms. Matthews said the Senior Issues (B) Task Force will continue its core mission to examine issues affecting older Americans. She said like last year, it is anticipated that the Task Force will focus on long-term care insurance (LTCI) issues. The Task Force established a new subgroup, the Long-Term Care Insurance Model Update (B) Subgroup, to review the existing NAIC LTCI models to determine if any changes need to be made. She said that in addition to this work, the Subgroup will also consider any additional changes to these models as a result of the Long-Term Care Insurance (EX) Task Force’s discussions.

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

July 1, 2021 / May 25, 2021

Meeting Summary Report

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met July 1 and May 25, 2021. During these meetings, the Subgroup:

1. Discussed a plan to complete several short consumer guides on the claims process.
2. Discussed draft claims process-related guides—appeals process, medical necessity, explanation of benefits (EOBs), claims filing and billing codes and claims. The Subgroup agreed to consider and make edits to the guides over the next few weeks. Following completion of the edits, the Subgroup anticipates conducting an e-vote of the Subgroup members after the Summer National Meeting to consider adoption of the guides.

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Draft: 7/19/21

Consumer Information (B) Subgroup
Virtual Meeting
July 1, 2021

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met July 1, 2021. The following Subgroup members participated: Mary Kwei, Chair (MD); Debra Judy, Vice Chair, and Tara Smith (CO); William Rodgers (AL); Randy Pipal (ID); Michelle Baldock, Ryan Gillespie, and Sara Stanberry (IL); Alex Peck and Jenifer Groth (IN); Brenda Johnson (KS); Sherry Ingalls and Judith Watters (ME); Camille Anderson-Weddle, Carrie Couch, Amy Hoyt, Jessica Schrimpf, and Michelle Vickers (MO); Kathy Shortt (NC); Laura Arp and Barbara Peterson (NE); Mike Rhoads and Rebecca Ross (OK); Katie Dzurec, Elizabeth Hart, and Lars Thorne (PA); Gretchen Brodkorb, Candy Holbrook, and Jill Kruger (SD); Heidi Clausen and Tanji J. Northrup (UT); and Jennifer Stegall (WI). Also participating was: Jana Jarret (OH).

1. Adopted its May 25 and April 1 Minutes

The Subgroup met May 25 and April 1. During its May 25 meeting, the Subgroup discussed a plan to complete several short consumer guides on the claims process. During its April 1 meeting, the Subgroup took the following action: 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); and 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.

Mr. Rhoads made a motion, seconded by Ms. Dzurec, to adopt the Subgroup's May 25 (Attachment 1) and April 1 (Attachment 2) minutes. The motion passed unanimously.

2. Discussed Briefs on the Claims Process

Ms. Kwei brought up the draft guides to the claims process (see Attachments 3-7). She asked members and interested parties to send detailed wording changes by email.

Ms. Kwei asked for comments on the guide to filing claims. Kris Hathaway (AHIP) said her organization would send detailed wording changes. She also said the claims guide references explanations of benefits, but it did not explain what an explanation of benefits (EOB) is. She suggested linking to the separate guide on EOBs. Harry Ting (Health Care Consumer Advocate) suggested the guide include a recommendation for consumers not to pay a bill from a provider before their health insurer has processed a claim. He also suggested a recommendation for consumers to tell their providers about all insurance plans they are enrolled in in order to facilitate coordination of benefits.

Ms. Kwei brought up the guide on understanding EOBs. Mr. Ting said that consumers with more than one insurance plan should expect separate EOBs from each of their plans. Ms. Hathaway questioned whether the guide should reference surprise billing. Ms. Kwei said the group plans a separate guide on surprise billing. Ms. Judy asked about the reference to alternate addresses to send an EOB in case sending one to the policyholder would put an individual in danger. She said the language could also reference confidential services even without a threat of danger.

Ms. Kwei asked for comments on the guide on understanding claims denials. Ms. Watters said that consumers must receive information on how to appeal in their denial letter, but the sample letter in the draft is a helpful resource for consumers.

Ms. Kwei brought up the guide on medical necessity. Mr. Ting questioned whether the guide provides more detail than consumers are looking for. Ms. Watters said the content is challenging and hard to make consumer-friendly. Ms. Kwei said providers' offices could use the document in addition to consumers. Bonnie Burns (California Health Advocates—CHA) said the guide should refer consumers to the provisions in their plan documents rather than list complex definitions directly. Ms. Arp clarified the difference between consumer and provider appeals, saying that consumer appeals come with additional rights. She said she approves of the current language. Ms. Dzurec said that it would not be a bad thing if content from the documents overlapped and that complex medical necessity terms could be useful for some consumers. Ms. Jarret and Ms. Kruger said the guide should point out that medical necessity does not guarantee coverage of a service. Brenda J. Cude

(University of Georgia) asked about the difficult language in the medical necessity definition. Ms. Arp said the details are important for some cases and suggested referencing denials based on medical decision-making. Ms. Cude asked whether the language comes from plan language or state law.

Ms. Kwei asked for comments on the guide to claims codes. Ms. Hathaway said AHIP has suggested changes and examples to add in this guide.

Ms. Kwei said the Subgroup has held off on drafting a guide on balance billing while it awaits rules from the federal government under the NSA. She asked whether the Subgroup should continue to wait. Ms. Hathaway said that since rules are expected soon, the Subgroup should wait until its next meeting. Others agreed.

Ms. Kwei asked for comments on the overall structure of the guides. Ms. Judy and Ms. Cude supported the use of a question and answer (Q&A) format. Ms. Kwei asked whether the guides should be formatted or in plain text. Subgroup members said their states would want to add branding, so plain versions are preferred.

The Subgroup agreed to provide further edits within two weeks.

Ms. Shortt said she missed the early part of the meeting and asked about changes to the guide on medical necessity. She said the definitions were taken almost directly from the North Carolina statute. Ms. Kwei said some readers would appreciate more general descriptions, but others will want to know precisely what the statute says. Ms. Watters suggested more general language that then directs readers to each states' laws. The Subgroup discussed whether to use general language with pointers to other sources. Eric Ellsworth (Consumers Checkbook) said that health insurers should be encouraged to post their definitions of medical necessity on their websites. Ms. Shortt, Ms. Arp, and Ms. Cude agreed to collaborate on updates to the medical necessity guide.

Ms. Kwei said the Subgroup plans to conduct an e-vote on the final documents once edits have been made.

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

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Draft: 6/4/21

Consumer Information (B) Subgroup
Virtual Meeting
May 25, 2021

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met May 25, 2021. The following Subgroup members participated: Mary Kwei, Chair, and Paul Meyer (MD); William Rodgers and Anthony L. Williams (AL); Michele Mackenzie, Kathy McGill and Randy Pipal (ID); Michelle Baldock and Ryan Gillespie (IL); Alex Peck (IN); LeAnn Crow, Brenda Johnson and Tate Flott (KS); Judith Watters (ME); Helen Bassett, Galen Benshoof and Candace Gergen (MN); Camille Anderson-Weddle, Carrie Couch, Amy Hoyt, Jessica Schrimpf and Michelle Vickers (MO); Kathy Shortt (NC); Laura Arp and Martin Swanson (NE); Kurt Cagle and Mike Rhoads (OK); Katie Dzurec and Elizabeth Hart (PA); Gretchen Brodkorb, Lisa Harmon and Jill Kruger (SD); David Combs, Bill Huddleston, Jennifer Ramcharan and Vickie Trice (TN); Tanji J. Northrup, Shelley Wiseman and Jaakob Sundberg (UT); and Barbara Belling, Eric Cormany, Diane Dambach, Darcy Paskey, Jennifer Stegall, Jody Ullman and Julie Walsh (WI). Also participating was: Jana Jarrett (OH).

1. Discussed Briefs on the Claims Process

Ms. Kwei noted that the Subgroup had finalized its addendum to the Frequented Asked Questions about Health Care Reform (FAQ) document, and she said the Subgroup would return to the FAQ document prior to the beginning of Open Enrollment in the fall. She said the Subgroup would next turn to consumer guides on the claims process, as had been discussed on previous calls.

Ms. Kwei asked for input from Subgroup members and interested parties on how the guides should be written. Bonnie Burns (California Health Advocates—CHA) asked whether the guides would take the form of a FAQ document. Ms. Kwei responded that she is open to suggestions; although, she said she envisioned a series of separate, stand-alone guides that were brief, hopefully 1–2 pages. She mentioned that one of the most popular documents Maryland makes available to consumers is a short one on in- versus out-of-network claims issues, with definitions, explanations and FAQ. Ms. Shortt said North Carolina provides consumers with a six page toolkit on medical necessity denials that helps consumers through their own appeals. Ms. Jarrett suggested that the documents be thought of as tip sheets or infographics rather than guides. Harry Ting (Healthcare Consumer Advocate) said an existing brochure from Colorado is a useful model for appeals, as well as a sample letter Pennsylvania provides. Eric Ellsworth (Consumers Checkbook) said consumers need examples of what can be challenged through appeals and what cannot.

Ms. Kwei listed the topics that had been proposed and discussed on past calls, including filing claims; understanding explanations of benefits (EOBs); how to appeal a denial; medical necessity; balance billing; and CPT codes. Ms. Burns said the issues with current procedural terminology (CPT) codes should be covered in the guide to denied claims. She noted that individuals covered by Medicare and Medicaid have different issues with appeals, and there are a good deal of existing documents for the Medicare population. She asked whether EOBs are similar enough across insurers and different types of insurance (TOIs) that one guide could help with all of them. Ms. Kwei said EOBs are not standardized, but they all follow a general template. Ms. Dzurec said denial codes may not fully explain the reason a claim was denied; she said medical necessity may be implicated without being mentioned. She said those who appeal should start with the TOI, because the regulatory agency and potential helpers differ. She said after that determination, there is some baseline content that the Subgroup can develop, then work with sister agencies to determine what is helpful for those covered by other TOIs.

Joe Touschner (NAIC) asked whether the guides are intended for enrollees in state-regulated plans or for consumers with any type of coverage. Ms. Kwei said there is often a distinction made between public plans and commercial plans, and commercial plans include self-funded plans and others not regulated by the state. She said the focus should be on the plans states regulate; although, a guide on how to read an EOB should be applicable for non-state regulated plans, as well. Mr. Ting said a guide should have content for any consumer, regardless of their coverage source, even if it does not go into detail. Mr. Ellsworth said consumers want an answer to their question, not to understand how the health care system works. He suggested organizing around a specific situation a consumer is in. He said FAQ can offer smaller bits of information that are easier to read and better able to be formatted on a mobile-friendly web page.

Ms. Kwei asked about existing documents that can serve as models for the guides. Ms. Dzurec said Pennsylvania could share the script for its YouTube videos. The Subgroup discussed the benefits of both digital and paper-based materials.

Ms. Burns said consumers are interested in getting answers to their questions; i.e., what it is, what they are looking at, why it happened, what they can do about it, and where they can get help.

Ms. Shortt explained that North Carolina has a unit that helps consumers file appeals with their insurers, and it provides sample appeal letters, as well as brochures, that explain how to reach the department.

Ms. Watters suggested producing a document that is broad to increase literacy, rather than a specific how-to in constructing an appeal.

Ms. Kwei asked for an individual to take the lead on each of the topics, with others assisting. Subgroup members volunteered for each of the topics, except balance billing. Ms. Kwei suggested that the balance billing guide should wait until more is known about federal regulations under the No Surprises Act. Kris Hathaway (America's Health Insurance Plans—AHIP) said her organization would soon complete a consumer-facing one-pager on the No Surprises Act and would share it with the Subgroup. Ms. Kwei said each topic should be covered in one to two pages; for some, a graphic may be the best way to explain it.

Ms. Burns asked if in- and out-of-network concepts should be included. Ms. Kwei said those concepts could be included in the other topics.

The Subgroup agreed that draft guides for each topic should be completed by the end of June.

Ms. Hathaway offered to review the guides for consistency with health plan operations.

2. Discussed Other Matters

Ms. Kwei said some questions have been raised regarding how the Subgroup can better reach consumers with its materials. She said the various sources of coverage, different insurance regulators, and variety of consumer situations all create challenges to having general materials. She said the Subgroup generally relies on states to fill in the specifics where they can. She said the Subgroup is open to suggestions on how it can better fulfill its charges, which center around developing resources for state insurance regulators and others who assist consumers.

Mr. Ting said consumer representatives are concerned that many consumers do not look for information online from insurance departments. He said departments should get the information out to consumers, rather than wait for consumers to come to the departments. He suggested a survey to identify best practices among the states. He said some examples are distributing guidance on choosing plans to consumers who disenroll from Medicaid or file unemployment claims. Ms. Arp said search optimization is important to ensure that insurance department materials come up when consumers search for information on claim denials or other issues. Ms. Dzurec suggested working with communications staff to think about how to better optimize for searches and otherwise break down silos between drafters and communications work.

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

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Virtual Meeting

(in lieu of meeting at the 2021 Summer National Meeting)

HEALTH INNOVATIONS (B) WORKING GROUP

Tuesday, July 27, 2021

3:00 – 4:30 p.m. ET / 2:00 – 3:30 p.m. CT / 1:00 – 2:30 p.m. MT / 12:00 – 1:30 p.m. PT

Meeting Summary Report

The Health Innovations (B) Working Group met July 27, 2021. During this meeting, the Working Group:

1. Adopted its March 26 minutes, which included the following action:
 - A. Heard presentations on telehealth.
 - B. Discussed state responses to COVID-19.
2. Discussed its approach to fulfilling charges received from the Special (EX) Committee on Race and Insurance.
3. Heard presentations on hospital price transparency requirements from the federal Centers for Medicare and Medicaid Services (CMS) Center on Medicare and on insurer price transparency requirements from the CMS Center for Consumer Information and Insurance Oversight (CCIIO).
4. Heard a presentation from FAIR Health on its research and resources related to health care price transparency.
5. Heard a presentation from Consumers' Checkbook on ways to make health care price information relevant and understandable for consumers.

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Draft: 8/10/21

Health Innovations (B) Working Group
Virtual Meeting (*in lieu of meeting at the 2021 Summer National Meeting*)
July 27, 2021

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met July 27, 2021. The following Working Group members participated: Andrew R. Stolfi, Chair, and TK Keen (OR); Laura Arp, Co-Vice Chair (NE); Nathan Houdek and Jennifer Stegall, Co-Vice Chairs, Barbara Belling, Diane Dambach, Darcy Paskey, Jody Ullman, and Richard Wicka (WI); Andria Seip and Cynthia Banks Radke (IA); Stephen Chamblee, Meghann Leaird, and Alex Peck (IN); Craig Van Aalst, Julie Holmes, Vicki Schmidt, and Tate Flott (KS); Sherry Ingalls, Joanne Rawlings-Sekunda, and Mary Hooper (ME); Karen Dennis, and Sarah Wohlford (MI); Galen Benshoof (MN); Carrie Couch, Chlora Lindley-Myers, and Amy Hoyt (MO); Chrystal Bartuska, John Arnold, Angie Voegele and Karri Volk (ND); Lisa Cota-Robles, Michelle Heaton and Maureen Belanger (NH); Philip Gennace (NJ); Paige Duhamel and Viara Ianakieva (NM); Jessica K. Altman and Sandra L. Ykema (PA); Rachel Bowden, Valerie Brown, Blake Davenport, R. Michael Markham, Dylan MacInerney, Monica Pinon, and Barbara Snyder (TX); Heidi Clausen, Shelley Wiseman, Tanji J. Northrup, and Jaakob Sundberg (UT); Jane Beyer and Jennifer Kreitler (WA); and Joylynn Fix (WV).

1. Adopted March 26 Minutes

The Working Group met March 26 and took the following action: 1) heard presentations on telehealth policy changes during the COVID-19 pandemic; and 2) discussed changes to state insurance department business practices during the pandemic. Commissioner Altman made a motion, seconded by Commissioner Schmidt, to adopt the Working Group's March 26 minutes (*see NAIC Proceedings – Spring 2021, Health Insurance and Managed Care (B) Committee, Attachment Two*). The motion passed unanimously.

2. Discussed New Charges from the Special (EX) Committee on Race and Insurance

Commissioner Stolfi brought up charges for the Working Group recently approved by the Special (EX) Committee on Race and Insurance. He said they focus on two methods that could be used to reduce disparities, including telehealth and alternative payment models. He said they also ask the Working Group to evaluate programs to reduce racial disparities. Commissioner Stolfi said a potential way is to gather information on two questions: 1) Does telehealth reduce disparities by improving access to care?; and 2) Do alternative payment models reduce disparities by improving access to care? He said after evaluating the questions, the Working Group could make recommendations to the Health Insurance and Managed (B) Committee and ultimately the Special (EX) Committee on Race and Insurance.

Commissioner Stolfi asked for input on this approach. Commissioner Altman said the plan makes sense. She said that telehealth could possibly exacerbate disparities but also has the potential to reduce them. Commissioner Stolfi said another part of the charge centers on programs to improve access to historically underserved communities. He asked Working Group members and interested parties to send ideas and programs that should be addressed under this part of the charge.

3. Heard Presentations on Price Transparency

Commissioner Stolfi said price transparency ideally would be beneficial to consumers and that it could change dynamics between payers and providers and reduce costs.

Dr. Terri Postma (federal Centers for Medicare and Medicaid Services—CMS Center for Medicare) provided an overview of the hospital price transparency requirements. She said the rule is a first step and must be viewed in context with other transparency rules. She said prior rules required chargemaster prices to be posted online. She said that due to concerns with this rule, the CMS updated the rules to require hospitals to post their standard charges in two ways. She said they must display charges for “shoppable” services in consumer-friendly formats and all charges in machine-readable format. She outlined key definitions in the rule, including which hospitals must comply, how items and services are identified, and what “standard charges” means. She noted the monitoring and enforcement authorities of the CMS.

Matthew Lynch (federal Center for Consumer Information and Insurance Oversight—CCIIO). Mr. Lynch said a recent executive order on transparency shows the administration's commitment to the issue. He reviewed the transparency in coverage

requirements applicable to insurers. Mr. Lynch identified the two key provisions as: 1) a requirement for a self-service price comparison tool for consumers to determine their out-of-pocket costs in advance of a service; and 2) a requirement to post prices for 500 shoppable services by January 2023. He said insurers must disclose the remainder of services by January 2024. He said the rule also requires posting of machine-readable files with in-network negotiated rates and historical out-of-network payments. He said states have primary enforcement authority, so the CMS would enforce only if a state does not substantially enforce, with the exception of federal Employee Retirement Income Security Act (ERISA) plans. He provided the email for questions about the insurer transparency rules, PriceTransparencyinCoverage@cms.hhs.gov.

Commissioner Stolfi asked what level of compliance the CMS has seen with the rules. Dr. Postma said the CMS has conducted proactive audits since January and also received complaints. She said her impression is most issues are with the comprehensive machine-readable file requirement. She said the CMS plans an open-door forum to clarify the requirement. She said some hospitals offer price estimator tools that give a range of prices, not a consumer-specific amount that takes their insurance coverage into consideration.

Dr. Postma discussed billing codes, clarifying the different types of codes used to classify prices. Mr. Lynch said the CCIIO would use similar codes.

Commissioner Stolfi asked about the shoppable services. Dr. Postma said her team worked with the CCIIO to analyze Exchange data and other research to identify commonly used services. Mr. Lynch said the CCIIO looked at both commonly used services and services that have wide cost differences in the same geography.

Mr. Sundberg asked whether price transparency could lead hospitals to raise prices and how prices could be tracked over time to determine if prices do increase. Dr. Postma said the CMS concluded that the benefits of transparency greatly outweigh the risk of higher prices. She said machine-readable files must include date information. Mr. Lynch said the long-term goal is lowering prices, but in the short-term, there could be an effect of reduced dispersion in prices, which would include raising the lowest prices and lowering the highest.

Robin Gelburd (FAIR Health) outlined FAIR Health's work as a private claims repository. She said FAIR Health works with federal agencies and state governments to provide trusted, independent data. She discussed the tools FAIR Health makes available for consumers to research medical costs, including both in-network and out-of-network prices. She said integrating price transparency into clinical decision aids can improve shared decision making between patients and providers. She mentioned FAIR Health's research and resources, including reports on COVID-19 and a monthly telehealth tracker.

Eric Ellsworth (Consumers' Checkbook) presented on how greater data would be more useful for consumers. He said consumers shop not only on cost, but also on value, so health care shopping should evolve in that direction. He said price transparency is a big step forward, but consumers still lack key information to aid their shopping. He said that consumers do not order medical services for themselves and that insurers determine payment amounts. He pointed out that consumers often hold the risk for unexpected costs and bad outcomes and that they may never know the full cost of their care. He said consumer needs include individual provider-level quality information, better information on network status, cost information organized around consumer decisions rather than billing codes, detailed estimates of costs with contingency information, and better protection from claim denials. He described requirements for advance explanations of benefits (EOBs) as a game changer, but he said machine-to-machine data flows need to be improved. He said patient-reported outcomes are the biggest gap in quality reporting.

Commissioner Stolfi asked about the use of data from All Payer Claims Databases (APCDs). Ms. Gelburd said that FAIR Health conducted a pilot with New York to make APCD data available to consumers.

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

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*Virtual Meeting**(in lieu of meeting at the 2021 Summer National Meeting)***REGULATORY FRAMEWORK (B) TASK FORCE**

Wednesday, July 28, 2021

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

Meeting Summary Report

The Regulatory Framework (B) Task Force met July 28, 2021. During this meeting, the Task Force:

1. Adopted its June 15 and March 25 minutes, which included the following action:
 - A. Discussed and adopted a new 2021 charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper on issues related to the state regulation of certain pharmacy benefit manager (PBM) business practices and the effect, if any, of the recent U.S. Supreme Court decision in *Rutledge v. the Pharmaceutical Care Management Association (PCMA)* on these current and emerging state laws and regulations regulating such business practices. The white paper will also examine the role PBMs, pharmacy services administrative organizations (PSAOs), and other prescription drug supply chain entities play in the provision of prescription drug benefits.
2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its July 12 and June 7 minutes. During these meetings, the Subgroup took the following action:
 - A. Established a new public comment period ending July 2 to receive comments on Sections 1–7 of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)*.
 - B. Began discussion of the comments received on Sections 1–7 of Model #171 received by the July 2 public comment deadline. The Subgroup anticipates meeting approximately every two weeks to continue its discussions of the comments received.
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. The Working Group plans to meet July 30 in to discuss any 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* with respect to ERISA preemption of state laws regulating PBM business practices. The Working Group will also discuss 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 PBM business practices. Following these discussions, the Working Group 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, including its July 20 and April 21 minutes. During these meetings, the Working Group took the following action:
 - A. Received an update from the U.S. Department of Labor (DOL) and the federal Centers for Medicare & Medicaid Services (CMS) on their work related to the recently enacted federal Consolidated Appropriations Act of 2021 (CAA), which amended the MHPAEA to provide important new protections. In anticipation of new 2021 charges from the Special (EX) Committee on Race and Insurance, the Working Group also discussed equity and diversity in the mental health/substance use disorder (MH/SUD) treatment context. The Working Group plans to meet Aug. 5 to hear a provider perspective on mental health parity.

- 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 plans to resume meeting after the Summer National Meeting to work on a new 2021 charge to develop a white paper on issues related to the state regulation of certain PBM business practices. The white paper will also examine the role PBMs, PSOs, and other prescription drug supply chain entities play in the provision of prescription drug benefits.
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 recent publications, including a 50-state survey of state employee benefit plans and efforts to restrain health care costs and state actions to expand telemedicine access during COVID-19 and future policy considerations. The CHIR is researching and expects to release issue briefs or blogs on standardized plans, limited plan sales, state "Easy Enrollment" programs, efforts by select state-based marketplaces (SBMs) to improve health equity, and small group health insurance market trends. The CHIR presentation also highlighted some of the CHIR's future work related to NSA implementation and technical assistance available to the states and its ongoing work related to network adequacy. The CHIR will also be looking more closely at health care cost containment through initiatives such as federal and state public option programs and the role of ERISA and its impact on state efforts to address cost containment with respect to employer plans.
7. Heard a presentation on the NSA's interim final rules and implications for the states. The presentation provided an overview of the NSA's scope, including what types of plans it covers and where its protections apply. The NSA's interim final rules were issued July 1 with an effective date of Sept. 13. The interim final rules include provisions focused on both patients and regulated entities. The patient-focused provisions outline how patients can calculate cost-sharing, include notice-and-consent waivers provisions, and establish a consolidated complaints process. The regulated entities-focused provisions outline how to calculate the qualifying payment amount and include disclosure requirements and provisions related to communications between insurers and providers. 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. As noted in the presentation, the NSA is silent on which state agency is to enforce the NSA's provider provisions. The presentation also highlighted key considerations for the states, particularly that state laws can be more protective of consumers if the state law does not "prevent the application of federal law." It is anticipated that the federal government will issue additional NSA rules in 2021, including federal rules on the independent dispute resolution process (interim final rule) and enforcement and air ambulance data reporting (proposed rule). The presentation noted that additional federal rulemaking will occur over time on other NSA requirements, such as accurate provider directories, gag clauses, and PBM reporting requirements. However, these rules will not be promulgated prior to the NSA's 2022 effective date.

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

SENIOR ISSUES (B) TASK FORCE

Thursday, July 29, 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

Meeting Summary Report

The Senior Issues (B) Task Force met July 29, 2021. During this meeting, the Task Force:

1. Adopted its June 8 minutes, which included the following action:
 - A. Adopted its Feb. 23 and Oct. 20, 2020, minutes.
 - B. Discussed an article on bundling Medicare Supplement and Short-Term Care.

2. Adopted the report of the Long-Term Care Insurance Model Update (B) Subgroup, which included its July 15, May 27, May 6, and April 22 minutes.

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Agenda Item #3

Hear a Discussion from the Biden Administration on the Implementation and Enforcement of the Federal No Surprises Act (NSA) Provider Requirements—*Jeff Wu (Center for Consumer Information and Insurance Oversight—CCIIO)*

Agenda Item #4

Hear a Panel Discussion on NSA Provider Compliance and Enforcement Issues

—*Molly Smith (American Hospital Association—AHA), Emily Carroll (American Medical Association—AMA) and Melanie de Leon (Federation of State Medical Boards—FSMB)*



**American Hospital
Association™**

Advancing Health in America

No Surprises Act: Provider Compliance and Enforcement Issues

National Association of Insurance Commissioners:
Health Insurance and Managed Care Committee

August 16, 2021

Key Messages

- ✓ Hospitals and health systems strongly support patient protections against surprise medical bills and will work diligently to be in compliance as of January 1, 2022.
- ✓ The No Surprises Act is a large and comprehensive piece of legislation with a number of different interdependent policies. Stakeholders will need time to implement the various components and need adequate and comprehensive guidance from both the federal and state governments.
- ✓ Oversight will be critical; yet, the role of the federal government and states is insufficiently clear on a number of key points.

Primary Implementation Issues

- Gaining clarity on scope and application of policies: Which patients? Which plans? Which law?
- Developing notice/consent and disclosure documents and policies and building into work flows.
- Developing processes to send/receive information from plans and issuers absent standard electronic transactions.
- Training, training, training – leadership, intake, scheduling, revenue cycle, financial assistance, etc.

Priority Areas for Oversight/Enforcement

Providers

- Adherence to the ban on balance billing, incl. proper cost-sharing
- Appropriateness of transfers
- Proper notice/consent procedures followed
- Sharing of good faith estimates

Plans/Issuers

- Facilitate transfers
- Calculation of the QPA & timely sharing of patient cost-sharing amount with providers
- Payment to providers
- Development of advanced EOBs
- Network adequacy?

Oversight & Enforcement Challenges

1. Complexity of the Rules (Examples Only)

	Emergency Services - OON	Post-Stabilization - OON		Scheduled Service - Facility IN; Provider OON		Scheduled Service – All IN	Scheduled Service – All OON
	Applies Equally to Facility and Provider	Facility	Provider	Facility	Provider	Applies Equally to Facility and Provider	Applies Equally to Facility and Provider
Balance Billing Protections Apply	Yes	Yes	Yes	No	Yes	No	No
Eligible for Balance Billing Through Notice/Consent, including Good Faith Estimate	No	Yes	Maybe, depends on type of provider	N/A	Maybe, depends on type of provider	N/A	N/A
Good Faith Estimate/ Advanced EOB Required (Sections 111, 112)	No	Assume no, but may depend on definition of “scheduled” for purposes of these sections	Assume no, but may depend on definition of “scheduled” for purposes of these sections	Maybe, depends on definition of “upon request”			

Examples of Oversight and Enforcement Challenges

2. Timeline & Standards for Implementation (Examples Only)

	Date to Implement	Work Force Training Work Flow Modification Technology Changes	Standard Transaction Available	Federal Guidance Released	Dependent on Implementation of Other Provisions
Balance Billing Protections Requirements	January 1, 2021 (unless plan year begins later?)	Yes	N/A	Yes	Yes – Calculation of QPA
Notice/ Consent	January 1, 2021 (unless plan year begins later?)	Yes	No – needed to share forms with plans	Yes	Yes – Good Faith Estimates
Good Faith Estimate	January 1, 2021 (unless plan year begins later?)	Yes	No – needed to share information with plans	No	No
Advanced EOB	January 1, 2021 (unless plan year begins later?)	Yes	No – needed to share information with providers	No	Yes, AEOB dependent on GFE; patient consent (?)
Qualifying Payment Amount	January 1, 2021 (unless plan year begins later?)	Yes (though defer to plans/issuers)	No	Yes	No

Oversight and Enforcement Challenges

3. Federal or state responsibility? (Examples Only)

- Which oversight body has responsibility for each provision? Federal or state? State DOI or DOH?
- Will the states need to pass laws to enable them to fulfill their duties? If so, what will that mean for timely and consistent enforcement of a federal law?
- Will there be national standards to minimize variation?
- What data and reporting infrastructure exists to ensure tracking of complaints and outcomes nationally?

Recommendations

- Clear articulation of which components of the law will be overseen by the federal government and which by the states.
- Crosswalk between the federal and state laws and clear assessment of which states meet the standards for compliance on relevant provisions, e.g., notice and consent; and protections against balance billing.
- Clear standards for what constitutes adequate state oversight and an articulation of how the federal government plans to determine whether oversight is adequate.
- Data submission process with standards for states to report complaints and outcomes to the federal government for tracking and oversight.

Thank You and Discussion

Molly Smith

Group Vice President for Public Policy

American Hospital Association

mollysmith@aha.org



The No Surprises Act

National Association of Insurance Commissioners

**Emily Carroll
American Medical Association
August 16, 2021**

No Surprises Act

Surprise medical billing

- Patient cost-sharing protections
- Payment to providers
- Open negotiations and independent dispute resolution

Balance billing/notice and consent

Price transparency/advanced EOBs

Directories

Continuity of care

APCDs

Challenges and opportunities in implementing the NSA

Open negotiations and IDR Process

State preemption

Notice and consent

Advanced EOBs

Enforcement

Open negotiations and the independent dispute resolution process

- Accessibility of IDR process
- Timelines
- Initial payments or denials
- Batching of claims
- “Cooling off” period
- Putting the QPA in context

State preemption

- Specified state law
- Scope of federal law and interaction between federal and state laws
- State opt-ins provisions
- Clarity on which laws apply for patients and providers
- Additional guidance?

Notice and consent requirements

- Guidance included in July 12th IFR
- Accessibility of information to be included
- Good faith estimates
- Interaction with existing state requirements
- Standard forms

Good faith estimates and advanced EOBs

- Ensuring meaningful information to patients
- Changes to the practice workflow
- Timelines
- Need for standard automated transactions
- Interaction with other transparency initiatives

Enforcement

- State enforcement for state regulated plans
- Federal enforcement for self-funded group plans and state-regulated plans when state fails to substantially enforce.
- State agency to enforce provider provisions
- Penalties on providers up to \$10,000
- Good faith efforts at compliance for some remaining provisions

Looking ahead



**The No Surprises Act : A Process
for Collaboration in Compliance**

**Melanie de Leon, JD
August 16, 2021**

Federation of State Medical Boards (FSMB)



**FEDERATION OF
STATE MEDICAL BOARDS**

- ✓ Founded in 1912, we are the national, non-profit organization that represents all 70 of the state medical and osteopathic boards across the United States
- ✓ State medical boards protect the public through the licensing, disciplining and regulation of 1 million+ physicians, PAs, and other health care professionals
- ✓ FSMB supports state medical boards through education, assessment, research and advocacy and promotes regulatory best practices across states

FSMB Vision and Mission



VISION

The FSMB supports state medical boards as they **protect** the public and promote quality health care, partnering and innovating with them to shape the future of medical regulation.



MISSION

Serves as a national voice for state medical boards, **supporting** them through education, assessment, data, research and advocacy while **providing** services and initiatives that promote patient safety, quality health care and regulatory best practices.

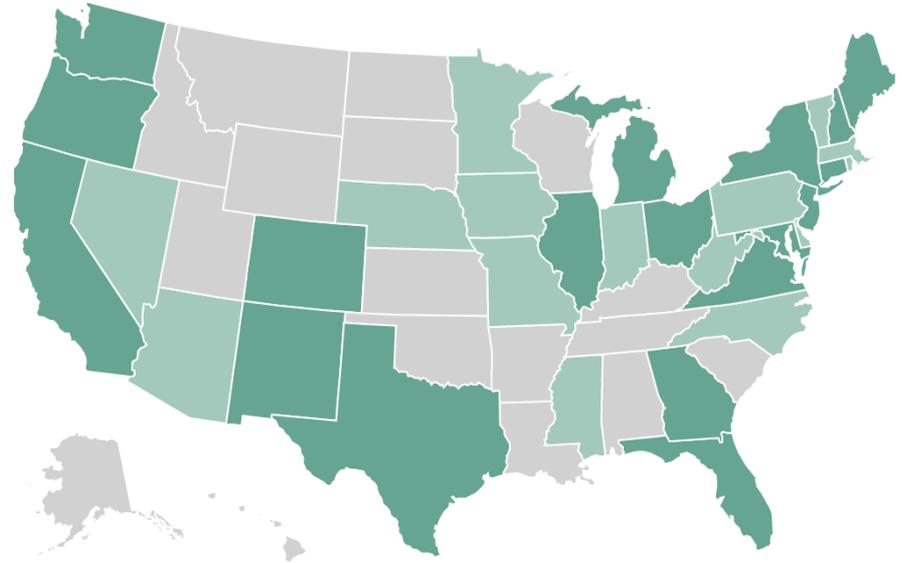
Related FSMB Policy

Guidelines for the Structure and Function of a State Medical and Osteopathic Board (House of Delegates May 2021)

- ✓ *Section XV, Grounds for Action: The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct, which should be defined to mean, but not be limited to, the following. .*
- ✓ *27. Employing abusive, illegal, deceptive, or fraudulent billing practices*

Surprise Billing State Laws

- ✓ Thirty-three (33) states have some form of balance bill protection laws
- ✓ Fourteen (14) states have partial balance bill protections
- ✓ Nineteen (19) states have comprehensive balance billing protections



- No Balance Billing Protections
- Partial Balance Billing Protections
- Comprehensive Balance Billing Protections

Washington Balance Billing Protection Act



APPLICABILITY

An out-of-network provider or facility may not balance bill for:

- ✓ Emergency services or
- ✓ Nonemergency health care services provided at an in-network hospital or an in-network ambulatory surgical facility if the services:
 - ❖ Involve surgical or ancillary services and
 - ❖ Are provided by an out-of-network provider.

Enforcement



PARTICULARS

- ✓ Goal is to give the provider or facility a chance to correct or cure its behavior
- ✓ If a provider has engaged in a *pattern* of unresolved violations regulator may levy a fine or cost recovery
- ✓ A pattern of violations constitute unprofessional conduct under the Uniform Disciplinary Act

Collaboration



PARTNERSHIP

- ✓ Office of Insurance Commissioner may submit information regarding violations to disciplining authority for action
- ✓ MOU regarding data sharing
- ✓ No complaints to regulator yet



Thank you!

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)*

Agenda Item #6

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