HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Aug. 16, 2021, Minutes
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Draft Pending Adoption

Draft: 8/23/21

Health Insurance and Managed Care (B) Committee
Columbus, Ohio
August 16, 2021

The Health Insurance and Managed Care (B) Committee met in Columbus, OH, Aug. 16, 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 (WA); and James A. Dodrill represented by Ellen Potter (WV). Also participating were: Alan McClain (AR); David Altmaier (FL); Doug Ommen (IA); Mike Chaney (MS); Troy Downing (MT); Eric Dunning (NE); Barbara D. Richardson (NV); Elizabeth Kelleher Dwyer (RI); Carter Lawrence (TN); Doug Slape (TX); Don Beatty (VA); and Tregenza A. Roach (VI).

1. Adopted its June 22 and Spring National Meeting Minutes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Melanie de Leon (Federation of State Medical Boards—FSMB) presented on “The No Surprises Act: A Process for Collaboration in Compliance.” She described the FSMB, including its role and functions, which is to support state medical boards through education, assessment, research, and advocacy as well as promoting regulator best practices across the states. She discussed how the NSA presents an opportunity for collaboration between stakeholders in complying with its requirements. In focusing on this, Ms. de Leon highlighted Washington’s balance billing law. She discussed how Washington is enforcing its
law with a goal of giving providers and facilities a chance to correct or cure any violations. She also discussed how the Washington Department of Insurance (DOI) has established a partnership with state agencies with provider oversight to share information regarding any violations of the Washington law. The Washington DOI has signed a memorandum of understanding (MOU) regarding data sharing to assist in this partnership effort. Ms. de Leon noted that, to date, the Washington DOI has not received any complaints involving provider violations.

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

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

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

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

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

   Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
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.
[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

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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.

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.
The 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 Kwe, 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 Two-A) and April 1 (see NAIC Proceedings – Spring 2021, Health Insurance and Managed Care (B) Committee, Attachment One) minutes. The motion passed unanimously.

2. Discussed Briefs on the Claims Process

Ms. Kwei brought up the draft guides to the claims process: 1) appeals (Attachment Two-B); 2) codes and claims (Attachment Two-C); 3) explanation of benefits (EOBs) (Attachment Two-D); 4) filing health care claims (Attachment Two-E); and 5) medical necessity (Attachment Two-F). 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 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 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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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 Schrimpfl 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 Corman, 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 Frequent 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 onePager 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.
When you use medical services, you or your provider file a claim to your health plan. Most of the time, the health plan will pay the claim, either directly to the provider or to you if you have already paid for your medical care. Sometimes your health plan will say “no” to a claim, infull or in part, for benefits or services you believe should have been covered. Here are the steps you can take:

**Filing an Internal Appeal**

By filing an internal appeal, you are requesting your health plan to review the denial decision in a fair and complete way. You have up to six months (180 days) after finding out your claim was denied to file an internal appeal.

- If the denial is for a medical reason, ask your health care provider to contact your health plan to request reconsideration of your claim based on additional information that your provider can supply. If your life, health, or ability to function could be jeopardized, you can request that the appeal be reviewed on an expedited basis.
- Ask your health plan how to file an internal appeal by contacting the customer service number provided on your insurance card, materials, or
- Write a letter to your health plan requesting an internal appeal. Make sure to include your name, claim number, and health insurance ID number. You should include any additional information, such as a letter from your provider, that helps support your claim. (See reverse side for sample letter.)

Upon receiving your request, your health plan has a specific amount of time to review and issue a decision on the internal appeal.

**Filing an External Review**

If your health plan does not change its decision as a result of the internal appeal, an external review can be requested. An external review is performed by an independent review organization. You must ask for an external appeal within a specific amount of time after receiving the decision of your internal appeal.

- Your internal appeal notice should provide information on requesting an external review.
- Your state’s insurance regulatory agency is usually in charge of the external review process.
- New information can be submitted to support your position.
- The external reviewer will provide you and your health plan with written notice of its decision within a specific amount of time after receiving the review assignment.
- If the external review results in a reversal of your health plan’s decision to deny, the company must approve benefits for the covered services.

*If you have questions or think your health plan is doing something wrong, contact your state insurance regulatory agency. A directory of all state insurance regulatory agencies is*
Health Care Bills: Codes and Claims

Most of the time, your health care provider will submit claims to your health insurance plan for you, and you don’t need to know how information is entered on the claim. However, sometimes you may have to submit a claim yourself, or your plan may deny a claim. When that happens, you will want to know more about claims and the billing codes used on them.

Why would I need to worry about codes?

When you see a provider who does not participate in your health plan’s network, you might have to file a claim with the plan yourself. Filing a claim means asking the plan to pay its portion of the health care provider’s bill. In order to process the claim, your health plan will need to know the proper codes. You will need to get an invoice from your provider that includes the codes to submit with your claim.

Your health plan may also deny a claim. When you contact your health plan, you might be told that the wrong code was used. Knowing how codes are used can help you get your bill paid.

How are codes used on a claim?

Information is entered on claims using codes. These codes are used as a way to describe the service you received. There are diagnosis codes, which may also be called the ICD-10 codes. Diagnosis codes describe the reason that you received treatment. There are procedure codes, which may be called the CPT codes. These codes describe the treatment you received. There are also codes used by facilities and hospitals to describe the services or supplies they provided.

All of these codes make it possible to send the insurance company detailed information in a condensed way. There are standard references that define the codes, often with very specific details. When a code is used, it gives a summary of a detailed diagnosis or service, using a few numbers.

Why would the health plan deny a claim based on the code?

A health plan may deny a claim if the code does not match the services that were performed or the services the plan expected based on the diagnosis. The definitions of codes can be detailed, and if the medical records don’t record each detail of a code definition, the claim may be denied for an incorrect code. There may be another code that describes the services better.

When you see a doctor for what are called evaluation and management services, there are different levels of codes. Most visits to your family physician are evaluation and management services. The doctor asks about your medical history, examines you, and makes a decision about how to treat you. The level of the service depends on how complex these steps are and how long they take. There are five levels of these services. If the doctor’s office bills for a higher level than was provided, the claim may be denied.

There are other reasons that a claim may be denied based on the code that was used. You can call your health plan to ask questions, and also ask the provider’s billing office to check the code. You can also file an appeal of a denied claim.
Health Care Bills: Explanation of Benefits

After your visit to your doctor or another health care provider, you'll receive information about your claim in the form of an Explanation of Benefits, or EOB. The EOB is not a bill. It is an explanation generated as part of the claims process and shows you the payment breakdown for the services received.

What does the EOB tell me?

Essentially, the EOB will tell you how much your provider charged, how much the health plan paid, and how much you are responsible for or owe your provider. Your EOB comes from your health plan and is separate from the bill your provider may send. Make sure to compare “owed” amounts listed on the EOB with the bill from your provider’s office or the co-pay you already paid.

What does the EOB look like?

This document may be mailed to you or be made available electronically in your member portal.

Not all EOBs look alike, but here are a few things to look for on your EOB:

- Information about the person receiving the services, including the ID number and the member name sometimes identified as “patient” – if it’s your insurance, the EOB will usually include the notation “self” when referring to the patient, if the insurance is through your spouse or your parent, then their name will be included on the EOB;
- A list of the services received, which should include the dates of service and may include billing codes – if the billing codes are not provided on the EOB, there should be notes about how to get the codes if you would like to review them;
Information about the provider or facility – this may be the name of a specific doctor, nurse practitioner, psychologist, physical therapist, etc., or it may be the name of a laboratory, hospital, or other office;

The amount billed by the provider or facility;

The “allowed” amount is the amount the health plan designates for each service – when you go to an in-network provider, the health plan will pay that provider all or a portion of a negotiated rate for the services provided. Do not be surprised if the allowed amount is lower than the provider/facility billed amount;

The amount the health plan paid for each service.

Any amount you owe to the provider – this amount may include the copay you paid in the office at the time of your visit;

Information about denials, additional details, or other notes – you may see codes in line with each service, and the codes should be defined below the table listing the services.

How else is an EOB helpful?

The EOB is also an important tool for tracking how much you have spent on out-of-pocket health care costs. It will tell you how far along you are in meeting your deductible and your out-of-pocket limit for the year. If you’ve reached your out-of-pocket limit and you are asked to pay for services, you should contact your health plan right away.

Finally, your EOB has instructions for filing a grievance or appeal if coverage for your services is denied or only partially covered.

Who receives the EOB?

Usually, the EOB goes to the primary person listed on the health plan documents. If an employer provides the health plan, the employee is usually the person who receives EOBs, including the EOBs for a spouse and dependents. If disclosure of the information on an EOB would place you in danger, you may ask the health plan to send your EOBs to an alternate address.
Health Care Bills: Filing Health Insurance Claims

When you have a medical procedure or visit, you usually pay your health care provider (doctor, hospital, therapist, etc.) a co-pay to cover your portion of the provider’s bill. You expect your health plan to pay the rest of the bill. To ask the health plan to pay its share, the provider will file a claim with your health plan.

However, there are some cases when you might have to file a claim yourself. This could happen when you go to an out-of-network provider, when the provider does not accept your insurance, or when you are traveling.

If you need to file your own health insurance claim, here’s what you need to know:

**How do I file a claim with my health plan?**

Look at your health insurance card for the correct website or phone number to use.

There will likely be a link on the health plan’s website to file a claim. The plan will have a form to complete for filing a claim and information on how to submit the claim. If you cannot find this information on the website, call the number on your insurance card and the customer support representative can inform you how to file a claim.

**What will I need?**

You will need the itemized bill from your health care provider. This will include the date of service, a list of procedures or services completed, and the provider’s charge for each service. It will also include a description of each service or the code for each procedure.

You will also need information such as your social security number, your insurance ID number, your employment status (if the reason for medical care was due to an accident or illness at work), and whether to send payment directly to the provider or to you.

**When do I file the claim?**

File the claim as soon as it is possible after the procedure or service is completed. Many health plans have a time limit for how long you have to file a claim, such as within 90 days of the service.

**Where do I submit the claim?**

While each health plan will inform you where to send the information, often it is to the address on the back of your health insurance card.

**What happens after you file the claim?**

After you file the claim, the health plan has a limited time (it varies per state) to inform you if they have accepted or denied the claim. The company will send you an explanation of benefits. If you selected the payment to be sent directly to you, you will receive the payment and then you will need to pay the provider directly if you have not already done so.

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What is medical necessity?

Medical necessity is a term used by health insurance companies to describe the coverage that is offered under a benefit plan. In the policy and benefit summary, the language that informs a person about what is covered under their insurance plan will generally describe benefits that are available “when medically necessary.” So, what does this mean?

How does medical necessity affect coverage for my health care services?

The way your health plan defines medical necessity impacts how it decides which health care services it will pay for. Generally, health plans pay a portion of the bill for covered services that fit the definition of medical necessity.

Health insurance plans will provide a definition of “medical necessity” or “medically necessary services” in the policy. There may also be a definition that is found in state law. The following elements may be included within a definition for “medical necessity.” These are services that are:

- provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and except for clinical trials that are described within the policy, not for experimental, investigational, or cosmetic purposes;
- necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or its symptoms;
- within the generally accepted standards of medical care in the community; and/or
- not solely for the convenience of the insured, the insured’s family or the provider.

Policy language may also include provisions to consider:

- the cost effectiveness of the requested treatment;
- alternative services or supplies for covered services; and/or
- the setting where medically necessary services are eligible for coverage.

Self-funded plans that are not under state insurance regulatory authority typically hire Third Party Administrators to administer their health benefits. The Summary Plan Description, which describes the covered services and issued to covered employees, may include a definition for medical necessity.

Medicare defines “medically necessary” as health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Each state may have a definition of “medical necessity” for Medicaid services within their laws or regulations.

How is “medical necessity” determined?

A doctor’s attestation that a service is medically necessary is an important consideration. Your doctor or other provider may be asked to provide a “Letter of Medical Necessity” to your health plan as part of a “certification” or “utilization review” process. This process allows the health plan to review requested medical services to determine whether there is coverage for the requested service. This can be done before, during, or after the treatment.

A “precertification review” is conducted before the treatment has been provided and allows the health plan to decide if the requested treatment satisfies the plan’s requirements for medical necessity. This can be done by reviewing the Letter of Medical Necessity, medical records, and the plan’s medical policies for coverage.

A “concurrent review” occurs during the treatment to decide if the ongoing treatment is medically necessary.

A “retrospective review” occurs after the treatment has been provided to decide if the services were medically necessary, experimental, cosmetic or sometimes whether there was truly a need for emergency services.

What is a medical policy?

Definitions for medical necessity include a requirement that the treatment is within the accepted standards in the medical community. This is defined in the health plan’s medical policy.

A health plan must make its medical policy available to you if it is used to make a decision to deny you coverage.

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What about experimental, investigational or cosmetic services?

Some definitions of medical necessity include the requirement that they are “not for experimental, investigational or cosmetic purposes.” Health plans may use their medical policies to determine if a treatment is considered experimental for your condition. This holds true for conditions that can be considered cosmetic but may also have a medical purpose. Medical records may be used to help make medical necessity determinations, but decisions may be based on the available scientific literature as well.

Does medical necessity affect emergency services?

Emergency services may be reviewed retrospectively to see if the care was appropriate to your diagnosis and medically necessary for an emergency level of care. The standard for making this coverage decision is made on the “prudent layperson” standard, which allows that a precertification is not necessary if a prudent layperson would believe that an emergency condition existed and that a delay in treatment would worsen that condition.

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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, Meghan Learid, 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 (WA).

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, except for federal Employee Retirement Income Security Act (ERISA) plans. He provided the email for questions about the insurer transparency rules, PriceTransparencyinCoverage@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.