REGULATORY FRAMEWORK (B) TASK FORCE

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Draft: 12/13/19

The Regulatory Framework (B) Task Force met in Austin, TX, Dec. 7, 2019. The following Task Force members participated: Michael Conway, Chair (CO); Scott A. White, Vice Chair (VA); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Steve Ostlund (AL); Allen W. Kerr represented by Ryan James (AR); Stephen C. Taylor represented by Howard Liebers (DC); David Altmaier represented by James Dunn III (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Vicki Schmidt (KS); Nancy G. Atkins represented by John Melvin (KY); John Elias represented by Maureen Belanger (MA); John G. Franchini represented by Kendall Buchanan (SC); Larry Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser represented by Tanji Northrup (UT); Mike Causey represented by Ted Hamby (NC); Jon Godfried (ND); Bruce R. Ramge represented by Martin Swanson and Laura Arp (NE); John Elias represented by Maureen Belanger (NH); John G. Franchini represented by Kendall Buchanan (SC); Larry Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser represented by Tanji Northrup (UT); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); and James A. Dodrill represented by Erin K. Hunter (WV).

1. **Adopted its Oct. 2 and Summer National Meeting Minutes**

The Task Force met Oct. 2 and Aug. 3. During its Oct. 2 meeting, the Task Force adopted its 2020 proposed charges.

Mr. Trexler made a motion, seconded by Mr. Swanson, to adopt the Task Force’s Oct. 2 (Attachment One) and Aug. 3 (see NAIC Proceedings – Summer 2019, Regulatory Framework (B) Task Force) minutes. The motion passed unanimously.

2. **Adopted its Subgroup and Working Group Reports**

Mr. Keen made a motion, seconded by Commissioner Godfread, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Nov. 25 (Attachment Two), Nov. 19 (Attachment Three), Nov. 4 (Attachment Four), Oct. 28 (Attachment Five), Oct. 7 (Attachment Six) and Sept. 16 (Attachment Seven) minutes; the ERISA (B) Working Group (Attachment Eight); the HMO Issues (B) Subgroup, including its Nov. 21 (Attachment Nine) and Sept. 16 (Attachment Ten) minutes; and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its Oct. 3 (Attachment Eleven), Aug. 29 (Attachment Twelve), Aug. 22 (Attachment Thirteen) and Aug. 15 (Attachment Fourteen) minutes. The motion passed unanimously.

3. **Heard an Update on the CHIR’s Work Related to the ACA**

Justin Giovannelli (Center on Health Insurance Reforms—CHIR, Georgetown University Health Policy Institute) provided an update on the CHIR’s work related to the federal Affordable Care Act (ACA) and other issues of interest to state insurance regulators. He highlighted a forthcoming CHIR report, supported by the Commonwealth Fund, concerning state oversight of health care sharing ministries. He explained how health care sharing ministries are treated under the ACA. Mr. Danzeiser said the National Council of Insurance Legislators (NCOIL) has a draft model on health care sharing ministries, the Health Care Sharing Ministry Registration Model Act.

Mr. Giovannelli discussed the CHIR’s work regarding multiple employer welfare arrangements (MEWAs). He said the CHIR recently published thousands of pages of the U.S. Department of Labor’s (DOL) investigative records concerning MEWAs that it obtained in response to a 2018 Freedom of Information Act (FOIA) request. He said the CHIR has posted the materials and a summary of those materials on the CHIR website at [http://chirblog.org/the-mewa-files/](http://chirblog.org/the-mewa-files/). The CHIR anticipates providing additional analysis of these materials soon. He said the CHIR will continue to track and analyze state regulatory approaches to MEWAs and short-term, limited-duration plans (STLDPs) in the wake of recent federal rule changes with respect to these products.

Mr. Giovannelli also discussed the CHIR’s work related to state reforms affecting the individual market, including state actions involving the ACA’s section 1332 waiver program and state actions to improve the affordability of comprehensive coverage. He highlighted future CHIR research projects, including projects related to reinsurance, standardized health plans and state strategies concerning the Small Business Health Options Program (SHOP). He discussed the CHIR’s ongoing state technical
assistance regarding insurance regulatory matters with the support of the Robert Wood Johnson Foundation through its State Health and Value Strategies Program. He also highlighted the CHIR’s assistance, provided with the support by the Laura and John Arnold Foundation, to state and federal policymakers regarding regulatory approaches to balance billing.

Commissioner Conway asked about the CHIR’s timing for its reinsurance report. Mr. Giovannelli said the CHIR anticipates publishing a report in early Spring 2020. Commissioner Godfread asked Mr. Giovannelli if the CHIR has a position on provisions in the federal bills on balance billing that propose to use arbitration as the method for determining the out-of-network provider payment. Mr. Giovannelli said the CHIR has not taken any position on that issue, but its governing principle with respect to such legislation is that the consumer be held harmless.

4. **Heard a Presentation on the Implementation of a Consumer Purchasing Model in Summit County, CO**

Tamara Pogue-Drangstveit (Peak Health Alliance—Peak) provided an overview of the Peak community-based model for providing health insurance. She said this model provides existing community-based efforts with access to expertise and resources while maintaining local control. She said Peak is a non-profit purchasing cooperative governed by the local community. Peak also is a non-risk-bearing entity.

Ms. Pogue-Drangstveit described the traditional model used to provide health insurance benefits and Peak’s model. She highlighted the differences between the traditional model and Peak’s model. She described the process used to develop the Peak model, including the challenges encountered in developing such a model. She detailed how Peak set prices for certain services and procedures. She described Peak’s plan benefit designs, highlighting its plan benefit designs for mental health benefits.

Ms. Pogue-Drangstveit said Peak is working to duplicate its model in other Colorado counties. She described Peak’s core values, which are central to making the model work. Those core values include: 1) protecting local health care; 2) recognizing the unique challenges of rural health; 3) using data, not anecdotes; and 4) prioritizing collaboration.

Ms. Duhamel asked if Peak’s health benefit plans are sold on the ACA’s health insurance exchanges. Ms. Pogue-Drangstveit said Peak’s health benefit plans are sold both on and off the ACA’s health insurance exchanges. She also discussed the unintended consequences on the subsidized population because of Colorado’s reinsurance program and Peak’s successes. Mr. Humphreys asked how Peak’s model can be expanded to other states. Ms. Pogue-Drangstveit said Peak will only go into an area if it has a “sponsor” in order to have buy-in and credibility with the community and other stakeholders. Ms. Dzurec asked about Peak’s experience with rural hospitals and provider facilities and their lack of an ability to reduce prices due to their tight profit margins. Ms. Pogue-Drangstveit said that before approaching such facilities, Peak reviewed the data to determine if the pricing issue stems from over- or under-utilization or something else. Mr. Blackwell asked how the Peak model works with prescription drugs. Ms. Pogue-Drangstveit said Peak chose not to tackle prescription drug pricing during its first year. She said Peak plans to look at the data and prices for prescription drugs provided in facilities. She said Peak also plans to ask insurers how they can reduce prescription drug prices.

5. **Heard a Presentation on Health Care Cost Trends and Affordability**

Leanne Gassaway (America’s Health Insurance Plans—AHIP) discussed current health care cost trends and approaches to improving consumer affordability. She discussed three levers to lower premiums: 1) reducing the cost of health care; 2) offering premium savings; and 3) increasing participation to balance risk. She discussed AHIP’s suggested solutions to lower premiums for each lever.

To reduce health care costs, Ms. Gassaway suggested that curbing prescription drug costs is critical. She discussed the four themes that AHIP believes contribute to high prescription drug costs, including: 1) a broken and distorted pharmaceutical market; 2) excessive price increases on new and older drug therapies; and 3) high launch prices. She suggested that state solutions address this issue, including providing drug price transparency to consumers and providers.

Ms. Gassaway said another key to reducing health care costs is to reduce surprise medical bills. She said surprise medical bills raise costs. She also said private equity staffing firms are part of the reason for the increase in costs due to their exploitation of patients seeking care. She described how this is occurring. She also discussed state solutions to protect patients from surprise medical bills. She described how third-party payments are also driving up premiums. She highlighted California legislation addressing the issue.
Ms. Gassaway discussed how state reinsurance programs established under the ACA’s section 1332 waiver program can offer premium savings. She also discussed ways to increase participation to balance risk, including increasing consumer outreach and education about plan coverage options.

Commissioner Conway questioned whether market forces alone can address prescription drug costs. Ms. Gassaway said the states need to begin with providing prescription drug price transparently in order to obtain the necessary information to make more informed policy decisions. Commissioner Schmidt expressed concern that some of the information included in Ms. Gassaway’s presentation regarding prescription drug prices is out-of-date, and as such, it might not reflect the current situation. She also questioned why Ms. Gassaway did not mention pharmacy benefit managers (PBMs). Ms. Gassaway said AHIP views PBMs as partners in controlling prescription drug costs. She said pharmaceutical manufacturers set the prices, and AHIP does not view PBMs as driving up prescription drug costs.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
The Regulatory Framework (B) Task Force met via conference call Oct. 2, 2019. The following Task Force members participated: Michael Conway, Chair (CO); Scott A. White, Vice Chair (VA); Lori K. Wing-Heier represented by Sarah Bailey and Jacob Lauten (AK); Jim L. Ridling represented by William Rodgers (AL); Allen W. Kerr and Mel Anderson (AR); Ricardo Lara represented by Sheirin Ghoddoucy (CA); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Cynthia Banks Radke (IA); Dean L. Cameron represented by Fernanda Vallejo (ID); Vicki Schmidt represented by Julie Holmes (KS); Gary Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Steve Kelley represented by Candace Gergen (MN); Chlora Lindley-Myers represented by Carrie Couch and Jessica Schrmpf (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Ross Hartley (ND); Bruce R. Ramge represented by Martin Swanson (NE); Glen Mulready represented by Ron Kreiter (OK); Andrew Stolfi represented by Gayle Woods (OR); Jessica Altman (PA); Raymond G. Farmer represented by Kendall Buchanan (SC); Larry Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser represented by Jaakob Sundberg and Heidi Clausen (UT); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); James A. Dodrill represented by Ellen Potter and Joylynn Fix (WV); and Jeff Rude (WY).

1. **Adopted its 2020 Proposed Charges**

Commissioner Conway said that prior to the conference call, NAIC staff distributed the Task Force’s 2020 proposed charges. He explained that the proposed charges generally are unchanged from the Task Force’s 2019 charges. He said the main substantive change is in the Accident and Sickness Insurance Minimum Standards (B) Subgroup’s charge deleting the reference to the *Accident and Sickness Insurance Minimum Standards Model Act* (#170) because the Subgroup completed its work on Model #170 earlier this year. Mr. Lauten suggested a technical change to the Task Force’s charge 1E. He suggested revising the charge’s language for consistency with the language in the Task Force’s charge 1F. There was no objection.

Ms. Nollette made a motion, seconded by Mr. Danzeiser, to adopt the Task Force’s 2020 proposed charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
2020 PROPOSED CHARGES

REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products and Services

1. The Regulatory Framework (B) Task Force will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2019-2020.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the ERISA (B) Working Group, monitor, analyze and report on developments related to association health plans (AHPs).
   F. Monitor, analyze and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

2. The Accident and Sickness Insurance Minimum Standards (B) Subgroup will:
   A. Review and consider revisions to the Accident and Sickness Insurance Minimum Standards Model Act (#170) and its companion regulation, the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171).

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

4. The HMO Issues (B) Subgroup will:
   A. Revise provisions in the Health Maintenance Organization Model Act (#430) to address conflicts and redundancies with provisions in the Life and Health Insurance Guaranty Association Model Act (#520).

5. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will:
   A. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 25, 2019. The following Subgroup members participated: Melinda Domzalski-Hansen, Co-Chair (MN); Glen Mulready, Co-Chair, represented by Buddy Combs (OK); Eric Unger (CO); Chris Struk (FL); Frank Opelka (LA); Camille Anderson-Weddle (MO); Martin Swanson (NE); Gayle Woods (OR); Katie Dzurec (PA); Glynda Daniels (SC); Rachel Bowden and Sean Fry (TX); Heidi Clausen and Jaakob Sundberg (UT); Emily Brown (VT); Andrea Philhower and Michael Bryant (WA); and Jennifer Stegall (WI).

1. Continued Discussion of the July 30 Comments on Sections 1–5 of Model #171

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), beginning with Section 5L, the definition of “preexisting condition.” However, before starting that discussion, she said the Subgroup needs to complete its discussion of Section 5K, the definition of “physician.”

Ms. Domzalski-Hansen reminded the Subgroup of its discussion of Section 5K during its Nov. 19 conference. She said during this discussion, Ms. Philhower had agreed to rewrite the provision for clarity. Ms. Philhower said that following the Subgroup’s Nov. 19 call, she reviewed the provision and decided that Section 5K does not belong in Section 5—Policy Definitions; it should be moved to Section 7—Accident and Sickness Minimum Standards for Benefits because it is more of a substantive provision than a definition. After discussion, the Subgroup agreed to move Section 5K’s provisions to Section 7.

The Subgroup next discussed Section 5L, the definition of “preexisting condition.” Ms. Domzalski-Hansen said the Subgroup received comments on Section 5L from America’s Health Insurance Plans (AHIP), the Missouri Department of Insurance (DOI), the Washington DOI, and the NAIC consumer representatives. Chris Petersen (Arbor Strategies, LLC), speaking on behalf of AHIP, said AHIP’s comments suggest that the Subgroup consider different definitions of “preexisting condition” for supplementary products and short-term, limited-duration plans (STLDPs) because of the differences in the type of coverage. He said that for supplementary products, AHIP believes the definition of “preexisting condition” in Section 5L should remain unchanged. He said the NAIC consumer representatives’ suggested revisions for the term are not appropriate for supplementary products because they are excepted benefits, and they are not required to comply with the requirements under the federal Affordable Care Act (ACA) for comprehensive health insurance products. He said he also believes that the provisions in the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170), the companion model to Model #171, would prohibit such changes. He said that if the Subgroup believes changes for this definition need to be made for STLDPs, then the Subgroup should include those changes in the provisions in Model #171 applying only to STLDPs.

The Subgroup discussed whether to delete the specific timeframes in the definition and include specific timeframes in the specific sections for each product covered under Model #171. The Subgroup also discussed whether there should be a general definition of this term in Section 5 or if the definition should be removed and included in Section 7 for each product described in that section. After additional discussion, the Subgroup decided to move Section 5L to Section 7 without a timeframe and include a timeframe for each product described in Section 7.

The Subgroup discussed the Missouri DOI’s suggestion to remove language in the definition concerning the prudent layperson standard. Sarah Lueck (Center on Budget and Policy Priorities—CBPP) pointed out that the NAIC consumer representatives made a similar suggestion. She explained that the NAIC consumer representatives suggest such a revision because the prudent layperson standard is hard for consumers to understand when completing an application with respect to previous or current health conditions, and the suggested revised language is easier for consumers to understand.

J.P. Wieske (Horizon Government Affairs) expressed concern with the NAIC consumer representatives’ suggested revision, particularly with respect to disability income protection coverage. He said the potential revision would make it easier for consumers to game the system. He said consumers could delay seeing a physician, apply for coverage knowing that they have a medical condition; and because there are no waiting periods, they could receive coverage under the policy immediately. Ms. Lueck said the NAIC consumer representatives’ suggested revision adds transparency to the definition and as such, should be
beneficial to insurers. The Subgroup discussed the NAIC consumer representatives’ suggested revision. Ms. Stegall asked Ms. Lueck if she knew of any state’s definitions of “preexisting condition” that strike the appropriate balance with respect to consumer understanding while not contributing to the ability of consumers to game the system. Ms. Lueck said she did not. However, she agreed to research it. Katie Keith (Out2Enroll) agreed to send the Subgroup information on the subject compiled by the Kaiser Family Foundation (KFF). Mr. Petersen asked if the KFF’s information relates to major medical coverage. Ms. Keith said it did. Mr. Petersen suggested that the Subgroup needed to receive information related to supplementary coverages. After discussion, the Subgroup agreed that any information it receives on this issue would be valuable to the Subgroup as it continues its discussions of the term.

The Subgroup next discussed the Washington DOI’s suggestion to delete language in Section 5L’s drafting note seemingly related to post-claims underwriting when an insurer reviews an insured’s health history and as a result of that review decides to exclude a specific condition. Ms. Philhower said she is concerned about the discriminatory aspects of such language. Mr. Wieske said he believes that this language is a holdover from Model #171’s provisions when it included comprehensive health insurance coverage. The Subgroup discussed removing the language. Ms. Bowden suggested that regardless of whether it is removed, language should be added to Section 8—Required Disclosure Provisions alerting consumers about the importance of completing applications as accurately as possible, particularly as to the consumer’s health history. Ms. Lueck questioned whether state insurance regulators should permit post-claims underwriting. She questioned why insurers cannot perform pre-claims underwriting, which is more transparent to the consumer than post-claims underwriting. The Subgroup discussed Ms. Lueck’s comments and acknowledged her concerns. However, given the ability of consumers to game the system, post-claims underwriting occurs and is needed. The Subgroup noted, however, that state insurance regulators must monitor insurers to ensure that they do not abuse the post-claims underwriting process. After additional discussion, the Subgroup accepted the Washington DOI’s suggestion to delete the language in Section 5L’s drafting note and discuss the issue raised in the language when the Subgroup discusses Section 8.

Ms. Domzalski-Hansen said she expects the Subgroup to meet next via conference call after the Fall National Meeting.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 19, 2019. The following Subgroup members participated: Melinda Domzalski-Hansen, Co-Chair (MN); Debra Judy (CO); Howard Liebers (DC); Chris Struk (FL); Robert Wake (ME); Camille Anderson-Weddle and Carrie Couch (MO); Martin Swanson (NE); Katie Dzurec (PA); Shari Miles (SC); Rachel Bowden (TX); Anna Van Fleet (VT); Andrea Philhower and Michael Bryant (WA); and Nathan Houdek and Jennifer Stegall (WI).

1. Continued Discussion of the July 30 Comments on Model #171, Sections 1–5

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), beginning with Section 5J, the definition of “partial disability.” She said, however, before starting that discussion, the Subgroup needs to complete its discussion of Section 5I, the definition of “one period of confinement.”

Ms. Domzalski-Hansen reminded the Subgroup that during its Nov. 4 conference call, the Subgroup discussed Section 5I and whether its use of the word “means” was appropriate given the language used in other definitions in Section 5, such as “may be defined” or “shall be defined.” She said the Subgroup decided to change “means” to “shall be defined.” She said the Subgroup also discussed how the term is used in policy forms, and after discussion, the Subgroup decided to seek additional information from stakeholders to answer this question. Ms. Domzalski-Hansen said she sent an email to stakeholders asking for a response to these questions: 1) What type of policies currently use this language?; 2) How is this language currently used in the policies?; and 3) Do your policies use this language for one event for each period of time or for multiple events in one period of time? She said she received comments from AFLAC; the Health Benefits Institute and the Missouri Department of Insurance (DOI).

Ms. Domzalski-Hansen discussed AFLAC’s comments. She said that in its comments, AFLAC said it uses the term “period of hospital confinement” in its hospital indemnity policies. She said AFLAC noted that its short-term disability income policies include provisions discussing one event for each time period versus multiple events in a time period.

Ms. Domzalski-Hansen discussed the Missouri DOI’s comments from Mary Mealer (MO). She said Ms. Mealer said she searched for the term “confinement” in recent health filings in the System for Electronic Rate and Form Filing (SERFF). She said Ms. Mealer found that the term “confinement” is only used in comprehensive health filings and describing benefits. The term was not defined in these policies nor used as “one period of confinement.” She said Ms. Mealer found language concerning “successive period of coverage stays” in hospital indemnity policy filings.

J.P. Wieske (Horizon Government Affairs), representing the Health Benefits Institute, said the Health Benefits Institute believes that the definition of “one period of confinement” in Section 5I is used by insurers in at least two policy forms—supplemental accident benefits and fixed indemnity products. He said it is likely that this term is used in other policy forms, but for policies that would not be covered under Model #171. Mr. Wieske said it is important that the Subgroup understand that the policies using this language will be using the language in multiple ways, with some insurers paying on a per incident basis and others on a per service basis, and may apply separate cost-sharing per incident. He provided examples of how benefits could be paid using Section 5I’s definition of the term when multiple hospital visits are necessary arising from the same injury or sickness. He also described from a consumer’s viewpoint how a narrow and broad definition of the term could affect benefits.

Mr. Wieske said the Health Benefits Institute suggests modifying Section 5I as follows: “One period of confinement” means one or more consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time defined in the policy but not more than [ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.]

*Drafting Note: This language is used in multiple policy forms that may pay benefits differently [e.g. on per incident or per service basis]. States may want to establish minimum policy standards that differ based on how the benefit is to be paid by the insurer and the type of policy.*

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The Subgroup discussed the Health Benefits Institute’s suggested revisions to Section 5I. Mr. Bryant questioned the language in Section 5I concerning the maximum number of days and asked if there was a way to simplify the language. Ms. Domzalski-Hansen questioned the addition of the brackets noting that including brackets would add variability to the language instead of establishing minimum standards for insurers with respect to the policies covered under Model #171. After additional discussion, the Subgroup decided to delete Section 5I and move its provisions to Section 7—Supplementary and Short-Term Health Minimum Standards for Benefits.

The Subgroup next discussed Section 5J, the definition of “partial disability.” Sarah Lueck (Center on Budget and Policy Priorities—CBPP) discussed the NAIC consumer representatives’ comments, which suggest that the Subgroup consider revising Section 5J(2) to add the language “including compensation in the form of goods and services.” She said the NAIC consumer representatives are suggesting this language to address situations when an individual is partially disabled and is employed in work not compensated through wages or profits. She explained that the Subgroup discussed the NAIC consumer representatives’ comments during its Nov. 4 conference call, but during that discussion, she neglected to tie the suggested revisions for Section 5J(2) to the NAIC consumer representatives’ suggested revisions for Section 5O, the definition of “total disability.”

Mr. Wieske reiterated his concern on whether an insurer would be able to determine the compensation to be provided to the insured in such a situation because of the difficulty in determining the value of goods and services. Chris Petersen (Arbor Strategies LLC) expressed concern with the possibility of disputes arising related to the valuation of the goods and services. Some Subgroup members agreed with Mr. Wieske’s and Mr. Petersen’s concerns. After discussion, Ms. Lueck agreed to withdraw the NAIC consumer representatives’ suggested revisions for Section 5J.

The Subgroup next discussed Section 5K, the definition of “physician.” Ms. Domzalski-Hansen said the Washington DOI submitted comments asking for clarification of Section 5K’s existing language. Ms. Philhower said her comments concerned whether the language in Section 5K(1) is an “any-willing provider” provision or something else. The Subgroup discussed her concern and decided the language was not an “any-willing provider” provision, but language requiring an insurer, for a provider contracted with the insurer, to permit the provider to the extent of its contractual obligations to provide the services within the scope of the provider’s licensed authority and applicable laws. Ms. Philhower said she also has questions about the language in Section 5K(2). She said it is unclear what the language “definition or concept” means. She also asked about the language “an owner or assignee.” Mr. Wake cautioned the Subgroup that the term “assignee” could be the physician in some cases. Mr. Bryant suggested changing the language to “policyholder or beneficiary.” Ms. Van Fleet said she believes the problem is Section 5K(2)’s construction. After discussion, Ms. Philhower volunteered to revise Section 5K for clarity for the Subgroup’s review during a future conference call.

Ms. Domzalski-Hansen said she believes the Subgroup could complete its review of the comments received on Sections 1–5 with two more conference calls. She said she would like the Subgroup to meet prior to the Fall National Meeting. The Subgroup expressed support for Ms. Domzalski-Hansen’s plan.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 4, 2019. The following Subgroup members participated: Glen Mulready, Co-Chair (OK); Melinda Domzalski-Hansen, Co-Chair (MN); Adam Boggess (CO); Chris Struk (FL); Frank Opelka (LA); Mary Mealer (MO); Gayle Woods (OR); Rachel Bowden (TX); Tanji Northrup and Jaakob Sundberg (UT); Phil Keller and Anna Van Fleet (VT); Andrea Philhower and Michael Bryant (WA); and Jennifer Stegall (WI).

1. Continued Discussion of the July 30 Comments on Model #171, Sections 1–5

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), beginning with Section 5I, the definition of “one period of confinement.” She reminded the Subgroup that during its Oct. 28 conference call, the Subgroup discussed this provision and whether its use of the word “means” was appropriate given the language used in other definitions in Section 5, such as “may be defined” or “shall be defined.” She said that as the Subgroup requested, NAIC staff reviewed Section 5’s legislative history with respect to the definitions and found that there was nothing in the legislative history discussing the drafters’ intent in using “means,” “may be defined,” or “shall be defined.”

Ms. Domzalski-Hansen said that given this, she surveyed the Subgroup members on the issue. She said the responses she received indicated that in order to determine the appropriate language, the Subgroup would need to determine the intent of the provision, such as whether it is permissive or mandatory. She said the Subgroup has at least two options to consider related to the issue: 1) defer discussion on the issue until the Subgroup reviews Model #171’s substantive provisions where the terms are used; or 2) not defer the discussion and resolve the issue while the Subgroup is discussing Section 5.

The Subgroup discussed Ms. Domzalski-Hansen’s options. Ms. Philhower suggested that the Subgroup not defer the discussion and beginning with Section 5I review each definition as to its intent to decide whether the language should be “means,” “may be defined,” or “shall be defined.” She said because there has been no discussion prior to Section 5I on this issue, the Subgroup should not go back and review the definitions in Section 5 that it has already discussed. The Subgroup accepted Ms. Philhower’s suggestion.

The Subgroup discussed whether Section 5I should say “means,” “may be defined,” or “shall be defined.” Mr. Keller asked for clarification on how the Subgroup plans to use the term “one period of confinement” in policy forms. The Subgroup discussed Mr. Keller’s question, but it reached no conclusion. The Subgroup next discussed changing “means” to “may be defined” and the substantive implications of such a change. After discussion, the Subgroup decided to change “means” to “shall be defined.” Ms. Domzalski-Hansen said she would send out a question to stakeholders on how the term “one period of confinement” is used in policy forms. She said the Subgroup would return to this discussion during its next conference call Nov. 19.

The Subgroup next discussed Section 5J, the definition of “partial disability.” Sarah Lueck (Center on Budget and Policy Priorities—CBPP) discussed the NAIC consumer representatives’ comments, which suggest that the Subgroup consider revising Section 5J(2) to add the language “including compensation in the form of goods and services.” She said the NAIC consumer representatives are suggesting this language to address situations when an individual is partially disabled and is employed in a work not compensated through wages or profits. J.P. Wieske (Horizon Government Affairs) questioned whether an insurer would be able to determine the compensation to be provided to the insured in such a situation because of the difficulty in determining the value of goods and services. The Subgroup discussed the NAIC consumer representatives’ suggested revision and decided to defer making a decision. The Subgroup requested that the NAIC consumer representatives submit additional comments on the issue for the Subgroup to consider during its next conference call Nov. 19. The Subgroup next discussed Section 5K, the definition of “physician.” Ms. Domzalski-Hansen said the Washington Department of Insurance (DOI) submitted comments asking for clarification of Section 5K’s existing language. The Subgroup deferred discussion of the Washington DOI’s comments until its next conference call Nov. 19.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
Accident and Sickness Insurance Minimum Standards (B) Subgroup
Conference Call
October 28, 2019

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 28, 2019. The following Subgroup members participated: Glen Mulready, Co-Chair, represented by Buddy Combs (OK); Melinda Domzalski-Hansen, Co-Chair (MN); Chris Struk (FL); Frank Opelka (LA); Mary Mealer (MO); Martin Swanson (NE); Katie Dzurec (PA); Kendall Buchanan (SC); Jaakob Sundberg and Heidi Clausen (UT); Phil Keller and Anna Van Fleet (VT); Michael Bryant (WA); and Nathan Houdek (WI).

1. Continued Discussion of the July 30 Comments on Model #171, Sections 1–5

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) beginning with Section 5D, the definition of “hospital.” She reminded the Subgroup that during its Oct. 7 conference call, the Subgroup began discussion of the comments received on Section 5D, but it did not complete its discussion.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) discussed the NAIC consumer representatives’ comments, which suggest the Subgroup consider revising Section 5D(2)(b) and deleting Section 5D(2)(c) to remove obsolete language and for consistency with other Subgroup proposed revisions. Chris Petersen (Arbor Strategies LLC) expressed concern with deleting Section 5D(2)(c) because its deletion could be inconsistent with various state laws defining “hospital.” J.P. Wieske (Horizon Government Affairs) said Section 5D(2), if permitted under state law, allows plans to exclude the facilities listed as a type of hospital facility from a plan’s policy provisions. Some Subgroup members expressed concern with deleting the provision. After discussion, the Subgroup decided to leave Section 5D unchanged except for adding the Missouri Department of Insurance’s (DOI) clarifying revisions.

The Subgroup next discussed the comments received on Section 5E, which defines the term “injury.” Ms. Mealer said the Missouri DOI suggests deleting Section 5E(4) because “disability” has nothing to do with a definition of “injury.” She said the Missouri DOI also suggests deleting Section 5E(5) because there is most likely a better way to ensure the policy does not pay for workers’ compensation claims or claims under medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts. Ms. Lueck suggested the Subgroup delete the language “independent of disease or bodily injury” in Section 5E(1) because of the language’s potential to limit the types of claims that could be made. The Subgroup discussed whether to delete the language “or bodily injury” in Section 5E(1). The Subgroup discussed the interaction of Section 5E(1) and Section 5E(2). Jolie H. Matthews (NAIC) explained that this definition is new and was most likely derived from a similar definition in the Interstate Insurance Product Regulation Commission’s (Compact) disability income standards. Ms. Buchanan suggesting deleting Section 5E(2) because it appears to be duplicative of Section 5E(1). The Subgroup agreed to delete Section 5E(2). The Subgroup also decided to delete the language “or bodily injury” in Section 5E(1).

Mollie Zito (UnitedHealthcare) discussed UnitedHealthcare’s suggestion to add the following sentence to Section 5E(1): “All injuries due to the same accident are deemed to be one injury.” Ms. Lueck asked if an “injury” only results from an “accident.” She pointed out that the definition of “accident” in the former Section 5B was deleted. Ms. Zito said UnitedHealthcare is proposing a new definition of “accident.” The Subgroup discussed issues related to “intentional” and/or “self-inflicted” accidents and the definition of “injury.” After additional discussion, the Subgroup deferred making a decision on UnitedHealthcare’s suggested revision.

The Subgroup next discussed Section 5G, which defines the term “mental or nervous disorder.” Ms. Mealer said the Missouri DOI’s suggested revision to Section 5G updates the definition to reflect current terminology. Mr. Petersen asked if the Missouri DOI’s language is consistent with how the term is used and defined in recent NAIC models. Ms. Matthews said she would review the NAIC models for consistency. The Subgroup agreed to accept the Missouri DOI’s suggested revision to Section 5G subject to any changes NAIC staff may make for consistency with similar language and definitions used in recent NAIC models.

The Subgroup next discussed Section 5H, which defines the term “nurse.” Ms. Lueck said the NAIC consumer representatives suggest revising Section 5H to include a reference to “advance practice nurse.” She said this additional language is consistent with current terminology. The Subgroup agreed to accept the suggested revision.
The Subgroup next discussed Section 5I, which defines the term “one period of confinement.” Ms. Mealer said the Missouri DOI suggests deleting the term because it is not used in the proposed revised model. Ms. Matthews said she did a search and found the term is no longer used because provisions in the model using the term are to be deleted. Mr. Petersen said if this term is used in policies, it should not be deleted. After discussion, the Subgroup agreed to retain the term. The Subgroup discussed whether it is appropriate for the definition to use the word “means” instead of the language used in other definitions in Section 5, such as “may be defined” or “shall be defined.” After additional discussion, the Subgroup requested NAIC staff to review the legislative history for the terms in Section 5 to determine if the drafters had any specific intent for the differing language. Ms. Domzalski-Hansen said she would also survey the Subgroup members prior to the Subgroup’s Nov. 4 conference call to see if the Subgroup members had specific suggestions to address this issue.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 7, 2019. The following Subgroup members participated: Glen Murready, Co-Chair (OK); Melinda Domzalski-Hansen, Co-Chair (MN); Eric Unger (CO); Chris Struk (FL); Jeff Zewe (LA); Robert Wake (ME); Mary Mealer and Molly White (MO); Gayle Woods (OR); Katie Dzurec and Michael Humphreys (PA); Kendall Buchanan (SC); Jaakob Sundberg and Heidi Clausen (UT); Anna Van Fleet (VT); Andrea Philhower (WA); and Julie Walsh (WI).

1. Continued Discussion of the July 30 Comments on Model #171, Sections 1–5

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). She said prior to the Subgroup continuing those discussions, as discussed during the Subgroup’s Sept. 16 conference call, she developed the following language for the Subgroup’s review for revising Section 5A—Policy Definitions: “A. A supplementary health insurance policy; a short-term health insurance policy; a limited scope dental insurance policy; or a limited scope vision insurance policy delivered or issued for delivery to any person in this state shall contain definitions respecting the matters set forth below that comply with the requirements of this section, if the policy contains one of the terms or definitions below.”

Ms. White suggested revising the suggested language to state “one of the terms and/or definitions below.” Barbara Klever (Blue Cross and Blue Shield Association—BCBSA) suggested adding the word “certificate” with respect to a short-term health insurance policy in order to ensure it applies to association coverage. The Subgroup discussed whether it was appropriate to add “certificate” given Section 5’s scope and the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170). After additional discussion, the Subgroup decided to defer making a decision until it discusses the substantive sections in Model #171.

The Subgroup next discussed whether to delete Section 5C, which defines “disability” or “disabled.” Ms. Domzalski-Hansen reminded the Subgroup that during its Sept. 16 conference call, the Subgroup discussed the Washington Department of Insurance’s (DOI) suggestion to delete Section 5C but deferred making a decision until NAIC staff could research why the definition was added. She explained that NAIC staff found that this definition is derived from the Interstate Insurance Product Regulation Commission’s (Compact) disability income standards, but the definition in Section 5C does not match the Compact’s definition for the term. She said the Subgroup has at least two options: 1) delete the definition for the term; or 2) revise it to match the Compact’s definition for the term. The Subgroup discussed the options. After additional discussion, the Subgroup decided to delete Section 5C and rely on the definitions of other terms in the model to determine what is a “disability,” such as “partial disability,” “total disability” and “residual disability.” The Subgroup also agreed, if necessary, to revisit its decision later.

The Subgroup next discussed the comments received on Section 5D, which defines “hospital.” Ms. Domzalski-Hansen said America’s Health Insurance Plans (AHIP), the Missouri DOI and the NAIC consumer representatives submitted comments on Section 5D. Chris Petersen (Arbor Strategies LLC), representing AHIP, said AHIP suggests adding “facilities existing primarily to provide psychiatric services” to Section 5D(2) because these types of facilities are not hospitals. Some Subgroup members expressed concern with adding the suggested language.

The Subgroup discussed the Missouri DOI’s suggested revisions to Section 5D(2). Ms. White said the Missouri DOI’s suggested revisions are meant to clarify the language. After discussion, the Subgroup agreed to accept the Missouri DOI’s suggested revisions. The Subgroup discussed whether it could accept AHIP’s suggested language because it accepted the Missouri DOI’s suggested revisions. The Subgroup deferred making a decision on AHIP’s suggested language. Sarah Lueck (Center on Budget and Policy Priorities—CBPP) discussed the NAIC consumer representatives’ comments, which suggests the Subgroup consider revising Section 5D(2)(b) and deleting Section 5D(2)(c) to remove obsolete language. The Subgroup deferred discussion of the NAIC consumer representatives’ suggested revisions until its next conference call on Oct. 28.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Sept. 16, 2019. The following Subgroup members participated: Glen Mulready, Co-Chair, and Tyler Laughlin (OK); Melinda Domzalski-Hansen, Co-Chair (MN); Mary Grover (CO); Chris Struk and Shannon Doheny (FL); Frank Opelka (LA); Robert Wake (ME); Mary Mealer (MO); Martin Swanson and Laura Arp (NE); Gayle Woods (OR); Michael Humphreys (PA); Kendall Buchanan (SC); Tanji Northrup (UT); Anna Van Fleet (VT); Michael Bryant (WA); and Nathan Houdek (WI).

1. Discussed July 30 Comments on Model #171, Sections 1–5

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to begin its review of and discuss section-by-section the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). She said no comments were received on Model #171’s title or its table of contents.

Ms. Domzalski-Hansen said the Missouri Department of Insurance (DOI) submitted comments on Section 1—Purpose suggesting adding the word “renewal.” Ms. Mealer said the Missouri DOI suggests adding this word because the model’s provisions should apply to renewals, as well as the initial purchase. Ms. Domzalski-Hansen suggested also adding the word “continuation” because in some situations, the coverage may not be “renewed” but “continued.” Chris Petersen (Arbor Strategies LLC), representing America’s Health Insurance Plans (AHIP), said the word “purchase” is interpreted to include “sale and renewal.” The Subgroup discussed whether to add these references and at the end of the discussion, it decided to add the language “renewal and continuation.”

No comments were received on Section 2—Authority.

Ms. Domzalski-Hansen said the Blue Cross and Blue Shield Association (BCBSA), the Missouri DOI and the Washington DOI submitted comments on Section 3A—Applicability and Scope. Jeremy Crandall (BCBSA) said the BCBSA suggests revising Section 3A to include the language “regardless of the situs of the delivery of the contract” to ensure it is clear Model #171 applies to short-term, limited-duration coverage issued through out-of-state group trusts or associations and is consistent with the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (formerly the Accident and Sickness Insurance Minimum Standards Model Act) (#170). After discussion, the Subgroup agreed to accept the BCBSA’s suggested revisions.

Ms. Mealer said the Missouri DOI suggests deleting the word “also” in its comments on Section 1—Purpose because the word is unnecessary. The Subgroup agreed to accept the suggested revision. Mr. Bryant said the Washington DOI suggests adding the word “ supplementary” to the term “hospital indemnity or other fixed indemnity” because Model #171 does not apply to all hospital indemnity plans, such as comprehensive hospital indemnity plans. Mr. Petersen said that based on the revisions to Model #170, Model #171 has been restructured to apply to supplementary plans. He said that in addition, Model #170 does not define “supplementary hospital indemnity.” After discussion, Mr. Bryant withdrew the Washington DOI’s comment.

The Subgroup next discussed the Missouri DOI’s suggested revision to Section 3B to delete the words “shall apply” and replace it with “applies.” Ms. Mealer said the Missouri DOI’s suggested revision is clarifying. The Subgroup agreed to accept the suggested revision. No comments were received on Section 3C or Section 3D

No comments were received on Section 4—Effective Date.

The Subgroup next discussed the comments received on Section 5A—Policy Definitions. Mr. Crandall said the BCBSA’s suggested revisions to Section 5A are intended to track the definition of “short-term, limited-duration health insurance” in Model #170. Ms. Mealer said the Missouri DOI’s suggested revisions are meant to reduce redundancy and provide precision and consistency. The Subgroup discussed the suggested revisions, including whether to use the word “policy” or “coverage.” Mr. Petersen said the Subgroup will have to decide what terminology to use throughout Model #171 to refer to these plans. The Subgroup also discussed whether it was appropriate to add the word “certificate.” Mr. Laughlin pointed out that “policy” is
defined in Model #170. He suggested merging the BCBSA and the Missouri DOI suggested revisions. Ms. Domzalski-Hansen said she would develop language for the Subgroup to discuss during its next conference call Oct. 7.

The Subgroup next discussed the comments received on Section 5B. Ms. Mealer said the Missouri DOI’s comments to Section 5B(2) are intended to be clarifying. The Subgroup agreed. Sarah Lueck (Center on Budget and Policy Priorities—CBPP) discussed the NAIC consumer representatives’ comments. She explained that the suggested revisions update the language by deleting and revising outdated terminology. Jolie Matthews (NAIC) asked if the suggested revision to delete the language “drug addicts and alcoholics” and replace it with “individuals with a substance-related disorder” is correct. She suggested that the language should be “substance use disorder.” After discussion, the Subgroup agreed to accept the NAIC consumer representatives’ suggested revisions to Section 5B except for the language “substance-related disorder.” The Subgroup agreed that this should be “substance use disorder.” The Subgroup also agreed to allow NAIC staff to update any obsolete, outdated language throughout Model #171.

The Subgroup next discussed the Washington DOI’s suggestion to delete Section 5C, which defines “disability” or “disabled.” Mr. Bryant said the Washington DOI suggests Section 5C is not necessary because Model #171 defines “partial disability,” “residual disability” and “total disability” with respect to the inability to work. The way “disability” or “disabled” is defined in Section 5C is confusing because it is not defined with respect to the inability to work. Mr. Petersen expressed support for the Washington DOI’s comments. Mr. Laughlin suggested the Subgroup defer deleting Section 5C until it could determine why it was added. NAIC staff agreed to search the Subgroup’s 2016 minutes to find this information for discussion during the Subgroup’s Oct. 7 conference call.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The ERISA (B) Working Group of the Regulatory Framework (B) Task Force met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: Robert Wake, Chair (ME); Ryan James (AR); Kate Harris (CO); Howard Liebers (DC); Andria Seip (IA); Craig Van Aalst (KS); Frank Opelka (LA); Grace Arnold and Steve Kelley (MN); Angela Nelson (MO); Laura Arp and Martin Swanson (NE); Laura Miller (OH); Ron Kreiter (OK); Jill Kruger (SD); Doug Danzeiser (TX); Tanji Northrup (UT); Toni Hood (WA); and Richard Wicka (WI). Also participating were: Paige Duhamel (NM); Tashia Sizemore (OR); and Sarah Neil (RI).

1. **Adopted its Summer National Meeting Minutes**

Mr. Wicka made a motion, seconded by Ms. Kruger, to adopt the Working Group’s Aug. 3 minutes (*see NAIC Proceedings – Summer 2019, Regulatory Framework Task Force, Attachment Four*). The motion passed unanimously.

2. **Discussed MEWAs and AHPs**

Mr. Wake asked for information on state activities regarding multiple employer welfare arrangements (MEWAs) and association health plans (AHPs) since the District Court for the District of Columbia issued its opinion in *New York v. U.S. Department of Labor*, vacating critical portions of the U.S. Department of Labor’s (DOL) final rule on AHPs. Mr. James said Arkansas has issued Rule 119, which establishes requirements for licensing and operations of self-funded MEWAs and explains registration requirements for fully insured MEWAs. He said the rule is scheduled to take effect next week. Ms. Seip said that Iowa has seen increased interest in forming MEWAs in Iowa and that there are two new MEWAs for 2020 and a handful of applications pending. Ms. Arp said that in Nebraska, there is a fully insured MEWA that formed, but it included self-employed individuals, so in order to be able to keep operating, it has reorganized to provide two consecutive term, short-term limited duration (STLD) plans, using an association product sold to individuals.

William F. Megna (MEWA Association of America—MAA) said his organization is holding its first annual meeting on Dec. 9 at the Hyatt Place Austin hotel in Austin, TX, to discuss the development of uniform standards for regulation and solvency protections for self-funded MEWAs. He said the MAA would like to work with state insurance regulators on these standards and that everyone is welcome to attend.

Justin Giovannelli (Georgetown Center for Health Insurance Reform—CHIR) has started to research federal oversight of MEWAs. He said CHIR made a Freedom of Information Act (FOIA) request to the U.S. Department of Labor (DOL) and has received several thousand pages of DOL investigative records regarding MEWAs, including AHPs. Information continues to be released and is available to the public at [http://chirblog.org/the-mewa-files/](http://chirblog.org/the-mewa-files/). Analysis of this information by CHIR is planned.

Amber Rivers (DOL Employee Benefits Security Administration—EBSA) explained that the DOL has recently undergone a reorganization. Ms. Rivers is currently the Acting Director of the Office of Health Plan Standards and Compliance Assistance, within EBSA, which is the position formerly occupied by Amy Turner, who is now the Deputy Assistant Secretary for Regional Office Operations within EBSA. Colleen McKee is the head of the Office of Health Investigations within the Office of Enforcement within EBSA. While there have been some internal changes, Ms. Rivers assured the Working Group that there should not be any discernable difference for the NAIC; the DOL continues to want to partner with the NAIC in areas of shared jurisdiction.

Having no further business, the ERISA (B) Working Group adjourned into 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.
The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 21, 2019. The following Subgroup members participated: Don Beatty, Chair (VA); Dayle Axman (CO); Toma Wilkerson (FL); Ryan Gillespie (IL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson (NE); Ron Pastuch (WA); Jennifer Stegall (WI); and Joylynn Fix (WV).

1. Discussed and Agreed Upon Recommendations for Revising Model #430

Mr. Beatty said that prior to the conference call, NAIC staff had distributed a cover memorandum (Attachment Nine-A) and Virginia’s revised recommendations for revising the Health Maintenance Organization Model Act (#430) for consistency with the revised Life and Health Insurance Guaranty Association Model Act (#520) (Attachment Nine-B). He discussed the recommendations, explaining that Virginia’s approach is to leave Model #430 unchanged because leaving it unchanged will provide the states that have not included health maintenance organizations (HMOs) as members under their life and health guaranty association’s statute, and those states that have not yet adopted the revised Model #520, with the guidance provided in the model they have come to rely on. He said those states that have adopted the revised Model #520 and currently have provisions in their laws or regulations based on Model #430 will have the guidance provided in the proposed drafting notes for the relevant sections in Model #430 in order for them to determine if they should amend their laws and regulations.

Mr. Wake explained that Maine’s approach (Attachment Nine-C) to revising Model #430 is substantially the same approach taken in Virginia’s revised recommendations. He said the main difference is that Maine’s approach is to revise Model #430 to reflect the states that have adopted the revised Model #520 rather than Virginia’s approach to leave Model #430 unchanged for those states that have not adopted the revised Model #520.

The Subgroup discussed the both recommendations. Chris Petersen (Arbor Strategies, LLC) expressed concern with the drafting note language in the Virginia Insurance Bureau’s recommendation to have the states consider repealing provisions in their laws or regulations concerning Section 19—Hold Harmless Provision Requirements for Covered Persons. He also expressed similar concerns about Section 14—Continuation of Benefits. He noted that he had submitted a comment letter previously to the Subgroup from a coalition of health insurers (Coalition)—Aetna, Anthem, Cigna, Health Care Service Corporation (HCSC) and UnitedHealthcare expressing those same concerns with weakening or eliminating these important consumer protections. He expressed support for Maine’s recommendations. Bonnie Burns (California Health Advocates) also expressed concern with repealing Section 19. Jeremy Crandall (Blue Cross and Blue Shield Association—BCBSA) also expressed support for Maine’s recommendations. Bob Ridgeway (America’s Health Insurance Plans—AHIP) noted that AHIP had submitted previous comments to the Subgroup suggesting the Subgroup take the approach to revising Model #430, as the Virginia Insurance Bureau’s revised recommendations reflect, because of the number of states that have adopted the revised Model #520. He expressed support for the Virginia Insurance Bureau’s revised recommendations and Maine’s suggested approach for revising Section 19.

The Subgroup discussed whether Section 19 should be deleted. After discussion, the Subgroup decided that Section 19 should be retained and that no drafting note revisions are needed.

Mr. Wake made a motion, seconded by Mr. Swanson, to have the Subgroup accept Maine’s recommendations for revising Model #430, except for the recommendations for Section 19. The motion passed unanimously.

Mr. Beatty said he anticipated the Subgroup holding its next conference call sometime after the Fall National Meeting to review an initial draft of revisions to Model #430 based on Maine’s recommendations.

Having no further business, the HMO Issues (B) Subgroup adjourned.
TO:        Jolie H. Matthews  
          Senior Health and Life Policy Counsel  
          National Association of Insurance Commissioners  
FROM:      Virginia Bureau of Insurance  
DATE:      November 12, 2019  
RE:        HMO Issues (B) Subgroup  
          Potential Revisions to the HMO Model Act #430  

Upon review of the status of States’ adoption of the 2017 version of the *Life and Health Insurance Guaranty Association Model Act* (Model Act #520), the discussion during the HMO Issues (B) Subgroup’s September 16, 2019 conference call, and the comments received from America’s Health Insurance Plans (AHIP) and the National Organization of Life and Health Insurance Guaranty Associations regarding Virginia’s proposed revisions to the HMO Model Act (Model Act #430), we offer the following for consideration by the Subgroup.

We propose leaving the current requirements in the HMO Model Act as-is but recommend adding several Drafting Notes applicable to States that have adopted the Model Act #520 HMO requirements. Leaving the HMO Model Act as-is will provide States that may not include HMOs as member insurers under their Life and Health Insurance Guaranty Associations statute, and those States that have not yet adopted the 2017 Model Act revisions, with the guidance they have come to rely on. States that have adopted Model Act #520, and currently have provisions in their laws/regulations based on Model Act #430, will need to review the Sections of Model Act #430 that contain the new Drafting Notes to determine if they should amend their laws/regulations.

The Drafting Notes have been added to the following Sections:

Section 3 - Definitions:
- Subsection HH – “Uncovered Expenditures”
Section 14 – Continuation of Benefits
Section 19 – Hold Harmless Provision Requirements for Covered Persons
Section 20 – Uncovered Expenditures Deposit
Section 21 – Open Enrollment and Replacement Coverage in the Event of Insolvency

No changes have been proposed to:
- Section 5B(16) – Establishment of Health Maintenance Organizations
- Section 18 – Deposit Requirements
- Section 31 – Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations
Virginia’s Proposed Revisions to the NAIC’s Health Maintenance Organization Model Act (#430)

Section 3. Definitions

A. “Adverse determination” means a determination by a health maintenance organization or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health maintenance organization’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.

B. “Basic health care services” includes the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.

C. “Capitated basis” means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

D. “Coinsurance” means the percentage amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

Drafting Note: States that do not allow HMOs to impose a coinsurance requirement should not adopt this definition nor include the term when it is referenced throughout the model.

E. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of health maintenance organizations lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

F. “Copayment” means a specified dollar amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

G. “Covered benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.

H. “Covered person” means any person eligible to receive covered benefits under the terms of a health benefit plan.

I. “Deductible” means the amount a covered person is responsible to pay out-of-pocket before the health maintenance organization begins to pay the covered expenses associated with treatment.

J. “Enrollee” means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

K. “Evidence of coverage” means a statement that sets out the coverage and other rights to which the covered person is entitled under the health benefit plan and that may be issued by the health maintenance organization or by the group contract holder to an enrollee electronically or, upon request, in writing.

L. “Extension of benefits” means the continuation of coverage under a particular benefit provided under a contract following termination with respect to a covered person who is totally disabled on the date of termination.
M. “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

N. “Grievance” means a written complaint submitted by or on behalf of a covered person regarding:

(1) The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(2) Claims payment, handling or reimbursement for health care services; or

(3) Matters pertaining to the contractual relationship between a covered person and a health maintenance organization.

O. “Group contract” means a contract for health care services, which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

P. “Group contract holder” means a person, other than an individual, to which a group contract has been issued.

Q. “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

R. “Health care professional” means a physician or other health care practitioner license, accredited or certified to perform specified health services consistent with state law.

S. “Health care provider” or “provider” means a health care professional or facility.

T. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

U. “Health carrier” or “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 to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, managed care organization, health maintenance organization, a nonprofit hospital or medical 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.

Drafting Note: The term “hospital or medical service corporation,” as used in the model act, is intended to apply to any nonprofit health, hospital or medical service corporation or similar organization. In order to include such organizations in this section, which are also commonly referred to as “Blue Cross Blue Shield-type” plans, each state should identify these organizations in accordance with its statutory terminology for such plans or by specific statutory citation. Some states also may have to amend other laws to bring these organizations within the scope of this section since the portions of state law applicable to these organizations may provide that no other portion of the insurance code applies to these organizations without a specific reference to the other provision.

V. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for a covered person’s responsibility for copayments, coinsurance or deductibles.

W. “Individual contract” means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the enrollee.

X. “Insolvent” or “insolvency” shall mean that the health maintenance organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.
Y. “Intermediary organization” means a person, other than an individual, authorized to negotiate and execute provider contracts with health maintenance organizations on behalf of a group of health care providers or on behalf of a network, but does not include a provider or group of providers negotiating on its own behalf.

Z. “Network” means the group of participating providers providing services to a health maintenance organization.

AA. “Net worth” means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

BB. “Participating provider” means a provider that, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments, coinsurance or deductibles, from the health maintenance organization or other organization under contract with the health maintenance organization to provide payment in accordance with the terms of the contract.

CC. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or a combination of the foregoing.

DD. “Policyholder” means, for individual contracts, the individual in whose name the contract is issued, and for group contracts, the group contract holder.

EE. “Qualified actuary” means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the commissioner may require.

FF. “Replacement coverage” means the benefits provided by a succeeding carrier.

GG. “Risk bearing entity” means an intermediary organization that is at financial risk for services provided through contractual assumption of the obligation for the delivery of specified health care services to covered persons of the health maintenance organization.

HH. “Uncovered expenditures” means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which a covered person may also be liable in the event of the health maintenance organization’s insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.

Drafting Note: Subsection HH is not applicable to States that have adopted the 2017 version of the Life and Health Insurance Guaranty Association Model Act (#520), including the requirement that Health Maintenance Organizations be member insurers of the Life and Health Guaranty Association. States that have adopted the 2017 version of Model Act #520 and currently have provisions in their laws/regulations based on Subsection HH, should consider repealing/deleting such provisions.

Drafting Note: Subsection HH defines uncovered expenditures for use in Section 20. They will vary in type and amount, depending on the arrangements of the health maintenance organization. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the covered person even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

II. “Utilization review” means a set of formal techniques utilized by or on behalf of the health maintenance organization designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Section 14. Continuation of Benefits

A. The commissioner shall require that each health maintenance organization have a plan for handling insolvency that provides for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.
B. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider, after the health maintenance organization’s insolvency, to provide covered services through the period for which premium has been paid to the health maintenance organization on behalf of the covered person or until the covered person’s discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency will continue until their confinement in an inpatient facility is no longer medically necessary;

(3) Insolvency reserves;

(4) Acceptable letters of credit; or

(5) Any other arrangements to assure that benefits are continued as specified above.

**Drafting Note:** In the event of an insolvency for States that have adopted the 2017 version of the Life and Health Insurance Guaranty Association Model Act (#520), including the requirement that Health Maintenance Organizations (HMO) be member insurers of the Life and Health Guaranty Association, benefits and coverages will be provided pursuant to [insert reference to state’s guaranty association statute based on Sections 2B and 8B(2) of the Model Act]. States that have adopted the 2017 version of Model Act #520 and currently have provisions in their laws/regulations based on Section 14, should consider repealing/deleting such provisions.

**Section 19. Hold Harmless Provision Requirements for Covered Persons**

A. Except for coinsurance, deductibles or copayments as specifically provided in the evidence of coverage, in no event, including but not limited to nonpayment by the health maintenance organization, insolvency of the health maintenance organization or breach of contract among the health maintenance organization, risk bearing entity or participating provider, shall a risk bearing entity or participating provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization) acting on behalf of the covered person for covered services provided. No risk bearing entity or participating provider, nor any agent, trustee or assignee of the risk bearing entity or participating provider may maintain an action at law against a covered person to collect sums owed by the health maintenance organization.

B. All contracts among health maintenance organizations, risk bearing entities, and participating providers shall include a hold harmless provision specifying protection for covered persons. Any attempted waiver or amendment in a manner materially adverse to the interests of covered persons of a hold harmless provision shall be null and void and unenforceable.

C. The requirement of Subsection B shall be met by including a provision substantially similar to the following:

“Provider agrees that in no event, including but not limited to nonpayment by the health maintenance organization or intermediary organization, insolvency of the health maintenance organization or intermediary organization, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization or intermediary organization) acting on behalf of the covered person for covered services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, copayments or services in excess of limits, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons.”

D. (1) Any statement sent to a covered person shall clearly state the amounts billed to the health
maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(2) All contracts among health maintenance organizations, risk bearing entities, and participating providers shall require that all statements sent to covered persons clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(3) The notice requirements in this subsection shall be met by including in the statement to covered persons a provision substantially similar the following:

NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY AMOUNTS OWED BY YOUR HEALTH MAINTENANCE ORGANIZATION

E. Any violation of the provisions of this section shall constitute an unfair trade practice pursuant to [insert reference to state insurance fraud statute] and shall subject the health care provider to monetary penalties in accordance with [insert reference to state insurance fraud statute] and notification to the [insert reference to appropriate licensing entity for type of provider].

Drafting Note: For States that have adopted the 2017 version of the Life and Health Insurance Guaranty Association Model Act (#520), including the requirement that Health Maintenance Organizations (HMO) be member insurers of the Life and Health Guaranty Association, health care providers will be protected against loss due to an impairment or insolvency of an insurer (HMO) pursuant to Section 3B(1) of the Model Act. States that have adopted the 2017 version of Model Act #520 and currently have provisions in their laws/regulations based on Section 19, should consider repealing/deleting such provisions.

Drafting Note: States that do not authorize insurance departments to take action against providers should not adopt Subsection E and should consider other options such as contacting the state attorney general’s office or other appropriate state official.

Drafting Note: States with consumer protection acts that provide covered persons with a private right of action should consider including a reference in Subsection E.

Section 20. Uncovered Expenditures Deposit

A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of 120 percent of the health maintenance organization’s outstanding liability for uncovered expenditures for covered persons in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

B. The deposit required under this section is in addition to the deposit required under Section 18 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

C. (1) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

   (a) A substitute deposit of cash or securities of equal amount and value is made;

   (b) The fair market value exceeds the amount of the required deposit; or
(c) The required deposit under Subsection A is reduced or eliminated.

(2) Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

D. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of covered persons of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

E. The commissioner may by regulation prescribe the time, manner and form for filing claims under Subsection D.

F. The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

**Drafting Note:** Section 20 is not applicable to States that have adopted the 2017 version of the Life and Health Insurance Guaranty Association Model Act (#520), including the requirement that Health Maintenance Organizations be member insurers of the Life and Health Guaranty Association. States that have adopted the 2017 version of Model Act #520 and currently have provisions in their laws/regulations based on Section 20, should consider repealing/deleting such provisions.

**Section 21. Open Enrollment and Replacement Coverage in the Event of Insolvency**

A. Enrollment Period

(1) In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group’s last regular enrollment period shall offer the group’s enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group covered persons of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization’s group contracts for these groups among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization’s service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization’s existing coverage that is most similar to each group’s coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization’s existing rating methodology and in accordance with state law.

(3) The commissioner shall also allocate equitably the insolvent health maintenance organization’s nongroup enrollees that are unable to obtain other coverage among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization’s service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall
offer the nongroup enrollees the health maintenance organization’s existing coverage for individual
or conversion coverage as determined by the enrollee’s type of coverage in the insolvent health
maintenance organization at rates determined in accordance with the successor health maintenance
organization’s existing rating methodology. Successor health maintenance organizations that do not
offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one
group for rating and coverage purposes.

B. Replacement Coverage

(1) “Discontinuance” shall mean the termination of the contract between the group contract holder and
a health maintenance organization due to the insolvency of the health maintenance organization,
and does not refer to the termination of any agreement between any individual enrollee and the
health maintenance organization.

(2) A health maintenance organization providing replacement coverage hospital, medical or surgical
expense or service benefits within a period of sixty (60) days from the date of discontinuance of a
prior health maintenance organization, shall immediately cover all covered persons who were
validly covered under the previous health maintenance organization at the date of discontinuance
and who would otherwise be eligible for coverage under the succeeding health maintenance
organization, regardless of any provisions of the contract relating to active employment, hospital
confine ment or pregnancy.

Drafting Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in the group market, a
succeeding carrier, including a health maintenance organization, is prohibited from including any nonconfine ment rules in its
plan of benefits and any actively-at-work rules provided in the succeeding carrier’s plan of benefits must provide that absence
from work due to any health status-related factor be treated as being actively-at-work.

(3) Except to the extent benefits for the condition would have been reduced or excluded under the prior
carrier’s contract or policy, no provision in a succeeding health maintenance organization’s contract
of replacement coverage that would operate to reduce or exclude benefits on the basis that the
condition giving rise to benefits preexisted the effective date of the succeeding carrier’s contract
shall be applied with respect to those covered persons validly covered under the prior carrier’s
contract or policy on the date of discontinuance.

Drafting Note: Section 21 is not applicable to States that have adopted the 2017 version of the Life and Health Insurance
Guaranty Association Model Act (#520), including the requirement that Health Maintenance Organizations be member insurers
of the Life and Health Guaranty Association. States that have adopted the 2017 version of Model Act #520 and currently have
provisions in their laws/regulations based on Section 21, should consider repealing/deleting such provisions.
Maine Comments on Revisions to HMO Model Act

November 18, 2019 (Corrected Version)

In August, the Virginia Bureau of Insurance proposed some revisions to the HMO Model Act (# 430) to bring it into conformance with the current version of the Life & Health Insurance Guaranty Association Model Act (# 520), which no longer excludes HMOs from the guaranty association. Comments on the proposed revisions pointed out that not all states have updated their guaranty fund laws to include HMOs. In response, Virginia has proposed a new approach, which would leave the HMO Model Act unchanged but add drafting notes describing the revisions that would be necessary for those states that no longer exclude HMOs from guaranty association membership.

While we agree that the revisions to the Model need to recognize that at least at this time, adoption of the model guaranty fund amendments has not been uniform, we believe the current proposal sends an unfortunate message, by treating the previous exclusion of HMOs as the default and recognizing the inclusion of HMOs in the guaranty association as an optional alternative some states might choose. We believe it should be the other way around — the text of the HMO Model should conform to the current version of the Guaranty Association Model, and there should be drafting notes describing what states should do if they choose to retain the prior version.

Also, NOLHGA observed that the proposed replacement for Section 14 does not accurately describe the responsibilities of the guaranty association to provide replacement coverage. While policies would remain in place for a brief period of time after the date of insolvency, backed by the guaranty association, long-term replacement coverage will be available from any solvent insurance carrier through a “special enrollment period.” This is the case whether or not there is guaranty association coverage. In general, in states that have adopted the 2017 amendments to the Guaranty Association Model, insolvent HMOs are treated like any other insolvent insurance carrier under the guaranty association laws, the health insurance laws, and the receivership laws. Therefore, there is no longer any need for the HMO laws to include an insolvency plan section that is unique to HMOs, and Section 14 should simply be repealed, not replaced.

Accordingly, we recommend the following substitute:

I. Preserve the prior numbering for ease of reference.

II. Repeal Subsection 3(HH), which currently defines the term “uncovered expenditures.” Amend the drafting note that will now follow Subsection 3(GG) to read as follows:

Drafting Note: Sections 3(HH), 14 and 20 have been repealed to bring this Model Act into conformity with the Life and Health Insurance Guaranty Association Model Act (Model #520), which was amended in 2017 to make health maintenance organizations members of the guaranty association. States that continue to exclude health maintenance organizations from guaranty association membership should retain former Subsection HH, which defined the term “uncovered expenditures.” These are costs that could be the responsibility of consumers if a health maintenance organization became insolvent without guaranty association protection for use in Section 20. They will vary in type and amount, depending on the arrangements of the health maintenance organization. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the covered person even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

III. Repeal Section 14, and replace it with the following drafting note:

Drafting Note: States that exclude health maintenance organizations from guaranty association membership should retain former Section 14, which required HMO-specific insolvency planning procedures to facilitate continuation of benefits after an insolvency.

IV. Consider amending the new drafting note after Section 19 to read as follows:

Drafting Note: Pursuant to Section 3B(1) of the Life and Health Insurance Guaranty Association Model Act (Model #520), both enrollees and health care providers will be protected against loss due to an impairment or insolvency of an insurer (HMO), a health maintenance organization, in states that have adopted the current version of Model #520.
This section has been retained because its primary purpose is no longer protecting consumers against insolvency, but protecting consumers against unfair billing practices. Many states now also require similar protections for consumers covered by other types of health carriers.

V. Repeal Section 20, and replace it with the following drafting note:

**Drafting Note:** States that exclude health maintenance organizations from guaranty association membership should retain former Section 20, which required health maintenance organizations to post uncovered expenditures insolvency deposits if their uncovered expenditures, as defined in former Section 3(HH), exceeded 10% of total health care expenditures.

VI. Repeal Section 21. No replacement drafting note is necessary, as open enrollment in replacement coverage is now governed by the ACA and state guaranteed-issue laws and is no longer an HMO-specific concern.
The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Sept. 16, 2019. The following Subgroup members participated: Don Beatty, Chair, and Raquel Pino (VA); Dayle Axman (CO); Toma Wilkerson (FL); Eric Anderson (IL); Robert Wake (ME); Chlora Lindley-Myers and Mary Mealer (MO); Martin Swanson (NE); Ron Pastuch (WA); Nathan Houdek and Jennifer Stegall (WI); and Joylynn Fix (WV).

1. **Exposed the Virginia Insurance Bureau’s Recommendations for Revising Model #430**

Mr. Beatty said that prior to the conference call, NAIC staff had distributed a cover memorandum and the Virginia Insurance Bureau’s (Bureau) recommendations for revising the *Health Maintenance Organization Model Act* (#430) for consistency with the revised *Life and Health Insurance Guaranty Association Model Act* (#520). Ms. Pino went through the suggested recommendations. She said the Bureau recommends deleting the definition of “uncovered expenditures” in 3HH because if a health maintenance organization (HMO) is treated as an insurer in the event of an insolvency, then the insolvency protections in Model #430 related to this definition are no longer needed. Chris Petersen (Arbor Strategies LLC), representing a coalition of health insurers (Coalition), suggested the Subgroup defer specific discussion of this recommendation because of the open issue of whether Section 20—Uncovered Expenditures Deposit, where this defined term is used, should be deleted as the Bureau recommends. The Subgroup agreed.

Ms. Pino discussed Section 14—Continuation of Benefits. She said this section establishes a mechanism for providing continuation of benefits for enrollees in the event of an insolvency. She said such a provision would not be necessary because the guaranty association would be responsible for obtaining replacement coverage for an insolvent HMO’s enrollees. She said the Bureau recommends deleting Section 14’s current language and replacing it with language stating that the guaranty association would be responsible for continuation of benefits and coverages in the event of an insolvency. Mr. Petersen explained that in the Coalition’s comment letter, it suggests retaining Section 14 because it provides a significant consumer protection to ensure consumers can continue to receive health care services. He explained that Section 14 does not address who will pay for that care. Under Model #520, the guaranty association would assume responsibility for paying claims, and under Section 14, providers are required to continue to provide health care services to the insolvent HMO’s enrollees. The Subgroup discussed whether Section 14 should be retained and amended to clarify its provisions as continuation of benefits in the event of an insolvency requiring providers to continue to provide health care services to the insolvent HMO’s enrollees. After additional discussion, the Subgroup deferred making a decision.

Ms. Pino said the Bureau recommends retaining Section 19—Hold Harmless Provision Requirements for Covered Persons and adding a drafting note stating that health care providers are protected against losses due to insolvency or impairment of an HMO under Model #520. She said the Bureau recommends deleting Section 20—Uncovered Expenditures Deposit. She said the uncovered expenditures insolvency deposit authorized by Section 20 is in addition to the deposit required under Section 18—Deposit Requirements. She said that because HMOs are now members of the life and health insurance guaranty associations and subject to assessments of failed long-term care insurance (LTCI) insurers, this additional deposit does not appear to be necessary. Ms. Pino said the Bureau recommends deleting Section 21—Open Enrollment and Replacement Coverage in the Event of an Insolvency. She said Section 21 establishes a mechanism for providing replacement coverage for enrollees in the event of an insolvency, which is no longer needed because the guaranty association would be responsible for obtaining replacement coverage for an insolvent HMO’s enrollees.

Bob Ridgeway (America’s Health Insurance Plans—AHIP) said that approximately 26 states to date have adopted the revised Model #520 adding HMOs as members of the life and health insurance guaranty associations. He asked if the Subgroup is contemplating adding a drafting note to alert those states that have not adopted the revised Model #520 to not adopt the revisions to Model #430. Mr. Beatty said he does not believe such a drafting note is necessary or appropriate because he is not sure it is an issue.

The Subgroup exposed the Bureau’s recommendations for a public comment period ending Oct. 15.
The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 3, 2019. The following Subgroup members participated: TK Keen, Chair, and Jesse O’Brien (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Chris Murray and Sarah Bailey (AK); William Rodgers (AL); Ryan James (AR); Lan Brown (CA); Andria Seip and Cynthia Banks Radke (IA); Vicki Schmidt (KS); Nancy G. Atkins and Patrick O’Connor (KY); Jeff Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Andrew Kleinendorst (MN); Chlora Lindley-Myers and Molly White (MO); Derek Oestreicher (MT); Gale Simon (NJ); Renee Blechner (NM); Michael Humphreys (PA); Rachel Drage-Rice (TN); Don Beatty (VA); Jennifer Kreitler (WA); Jennifer Stegall (WI); and Denise Burke (WY). Also participating were: Fleur McKendell (DE); and Robert Wake (ME).

1. **Heard a Presentation on the Kentucky PBM License Process**

   Mr. Keen said that during the Subgroup’s August conference calls, it heard from several stakeholders. He said the purpose of this conference call is to hear from one of the last major stakeholders, the states: Arkansas, Kentucky, Montana, New Mexico and Oregon. He said following this conference call, he anticipates surveying the Subgroup members to determine the Subgroup’s next steps, particularly if the Subgroup should hear from additional stakeholders before beginning its work to develop an NAIC model regulating pharmacy benefit managers (PBMs).

   Mr. O’Connor provided an overview of Kentucky’s PBM licensing process. He explained that during the 2016 legislative session, the Kentucky legislature passed Senate Bill 117 (S.B. 117), giving the Kentucky Department of Insurance (DOI) the authority to license PBMs; prior to the legislation’s passage, depending on their function, PBMs were licensed as third-party administrators (TPAs). He said S.B. 117 had two primary areas of concentration: 1) creating a framework for a separate PBM license in Kentucky with the Kentucky DOI and to subject PBMs to civil penalties; and 2) pharmacy reimbursement transparency requirements and reimbursement appeal process to the PBM and the Kentucky DOI. He said that in 2018, the Kentucky legislature passed S.B. 5, enhancing PBM reporting requirements and heightening penalties for PBM violations.

   Mr. Keen asked about staffing resources. Mr. O’Connor said the Kentucky DOI has two staffers. Mr. Murray asked about the number of MAC appeals the Kentucky DOI has received. Mr. O’Connor said during the law’s first year, it had no appeals, but since then, the Kentucky DOI has received approximately 3500 appeals. However, the number of appeals has decreased over time.

2. **Heard a Presentation on the Arkansas PBM Law**

   Mr. James discussed the Arkansas PBM licensure law. He said the law was enacted in 2018 and is like the Kentucky licensing law. He said Arkansas currently licenses 17 PBMs. He said the law served as a guidepost for the National Council of Insurance Legislators’ (NCOIL) Pharmacy Benefits Manager Licensure and Regulation Model Act. He explained that provisions in the law related to MAC pricing were passed in 2015 but were immediately challenged and are currently on appeal. Mr. James discussed other provisions in the law, including its gag clause provisions. He said in the recently concluded 2019 legislative session, the Arkansas law was tweaked with respect to spread pricing and claw backs. He also said provisions related to MAC pricing were revised, making the National Average Drug Acquisition Cost (NADAC) the minimum floor reimbursement threshold instead of the MAC.

   Mr. Ryan said that to implement the law, the Arkansas DOI established a new position, PBM coordinator, carved out from its legal division. He discussed the challenges the Arkansas DOI has encountered with respect to the MAC complaints. He also discussed possible future Arkansas legislation involving pharmacy services administrative organizations (PSAOs).
3. Heard a Presentation on the Montana PBM law

Mr. Oestreicher discussed the history, purpose and provisions of S.B. 71 to address issues related to PBMs, which passed in Montana but was ultimately vetoed. He noted that the National Academy for State Health Policy (NASHP) adopted S.B. 71 as model legislation, and Maine recently enacted legislation, L.D. 1504, which is based on S.B. 71.

Mr. Oestreicher said that before drafting S.B. 71, the Montana DOI considered two factors: 1) why prescription drug costs are so high; and 2) what state insurance departments can do to combat rising drug costs. He discussed the broken mechanisms in the prescription drug supply chain most likely contributing to high prescription drug costs. He said the Montana DOI considered different approaches to address the broken system, but ultimately, it decided to develop a bill using the DOI’s current regulatory authority over health insurers to address the issue. He said S.B. 71 comprised a list of best practices for insurers to include in their PBM contracts: 1) prohibit spread pricing; 2) require that all rebates be passed through the insurer; and 3) use rebate savings to directly lower premiums. He also discussed continuing legal and regulatory actions against the Montana DOI. He said the Montana DOI anticipates re-introducing the legislation during Montana’s 2021 legislative session.

Mr. Keen asked if S.B. 71 would have required additional staffing resources. Mr. Oestreicher said the Montana DOI did not anticipate having to hire additional staff because S.B. 71 relied on its regulatory authority over health insurers to enforce its PBM-related requirements. He said the bill’s fiscal note was $600 for the cost of the Montana DOI to promulgate rules. Ms. Seip asked about Maine’s law. Mr. Wake said the Maine law mirrors S.B. 71. Mr. Oestreicher pointed out that Maine’s law included a unique approach to spread pricing by permitting an insurer to allow spread pricing while requiring the insurer to account for the “spread” as an administrative cost for the purposes of the federal Affordable Care Act’s (ACA) medical loss ratio (MLR).

4. Heard a Presentation on the New Mexico PBM Legislation

Ms. Blechner discussed PBM legislation in New Mexico. She said legislation enacted in 2014 required minimum information from PBMs, but in 2019, legislation was enacted amending the law to allow the New Mexico DOI to establish PBM licensing requirements by regulation. She said PSAOs are required to register with the New Mexico DOI.

Ms. Blechner discussed the reimbursement provisions in New Mexico’s law, which includes provisions: 1) requiring objective and verifiable resources for drug pricing; 2) requiring the disclosure of derivative sources for formulating MAC prices for a particular provider on request; 3) prohibiting a PBM from paying a pharmacy less than it pays an affiliate; 4) allowing a pharmacy to appeal reimbursement disputes directly to the PBM or its PSAO; and 5) requiring PBMs to provide access to the MAC list to the New Mexico DOI and all network pharmacies.

Ms. Blechner discussed the provisions in New Mexico’s law involving contracts between pharmacies and PBMs. She said the New Mexico law prohibits PBMs from recouping monies, known as “claw backs,” from pharmacies as a result of low sales of certain drugs or patient noncompliance. She said the law also prohibits gag orders on pharmacists informing patients about lower cost options.

5. Heard a Presentation on the Oregon Law

Mr. O’Brien discussed PBM regulation in Oregon. He said Oregon enacted legislation in 2013 requiring PBMs to register. The legislation set a $50 registration fee and included restrictions on pharmacy audits and MAC pricing and appeals. He said the legislation was problematic due to its low registration fee and unclear enforcement mechanisms.

Mr. O’Brien said in 2017, the legislature passed legislation to address some of the issues with the 2013 law. He said the legislation: 1) allowed the Department of Financial Regulation (DFR) to set an annual registration fee by rule; 2) empowered the DFR to revoke or suspend a registration for misconduct; and 3) established a complaints process. During Oregon’s 2019 legislative session, the legislature enacted additional PBM-related legislation that: 1) prohibits gag clauses; 2) prohibits PBMs from requiring consumers to use mail-order; 3) strengthens existing MAC pricing requirements; and 4) establishes stronger rulemaking authority for the DFR. Mr. O’Brien said the DFR is currently working on promulgating rules but anticipates the
rules will focus on defining key terms, such as “specialty drug/pharmacy,” “ancillary service” and “generally available to purchase.” He said currently, there are 52 PBMs registered in Oregon.

Mr. O’Brien also discussed Oregon’s Prescription Drug Price Transparency program (Program). He explained that in 2018, the Oregon legislature passed House Bill 4005 (H.B. 4005) to increase prescription drug price transparency. The Program’s goal is to provide accountability for prescription drug pricing through transparency of specific cost and price information from pharmaceutical manufacturers and health insurers. Mr. O’Brien said Oregon’s next steps could include efforts to increase PBM transparency.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Aug. 29, 2019. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Sarah Bailey and Jacob Lauten (AK); William Rodgers and Anthony L. Williams (AL); Marjorie Farmer (AR); Bruce Hinze (CA); Howard Liebers (DC); Cynthia Banks Radke and Johanna Nagel (IA); Vicki Schmidt (KS); John Melvin (KY); Jeff Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Andrew Kleinendorst (MN); Mary Mealer and Molly White (MO); Derek Oestreicher (MT); Gale Simon (NJ); Renee Blechner (NM); Katie Dzurec, Karen M. Feather and Sandra L. Ykema (PA); Vickie Trice (TN); Eric Lowe (VA); Ron Pastuch (WA); Nathan Houdek and Jennifer Stegall (WI); Joylynn Fix and Ellen Potter (WV); and Denise Burke (WY). Also participating was: Matthew Veno (MA).

1. Heard a Presentation on Managing Prescription Drug Benefits from the PCMA and Horizon Government Affairs

April Alexander (Pharmaceutical Care Management Association—PCMA) and J.P. Wieske (Horizon Government Affairs) discussed the history, role and services that pharmacy benefit managers (PBMs) provide in managing prescription drug benefits. Ms. Alexander discussed how payer strategies regarding prescription drug benefits evolved over time, increasing the role PBMs play in the provision of prescription drug benefits by plans. She noted, however, that no plan is required to use a PBM. She provided a snapshot of the current PBM marketplace, explaining that competition in the PBM marketplace is strong. She said there are 66 PBMs in the U.S. Ms. Alexander acknowledged that, currently, three PBMs cover 75% of the marketplace, but she said this is changing due to market consolidation, vertical integration and new market entrants. She said that PBMs’ net profit is the lowest among those entities in the prescription drug supply chain.

Ms. Alexander discussed the services PBMs provide, including services that save plans money. She said PBMs provide other important services unrelated to cost savings, such as drug utilization review programs and programs to address opioid use issues.

Ms. Alexander discussed the contracting process between PBMs and plans. She explained that as part of the contracting process, PBMs offer various plan design models depending on a plan’s specific needs. She said plan sponsors always have the final say when creating a prescription drug benefit plan. The PBM does not determine benefit design, cost sharing levels, deductibles or other benefit design elements. The PBM is agnostic with respect to such decisions.

Ms. Alexander provided an example of a “negative” spread where the PBM can lose money on a drug or class of drugs using spread pricing. Mr. Wieske described spread pricing as a way a PBM hedges its risk in its contract with a plan.

Ms. Alexander discussed how PBMs drive savings and quality by using their ability to bring volume to drug manufacturers and the use of rebates. Mr. Wieske discussed how rebates help reduce premiums and cost-sharing and how the revenue is included in the medical loss ratio (MLR) calculation and reported in a plan’s MLR filing.

Ms. Alexander discussed how pharmacy networks developed by PBMs play a role in driving savings and quality. She described PBMs’ contracting process with a variety of pharmacies, typically through pharmacy services administrative organizations (PSAOs), to ensure a robust network for plan enrollees to access. She noted that PBMs have no insight into private contract terms between PSAOs and pharmacies.

Mr. Wieske discussed the NAIC’s work to date related to PBMs and prescription drug benefits. He highlighted the provisions in the Health Carrier Prescription Drug Benefit Management Model Act (#22). He explained that the focus of the NAIC’s work on Model #22 was on the consumer, not PBMs. He said that Model #22 regulates entities such as PBMs through a plan’s contract with the entity and does not directly regulate these entities. He said the Subgroup should look at Model #22’s provisions to decide its next steps.

Ms. Alexander described a world without PBMs. She said that without PBMs to manage the prescription drug benefit, plans would most likely incur 40% to 50% more in costs for a variety of reasons, including lack of competition between drug manufacturers, less efficient claims processing and less utilization of generic drugs.
Commissioner Schmidt asked about Ms. Alexander’s example illustrating “negative” spread. She questioned whether PBMs actually reimburse pharmacies based on the National Average Drug Acquisition Cost (NADAC) price as shown in the example. Ms. Alexander said the NADAC price is used as a proxy. She said this same data is used to show “positive” spread. Commissioner Schmidt suggested Ms. Alexander provide the Subgroup with the complete report, which includes this table. Ms. Alexander agreed to provide the information.

2. **Heard a Presentation on the Community Pharmacy Industry Perspective Regarding PBMs and Managing Prescription Drug Benefits from the NCPA**

Anne Cassity (National Community Pharmacists Association—NCPA) and Matthew Magner (NCPA) discussed the community pharmacy industry’s perspective regarding PBMs and managing prescription drug benefits. Ms. Cassity provided a profile of community pharmacists. She said 80% of community pharmacists are located in areas with populations of less than 50,000. She described the types of services that full-line, independent community pharmacists provide, such as medication therapy management; same-day, in-person delivery; immunizations; and blood pressure monitoring. Ms. Cassity explained that when the medication is covered by insurance, the consumer’s price for a drug is set by the PBM, not the pharmacy. If it is a cash transaction, then the pharmacy sets the price. Ms. Cassity said what community pharmacies charge consumers and are reimbursed is often determined by a competitor. She explained that PBMs own or are affiliated with competing retail, mail-order and/or specialty pharmacies. PBMs often require or incentivize consumers to use the PBM-owned pharmacy.

Ms. Cassity discussed how the lack of PBM oversight and regulation has had a negative impact on community pharmacies. She highlighted how this situation affects community pharmacies particularly in contracting with PBMs. She discussed how PBM steering to PBM-owned retail, mail-order and specialty pharmacies have caused consumers to lose access to trusted pharmacy providers. Between 2003 and 2018, 1,231 independent pharmacies closed in rural areas.

Mr. Magner discussed how PBMs have affected patient and payer costs. He said PBMs have no fiduciary duty to anyone but their shareholders. He said this results in a lack of accountability. He suggested the following solutions to address this issue: 1) reimbursement transparency; 2) accountability through licensure; and 3) ensuring patient access through anti-mandatory mail-order provisions, network adequacy requirements and limits on conflicts of interest.

Ms. White asked Mr. Magner about his comments concerning PBMs moving away from maximum allowable cost (MAC) lists towards generic effective rate reimbursement methodologies with respect to states enacting reimbursement transparency laws as a solution to PBMs’ lack of accountability. Mr. Magner said he made the comment to alert states that may be thinking of enacting such reimbursement transparency laws to not make the law too narrow. He said Arkansas and Maryland recently revised their laws to address this issue.

Mr. Veno asked Mr. Magner asked if the community pharmacy has a direct relationship with the PBM through the pharmacy’s contract with the PSAO. Mr. Magner said the community pharmacy would only have a direct relationship with the PBM if it contracted directly with the PBM. Mr. Veno questioned why PSAOs must “take it” or “leave it” with respect to the contract with the PBM if 80% of community pharmacies contract with PSAOs, which in turn contract with PBMs. Mr. Magner said because of antitrust laws, PSAOs may not decline a contract on behalf of a pharmacy. Mr. Veno questioned the value to community pharmacies of contracting with PSAOs because of this situation.

3. **Heard a Presentation on the Consumer Perspective of PBMs from Families USA**

Claire McAndrew (Families USA) discussed the effect of PBMs and prescription drug costs on consumers. She said consumers are struggling with high prescription drug costs. She discussed how consumers have dealt with this by not taking a medicine as prescribed or declining other medical tests or procedures or delaying doctors’ visits. Ms. McAndrew suggested that the entire drug supply chain has contributed to this rise in prescription drug costs. She discussed some state mechanisms for addressing prescription drug costs, such as price transparency, PBM regulations, anti-price gouging and drug importation.

Ms. McAndrew said PBMs present concerns for consumers due to their: 1) lack of transparency in pricing and the effect of rebates on prescription drug costs; 2) lack of accountability; 3) incentives to select high-cost drugs; and 4) potential to lead to higher prescription drug costs at the pharmacy counter for consumers with insurance. She discussed ways these concerns can be addressed, such as PBM registration and imposing a fiduciary duty on PBMs to plans.
4. **Heard a Presentation on PBMs and their Impact on Access and Affordability from the NASTAD**

Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) discussed PBMs and their impact on consumer access and affordability of prescription drugs. Ms. Killelea said PBMs play an outsized role in prescription drug access due to their involvement in formulary development, utilization management and pharmacy network design. She said the NAIC’s work on Model #22 and the *Health Benefit Plan Network Access and Adequacy Model Act* (#74) addressed some of these activities, but not all.

Ms. Killelea discussed how the lack of transparency regarding prescription drugs costs and the impact of rebates on these costs have affected consumers. She said that with respect to affordability, PBMs play a significant role in the ultimate prescription drug cost passed on to the consumer. She said rebates generated are generally used to defray premiums, but not used to reduce consumer prescription drug cost-sharing. She discussed how plan copay accumulator policies put the consumer in the middle between the plan and the drug manufacturer and how such policies are not a substitute for sound prescription drug pricing reforms.

Ms. Killelea outlined certain considerations for the Subgroup as it works to complete its charge, which included: 1) strengthening and reinforcing the applicability of relevant formulary and access protections included in Model #22; 2) strengthening conflict of interest standards to ensure that formulary and access decisions are based on clinical justifications and not PBM self-dealing; 3) reviewing network adequacy standards in Model #74 and ensuring that pharmacy network nuances are addressed; 4) developing transparency standards for PBM practices; and 5) ensuring rebates are used to defray consumer prescription drug cost-sharing, not just to defray premiums.

Mr. Keen said he anticipates the Subgroup meeting via conference call sometime in September to hear from the states on their work related to PBMs.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Aug. 22, 2019. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Chris Murray and Sarah Bailey (AK); Jerry Workman and Anthony L. Williams (AL); Ryan James (AR); Bruce Hinze (CA); Andria Seip (IA); Vicki Schmidt (KS); Patrick O’Connor (KY); Jeff Zewe (LA); Mary Kwei (MD); Joseph Stoddard (MI); Melinda Domzalski-Hansen and Krisi Bohn (MN); Molly White (MO); Marilyn Bartlett (MT); Gale Simon (NJ); Renee Blechner (NM); Katie Dzurec, Karen M. Feather and Sandra L. Ykema (PA); Michael Humphreys (TN); Don Beatty and Yolanda Tennyson (VA); Jennifer Kreitler (WA); Nathan Houdek and Jennifer Stegall (WI); and Joylynn Fix and Ellen Potter (WV). Also participating were: Matthew Veno (MA); and Jesse O’Brien (OR).

1. **Heard a Presentation on PBM Economics from the University of Southern California**

Neeraj Sood (Sol Price School of Public Policy, University of Southern California) discussed the role pharmacy benefit managers (PBMs) play in the pharmaceutical supply chain. He described the flow of services and the PBM’s relationship with other supply chain participants. He said PBMs are true middlemen; they play no role in the physical distribution of prescription drugs to consumers. Dr. Sood also discussed how PBMs make money describing how rebates and spread pricing play a role in PBM income.

Dr. Sood discussed how the PBM market functions and how rebates can create misaligned incentives for the PBM in choosing certain drugs for a health plan’s formulary, potentially resulting in higher premium and increased costs for consumers. He also discussed how the lack of competition in the supply chain and a consolidated PBM market also play a role in costs. Dr. Sood discussed how the new wave of vertical consolidation in the supply chain might further curtail competition and how it could result in misaligned incentives for the PBM. He provided two examples of such misaligned incentives when: 1) a PBM owns a pharmacy; and 2) a PBM owns a health plan. He also noted the high barriers to entry for new entrants in the drug supply chain.

Dr. Sood presented potential policy solutions to address issues he discussed in the drug supply chain. He recommended the following: 1) improve drug price transparency throughout the supply chain; 2) move from a rebate system to a discounts model; 3) mandate pass-through of rebate to consumers; 4) outlaw unfair business practices of PBMs; and 5) reduce barriers to entry in the PBM market.

Ms. Arp asked if vertical integration could address the misaligned incentive with respect to rebates. Dr. Sood agreed that vertical integration could address some of those issues, but he pointed out the issues with vertical integration.

Ms. White asked about drug pricing. Dr. Sood explained that market dynamics hinder lower drug prices. He said drug manufacturers typically set high drug prices to maximize profit for their shareholders, but not to limit consumer access to those drugs. He said that to address this, the pricing model needs to be changed.

Mr. O’Brien asked if spread pricing in the situation where a PBM contracts with a health plan to pay a set price for a drug benefits the health plan. Dr. Sood explained how in some scenarios, such a contract would not benefit the health plan even if the plan’s risk is limited due to the set drug price.

Mr. Veno asked Dr. Sood why he recommends limiting the use of spread pricing and rebates instead of prohibiting their use to address issues in the drug supply chain. Dr. Sood said PBMs are providing a service and need to make money for providing that service in some way. He said that if a state prohibits PBMs from using rebates or spread pricing to make money, then PBMs could receive payment by charging administrative fees. Dr. Sood said, however, that he does not have strong feelings on which approach policy makers should take to address these issues. Ms. Seip said the federal Affordable Care Act (ACA) requires health plans to maintain a certain medical loss ratio (MLR) to help to ensure that plans are providing value to enrollees. She asked if Dr. Sood thinks a similar requirement would work for PBMs. Dr. Sood said it is possible that an MLR requirement could provide similar benefits. He said the challenge would be making sure PBMs do not circumvent the requirement.
2. **Heard a Presentation on Prescription Drug Costs from PhRMA**

Saiza Elayda (Pharmaceutical Research and Manufacturers of America—PhRMA) described the evolution of medicine over time from medicines made of chemical compounds to medicines made from living cells. She discussed the biopharmaceutical research and development process, explaining that from drug discovery through U.S. Food and Drug Administration (FDA) approval, developing a medicine on average takes 10 to 15 years. She said the competitive U.S. market provides patients with access to innovative medicines faster. She also said more medicines are available to U.S. patients than in other countries, such as the United Kingdom (UK), Canada and France.

Ms. Elayda explained how competition drives down costs. She also explained how medicine cost growth is declining, noting that after discounts and rebates, brand drug medicine costs grew just 0.3% in 2018. She said that spending on retail and physician-administered medicines continues to represent just 14% of U.S. health care spending. She said prescription drug spending is projected to grow in line with health care spending through the next decade, while growth in other health care services will be five times total medicine spending growth through the next decade.

Ms. Elayda discussed the pharmaceutical supply chain and how the pharmaceutical distribution and payment system shapes the prices of brand name medicines. She provided examples. She said the current system needs to evolve to better reward results and ensure patients more directly benefit from the significant price negotiations between PBMs and biopharmaceutical companies. Ms. Elayda discussed drug access and affordability. She said that when drug coverage is subjected to a large combined (medical and drug) deductible, on average, patients pay a higher share of their drug costs compared with their other health care services costs. She explained the impact of drug coupon use on patient out-of-pocket spending on brand name drugs.

Ms. Elayda discussed market-based reforms that could make medicines more affordable and accessible, which included:

1) modernizing the drug discovery and development process; 2) promoting value-driven health care; 3) empowering consumers; and 4) addressing market distortions. She provided three key takeaways from her presentation: 1) after accounting for discounts and rebates, brand name drugs average net price increased just 1.9% in 2017; 2) in 2016, biopharmaceutical companies paid out $127 billion in rebates and discounts to government and private payers, but these rebates and discounts were typically not shared with patients at the pharmacy counter; and 3) 90% of all prescriptions filled in 2016 were generics, with projections that $140 billion of U.S. brand name drug sales will face competition from generics of biosimilars between 2017 and 2021. There is no similar type of cost containment for other health care services.

Mr. Swanson asked Ms. Elayda about the price increases for insulin over the past few years. He asked who controls such cost increases—the drug manufacturer or the PBM. Ms. Elayda said that PhRMA, as a trade association, does not have insight on this issue. She discussed factors drug manufacturers consider in making drug pricing decisions. Mr. Swanson asked if PhRMA could support an MLR requirement. Ms. Elayda said it is something PhRMA would take under consideration. She explained that PhRMA, as a trade association of drug researchers and developers, asks its members to return a majority of its profits back into research and development.

Commissioner Schmidt asked Ms. Elayda if she had a breakdown of the $140 billion brand name drug sales amount she referenced in her presentation. Ms. Elayda said she did not currently have the information but would follow up.

Mr. Keen said that if anyone had additional questions for the presenters, send them to NAIC staff.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Aug. 15, 2019. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Chris Murray (AK); Yada Horace, Steve Ostlund and William Rodgers (AL); Ryan James (AR); Bruce Hinze (CA); Johanna Nagel and Andria Seip (IA); Vicki Schmidt (KS); Nancy G. Atkins and Patrick O’Connor (KY); Jeff Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Melinda Domzalski-Hansen and Krisi Bohn (MN); Chlora Lindley-Myers, Mary Mealer, Amy Hoyt and Molly White (MO); Derek Oestreich and Marilyn Bartlett (MT); Gale Simon (NJ); Renee Blechner (NM); Michael Humphreys, Lorrie Brouse and Rachel Jade-Rice (TN); Eric Lowe and Yolanda Tennyson (VA); Jennifer Kreitler (WA); Nathan Houdek and Jennifer Stegall (WI); Joylynn Fix (WV); and Denise Burke (WY). Also participating were: Barbara D. Richardson (NV); and Marie Ganim (RI).

1. Heard Presentations

Mr. Keen said the purpose of the Subgroup’s conference call is to hear presentations from Jane Horvath (Horvath Health Policy and Research Faculty, Georgetown University) and Leanne Gassaway (America’s Health Insurance Plans—AHIP) concerning the pharmaceutical market and its regulatory framework and pharmacy benefit managers (PBMs) and their business practices.

   a. Horvath Presentation: “Basics of the Pharmaceutical Market & PBMs”

Ms. Horvath provided an overview of the regulatory and legal framework for the pharmaceutical industry. She explained the role of the U.S. Food and Drug Administration (FDA), the federal Centers for Medicare & Medicaid Services (CMS), and the states in regulating this industry. She provided a general overview of the basics of the product supply chain and the role pharmaceutical manufacturers, wholesalers, PBMs, insurers and pharmacies play in this supply chain. She explained the difference between prescription drug discounting and rebates. She noted that discounts are provided “up front” at the point of sale, and they are transparent. However, unlike discounts, rebates are not very transparent, and they occur after the sale of a product.

Ms. Horvath discussed stakeholder concerns with some PBM business practices, including concerns that these business practices: 1) disadvantage independent and regional pharmacy chains; 2) result in inappropriate patient pay and access policies; and 3) result in the lack of transparency to health plan clients. She discussed state responses to these concerns, including state legislative and regulatory activity. She pointed out trends in this activity resulting in more review of PBM business practices toward pharmacies, health plan clients, and enrollees. She discussed the increase in state legislation banning gag clauses.

Ms. Horvath discussed the different approaches the states have taken to regulate PBMs and their business practices, such as: 1) indirect regulation through the state insurance department’s existing regulatory authority over health insurers; 2) enacting specific PBM statutes regulating the contract between the pharmacies and health plans; and 3) requiring PBM licensure or registration. She discussed state policy approaches with respect to Medicaid and state employee health benefit plans to address PBM business practices concerning transparency and spread pricing. She discussed how the states have used reverse auctions to address rising prescription drug costs.

Ms. White asked Ms. Horvath about the timing of the reverse auctions with respect to the data given to PBMs to use in developing their bids. Ms. Horvath explained that a state would look at the data from previous years to determine which prescription drug classes and/or categories are the significant cost drivers. Then, the state would develop a request for proposals (RFP) using the reverse auction process. Mr. Keen asked about the diversity of formularies in the commercial market. Ms. Horvath said she does not believe there is great diversity, but there could be more diversity with respect to tiers.

   b. AHIP Presentation: “Pharmacy Benefit Managers Overview & Background”

Ms. Gassaway provided an overview of the prescription drug supply chain, and she discussed how insurers utilize PBMs and potential next steps for the Subgroup to consider related to its work in developing a new NAIC model regulating PBMs. Specifically, she discussed the supply flow and money flow for brand name drugs and generic drugs among the various entities in the supply chain, such as the drug manufacturers, wholesalers, PBMs, insurers and pharmacies. She discussed how rebates
play a role with respect to brand name drugs. She said insurers utilize PBMs to provide a variety of services, such as: 1) negotiating with drug manufacturers on price; 2) processing drug claims; 3) managing drug formularies; and 4) drug utilization review. She said insurers pay for these services in various ways: 1) administrative fees; 2) spread pricing; and 3) shared savings.

Ms. Gassaway discussed how drug rebates work as shared savings between the PBM and health benefit plan and how they work at the point of sale. She also discussed why AHIP does not believe rebates are the issue by pointing out that from the 300 million medications prescribed annually, 82% are generic and 18% are brand name. She also said only 2.4% of brand name drugs would be eligible for a point-of-sale rebate.

In discussing next steps, Ms. Gassaway said the Health Carrier Prescription Drug Benefit Management Model Act (#22) and the Health Benefit Plan Network Access and Adequacy Model Act (#74), taken together, establish a robust regulatory framework for the administration of prescription drug benefits. She outlined AHIP’s suggestions for regulating PBMs, including those provisions that should and should not be considered in any potential regulations and NAIC model.

Ms. Gassaway said she included two articles in her presentation related to issues relevant to the Subgroup’s discussions: 1) Milliman Analysis: Prescription Drug Rebates and Part D Drug Costs; and 2) Copay Coupons, Informational Explanation of How Drug Copay Coupons Work.

Mr. Oestreicher asked Ms. Gassaway for examples in which PBMs experienced net losses in arrangements involving spread pricing where the health plan pays the PBM a set price for a drug and the PBM pays the pharmacy more for the dispensed drug than the price set with the plan. Ms. Gassaway said because AHIP is an association, for legal reasons, it does not have this specific plan information. However, AHIP plan members have told Ms. Gassaway about their experiences and this scenario. Mr. Oestreicher said from his experience, particularly given the leverage PBMs have in contracting with affected parties, he was not sure how such a scenario would ever occur. April Alexander (Pharmaceutical Care Management Association—PCMA) said she believes there is data involving the Medicaid program where there are instances of both a positive and negative spread. She said she would provide this information to the Subgroup.

Mr. Keen asked Ms. Gassaway about the dollar numbers for the amount of money spent annually on brand name drugs versus generic drugs. Ms. Gassaway said she would provide the dollar numbers to the Subgroup, but she noted that specialty drugs and brand name drugs are driving the spending.

Mr. Swanson asked if AHIP has seen any difference in pricing to consumers in those states enacting legislation affecting PBM business practices. Ms. Gassaway said AHIP is beginning to gather data from its member plans related to spending, overall costs, dispensing fees, pharmacy participation and pharmacy networks. She said she believes it will take at least another six months before AHIP would be able to discern any trends and develop a report.

Mr. Oestreicher highlighted Montana’s experience with reducing prescription drug costs in its state employee health plan. He also mentioned Montana’s Senate Bill 71 (SB71), which was developed to address issues related to PBM business practices. SB71 passed, but it was ultimately vetoed. Mr. Oestreicher expressed his concern with information about SB71 that AHIP disseminated to state insurance regulators at the Summer National Meeting. He requested that the Subgroup allow him and Ms. Bartlett to provide a response to the AHIP information during a future Subgroup meeting. The Subgroup took Mr. Oestreicher’s request under advisement.

Ms. Seip asked Ms. Gassaway to clarify whether rebates were available only for brand name drugs. Ms. Gassaway confirmed that rebates are, for the most part, limited to brand name drugs. Ms. Seip asked about limiting the length of a drug manufacturer’s drug patent, extensions and evergreening that could have any impact on costs. Ms. Gassaway said there has been debate in the U.S. Congress (Congress) on this issue.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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