

Revised: 7/22/20

*2020 Summer National Meeting
Virtual Meeting*

REGULATORY FRAMEWORK (B) TASK FORCE

Tuesday, August 4, 2020

11:00 a.m. – 12:30 p.m. ET / 10:00 – 11:30 a.m. CT / 9:00 – 10:30 a.m. MT / 8:00 – 9:30 a.m. PT
WebEx Event

ROLL CALL

Michael Conway, Chair	Colorado	Steve Kelley	Minnesota
Bruce R. Ramge, Vice Chair	Nebraska	Chlora Lindley-Myers	Missouri
Jim L. Ridling	Alabama	Chris Nicolopoulos	New Hampshire
Lori K. Wing-Heier	Alaska	Mike Causey	North Carolina
Elizabeth Perri	American Samoa	Jon Godfread	North Dakota
Alan McClain	Arkansas	Glen Mulready	Oklahoma
Ricardo Lara	California	Andrew R. Stolfi	Oregon
Karima M. Woods	District of Columbia	Jessica K. Altman	Pennsylvania
David Altmaier	Florida	Raymond G. Farmer	South Carolina
Dean L. Cameron	Idaho	Larry D. Deiter	South Dakota
Robert H. Muriel	Illinois	Kent Sullivan	Texas
Doug Ommen	Iowa	Todd E. Kiser	Utah
Vicki Schmidt	Kansas	Scott A. White	Virginia
Sharon P. Clark	Kentucky	Mike Kreidler	Washington
Eric A. Cioppa	Maine	James A. Dodrill	West Virginia
Gary Anderson	Massachusetts	Mark Afable	Wisconsin

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

AGENDA

1. Consider Adoption of its Feb. 20, 2020, and 2019 Fall National Meeting Minutes
—*Commissioner Michael Conway (CO)*
2. Consider Adoption of its Subgroup and Working Group Reports
 - a. Accident and Sickness Insurance Minimum Standards (B) Subgroup
—*Commissioner Glen Mulready (OK) and TBD*
 - b. ERISA (B) Working Group—*Robert Wake (ME)*
 - c. HMO Issues (B) Subgroup—*Scott A. White (VA) and Don Beatty (VA)*
 - d. MHPAEA (B) Working Group—*Commissioner Jessica K. Altman (PA) and Katie Dzurec (PA)*
 - e. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
—*Commissioner Andrew R. Stolfi (OR) and TK Keen (OR)*
3. Hear an Update on the Center on Health Insurance Reforms' (CHIR's) Work Related to the Federal Affordable Care Act (ACA)—*Justin Giovannelli (CHIR, Georgetown University Health Policy Institute)*
4. Hear a Panel Presentation on Health Care Sharing Ministries—*Joel Noble (Samaritan Ministries International) and Justin Giovannelli (CHIR, Georgetown University Health Policy Institute)*
5. Hear a Discussion on Premium Holidays, Early Medical Loss Ratio (MLR) Rebate Payments and Adjustments to Cost-Sharing Benefits as a Result of Fewer Claim Filings in 2020 Due to COVID-19—*Jason Levitis (Levitis Strategies, LLC) and Randy Pate (Center for Consumer Information and Insurance Oversight—CCIO)*

6. Discuss Any Other Matters Brought Before the Task Force—*Commissioner Michael Conway (CO)*

7. Adjournment

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Agenda Item #1

Consider Adoption of its Feb. 20, 2020 and 2019 Fall National Meeting Minutes
—*Commissioner Michael Conway (CO)*

Draft: 2/24/20

Regulatory Framework (B) Task Force
Conference Call
February 20, 2020

The Regulatory Framework (B) Task Force met via conference call Feb. 20, 2020. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Ramge, Vice Chair, represented by Martin Swanson (NE); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Anthony Williams (AL); Allen W. Kerr represented by Mel Anderson and William Lacy (AR); Ricardo Lara represented by Tyler McKinney (CA); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Kathy McGill, Fernanda Vallejo and October Nickel (ID); Robert H. Muriel represented by Eric Anderson and Sara Stanberry (IL); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary Anderson represented by Kevin Beagan (MA); Steve Kelley represented by Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska and Sara Gerving (ND); Alexander K. Feldvebel represented by Karen McCallister (NH); Andrew R. Stolfi represented by Gayle L. Woods (OR); Jessica K. Altman represented by Michael Humphreys and Katie Dzurec (PA); Raymond G. Farmer represented by Shari Miles (SC); Larry D. Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Rachel Bowden and Matthew Tarpley (TX); Todd E. Kiser represented by Jaakob Sundberg and Heidi Clausen (UT); Scott A. White represented by Yolanda Tennyson (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); and James A. Dodrill represented by Ellen Potter and Tonya Gillespie (WV).

1. Appointed the MHPAEA (B) Working Group and Adopted its 2020 Revised Charges

Commissioner Conway said that prior to the conference call, NAIC staff distributed revised Task Force 2020 charges. He explained that the revised charges add charges for the MHPAEA (B) Working Group. He said that during this call, the Task Force will consider two motions: 1) a motion to appoint the MHPAEA (B) Working Group; and 2) a motion to adopt the Task Force's revised 2020 charges adding the charges for the Working Group.

Ms. Kruger made a motion, seconded by Director Lindley-Myers, to appoint the MHPAEA (B) Working Group. The motion passed unanimously.

Director Lindley-Myers made a motion, seconded by Ms. Kruger, to adopt the Task Force's 2020 revised charges (Attachment One-A). The motion passed unanimously.

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

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Draft Pending Adoption

Draft: 12/13/19

Regulatory Framework (B) Task Force Austin, Texas December 7, 2019

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); Gary Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake and Marti Hooper (ME); Steve Kelley (MN); Chlora Lindley-Myers represented by Angela Nelson (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by Ted Hamby (NC); Jon Godfread (ND); Bruce R. Ramge represented by Martin Swanson and Laura Arp (NE); John Elias represented by Maureen Belanger (NH); John G. Franchini represented by Paige Duhamel (NM); Glen Mulready represented by Ron Kreiter (OK); Andrew Stolfi represented by TK Keen and Rick Blackwell (OR); Jessica Altman represented by Michael Humphreys and Katie Dzurec (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 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/>. 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

Draft Pending Adoption

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 creditability 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.

Draft Pending Adoption

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.

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Agenda Item #2

Consider Adoption of its Subgroup and Working Group Reports

—*Commissioner Michael Conway (CO)*

Conference Call

ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS (B) SUBGROUP

December 16, 2019

Summary Report

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Dec. 16, 2019. During this call, the Subgroup:

1. Continued its discussion 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).
2. Set a public comment period ending Feb. 7 to receive comments on Section 6—Prohibited Policy Provisions and Section 7—Accident and Sickness Minimum Standards for Benefits of Model #171. The Subgroup had planned to begin meeting via conference call in February to complete its discussion of the comments received on Sections 1-5 and begin discussion of the comments received on Sections 6 and 7, but due to the COVID-19 health emergency and the loss of one of its co-chair, the Subgroup has not met since December 2019.

Draft: 1/2/20

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Conference Call
December 16, 2019

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Dec. 16, 2019. The following Subgroup members participated: Melinda Domzalski-Hansen, Co-Chair (MN); Glen Mulready, Co-Chair, represented by Buddy Combs (OK); Debra Judy (CO); Chris Struk (FL); Gayle Woods (OR); Katie Dzurec (PA); Shari Miles (SC); Rachel Bowden (TX); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet (VT); Andrea Philhower (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.” She reminded the Subgroup of its discussion of Section 5L during its Nov. 25 conference call.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) reiterated the purpose of the NAIC consumer representatives’ suggested revisions to the definition of “preexisting condition,” which is to provide an objective definition of the term for consumers 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. She reiterated the concern that consumers may not know they have a medical condition, but after completing an application, the consumer discovers his or her physician included the possibility of a consumer having a certain medical condition in the physician’s notes. Chris Petersen (Arbor Strategies LLC) said the Subgroup needed to review Section 7 of the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170), which establishes standards related to coverage of preexisting conditions. He suggested that this provision affects the changes the Subgroup can make to the definition of “preexisting condition” in Section 5L.

The Subgroup discussed Mr. Petersen’s comments. After discussion, the Subgroup decided to defer discussion of the issue until it completes its review of Section 5 and seek the following information from state insurance regulators and interested parties on the following: 1) how the term “preexisting condition” is defined in state law; 2) examples of how the definition of “preexisting condition” is applied differently to various products within the scope of Model #171; and 3) how Section 7 of Model #170 applies or does not apply to the definition of “preexisting condition” in Section 5L.

The Subgroup next discussed Section 5M, the definition of “residual disability.” Ms. Domzalski-Hansen said the Missouri Department of Insurance (DOI) submitted comments on Section 5M suggesting that certain language in the definition should be moved to a substantive provision in Model #171. After discussion, the Subgroup agreed to move the provision highlighted by the Missouri DOI to the appropriate provision or provisions in Section 7—Accident and Sickness Insurance Minimum Standards for Benefits.

The Subgroup next discussed Section 5N, the definition of “sickness.” The Subgroup discussed the Missouri DOI’s comments on Section 5N suggesting clarifying changes to the language and moving some of the language to a substantive provision in Model #171. Ms. Lueck said the NAIC consumer representatives also submitted comments on Section 5N suggesting the addition of a drafting note related to the application of any probationary period to a preexisting condition exclusion period. The Subgroup discussed the meaning of probationary period versus waiting period. Ms. Lueck asked about the impact of the Subgroup moving provisions in the various definitions in Section 5 to substantive provisions in Model #171 and whether, after moving the language, if the language would still be considered a minimum standard. The Subgroup discussed and agreed that such language would still be considered a minimum standard.

The Subgroup discussed whether to add the NAIC consumer representatives’ suggested drafting note to Section 5N. The Subgroup decided to add the drafting note. J.P. Wieske (Horizon Government Affairs—HGA) suggested that the proposed drafting note may not be needed if the Subgroup reworks the language in Section 5N to clarify the difference between a probationary period and a waiting period. Ms. Domzalski-Hansen suggested that the Subgroup revisit the language in Section

5N when it discusses Section 6—Prohibited Policy Provisions. Mr. Petersen volunteered to poll his membership about the appropriate terms, “probationary period” versus “waiting period,” currently being used by industry.

Mollie Zito (UnitedHealthcare) said UnitedHealthcare is withdrawing its comments on Section 5N.

Ms. Domzalski-Hansen said that in order to keep the Subgroup’s discussion moving forward following completion of its review of Section 5, she suggests the Subgroup set a public comment period ending Feb. 7, 2020, to receive comments on Section 6—Prohibited Policy Provisions and Section 7—Accident and Sickness Minimum Standards for Benefits. There was no objection to her suggestion.

Ms. Domzalski-Hansen reiterated the Subgroup’s request for additional information on the issues it discussed related to Section 5L, the definition of “preexisting condition.” She said that following the Subgroup conference call, she would work with NAIC staff to compose an email requesting the information for distribution to Subgroup members and interested parties.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Conference Call

HMO ISSUES (B) SUBGROUP

July 13, 2020 / June 11, 2020

Summary Report

The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met July 13 and June 11, 2020. During these meetings, the Subgroup:

1. Discussed the comments received by the public comment period ending March 18 on proposed revisions to the *Health Maintenance Organization Model Act* (#430) to address inconsistencies and redundancies in the model with the provisions in the *Life and Health Insurance Guaranty Association Model Act* (#520), which added health maintenance organizations as members of the guaranty association.
2. Adopted the proposed revisions to Model #430.

Draft: 7/21/20

HMO Issues (B) Subgroup
Conference Call
July 13, 2020

The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call July 13, 2020. The following Subgroup members participated: Don Beatty, Chair (VA); Keith Warburton (CO); Toma Wilkerson (FL); Ryan Gillespie (IL); DJ Wasson (KY); Robert Wake (ME); Chlora Lindley-Myers (MO); Martin Swanson (NE); Nathan Houdek (WI); and Joylynn Fix (WV).

1. Adopted its June 11 Minutes

The Subgroup met June 11 to review and discuss the comments received by the March 18 public comment deadline on the proposed revisions to the *Health Maintenance Organization Model Act* (#430).

Ms. Wilkerson made a motion, seconded by Ms. Fix, to adopt the Subgroup's June 11 minutes (Attachment ?-A). The motion passed unanimously.

2. Adopted a Motion to Forward Draft Model #430 Revisions to the Regulatory Framework (B) Task Force

Mr. Beatty said the purpose of the call is for the Subgroup to discuss the draft of proposed revisions to Model #430 which reflect the Subgroup's discussion during its June 11 conference call and consider forwarding the draft to the Regulatory Framework (B) Task Force for its consideration. He requested comments. There were no comments.

Mr. Wake made a motion, seconded by Ms. Wilkerson, to forward the draft of proposed revisions to Model #430 (Attachment ?-B) to the Regulatory Framework (B) Task Force for its consideration. The motion passed unanimously.

Having no further business, the HMO Issues (B) Subgroup adjourned.

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Draft: 6/18/20

HMO Issues (B) Subgroup
Conference Call
June 11, 2020

The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call June 11, 2020. The following Subgroup members participated: Don Beatty, Chair (VA); Keith Warburton (CO); Toma Wilkerson (FL); Ryan Gillespie (IL); DJ Wasson (KY); Robert Wake (ME); Carrie Couch (MO); Laura Arp (NE); Nathan Houdek (WI); and Joylynn Fix (WV).

1. Discussed March 18 Comments on Proposed Revisions to Model #430

Mr. Beatty said the purpose of the call is for the Subgroup to discuss the comments received on the proposed revisions to the *Health Maintenance Organization Model Act* (#430) for consistency with the revised *Life and Health Insurance Guaranty Association Model Act* (#520). He said the Subgroup received comments from the NAIC consumer representatives, the Blue Cross and Blue Shield Association (BCBSA), and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA).

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) said the NAIC consumer representatives strongly urge the Subgroup to retain Section 14—Continuation of Benefits and Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency because of the explicit consumer protections these sections provide. She said the NAIC consumer representatives have provided language for a potential drafting note for Section 14 suggesting that those states that have adopted the revised Model #520 consider alternative continuation of benefits language for Section 14 to ensure that enrollees' claims are paid during the transition period and/or while waiting for the commencement of alternative coverage.

Mr. Wake agreed that retaining Section 14 is important for those states that have not adopted the revised Model #520, which added health maintenance organizations (HMOs) as members of the guaranty association. He said, however, that for those states that have adopted the revised Model #520, it is unnecessary to retain Section 14 because continuation of benefits is covered through the guaranty association procedures. He also noted that the proposed drafting note for Section 2—Purpose and Intent alerts those states that have not adopted the revised Model #520 to retain Section 14. Mr. Wake said Section 21 is obsolete because of the guaranteed issue provision and other provisions in the federal Affordable Care Act (ACA). He said this is true regardless of whether a state has adopted the revised Model #520.

Mr. Beatty asked Joni Forsythe (NOLHGA) if the Subgroup needed to address a gap in coverage and retain Section 14. Ms. Forsyth said NOLHGA has not identified any gap in coverage that would require retaining Section 14. Ms. Howard said the NAIC consumer representatives are apprehensive about removing Section 14 just in case there is an issue. Chris Petersen (Arbor Strategies LLC) expressed support for the NAIC consumer representatives' concern, noting comments he had previously submitted to the Subgroup on this issue. He said, however, that he could support the Subgroup's decision to remove Section 14 if that is what it decides. Mr. Beatty said the Subgroup would proceed with deleting Section 14, but he urged anyone who believes that there will be a gap in coverage to alert the Subgroup.

Ms. Forsyth said NOLHGA takes no position on the proposed revisions to Model #430 as whole, but it has a few technical comments for the Subgroup's consideration. She said NOLHGA's first technical comment concerns the use of the word "conformity" in both option 1 and option 2 of the proposed drafting note to Section 2. She said NOLHGA believes the term "conformity" suggests a higher standard of assimilation with Model #520 than what the Subgroup intends with respect to the Model #430 revisions. To address this concern, she said NOLHGA suggests using the term "reconcile" instead. Ms. Forsyth also said NOLHGA does not understand why neither option 1 nor option 2 of the drafting note explains why Section 21 is being deleted. She said NOLHGA also suggests the Subgroup consider including the full text of the repealed provisions as an appendix to Model #430 in order to preserve the text.

Ms. Forsyth said that if the Subgroup decides to proceed with option 2, NOLHGA suggests clarifying language in option 2 concerning the purpose of the repealed Model #430 provisions by replacing the language "addressed issues arising from the lack of guaranty association protection" with "provided consumer protection for HMO enrollees in the event of an HMO insolvency, in the absence of guaranty association protection." She said NOLHGA's final technical comment concerns an additional section in Model #430 the Subgroup has not discussed, but which could conflict with the revised Model #520. She said Section 31—Statutory Construction and Relationship to Other Laws (formerly section 34) provides that, except as provided

in Model Act #430, provisions of state insurance laws do not apply to HMOs. She said Section 28—Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations (formerly section 31) provides that HMOs are subject to state receivership laws, but it does not include any reference to state guaranty association laws. Ms. Forsyth said this potential conflict could be resolved by adding “or other applicable laws” in the opening sentence of Section 31.

John Troy (BCBSA) said the BCBSA supports the Subgroup’s proposed revisions. He said the BCBSA supports including option 2 in the proposed revisions instead of option 1 because it is briefer and more to the point and, as such, more likely to be reasonably well understood.

The Subgroup discussed NOLHGA’s comments. Mr. Wake said he could support NOLHGA’s suggested revision to Section 31 with one change. He suggested the Subgroup add the language “or in other laws expressly referring to health maintenance organizations.” He said he suggests this language because it specifies the type of applicable law. Ms. Arp expressed support for Mr. Wake’s suggested revision because of its similarity to Nebraska law. Mr. Wake also expressed support for NOLHGA’s other suggested technical revisions. Ms. Wilkerson expressed similar support, but she asked if any other NAIC models included an appendix as NOLHGA suggests. Jolie H. Matthews (NAIC) said she has not seen similar appendices in other NAIC models, but that this would not preclude the Subgroup from adding such an appendix as part of the Model #430 revisions.

After additional discussion, the Subgroup directed NAIC staff to prepare another draft of proposed revisions to Model #430 that would include the following: 1) option 2 of the proposed drafting note for Section 2 with NOLHGA’s suggested revisions; 2) NOLHGA’s suggested revision to Section 31, with Mr. Wake’s additional suggested revision; and 3) NOLHGA’s suggestion to add an appendix with the repealed provisions. Mr. Beatty said the Subgroup would hold another conference call sometime in July to consider adopting the proposed revisions and forwarding the revised Model #430 to the Regulatory Framework (B) Task Force for its consideration.

Having no further business, the HMO Issues (B) Subgroup adjourned.

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MHPAEA (B) WORKING GROUP

Tuesday, July 28, 2020

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

Meeting Summary Report

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met July 28, 2020. During this meeting, the Working Group:

1. Adopted its June 24 minutes, which included the following action:
 - a. Adopted its June 5 minutes, which included the following action:
 - i. Adopted its March 19 minutes, which included the following action: 1) adopted its March 9 minutes; 2) discussed its plan to operate similar to the ERISA (B) Working Group; and 3) discussed its anticipated work for 2020 consistent with its 2020 charges.
 - ii. Discussed a draft quantitative treatment limitation/financial requirement (QTL/FR) template.
 - b. Discussed the comments received on the draft QTL/FR template received by the June 18 public comment deadline.
2. Heard a presentation on activities and work being done to assist self-funded group health plans and private employers to comply with mental health parity requirements under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008 (MHPAEA).
3. Heard a presentation from the American Psychiatric Association (APA) on state activities and legislation related to MHPAEA parity data reporting requirements.
4. Discussed current parity compliance resources and tools available to the states to determine plan compliance with the MHPAEA parity requirements and potential resources and tools the Working Group developed to supplement, but not supplant, these existing tools and resources.
5. Discussed next steps in developing supplemental MHPAEA parity compliance resources and tools for the states related to non-quantitative treatment limitations (NQTLs).

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Conference Call

PHARMACY BENEFIT MANAGER REGULATORY ISSUES (B) SUBGROUP
July 16, 2020

Summary Report

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call July 16, 2020. During this call, the Subgroup:

1. Discussed the ad hoc drafting group's draft pharmacy benefit manager (PBM) model act.
2. Exposed the PBM draft for a public comment period ending Sept. 1. The Subgroup plans to meet via conference call to begin discussion of the comments received sometime in September after the public comment period ends.

Draft: 7/23/20

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
July 16, 2020

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call July 16, 2020. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Sarah Bailey (AK); Anthony L. Williams (AL); Marjorie Farmer (AR); Bruce Hinze (CA); Howard Liebers (DC); Andria Seip (IA); Vicki Schmidt (KS); Daniel McIlwain (KY); Jeffrey Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Candace Gergen (MN); Amy Hoyt (MO); Derek Oestreicher (MT); Gale Simon (NJ); Renee Blechner and Paige Duhamel (NM); Michael Humphreys (PA); Rachel Jade-Rice (TN); James Young (VA); Jennifer Kreidler (WA); Nathan Houdek (WI); Ellen Potter (WV); and Denise Burke (WY).

1. Discussed and Exposed a Draft PBM Model

Mr. Keen said as directed by the Subgroup late last year, the ad hoc drafting group completed its work in developing a draft of a proposed new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (Attachment ?-A). He reminded the Subgroup that it had directed the ad hoc drafting group to develop a draft pharmacy benefit manager (PBM) model addressing licensing and gag clauses. He explained that during its discussions, the ad hoc drafting group discussed many issues beyond the scope of its charge from the Subgroup, which in many respects is reflected in the draft.

Mr. Keen said the ad hoc drafting group used the National Conference of Insurance Legislators' (NCOIL's) Pharmacy Benefits Manager Licensure and Regulation Model Act as a base for the draft. He provided a high-level overview of the draft's provisions. Ms. Seip asked if those states that have adopted provisions similar to the proposed Section 6—Gag Clauses Prohibited have had any issues with it and if they could share their experiences with its implementation. Ms. Farmer said Arkansas has had a similar provision in its law for years, and it has not experienced any implementation issues. Ms. Duhamel said New Mexico's experience with its law is the same as Arkansas' experience.

Mr. Keen said the ad hoc drafting group had a lot of discussion concerning Section 8—Regulations, particularly Section 8B, which includes a list of potential provisions the states could include in any regulations adopted to implement the proposed model's provisions. Ms. Arp explained that Section 8B was crafted as a compromise between those states that are at the forefront of pharmacy benefit manager (PBM) regulation, as reflected in the discussions during the Subgroup's information-gathering sessions, and those states that are just beginning to consider PBM regulation. Mr. Humphreys said he has concerns with the inclusion of Section 8B in an NAIC model, noting that his legislature most likely would not support such a provision. He suggested that the Subgroup consider developing a white paper on the topics outlined in Section 8B and a standalone PBM licensing model.

Mr. Oestreicher expressed support for Section 8B because he does not believe PBM licensure and gag clause provisions alone would lower prescription drugs costs for consumers. He said Section 8B gives the states the option to include provisions that would lower costs. He said the states that choose to add these provisions can find language in other state laws, such as Maine's law and the National Academy for State Health Policy's (NASHP's) model legislation. Ms. Seip suggested that it would be useful for the Subgroup to know what language the states have on these topics and their experiences. Mr. Hinze said the ad hoc drafting group considers Section 8B to be a starting point, not the end. Mr. Houdek asked about the Subgroup's next steps are if the Subgroup decides to move forward with the ad hoc drafting group's draft. Mr. Keen said assuming the Subgroup decides to move forward with the ad hoc drafting group's draft, the Subgroup's next steps would be to expose the draft for public comment and then discuss and make revisions to the draft based on the comments received.

Mr. Keen requested comments from interested parties. Chris Petersen (Arbor Strategies LLC), representing the Pharmaceutical Care Management Association (PCMA), said the PCMA submitted a comment letter suggesting that Section 4—Applicability and Section 6 are in conflict. He also suggested that the Subgroup revise Section 6 to mirror the federal gag clause language. He also said the current draft would not meet the NAIC requirement for an NAIC model to be adopted in a majority of the states because of the proposed language in Section 8B. Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) said PBM practices have a direct impact on consumer access and affordability; as such, the NAIC consumer representatives would be supportive of more substantive language in Section 8B. Kris Hathaway (America's Health Insurance Plans—AHIP) said AHIP would be supportive of a PBM licensure model. However, she suggested that the Subgroup keep in mind that PBMs are partners in keeping prescription drug costs low. She said the proposed provisions in Section 8B

would handcuff plans in lowering prescription drug costs. John Covello (Independent Pharmacy Cooperative) expressed concern with provisions in the draft, such as potential duplicative provisions in Section 3—Definitions and Section 4. Carl Schmid (HIV + Hepatitis Policy Institute) expressed support for Ms. Turner’s comments. He also expressed concerns that Section 5—Licensing Requirement does not include any enforcement or penalty provisions.

Mr. Hinze made a motion, seconded by Mr. Oestreicher, to accept the ad hoc drafting group’s draft as a starting point in the Subgroup work to develop a new NAIC model regulating PBMs. The motion passed unanimously.

Mr. Hinze made a motion, seconded by Ms. Farmer, to expose the draft for a 45-day public comment period. The motion passed unanimously.

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

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DRAFT

Agenda Item #3

Hear an Update on the Center on Health Insurance Reforms' (CHIR's) Work Related to the Federal Affordable Care Act (ACA)—*Justin Giovannelli (CHIR, Georgetown University Health Policy Institute)*

Update on Georgetown CHIR's Recent Work and Publications

National Association of Insurance Commissioners
Regulatory Framework (B) Task Force

August 4, 2020

Justin Giovannelli, J.D., M.P.P.
Associate Research Professor

Responses to COVID-19

- **States:** tracking actions affecting private coverage of critical services during the pandemic
- **Markets:** research brief based on interviews with executives from 25 health plans (from April – June)



Georgetown University Health Policy Institute

**CENTER ON HEALTH
INSURANCE REFORMS**

State Policy and the Individual Market

- Waiver-funded **Reinsurance**
- Developments under the **Section 1332** waiver program
- The market for **short-term, limited duration products**; state regulatory approaches to **STLDI**
- Other actions affecting the **affordability of comprehensive coverage**

Research supported by the Commonwealth Fund and
the Robert Wood Johnson Foundation



Georgetown University Health Policy Institute

**CENTER ON HEALTH
INSURANCE REFORMS**

Technical Assistance and Support

- Ongoing state technical assistance regarding insurance regulatory matters, including COVID response, through the **State Health and Value Strategies Program**
 - Supported by the Robert Wood Johnson Foundation
- Assistance for state and federal policymakers regarding regulatory approaches to **balance billing**
 - Supported by the Laura and John Arnold Foundation

Thank you

Justin Giovannelli

Associate Research Professor

(202) 687-4954

Justin.Giovannelli@georgetown.edu



Georgetown University Health Policy Institute

**CENTER ON HEALTH
INSURANCE REFORMS**

Agenda Item #4

Hear a Panel Presentation on Health Care Sharing Ministries—*Justin Giovannelli (CHIR, Georgetown University Health Policy Institute) and Joel Noble (Samaritan Ministries International)*

Health Care Sharing Ministries

National Association of Insurance Commissioners
Regulatory Framework (B) Task Force

August 4, 2020

Justin Giovannelli, J.D., M.P.P.
Associate Research Professor



Georgetown University Health Policy Institute

**CENTER ON HEALTH
INSURANCE REFORMS**

HCSMs and Consumer Confusion

While HCSMs are very careful to say they are not insurance, they sure look like insurance.

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- May be sold by insurance brokers (or others with a financial incentive to sign people up)
 - And packaged with supplemental insurance products
- Marketing may describe as replacement for insurance and/or suggest consumers can rely on HCSMs for financial protection
 - Although this is prohibited by law in several states





How Medi-Share compares traditional insurance

December 1, 2015 by Jack

At [Take Command Health](#), we recently started offering Medi-Share as a health insurance option on our website. For the first time, you can search for your doctors and compare your estimated out of pocket costs on Medi-Share side by side traditional carriers like Blue Cross, Aetna, Humana, and others.

We get a lot of questions about [Medi-Share](#) though (especially when people see how inexpensive it is!), and wanted to put together this review on how Medi-Share compares to traditional plans. It's definitely a great option for some, and may not be a fit for others.

Full disclosure: This is our first year to offer Medi-Share. Although I am planning trying it with my family in 2016, we nor our existing clients have any direct experience with it yet. If you have friends or family that use it, make sure to ask them too! We'll share more about our experience later next year.

UPDATE: I did use Medi-Share in 2016 with my family. It was great but there is a little bit of a learning curve. [Learn about our personal experience here.](#)

The basics: What is Medi-Share?

Medi-Share is a faith-based medical bill sharing program. While Medi-Share is very clear that they are *not* insurance, it sure looks like insurance and even "qualifies" as insurance in the eyes of the Affordable Care Act (ACA). Here's a quick video from Medi-Share:



What makes Medi-Share so much more affordable?

Medi-Share is essentially doing what insurance companies used to do in terms of restricting their risk pool. They don't take anyone who smokes, uses illicit drugs, etc. Everyone must testify to their faith in Jesus Christ and provide a church reference that they are actively living a Christian lifestyle. They won't deny you if you have a pre-existing condition, but you have to join their "health partners" group which costs a little more each month (\$80). This makes their underwriting so much cheaper and efficient compared to insurance companies--who have to take anyone and everyone at the same price. While Christians are not necessarily healthier, turns out they are a lot less "risky", and therefore less expensive to insure.

How is Medi-Share the same as traditional insurance?

- ✓ **ACA Compliant** - Under the ACA (Obamacare) everyone in the US is required to carry minimum health coverage or pay a penalty. Medi-Share meets the requirements just like plans from Blue Cross, Aetna, and others so you won't have to pay a penalty fee.
- ✓ **Doctor Network** - Medi-Share has a Preferred Provider Organization (PPO) network of doctors. Using "in network" doctors is important because you'll get better rates if you see doctors that Medi-Share has contracted with. Medi-Share is one of the last remaining PPO networks on the individual market in Texas and although it's not huge it's legit! It's built on MultiPlan's PHCS network, which is the same company that manages networks for some of the major traditional insurance companies. At [TakeCommandHealth.com](#), we've loaded Medi-Share's doctors into our system so you can see if yours is "in network" or not.
- ✓ **Premiums** - Medi-Share calls it your "share amount", but it's the monthly payment you have to make to stay on the plan.
- ✓ **Copays** - When you see a doctor or need services, Medi-Share has copays just like traditional plans. They're actually pretty good! (\$35 doctor visits for primary or specialists, \$125 emergency room, etc)
- ✓ **Deductibles** - Called the "Annual Household Portion" or AHP, this is the amount you have to pay out of pocket on your own before your bills are eligible for sharing (or reimbursement).

How is Medi-Share different from traditional insurance?

- ✓ **Sign up anytime** - No open enrollment limitations or deadlines.
- ✓ **Limitations on pre-existing conditions** - Medi-Share won't deny you for a pre-existing condition, but there may be a "phase-in" period before you'll get full coverage. As an example, if you're a member of Medi-Share before you get pregnant, the delivery will be covered. If you're pregnant and then sign up for Medi-Share, it won't be covered. You can find more guidance from Medi-Share [here](#).
- ✓ **You pay for preventive care** - On a traditional plan, your annual physicals, kids' immunizations, and anything else considered "preventive" are covered at no additional cost to you (you're paying those high premiums for something!). With Medi-Share, your typical



What proposed IRS update means for sharing ministries and HRAs

June 29, 2020 by Ruth S.

The Internal Revenue Service [recently issued a proposed rule](#) that would expand the ability of HRAs to reimburse employees tax free for monthly premiums (commonly referred to as “shares”) of health care sharing ministries. More flexibility is good news for the approximately [million Americans](#) who use these lower-cost programs to address health care needs and it would clear up the existing gray area surrounding the use of HRAs and health care sharing ministries.

The proposed rule concludes that fees for direct primary care, “share” ministry, and payments for some public coverage should be considered qualified medical expenses.

If adopted, the rule would shift a effort to separate out non-traditional payment programs and traditional insurance programs.

What is a health care sharing ministry?

First, let’s jump in to a little background information.

A health care sharing ministry is an [affordable alternative to traditional health insurance](#) that brings together a group of like-minded individuals that help each other share the burden of unexpected medical costs. They often have a PPO network along with a more affordable price tag.

With health care costs as high as they are, healthcare sharing ministries are exploding in popularity due to their lower costs and shared values they promote. Some examples are Medi-Share, Liberty HealthShare, Christian Healthcare Ministries, Allera, Altru Health Share, Shared Health Alliance and Samaritan Ministries.



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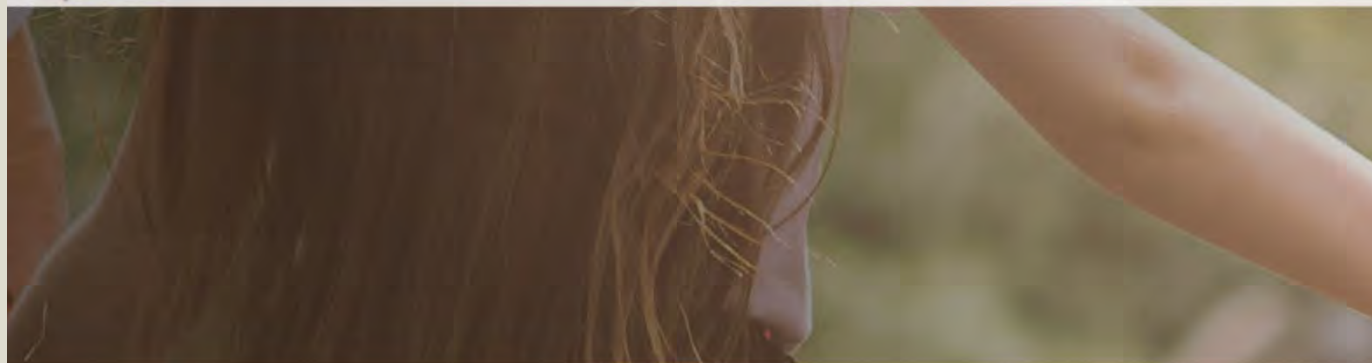
**CENTER ON HEALTH
INSURANCE REFORMS**

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[Home](#) / [Programs & costs](#)

Programs & costs

Gold Program

\$172 per unit, per month

- Most extensive financial support by sharing 100% of any medical incident exceeding \$500 (as long as all other Guidelines are met), up to \$125,000 per illness. [Read an example here.](#)
- Includes:
 - Inpatient or outpatient hospital incidents and surgery
 - Medical testing
 - Maternity
 - Physical therapy and home healthcare (up to 45 visits)
 - Incident-related doctor's office visits
 - Incident-related prescriptions
 - Removes the \$125,000 per illness cap when adding [Brother's Keeper](#)

Gold plus Brother's Keeper

- Shares expenses exceeding \$125,000 per illness to an unlimited amount
[Learn more about Brother's Keeper.](#)

Silver Program

\$118 per unit, per month

- Shares medical expenses exceeding \$2,500 as long as all other Guidelines are met, up to \$125,000 per illness.
- Includes:
 - Inpatient or outpatient hospital incidents and surgery
 - Surgery performed at any certified surgery center
- Does not include:
 - Maternity bills
 - Testing and treatment outside of a hospital

Silver plus Brother's Keeper

- Provides an additional \$100,000 of cost support
- With each annual renewal, members receive an additional \$100,000, accruing up to \$1 million per illness
[Learn more about Brother's Keeper.](#)

Bronze Program

\$78 per unit, per month

- Shares medical expenses exceeding \$5,000 as long as all other Guidelines are met, up to \$125,000 per illness.
- Includes:
 - Inpatient or outpatient hospital incidents and surgery
 - Surgery performed at any certified surgery center
- Does not include:
 - Maternity bills
 - Testing and treatment outside of a hospital

Bronze plus Brother's Keeper

- Provides an additional \$100,000 of cost support
- With each annual renewal, members receive an additional \$100,000, accruing up to \$1 million per illness
[Learn more about Brother's Keeper.](#)



What Our Members Receive from the Membership

Members present their Membership ID card to their health care provider and pharmacist for office/urgent care visits and discounts on prescriptions.

INCLUDED	 DIAMOND	 EMERALD	 SAPPHIRE	 RUBY
6 OFFICE/URGENT CARE/SPECIALIST VISITS ANNUALLY	Up to \$300 is shared on the member's behalf per visit after \$35 office visit MRA. Visits are per member, per calendar year.		The membership applies up to \$300 of charges per visit to the 1st then 2nd MRA. Anything outside of the six (6) will be the member's responsibility and do not apply to their MRA. Visits are per member, per calendar year.	
WELLNESS VISITS	Female members age 40 and over and male members age 50 and over. Eligible for sharing of one additional office visit during the calendar year. For female members age 40 and over, for a mammogram visit, the membership will share up to \$500 after the \$35 office visit MRA.		Female members age 40 and over and male members age 50 and over. Eligible for sharing of one additional office visit during the calendar year. For female members age 40 and over, for a mammogram visit, the membership will allow up to \$500 to be applied towards the MRA.	
MATERNITY	Maximum sharing limit per pregnancy applies: Year 1 – \$12,000 and Years 2+ – \$25,000 (90 day wait)		Maternity is not included.	
ADOPTION	\$5,000 eligible for sharing once the \$5,000 Adoption MRA has been met. (12 month wait)		Adoption is not included.	
CANCER TREATMENT	Maximum sharing amount Year 1 – \$10,000 and Years 2+ – Subject to annual and lifetime max after Cancer MRA has been met. Biennial screening requirements for females 40 and over and males 50 and over and 90 day wait		1st, then 2nd MRAs apply. Biennial screening requirements for females 40 and over and males 50 and over. 12 month waiting period	
LABORATORY SERVICES	\$500 Laboratory MRA applies. \$1,000 maximum sharing limit, per member, per calendar year. Laboratory services must be obtained through an in-network facility to be eligible for sharing. 90 day waiting unless billed with an eligible office visit or hospital stay or is part of a wellness or preventative care visit.	\$500 Laboratory MRA applies. \$500 maximum sharing limit, per member, per calendar year. Laboratory services must be obtained through an in-network facility to be eligible for sharing. 90 day waiting unless billed with an eligible office visit or hospital stay or is part of a wellness or preventative care visit.	Applied towards 1st, then 2nd MRAs. Allowed up to \$4,000, per member, per calendar year. 90 day waiting period unless part of wellness or preventative care visit.	
TELEMEDICINE	Unlimited utilization, with no consultation fee			
PRESCRIPTIONS	Altruia HealthShare members are allowed discounts for name brand and generic prescriptions.			
FLU SHOT	Reimbursement only. Max of \$25 per member, per calendar year			
FUNERAL NEEDS	\$5,000 maximum sharing limit per household, per calendar year. Discounts are available through Dignity Memorial, click here to learn more.		Funeral needs are not included. Discounts are available through Dignity Memorial, click here to learn more.	
SHARING AFTER 1ST AND 2ND MRAS ARE MET	The membership shares 100% of eligible medical needs for the remainder of the calendar year.			
MAXIMUM AMOUNT	Lifetime Limit of \$2,000,000 per member. No maximum per calendar year.	Lifetime Limit of \$1,000,000 per member. No maximum per calendar year.	Lifetime Limit of \$1,000,000 per member with a limit of \$250,000 per calendar year.	Lifetime Limit of \$1,000,000 per member with a limit of \$150,000 per calendar year.

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[How Do I Join?](#)[Apply Now](#)[Manna](#)[Current Members](#)[Refer a friend](#)**Q. What is the deductible?**

A. Members do not have deductibles. Instead, our members have an Annual Household Portion (AHP). Members choose an AHP ranging from \$1,000-\$10,500.

The AHP is the annual amount a household is responsible for before medical bills will be approved for sharing. The AHP only applies to Eligible Medical Bills. After the AHP has been met, ALL eligible medical bills will be submitted for sharing for the entire household.

[Back to Top](#)**Q. What is the monthly premium?**

A. Members do not have a monthly premium. Instead, our members contribute a monthly “share” based on age and how many in the household. Members deposit their monthly share into their sharing account and it goes directly into a fellow member’s sharing account to pay their medical bills.

[Back to Top](#)**Q. How does the claim (and sharing) process work?**

A. Members do not file claims, nor does the ministry handle claims because we are not an insurance company. If your eligible medical bill is paid, it is paid with funds received directly from another member. Members present their member ID card to their service provider. The service provider then discounts the bill accordingly, if within the Preferred Provider Organization network. The bill is then sent to us where we negotiate for further discounts. Here, we review the services provided to determine if the bill is eligible for sharing. After the AHP has been met and if the bill is eligible, it is eligible for sharing among the other members. For more details on what is eligible and how the AHP works, please review the Guidelines.



"In every single case our medical claims [needs] were shared in and we've never had a problem."

—Mr. & Mrs. Harshaw, TX



WHAT OUR MEMBERS HAVE TO SAY

Signup is Easy.



Apply Online



Get Approved



Start Saving

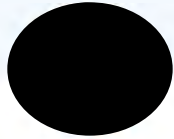
BECOME A MEMBER



Georgetown University Health Policy Institute

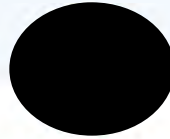
CENTER ON HEALTH
INSURANCE REFORMS

Testimonials



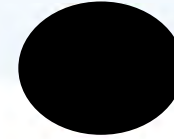
Holly

Liberty has been absolutely amazing! After needing unexpected emergency heart surgery after years of being healthy and not needing a Dr, Liberty was amazing working with different hospitals and helping me to maneuver through the medical bills! They paid my bills and for bills that I needed to get more information, they were helpful so I knew exactly what to get. They were always...

[READ MORE](#)

Mike

I am so pleased with my decision a few years ago to become a member of Liberty HealthShare. For many years I paid outrageous charges to my local big name health insurance provider with rates continuing to climb, as I had some heart problems, and coverage dropping as those rate increases occurred. I was beginning to feel scammed and bullied by my once trusted health care provider. Forced out...

[READ MORE](#)

Amber

We have been so pleased with Liberty Healthshare. We like being actively involved in our own health care, including choosing our physicians and other providers. They have been great to work with. We are self-employed. This is the best "coverage" we have ever had with a lower premium. We are so grateful!!

[READ MORE](#)

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WILL MY DOCTOR ACCEPT ALTRUA HEALTHSHARE?

Yes, we are part of MultiPlan which is a network that the majority of medical providers participate in. If a medical provider is not a part of the MultiPlan network, they should still accept us as your medical sharing of choice. See [Affiliated Providers](#) for details.

How to Use Your Membership

4.2 What Should I Do When I Need Medical Care?

In case of an emergency contact 911.

To help you get the most out of your membership, Altruia HealthShare uses an affiliated network of providers and facilities whenever possible. Using PHCS (Private Health Care Service) MultiPlan network contracted providers assists you in obtaining the maximum value of your membership. PHCS MultiPlan network contracted providers generally offer significant savings thereby lowering individual Member

ALTRUA HEALTHSHARE IS NOT INSURANCE 12

Responsibility Amounts. It's best to identify an affiliated provider and/or facility in your region before you seek care. To do so, simply go to www.altruiahealthshare.org/resources/affiliated-providers. You must present your member ID card to the provider at the time of services for discounts to apply.

If you use a non-affiliated provider or facility that does not accept Altruia HealthShare memberships standard reimbursement option, then once the 1st MRA has been met, you will be responsible for 50% of the eligible charges. The amount you are responsible for is \$5,000 of the next \$10,000 of charges. The 1st MRA varies depending on your membership. As charges are incurred the membership shares simultaneously.

4.3 What To Do When Your Provider Requires Self-Payment

If your provider will not accept the Altruia HealthShare member ID card, please ask if they can apply a self-pay discount. You will only be reimbursed for eligible medical needs for the services that were provided. An advance opinion of eligibility may be requested, but is not required. Itemized statements must include the following information (at a minimum) for Altruia HealthShare to accept them for review:

- › Provider's Name
- › Provider's Tax ID
- › Diagnosis Code (ICD-10)
- › Procedure Code (CPT, HCPCS or REV Codes)
- › Date of Service (DOS)

- › Billed Charges
- › Itemized receipt for Proof of Payment
- › A completed Reimbursement Form

A Needs Processing Form (NPF) and medical records may also be required, depending on the nature of your medical need. Log into your [Member Portal](#) and click the Needs Processing Form button to complete your Needs Processing Form.

You may submit your needs request by sending the information through secure email to memberforms@altruiahealthshare.org, by fax to 1.512.382.5520, or through your [Member Portal](#).

4.4 Balance Bill

If your provider or facility bills you for an amount exceeding the allowed amount for an eligible medical need, you may submit a revised bill reflecting the balance for the remaining amount in addition to proof of payment for any applicable MRA amounts. The membership will reprocess the eligible medical need according to the Membership Guidelines.

4.5 Timely Filing

- › You or your provider must submit requests for sharing no more than six months after the date you received service
- › Requested documentation you or your provider submit for sharing more than 6 months after the date it was requested (Needs Processing Form, medical records, etc.) will not be eligible for sharing



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 - And packaged with supplemental insurance products
- Marketing may describe as replacement for insurance and/or suggest consumers can rely on HCSMs for financial protection
 - Although this is prohibited by law in several states



You've Got Choices

Sort By **Deductible**

Insurance Carriers

Doctor Networks

HSA Eligible

Plan Types

Enrollment Fee

- ☐ Ambetter
- ☐ Blue Cross and Blue Shield of Texas
- ☐ Medi-Share
- ☐ Oscar
- ☐ Pivot Health

+ Add Doctors

+ Add Prescriptions

Share Plan

Medi-Share AHP 1750

Annual Household
Portion
\$1,750 / family

Max-Out-Of-Pocket
\$1,750 / family

Your Doctors
-

Rx Costs
-

Network Type
PPO

Monthly Share Amount
\$403/mo
Plus \$50 app fee

More Details

Choose Plan

☐ **PIVOT HEALTH**

Short-Term

Pivot Deluxe 2500

Deductible
\$2,500 / person

Max-Out-Of-Pocket
\$3,000 / person

Your Doctors
-

Rx Costs
-

Total Coverage
\$1,000,000

Monthly Premium
\$337.54/mo
Plus \$15 app fee

More Details

Choose Plan

☐ **Medi-Share**

Share Plan

Medi-Share AHP 3000



Medical Cost Sharing

A Refreshing and Affordable Healthcare Alternative



Why It Matters



Win + Retain New Customers

Surprise and delight your clients with lower cost and transparency.



Earn Financial Rewards

Enjoy our competitive compensation program.



Blaze a New Trail

Join us in creating a new normal in healthcare.



"Sedera has been a breath of fresh air to an industry and space that is often void of transparency, humanity, and love. My clients have enjoyed working with them and having Sedera has their health plan."

Tom, Sedera Certified Affiliate



HCSMs and Consumer Confusion

While HCSMs are very careful to say they are not insurance, they sure look like insurance.

- May be sold by insurance brokers (or others with a financial incentive to sign people up)
 - And packaged with supplemental insurance products
- **Marketing may describe as replacement for insurance and/or suggest consumers can rely on HCSMs for financial protection**
 - Although this is prohibited by law in several states



Breaking Every Mold

Meet increasing health care cost with inclusive, ACA exempt medical cost sharing within our faithful community. OneShare Health breaks every mold, offering cost, quality, and flexibility, plus inclusivity and simplicity unlike any other Health Care Sharing Ministry.

Our Promise

Affordable membership Faithful community Comprehensive sharing
Mutual blessings Simple administration

Members receive comprehensive access to high-quality healthcare with membership contributions as low as \$115 Individual, \$185 Individual +1, \$277 Family

Designed With You In Mind



Affordable

Meet increasing health care costs with affordable, inclusive, and ACA-exempt medical cost-sharing programs.



Easy Enrollment

We offer health-sharing programs with next-day effective dates and year-round enrollment periods.



Wide Network

Access one of the largest Provider Networks in the nation and find a provider that fits your needs.



Member Concierge

Receive personalized assistance and health care guidance from our Member Concierge for no additional cost.

\$38,845,181

Total Paid Shared Services:

\$1,701,765

Charitable Donations

Simple and Affordable Healthcare for You and Your Family

[Get a Quote](#)[How Sharing Works](#)[Why Solidarity](#)[Resources ▾](#)[Get a Quote](#)[Enroll Now](#)[\(844\) 313-4999](#)[Member Login](#)

Saving You Money, One Bill at a Time

With health care costs continuing to climb, it's hard to find quality health care that doesn't break your budget. With Solidarity Healthshare, we keep medical bills low by negotiating your medical bills for you. We use a standard system based on Medicare reimbursement rates that ensures providers are paid fairly and your bills are as low as they can be.



Let Us Help You Save Even More

We offer the [Solidarity Care Card](#) to help our members save on dental, vision, and prescription*† services. With our simple provider search page, you can access a large directory of participating providers to schedule your appointment with your provider of choice, and then pay the discounted fee at the time service is provided.

Telehealth

Our Telehealth service is a modern, easy-to-use telemedicine solution for non-emergency illnesses and general care. You have direct access to state-licensed and fully credentialed doctors, via phone or video consultations, to receive treatment and advice for common ailments, including colds, the flu, rashes, and more.



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*prescription discount services not available in WA

E. HOW DO I JOIN?

It's vitally important that you read and understand all CHM literature explaining who we are, what we do and how we do it. (This information is available to all prospective members via these Guidelines, in the CHM Information Pack and on chministries.org.) Based on that understanding, you may complete the Member Application online at join.chministries.org or by hard copy. (Your online acceptance is considered a digital "signature.")

Reading our materials will help you understand that **CHM is not insurance**. Health insurance requires a contract between you and a third party. The contract says that if you have medical bills covered by a health insurance policy, the company will be legally obligated to pay those bills for you. If the company doesn't pay, you and/or your medical provider can take action against it in a court of law.

Members of CHM do not have a contract. Instead, members follow the model of the Church, the Body of Christ. We as a Christian family recognize there is a need. We have a common focus on the need, a personal desire to assist with that need, and a common commitment to voluntarily assist one another with that need.

Sometimes people question how we can be sure our members will honor their commitment to carry each other's burdens. We point to our history: Since 1981 CHM members have faithfully shared eligible medical bills.



Christians' Obamacare Alternative

Lack of oversight resulted in mismanagement in the past. Christian Healthcare Ministries, formerly known as the Christian Brotherhood Newsletter, was placed under court-ordered receivership in 2000 after members complained to the Ohio attorney general's office about \$34 million in unpaid claims. The Rev. Bruce Hawthorn, founder of the newsletter, and his nephew, Daniel Beers, [were found liable](#) for civil and solicitation fraud, breach of fiduciary duty, conversion and unjust enrichment.

The lawsuit was filed by the Ohio attorney general and the mission associated with the newsletter in an attempt to recover donations attorneys say were used to buy luxury houses, motorcycles, fund high salaries, vacations and the living expenses of a stripper. Hawthorn and family members were ordered to pay \$14 million in punitive and compensatory damages.

Potential Harms to Consumers

- Misaligned expectations, about:
 - Covered benefits: “What Our Members Receive”
 - Out-of-pocket costs, provider networks: The “Promise” of “Affordable membership”
 - Likelihood of repayment: How HCSMs “can be sure” claims will be paid
- Deceptive practices
- Risk segmentation, undermining traditional insurance market



The Regulatory Framework

- Federal law exempts members of certain HCSMs from the individual mandate. No more, no less.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201



February 26, 2014

RE: Samaritan Ministries International – Review of Materials Submitted

Dear Mr. Heller,

This letter conveys the results of our review of the materials submitted in connection with your request for consideration as a health care sharing ministry for the purposes of subpart G of 45 CFR part 155, which governs the granting of certificates of exemption from the shared responsibility payment under section 5000A of the Internal Revenue Code (the Code) by an Affordable Insurance Exchange (also known as a Health Insurance Marketplace).

Section 5000A of the Code, as added by the Patient Protection and Affordable Care Act (Affordable Care Act), establishes an exemption from the shared responsibility payment for members of a health care sharing ministry. Section 1311(d)(4)(H) of the Affordable Care Act specifies that one of the minimum functions of an Exchange is to grant certificates of exemption from the shared responsibility payment under section 5000A of the Code in certain categories. Section 1411(a)(4) of the Affordable Care Act specifies that the Secretary of Health and Human Services (Secretary) shall establish a program for determining whether to grant a certification of exemption from the shared responsibility payment for certain categories of exemptions listed in section 5000A of the Code, including the exemption for members of a health care sharing ministry. The Secretary established this program in part through the process described in 45 CFR 155.615(c)(2), which provides that to be considered a health care sharing ministry for the purposes of certificates of exemption provided by an Exchange, an organization must submit information to HHS that substantiates the organization's compliance with the standards specified in section 5000A(d)(2)(B)(ii) of the Code.

Section 5000A(d)(2)(B)(ii)(I) – (V) specifies that, “the term ‘health care sharing ministry’ means an organization—

- (I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),
- (II) where members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance to these beliefs without regard to the state in which a member resides or is employed,
- (III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999 and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.”

Having completed the review of the materials you submitted dated December 12, 2013 and February 6, 2014, the Centers for Medicare & Medicaid Services (CMS) has determined that Samaritan Ministries International has submitted sufficient information to substantiate its compliance with the standards specified in section 5000A(d)(2)(B)(ii) of the Code and will be considered a health care sharing ministry for the purposes of subpart G of 45 CFR part 155.

This determination is limited to Samaritan Ministries International's compliance with standards relevant to an organization being considered a health care sharing ministry for the purposes of subpart G of 45 CFR part 155. As such, this determination does not supersede other relevant state or federal laws that govern the conduct of Samaritan Ministries International. Furthermore, this determination does not reflect any decision by the Internal Revenue Service regarding Samaritan Ministries International's status as a health care sharing ministry or compliance with the Internal Revenue Code. Samaritan Ministries International should not inform its members or the general public that this determination provides any such rights or status other than those rights which flow from an organization being considered a health care sharing ministry for the purposes of subpart G of 45 CFR part 155, which relate strictly to an individual's eligibility under 45 CFR 155.605(d) to obtain from a Health Insurance Marketplace a certificate of exemption from the individual shared responsibility payment under section 5000A of the Internal Revenue Code.

Please note that if any change in your status or operation affects any of the information you have submitted to CMS for the purpose of requesting consideration as a health care sharing ministry pursuant to 45 CFR 155.615(c)(2), you must notify CMS within 30 days of such change. If your organization no longer meets the standards specified in section 5000A(d)(2)(B)(ii) of the Code, CMS may revoke this decision regarding the status of Samaritan Ministries International as a health care sharing ministry for the purposes of subpart G of 45 CFR part 155.

If you have any questions or concerns, please contact Ben Walker at benjamin.walker@cms.hhs.gov. Thank you for your cooperation.

Sincerely,

Gary Cohen
Director, Center for Consumer Information & Insurance Oversight

The Regulatory Framework

- Neither the federal mandate exemption nor any other federal provision preempts state regulatory authority over HCSMs
- States can (and do) set standards for HCSMs and ensure they are adhered to.



State Regulatory Options

- Active, ongoing oversight to ensure compliance with state standards
 - Including demonstration of compliance at front-end (registration)
- Data showing how HCSMs operate
 - Enrollment
 - Marketing materials
 - Financial info sufficient to assess members' risk of facing unpaid claims
- No financial incentives for enrollment
- No marketing suggesting HCSM is operating in a financially sound manner or that it has had a successful history of meeting subscribers' financial or medical needs



Thank you

Justin Giovannelli

Associate Research Professor

(202) 687-4954

Justin.Giovannelli@georgetown.edu



Georgetown University Health Policy Institute

**CENTER ON HEALTH
INSURANCE REFORMS**

SamaritanTM


MINISTRIES

Presentation to NAIC Regulatory Framework (B) Task Force
August 4, 2020

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Samaritan Ministries coordinates and connects members to care for the whole need with prayer, encouragement, and financial support.

We believe health care needs are multi-dimensional; emotional and spiritual, as much as physical and financial.



25+ years.

\$30 million+ shared each month.

272,453 people nationwide.



Best practices

samaritanministries.org/bestpractices

- A health care sharing ministry does not assume any transfer of medical risk from its members or make any guarantee of payment for any expenses.
- A health care sharing ministry primarily acts as a facilitator for the bearing of medical burdens by strengthening the member-to-member connection that occurs through the voluntary medical burden-sharing process and does not include the pooling of funds.

Insurance: an economic device transferring risk from an individual to a company and reducing the uncertainty of risk via pooling. - *National Association of Insurance Commissioners glossary*

Best practices

- Conforms with the statutory definition of a qualifying Health Care Sharing Ministry (HCSM) as written in 26 USC § 5000A(d)(2)(B)(ii) of the PPACA.
- A health care sharing ministry should ensure that member dollars go primarily to meet medical needs, ideally maintaining a total administrative and program cost of less than 20%.

Best practices

- A health care sharing ministry should clearly communicate the following information to those who are interested in joining the ministry:
 - The health care sharing ministry is not an insurance company, nor does it offer any insurance product.
 - The sharing of medical costs is completely voluntary, and neither a member nor the health care sharing ministry is compelled by a legal agreement to pay the costs for medical bills submitted for sharing. However, a member choosing to not send a share may lead to their membership privileges being suspended.
 - All members will maintain their legal responsibility to pay for the medical bills they incur irrespective of whether they receive payment from the voluntary actions of other members or the ministry through the sharing process.

Best practices

- A health care sharing ministry should not require their members to apply for government assistance or state aid as part of the ministry's sharing process.
- A health care sharing ministry ideally should not use health insurance agents, health insurance agencies, health insurance brokers, health insurance producers, or health insurance representatives.

Regulation and Oversight

- Samaritan Ministries values transparency. We would not find it unreasonable to report info annually.
- However, we are concerned with requiring non-insurance entities such as health care sharing ministries to register with the DOI. HCSMs that are 501c3 charities should not be subject to any portion of an Insurance Code.

Regulation and Oversight

- We would advocate that HCSMs be subject to the state's laws that apply to charities, which would include fraud/consumer protection.
- Similarly, if the HCSM fits the ACA definition, it is a charity and therefore any state registration should be with the Attorney General, not the DOI.
- The registration and required info that is sent to the Attorney General can be shared by that department with DOI so the consumer questions can be addressed if those arise.

SamaritanTM

MINISTRIES

Questions?

joel.noble@samaritanministries.org

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Agenda Item #5

Hear a Discussion on

Premium Holidays, Early Medical Loss Ratio (MLR) Rebate Payments and Adjustments to

Cost-Sharing Benefits as a Result of Fewer Claim Filings in 2020 Due to COVID-19

—*Jason Levitis (Levitis Strategies, LLC) and Randy Pate (Center for Consumer Information and Insurance Oversight—CCIO)*

Agenda Item #6

Discuss Any Other Matters Brought Before the Task Force

—*Commissioner Michael Conway (CO)*