



NATIONAL MEETING SPRING 2023

Draft date: 2/24/23

*2023 Spring National Meeting
Louisville, Kentucky*

REGULATORY FRAMEWORK (B) TASK FORCE

Wednesday, March 22, 2023

12:00 – 1:00 p.m.

Kentucky Convention Center—Ballroom C—Main Concourse Level

ROLL CALL

Sharon P. Clark, Chair	Kentucky	Chris Nicolopoulos	New Hampshire
Glen Mulready, Vice Chair	Oklahoma	Marlene Caride	New Jersey
Mark Fowler	Alabama	Jennifer Catechis	New Mexico
Lori K. Wing-Heier	Alaska	Mike Causey	North Carolina
Peni Itula Sapini Teo	American Samoa	Jon Godfread	North Dakota
Ricardo Lara	California	Joseph Rios Jr.	Northern Mariana Islands
Michael Conway	Colorado	Judith L. French	Ohio
Andrew M. Mais	Connecticut	Andrew R. Stolfi	Oregon
Karima M. Woods	District of Columbia	Michael Humphreys	Pennsylvania
Dean L. Cameron	Idaho	Alexander S. Adams Vega	Puerto Rico
Amy L. Beard	Indiana	Larry D. Deiter	South Dakota
Doug Ommen	Iowa	Cassie Brown	Texas
Vicki Schmidt	Kansas	Jon Pike	Utah
Timothy N. Schott	Maine	Scott A. White	Virginia
Gary D. Anderson	Massachusetts	Mike Kreidler	Washington
Grace Arnold	Minnesota	Allan L. McVey	West Virginia
Eric Dunning	Nebraska	Nathan Houdek	Wisconsin

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

AGENDA

1. Consider Adoption of its 2022 Fall National Meeting Minutes
—*Commissioner Sharon P. Clark (KY)* Attachment One
2. Consider Adoption of its Subgroup and Working Group Reports
 - A. Accident and Sickness Insurance Minimum Standards (B) Subgroup
—*Andrew Schallhorn (OK) and Rachel Bowden (TX)*
 - B. Employee Retirement Income Security Act (ERISA) (B) Working Group
—*Robert Wake (ME)*
 - C. Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
—*Erica Weyhenmeyer (IL)*
 - D. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup—*TK Keen (OR)*

3. Hear an Update on the Center on Health Insurance Reforms' (CHIR's) Work
—*Maanasa Kona (CHIR, Georgetown University Health Policy Institute)*
4. Discuss Any Other Matters Brought Before the Task Force
—*Commissioner Sharon P. Clark (KY)*
5. Adjournment

Agenda Item #1

Consider Adoption of its 2022 Fall National Meeting Minutes
—*Commissioner Sharon P. Clark (KY)*

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Draft: 12/21/22

Regulatory Framework (B) Task Force
Tampa, Florida
December 13, 2022

The Regulatory Framework (B) Task Force met in Tampa, FL, Dec. 13, 2022. The following Task Force members participated: Vicki Schmidt, Chair (KS); Sharon P. Clark, Vice Chair (KY); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Yada Horace (AL); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Jared Kosky (CT); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Amy L. Beard represented by Meghann Leaird (IN); Gary D. Anderson represented by Kevin Beagan (MA); Timothy N. Schott represented by Robert Wake (ME); Anita G. Fox represented by Sarah Wohlford (MI); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning, Laura Arp, and Maggie Reinert (NE); Chris Nicolopoulos represented by Maureen Belanger (NH); Russell Toal represented by Paige Duhamel (NM); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Molly Nollette (WA); Nathan Houdek (WI); and Allan L. McVey represented by Ellen Potter (WV). Also participating was: Erica Weyhenmeyer (IL).

1. Adopted its Oct. 11 and Summer National Meeting Minutes

The Task Force met Oct. 11 and Aug. 10. During its Oct. 11 meeting, the Task Force took the following action: 1) decided not to consider revisions to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22). The revisions would have addressed a concern raised during a presentation from the Association for Accessible Medicines (AAM) about a provision in Model #22 on drug substitutions for certain biosimilar drugs at the Task Force's meeting at the Summer National Meeting; and 2) adopted its 2023 proposed charges.

Keen made a motion, seconded by Kruger, to adopt the Task Force's Oct. 11 (Attachment One) and Aug. 10 (see *NAIC Proceedings – Summer 2022, Regulatory Framework (B) Task Force*) minutes. The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

a. Accident and Sickness Insurance Minimum Standards (B) Subgroup

Arp said the Accident and Sickness Insurance Minimum Standards (B) Subgroup met Dec. 5, Nov. 28, Nov. 14, Oct. 31, Sept. 29, Sept. 12, and Aug. 29. She said during these meetings, the Subgroup discussed comments received on Section 8—Supplementary and Short-Term Minimum Standards for Benefits of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). The Subgroup completed its work on Section 8. Arp said the Subgroup discussed its upcoming work on Section 9—Required Disclosure Provisions. The Task Force requested comments with a public comment period ending Nov. 18 on this section and the remaining section in Model #171, Section 10—Requirements for Replacement of Individual Supplementary and Short-Term Insurance.

Because Arp would be resigning from the Nebraska Department of Insurance (DOI) at the end of the year and would no longer be attending national meetings as a representative of the DOI, Commissioner Schmidt recognized

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and expressed appreciation for the work Arp has done for the Subgroup since she became its co-chair and the work she has done for other groups that report to the Task Force.

b. ERISA (B) Working Group

Wake said the Employee Retirement Income Security Act (ERISA) (B) Working Group has not met in open session since the Summer National Meeting, but it is continuing its work to update the NAIC chart on multiple employer welfare arrangements (MEWAs)/multiple employer trust (MET) and association plans and surveying the states regarding their stop loss laws in relation to level-funded plans. He said the Working Group continues to serve as a forum and facilitate discussions among state insurance regulators and federal regulators on issues involving ERISA plans and MEWAs, and it held a regulator-only meeting on Sept. 8 as part of this work. He said the Working Group also stands ready to assist the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup on any issues it encounters related to ERISA preemption issues as the Subgroup works on its white paper concerning pharmacy benefit managers (PBMs) and their business practices, including the implications of the *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* decision and any subsequent decisions on such business practices.

Wake also discussed an upcoming hearing in the U.S. Court of Appeals for the Eleventh Circuit related to an appeal from a district court's approval of a settlement of a consolidated multi-state, anti-trust class action against the Blue Cross Blue Shield Association (BCBSA) and its members. He said Oklahoma has taken the lead in drafting and submitting a multi-state amicus brief. He said the amicus brief does not address the merits of the settlement, but it urges the Eleventh Circuit Court in its decision to accurately describe the nature and regulatory status of stop loss insurance. He said several states have signed onto the brief. He urged any other states wishing to sign on as well to reach out to the Oklahoma DOI as soon as possible.

c. MHPAEA (B) Working Group

Weyhenmeyer said the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group continues to serve as a forum and an opportunity for Working Group members and interested state insurance regulators to discuss MHPAEA enforcement and compliance issues. Given this, many of the Working Group's meetings since the Summer National Meeting have been in regulator-to-regulator session. Weyhenmeyer said the Working Group has also continued to dialogue with the federal agencies, the U.S. Department of Labor (DOL), and the federal Centers for Medicare & Medicaid Services (CMS) charged with implementing the federal mental health parity requirements.

Weyhenmeyer said the Working Group has met in person at each of the national meetings this year in addition to its regulator-to-regulator in-person and virtual meetings. She said the Working Group will be meeting Dec. 14 in an open session and a regulator-to-regulator session. In the open session, the Working Group will hear presentations on parity issues from America's Health Insurance Plans (AHIP) and the BCBSA.

Weyhenmeyer said as part of the Working Group's work this year, the Working Group held a series of regulator-to-regulator sessions to discuss potential changes to the mental health parity chapter of the *Market Regulation Handbook*. The Working Group finished its review and forwarded its suggested revisions to the Market Conduct Examination Guidelines (D) Working Group for its consideration. Weyhenmeyer said the Market Conduct Examination Guidelines (D) Working Group reviewed the MHPAEA (B) Working Group's suggested revisions and adopted them. The Market Regulation and Consumer Affairs (D) Committee adopted the revisions as well. The revised mental health parity chapter is available for state insurance regulators to use as part of their mental health parity compliance and enforcement efforts.

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Weyhenmeyer said the Working Group is also continuing to monitor congressional activity related to mental health parity. She said the U.S. House of Representatives (House) passed legislation that would provide grants to the states to assist them with mental health parity plan compliance determination, enforcement, and training; but to date, there has not been any activity related to the legislation from the U.S. Senate (Senate). She said the Working Group is anticipating an updated proposed rule related to mental health parity from the DOL and the CMS. Once the proposed rule is published, she hopes to hold a Working Group meeting to discuss it and decide whether the NAIC should comment on it through the Government Relations (EX) Leadership Council.

d. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

Keen said the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will meet Dec. 15. He said during this meeting, the Subgroup plans to consider adoption of its Oct. 24 and Summer National Meeting minutes. During its Oct. 24 meeting, the Subgroup continued its work on hearing presentations from various stakeholders on issues from their perspectives on the Subgroup's 2022 charge to develop a white paper to: 1) analyze and assess the role PBMs, pharmacy services administrative organizations (PSAOs), and other supply chain entities play in the provision of prescription drug benefits; 2) identify, examine, and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements; rebating; and spread pricing, including the implications of the *Rutledge* decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.

Keen said yesterday, the Subgroup released a working draft of the PBM white paper. He said during its Dec. 15 meeting, the Subgroup will discuss its work on developing the working draft, including hearing from the leaders of each of the white paper section drafting groups on their process for developing an initial draft of their section. He emphasized that the draft is a working document. The Subgroup plans to edit and refine the document before releasing an official draft for public comment. Keen explained that the Subgroup aims to have the white paper focus on the current state of play as far as PBMs and PBM regulation and business practices, as well as not have it try to predict any future changes in such regulation or business practices.

Kosky made a motion, seconded by Keen, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Dec. 5 (Attachment Two), Nov. 28 (Attachment Three), Nov. 14 (Attachment Four), Oct. 31 (Attachment Five), Oct. 18 (Attachment Six), Sept. 29 (Attachment Seven), Sept. 12 (Attachment Eight), and Aug. 29 (Attachment Nine) minutes; the ERISA (B) Working Group; the MHPAEA (B) Working Group, including its Aug. 11 minutes (Attachment Ten); and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. The motion passed unanimously.

3. Heard a Presentation on a Potential Consumer Disclosure and Labeling Regime for Ancillary Health Products

Jackson Williams (Dialysis Patient Citizens—DPC) presented on “Addressing Low-Value Insurance Products Through Improved Consumer Information.” The presentation is based on an article titled, “Addressing Low-Value Insurance Products with Improved Consumer Information: The Case of Ancillary Health Products,” which is to be published in the Journal of Insurance Regulation (JIR).

Williams discussed how disclosure laws shape consumer information at three stages of the shopping process; i.e., first impression, pre-decision, and post-decision. He discussed how the current sales regime of products, such as short-term health insurance and supplemental health insurance products, favors the sellers of these products and leads to the marketing of insurance products offering low value to consumers. He suggested that state insurance regulators could address this by mandating a robust regime of disclosures and labeling, which he described as “comparative disclosures.” He discussed currently mandated comparative disclosures for products, such as bourbon and orange juice and requirements under the federal Truth in Lending Act (TILA) that require the disclosure of an annual percentage rate to permit an apples-to-apples comparison of offers of credit and the so-

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called “Monroney label,” required under the federal Automobile Information Disclosure Act of 1958, to be affixed on new cars that facilitate the comparison of vehicle prices and attributes.

Williams said similar identity standards can be created for health insurance and critical illness insurance. He recommended that state insurance regulators: 1) prohibit the use of the term “health insurance” when the product has an actuarial value less than 60%; and 2) allow short-term health products to use alternate names, such as “mini-med” or “medical bill assistance plan,” when the product does not offer that level of benefits. He also recommended the creation of a “unit price” for product comparisons, such as requiring the disclosure of loss ratio or a classification system for short-term products, such as MiniMed 1, MiniMed 2, or MiniMed 3 based on minimum coverage standards at each level.

Williams discussed additional recommendations, including establishing a uniform product summary for short-term insurance, creating a uniform product label with common scenarios by age group, and ensuring that representations are not misleading throughout the sales process or transaction.

Williams said his suggestions would structure the market to promote competition on price and quality. He said his approach avoids “command-and-control” regulations in favor of a light regulatory touch to facilitate informed consumer choices and lets market forces shape products.

4. Heard a Presentation on ICHRAs

Katherine Hempstead (Robert Wood Johnson Foundation—RWJF) provided an overview of individual coverage health reimbursement arrangements (ICHRA), including its potential for more consumer choice, its growth implications for the individual market, the challenges and barriers to its take-up by employers, and interest from brokers and health insurers. She said initially, there were high expectations with the U.S. Department of the Treasury (Treasury Department) projecting that 800,000 employers and 11 million workers would be using ICHRAs within five years after its creation in January 2020. A recent HRA Council report indicates rapid growth between 2020 and 2022 from a very low base, with ICHRA adoption more than tripling. Overall, however, the current take-up rate for ICHRAs is very low.

In discussing the challenges to ICHRAs, Hempstead described the many barriers affecting the rate of take-up by employers, such as: 1) the individual market often being more expensive than the small group market; 2) the lack of awareness among employers; 3) the lack of support from brokers; 4) opposition from some groups of employees and other stakeholders; and 5) ICHRAs must be purchased off-exchange to use pre-tax dollars. She cited two studies tracking the awareness, familiarity, and opinions of employers and employees about ICHRAs. The study findings indicated that employers are not offering ICHRAs because: 1) they do not understand them; 2) their broker did not recommend them; 3) they believe ICHRAs are too complicated to administer; 4) their employees are not interested; and 5) ICHRAs are not good for employees. Hempstead said other concerns with ICHRAs include: 1) the potential for adverse selection within the company; 2) it being hard to prevent consumers from buying “junk” coverage; and 3) “affordable” ICHRAs possibly being harmful to low-income workers.

Hempstead suggested a few policy recommendations to address some of these issues, including: 1) allowing a choice between group plans and ICHRAs; 2) requiring that ICHRAs be offered to all employees; 3) protecting workers from “junk” plans; and 4) conducting outreach and education to employers.

Seip asked Hempstead if she researched the rate of take-up of other types of health reimbursement arrangements (HRAs) in comparison to the take-up for ICHRAs to see if the differences, if any, could be attributed to the lack of sophistication and knowledge of this type of HRA by small employers versus large employers. Hempstead said the HRA Council’s study did a comparison of ICHRAs with qualified small employer health reimbursement

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arrangements (QSEHRAs). She has not conducted a study or comparison with other types of HRAs, but that could be something she could search for and provide additional information on later.

Duhamel asked if Hempstead's analysis takes into consideration the financial assistance available to consumers in the individual market health insurance exchanges. She explained that in New Mexico, the contributions small employers are offering to their employees to purchase coverage from the small employer do not match up to what an employee is eligible for and can receive through the purchase of a qualified health plan (QHP) on the health insurance exchange, particularly if the employee is eligible for advance premium tax credits (APTCs). She asked about Hempstead's thoughts on the usefulness of ICHRAs in expanding access to coverage under these circumstances when the QHP coverage an employee can receive, particularly those eligible for APTCs, will most likely be better than the coverage the employee would receive under the small employer plan with an ICHRA.

Hempstead agreed that given the current circumstances with the APTCs being extended, some employees, particularly low-wage employees, would be better off obtaining coverage through the individual market health insurance exchanges and not the small employer's plan with the ICHRA. She said she has heard anecdotally of some small employers offering ICHRA coverage that is intentionally only affordable to their high-wage employees so that their low-wage employees can obtain coverage through the individual market health insurance exchanges. She also said because of the APTCs and other types of subsidies that states may be offering, this could be one reason why ICHRAs are not being used and affecting its rate of take-up. Kruger agreed with Duhamel's comments about some small employers encouraging their employees to obtain coverage through the individual market health insurance exchanges because of the availability of APTCs, rather than the small employer offering coverage through the small group market. Hempstead said although she has not found a way to measure such a shift, she is sure it is happening.

5. Heard a Federal Update

Joe Tuschner (NAIC) provided a federal update on issues of interest to the Task Force. He said there continues to be broad, bipartisan interest in legislation to improve the care and coverage of mental and behavioral health in the U.S. Congress (Congress). He explained that the states are the primary enforcers of the MHPAEA, but no federal funding is provided to assist states in enforcing it. He said the NAIC sent a letter to Congress in support of efforts to provide grant funds to states for the enforcement of the MHPAEA. He said as Weyhenmeyer noted, the House passed a bill, the Restoring Hope for Mental Health and Well-Being Act of 2022 (HR 7666), authorizing \$10 million per year for five years for grants to states for MHPAEA enforcement; the Senate has not yet acted on the bill, but the legislation is part of the conversation in the current congressional lame duck session.

Tuschner discussed telehealth and the potential for increased flexibility in its use. He noted that many of the changes expanding the use of telehealth are tied to the public health emergency (PHE), but there seems to be some support for maintaining some of these expanded uses after the PHE ends sometime next year, with the possibility of extending them until the end of 2023.

Tuschner discussed the changes in congressional leadership on some of the key committees involved in health insurance legislation. He noted that even with these leadership changes, there seems to be continued interest in prescription drug issues and the marketing of health plans, particularly the marketing of Medicare Advantage plans.

Tuschner said on the federal regulatory side, the CMS just released the Notice of Benefit and Payment Parameters for 2024 proposed rule. He said the CMS will provide a summary of that proposed rule during the Health Insurance and Managed Care (B) Committee's meeting on Dec. 14. He said the CMS recently sent out a request for information (RFI) concerning essential health benefits (EHBs) seeking information on how the benefits are described and how they are updated. He noted that there is a key role for state insurance regulators in how

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these benefits should be described and how they should be updated. As such, it is likely that state insurance regulators will submit comments on the RFI and any proposed rule that results from the RFI. He said the NAIC and several state DOIs submitted comments on the proposed rule related to the non-discrimination provisions under Section 1557 of the federal Affordable Care Act (ACA). He anticipates the final rule being released soon. He said he anticipates the federal agencies charged with implementing the MHPAEA releasing a proposed rule concerning state mental health parity enforcement.

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 Sharon P. Clark (KY)

- *Accident and Sickness Insurance Minimum Standards (B) Subgroup*
—Andy Schallhorn (OK) and Rachel Bowden (TX)
- *Employee Retirement Income Security Act (ERISA) (B) Working Group—Robert Wake (ME)*
- *Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group*
—Erica Weyhenmeyer (IL)
- *Pharmacy Benefit Manager Regulatory Issues (B) Subgroup—TK Keen (OR)*

*Virtual Meetings***ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS (B) SUBGROUP**

March 13, 2023 / February 27, 2023 / February 13, 2023

Summary Report

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met March 13, Feb. 27, and Feb. 13, 2023. During these meetings, the Subgroup:

1. Discussed the comments received on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), specifically, Section 8A—General Rules.
2. Discussed its upcoming work to review the remaining provisions in Model #171 in the following order:
 - a) the remainder of Section 8, including revisiting the proposed new subsection on STLD plans to discuss the Feb. 24 comments received on that section; b) Section 7—Prohibited Policy Provisions; c) revisit Section 5—Definitions and Section 6—Policy Definitions to reconcile any inconsistencies that may have arisen after the Subgroup’s review of the substantive provisions of Model #171; and d) Section 9—Required Disclosure Provisions.

Draft: 3/16/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
March 13, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met March 13, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Chris Struk (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson (NE); Heidi Clausen (UT); Anna Van Fleet, Jamie Gile, and Mary Block (VT); and Ned Gaines (WA).

1. Continued Discussion of Section 8A of Model #171

The Subgroup continued its discussion of the comments received on Section 8A—General Rules of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), beginning with the NAIC consumer representatives' suggestion to delete the language "within a period of less than fourteen (14) days" in Section 8A(7). The Subgroup decided to revise the timeframe to 30 days. The Subgroup also agreed, if necessary, to revisit its decision based on any stakeholder concerns.

2. Discussed Comments Received on Section 7 of Model #171

The Subgroup next discussed the comments received on Section 7—Prohibited Policy Provisions, beginning with the NAIC consumer representatives' comments for Section 7A. Section 7A prohibits specified policies from establishing provisions related to probationary or waiting periods, during which no coverage is provided under the policy under certain circumstances. Section 7A also provides that a policy may contain a probationary or waiting period for certain diseases or conditions. The NAIC consumer representatives suggest numerous revisions to this provision, including adding a provision prohibiting a supplementary or short-term, limited-duration (STLD) health insurance policy from being issued, delivered, or used in the state unless the policy has been filed and approved by the commissioner. The Subgroup discussed the suggested revisions but decided not to accept them. The Subgroup decided to accept the Maine Department of Insurance's (DOI's) suggested revisions to Section 7A, which streamline the existing language and incorporate the language in Section 7C related to preexisting condition exclusion periods. After discussing the Vermont DOI's comments on Section 7A, which question the list of specific conditions described in the provision for which a policy may have a probationary or waiting period, the Subgroup agreed to delete the reference to "appendix" because it appears to be obsolete.

The Subgroup next discussed the comments received on Section 7B. Section 7B prohibits an insurer from issuing a policy or rider for additional coverage as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. The NAIC consumer representatives and the Health Benefits Institute (HBI) suggest deleting the provision because it is not a common provision included in health insurance coverage. The HBI also suggests adding a drafting note that explains why the provision was deleted and suggests that those states where policy dividends are available for policies covered by Model #171 look at how such dividends are treated in life insurance. After discussion, the Subgroup agreed to delete Section 7B and add the HBI's suggested drafting note.

The Subgroup next discussed the Maine DOI's suggestion to delete Section 7C. Section 7C prohibits an insurer from excluding coverage for a loss due to a preexisting condition for a period greater than 12 months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease, or physical condition or prior medical care and treatment and the preexisting

condition is not specifically excluded under the terms of the policy or certificate. After discussion, the Subgroup agreed to delete Section 7C because its provisions are folded into the revised language for Section 7A.

The Subgroup next discussed Section 7D. Section 7D describes provisions that may be included in a disability income protection policy. America's Health Insurance Plans (AHIP) suggests adding the word "option" after "cash value benefit." The Subgroup accepted the suggested revision. The Subgroup discussed the NAIC consumer representatives' suggestion to delete the term "suspension" and replace it with "cancellation." The Subgroup decided not to accept the suggested revision because of the different meanings and applications of these terms in accordance with common insurance terminology.

The Subgroup discussed the Texas DOI's suggestion to add language to Section 7, clarifying that, except for STLD plans and limited scope dental and vision plans, the policies covered under Model #171 cannot coordinate because the *Coordination of Benefits Model Regulation* (#120) excludes these types of coverages from the definition of "plan." However, because Model #120 does not technically apply to policies that are not "plans," some insurers attempt to limit coverage to "excess only." After discussion, the Subgroup agreed to consider adding such language. Bowden volunteered to draft language for the Subgroup's consideration.

The Subgroup next discussed the Texas DOI's comments on Section 7E. Section 7E prohibits a hospital confinement indemnity or other fixed indemnity coverage from containing a provision excluding coverage because of confinement in a hospital operated by the federal government. The Subgroup discussed why Section 7E is limited to hospital confinement indemnity, other fixed indemnity coverage, and hospitals operated by the federal government. The Subgroup did not make any decisions on whether to broaden Section 7E to include other coverages and other licensed facilities.

The Subgroup next discussed Section 7F. Section 7F prohibits a policy from limiting or excluding coverage by type of illness, accident, treatment, or medical condition, except as provided in the section. The American Council of Life Insurers (ACLI) and AHIP suggest adding the words "non-commercial or recreational" to clarify Section 7F(4)(c). The Subgroup accepted the suggested revision.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 7F. The Subgroup did not complete its discussion of the comments, deferring discussion until the Subgroup's next meeting on March 27.

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

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Draft: 3/15/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
February 27, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Feb. 27, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson (NE); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet and Jamie Gile (VT); and Ned Gaines (WA).

1. Continued Discussion of Section 8A of Model #171

The Subgroup continued its discussion of the comments received on Section 8A—General Rules of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), beginning with the NAIC consumer representatives' suggestion to delete Section 8A(2)(c), which sets out provisions related to an individual's right to continue a policy up to a specified age under certain circumstances. The Subgroup discussed whether the provision should be retained and revised to delete the references to specific ages, similar to the changes the Subgroup agreed to for Section 8C—Disability Income Protection Coverage. After discussion, the Subgroup decided to delete the references to specific ages and revise the provision based on the Subgroup's preliminary revisions to Section 8C. The Subgroup agreed to revisit this proposed revision after it completes its review of all the comments received on Model #171.

The Subgroup next discussed the NAIC consumer representatives' suggestion to revise Section 8A(3) to delete the reference to "husband and wife" and replace it with "adult members." The NAIC consumer representatives also suggest deleting the references to "spouse" and replacing them with "person." The Subgroup agreed that it would be appropriate to delete the reference to "husband and wife" because it is outdated language. The Subgroup discussed whether replacing that reference with "adult members" would expand the scope of the provision and have unintended consequences. After discussion, the Subgroup decided to accept the Vermont Department of Insurance's (DOI's) suggestion to replace "husband and wife" with "married couple or civil union couple." The Subgroup discussed the appropriateness of adding "civil union" because such a partnership may not be applicable in every state. After discussion, the Subgroup decided to add a drafting note explaining the intent of the language, which it would review later. The Subgroup also agreed to revisit adding "civil union" and make a final decision after it completes its review of all the comments received on Model #171. The Subgroup deferred deciding on whether to delete "spouse" and replace it with "person" because of its concerns about unintentionally expanding the scope of the provision. The Subgroup agreed to revisit this issue later.

The Subgroup next discussed the NAIC consumer representatives' suggestion to delete the language "within a period of less than fourteen (14) days" in Section 8A(7). The Subgroup discussed whether deleting the language would be helpful or harmful to consumers. There also was discussion on whether to delete the provision altogether or change the time frame to 30 days. The Subgroup also discussed whether any changes were necessary because it does not appear that states have been receiving complaints about the 14-day provision. The Subgroup deferred additional discussion of the provision until its next meeting on March 13 to allow Cindy Goff (American Council of Life Insurers—ACLI) to poll ACLI members about this provision, including its 14-day time frame and whether there would be any concerns with revising the time frame to 30 days.

The Subgroup next discussed Section 8A(8). The NAIC consumer representatives and the Vermont DOI both suggest revising this provision to delete outdated language, such as the reference to "mental retardation or

physical handicap” and replacing it with “intellectual or physical disability.” They also suggest deleting the reference to “incapacity” and replacing it with “disability.” After discussion, the Subgroup agreed to accept the suggested revisions.

The Subgroup next discussed the NAIC consumer representatives’ suggestion to delete Section 8A(10). Section 8A(10) provides that a policy may contain a provision related to recurrent disabilities, but such a provision may not specify that a recurrent disability be separated by a period greater than six months. The Subgroup discussed whether deleting this provision would harm consumers. After additional discussion, the Subgroup decided to retain the provision, but consider moving it to Section 8C—Disability Income Protection Coverage.

The Subgroup next discussed the NAIC consumer representatives’ suggestion to add language to Section 8A(12) requiring that an accident-only policy providing benefits that vary according to the type of accidental cause to include in the disclosure materials required under Section 9 of Model #171, in addition to the outline of coverage, specified information on the circumstances when benefits payable under the policy will be lesser than the maximum payable benefit amount. The Subgroup agreed to accept the suggested revision.

Based on its previous discussions, the Subgroup did not accept the NAIC consumer representatives’ suggestion to delete the term “termination” in Section 8A(13) and replace it with the term “cancellation.”

The Subgroup next discussed the Texas DOI’s suggested revision to Section 8A(4) to expand the applicability of the provision to group coverage. The Subgroup discussed the suggested revision. After discussion, the Subgroup decided not to accept the suggested revision.

The Subgroup next discussed the Texas DOI’s suggested revision to Section 8A(5) to possibly expand the military service member protections to other federal or state laws. After discussion, the Subgroup decided to add a drafting note suggesting that the states may want to review other state and federal laws and regulations that may apply to this type of military service member protection.

The Subgroup next discussed the Texas DOI’s suggestion to expand Section 8A(8) to apply to group coverage. Section 8A(8) outlines requirements for continuing coverage for certain dependent children whose coverage would otherwise be terminated under the terms of the policy due to the attainment of a specified age. After discussion, the Subgroup agreed to preliminarily delete the word “individual” and have the provision apply to group coverage. The Subgroup also agreed to revisit its decision subject to industry concern about such a change.

The Subgroup next discussed the Texas DOI’s comments on Section 8A(11), suggesting expanding the time frames for paying accidental death and dismemberment benefits and disability income protection benefits. Bowden asked if Subgroup members and interested regulators took a different approach to this provision related to these time frames. A few states discussed their states’ related provisions. The Subgroup did not decide on whether to revise Section 8A(11) to reflect the Texas DOI’s comments.

The Subgroup reviewed the Texas DOI’s comments on Section 8A(12) and (13), suggesting that the Subgroup may want to move these provisions from Section 8A—General Rules to Section 8D—Accident-Only Coverage because they appear to only apply to accident-only coverage. The Subgroup did not decide whether to move the provisions.

The Subgroup next reviewed the Texas DOI’s comments on Section 8A(14). Bowden said she flagged this provision for the Subgroup for potential future discussion to add definitions for “policy period” and “benefit period” when it revisits Section 5—Definitions.

The Subgroup next discussed the Texas DOI's suggestion to broaden and revise Section 8A(15) as follows: "A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or include unfair exclusions. For example, a policy providing coverage for fractures or dislocations may not provide benefits only for 'full or complete' fractures or dislocations." After discussion, the Subgroup agreed to accept the suggested revision.

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

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Draft: 3/7/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
February 13, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Feb. 13, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Shari Miles (SC); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet and Jamie Gile (VT); and Ned Gaines (WA).

1. Discussed Proposed Revisions to the Introductory Language for Section 8 and Section 8A of Model #171

Before continuing its discussion of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), Schallhorn welcomed Bowden as the new Subgroup co-chair. He also said that moving forward, the Subgroup plans to meet every other week for 90 minutes in order for the Subgroup to complete its work on revising Model #171 by the end of the year.

The Subgroup discussed America's Health Insurance Plans' (AHIP's) and the American Council of Life Insurers' (ACLI's) suggestion to delete "short-term" in the introductory language for Section 8—Supplementary and Short-Term Health Insurance Minimum Standards for Benefits. Cindy Goff (ACLI) said the ACLI suggests this revision to reflect that provisions of Section 8 do not generally apply to short-term coverage. After discussion, the Subgroup decided not to accept the suggested revision for the introductory paragraph for Section 8, but as the Subgroup reviews the other provisions in Section 8, it will consider deleting the reference to such coverage, as appropriate, such as when the provision would not apply to such coverage. The Subgroup discussed the Texas Department of Insurance's (DOI's) comments suggesting revising the language to clarify that some combinations of products could disqualify a product from being considered an excepted benefit product. After discussion, the Subgroup decided such language was unnecessary because of other revisions the Subgroup has preliminarily agreed to include for this section.

The Subgroup next discussed AHIP's and the ACLI's suggestions to delete the reference to "short-term" in Section 8A—General Rules. After discussion, the Subgroup agreed to delete these references in Section 8A(1), (2), (3), and (4). After discussion, the Subgroup agreed to add AHIP's and the ACLI's suggested language "except for nonpayment of premium" in Section 8A(6). After discussion, the Subgroup did not accept AHIP's and the ACLI's suggestion to delete the reference to "short-term" in Section 8A(8).

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 8A(1) to delete the term "termination" and replace it with the term "cancellation." After discussion, the Subgroup decided not to accept the suggested revisions because of concerns of unintended consequences of such a change to standard insurance terminology. The Subgroup next discussed the NAIC consumer representatives' suggestion to delete Section 8A(2)(c), which sets out provisions related to an individual's right to continue a policy up to a specified age under certain circumstances. The Subgroup discussed whether the provision should be retained and revised to delete the references to specific ages similar to the changes the Subgroup agreed to for Section 8C—Disability Income Protection Coverage. After discussion, the Subgroup deferred deciding until its next meeting on Feb. 27.

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

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*Virtual Meeting***EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) (B) WORKING GROUP****Summary Report**

The Employee Retirement Income Security Act (ERISA) (B) Working Group did not meet at the Spring National Meeting. During its last open meeting, the Working Group:

1. Discussed and agreed to update the NAIC Chart on Multiple Employer Welfare Arrangements (MEWA)/Multiple Employer Trust (MET) and Association Plans. NAIC staff are surveying the states regarding their laws.
2. Discussed whether to update the ERISA Handbook at this time. The Working Group decided it would be premature to undertake, given all the case law that remains in flux in the courts.
3. Agreed to survey the states regarding their stop loss laws in relation to level funded plans.



NATIONAL MEETING SPRING 2023



*2023 Spring National Meeting
Louisville, Kentucky*

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) (B) WORKING GROUP

Thursday, March 23, 2023

2:00 – 2:30 p.m.

Meeting Summary Report

The MHPAEA (B) Working Group will meet March 23, 2023. During this meeting, the Working Group plans to:

1. Adopt its Feb. 24 minutes, which included the following action:
 - A. Adopting its 2022 Fall National Meeting minutes.
 - B. Hearing a discussion of parity issues with health insurers.
2. Hear a discussion of the *Wit v. United Behavioral Health* case.

Draft: 3/9/23

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Virtual Meeting
February 24, 2023

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met Feb. 24, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jimmy Harris (AR); Erin Klug (AZ); Cara Cheevers (CO); Kurt Swan (CT); Howard Liebers (DC); Elizabeth Nunes (GA); Andria Seip (IA); Julie Holmes (KS); Mary Kwei (MD); Andrew Kleinendorst (MN); Cynthia Amman (MO); David Dachs (MT); Ted Hamby (NC); Chrystal Bartuska (ND); Maureen Belanger (NH); Ralph Boeckman (NJ); Cass Brulotte and Paige Duhamel (NM); Laura Miller (OH); Ashley Scott (OK); Lindsie Swartz (PA); Glynda Daniels (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Brant Lyons (VA); Barbara Belling (WI); Tim Sigman (WV); and Tana Howard (WY).

1. Adopted Its 2022 Fall National Meeting Minutes

Northrup made a motion, seconded by Kruger, to adopt the Working Group's Dec. 14, 2022, minutes (Attachment ?-A). The motion passed unanimously.

2. Discussed Parity Issues with Health Insurers

Weyhenmeyer said the same speakers from (AHIP) and the Blue Cross Blue Shield Association (BCBSA) who presented at the 2022 Fall National Meeting were available to respond to follow-up questions from the Working Group.

Meghan Stringer (AHIP) reviewed the results of a survey AHIP conducted with its members on mental health care. She said AHIP's board had made a statement of commitment to expanding access to telehealth services, integrating behavioral health care into primary care, and continuing to provide mental health care at parity. She said AHIP's members have worked to expand access to mental health providers. She said mental health provider networks have grown by 48% and that four out of five plans have increased payments to mental health providers.

Kate Berry (AHIP) described member plans' work on integration of behavioral health care into primary care. She said AHIP's board has identified eight priorities on mental health, including bringing mental health services into primary care. She said AHIP recognizes there are a range of models around collaborative care with a range of payment methods. She said behavioral health care often also should be integrated into specialty care, not just primary care. Berry said integration can expand the workforce, for instance by bringing in social workers in family practice. She said telehealth has been extremely impactful in mental health services, including by increasing access and reducing stigma. She said other considerations are making electronic health records available to mental health providers and adding to the evidence base around mental health services.

Anshu Choudhri (BCBSA) reviewed some of the points from his presentation at the 2022 Fall National Meeting. He said BCBSA plans have prioritized certain areas in behavioral health, including mitigating workforce challenges and trying to drive innovation. He said youth mental health, addressing workforce challenges, and health equity are also key priorities.

Stringer shared an issue brief AHIP published on integrating mental health care.

Weyhenmeyer asked about the increase in the number of mental health providers and whether telehealth providers are included in the cited increase. Stringer said some providers offer a hybrid of telehealth services as well as in person, so she would have to check with the research team to confirm how they are included.

Duhamel brought up pending legislation in New Mexico that AHIP has opposed. She said New Mexico has not seen an increase in mental health provider networks, including psychiatrists, psychologists, and mid-level providers. She said the state has seen drops rather than increases and asked what types of providers have been added. Stringer said AHIP has worked to find a compromise on the legislation. She said the change in the number of mental health providers included 20% growth in psychiatrists, 50% growth in licensed therapists, and more than 80% in psychiatric nurse practitioners. She said the numbers are national.

Amman asked whether plans have the capability to filter out providers who are limited to facilities only and not available for outpatient referrals. She said there has been an increase in network participation by facilities, which is a good thing, but it may hide the number of providers available for patients who are not admitted to facilities. Stringer said AHIP did look at facilities separately from the number of providers. She said provider directory information is only as good as the data offered by providers. She said plans ask providers for information, but it is a challenge when they do not respond. Jen Jones (BCBSA) said some plans have established navigator programs to help patients get connected to the right providers for their care.

Duhamel said providers struggle with prior authorization. She asked what metrics are used by plans to monitor their consumer assistance programs, such as call abandonment, wait times, and successful prior authorization. Berry said prior authorization is burdensome for everyone. She said plans review their prior authorization policies and processes often. She said they are relatively selective in how they use prior authorization, focusing on the most high-volume services where there is variation in how providers practice. Choudhri said metrics on customer service would vary by plan. He said prior authorization is a difficult program to set up in cost and difficulty of administration, so plans focus on variation from clinically accepted guidelines. He said patient safety also factors in to ensure the appropriate course of treatment. He said plans work to make prior authorization more seamless and more transparent in the process.

Duhamel asked what plans are doing to streamline communication between third-party behavioral health administrators and the plans. She said New Mexico has seen breakdowns in communication from these delegated entities and has taken corrective action when there are differences in what is required from the plan and the delegated entity. Choudhri said plans work closely with delegated entities, and the expectation is that they follow plans' policies. He said some plans have moved more services in-house because of these breakdowns in communications.

Stringer said plans track metrics differently, but one plan she interacted with tracks factors like time to appointment, how long to the next appointment, how many appointments a patient has, and ensuring treatment is toward a certain outcome. Duhamel said it is difficult to get such metrics from plans.

Bartuska asked about payment parity for behavioral telehealth. She said a lack of parity in payments could lead some providers to stop offering behavioral treatment. Stringer said it is important to ask whether providers have a brick-and-mortar practice or only provide telehealth services. She said AHIP did a rough calculation that showed payments for telehealth appear to be rising faster than payments for in-person services for certain psychotherapy codes. Bartuska questioned whether telehealth-only practices should be paid the same as those with physical offices. Berry said it can cut both ways; providers want to be paid the same, but many stakeholders want to contain costs. She said many are still evaluating the cost and quality impact of virtual care, so there is not yet a clear answer. Choudhri said the emphasis should be on payment equity rather than payment parity. He said payment

for telehealth services could be paired with additional payment for care coordination. He said there is also difficulty in defining the scope of services, so flexibility is more important than a mandate for parity.

Brulotte said New Mexico prohibits additional barriers for telehealth and requires parity in payment. Berry said telehealth providers should be incorporated into regular networks, which could expand access.

Weyhenmeyer asked how plans have handled concerns from providers about prepayment audits. Choudhri said it varies from plan to plan and that he could not share detailed information without consulting them. Stringer said there is not a substantive difference between audit practices for mental health services and medical or surgical services. She said not all claims that are concerning can be looked at, and audits affect only a small number of claims overall.

Weyhenmeyer asked what contracting strategies have increased the number of participating providers. Berry said plans are doing everything they can, including paying more and reducing administrative burden where possible. Choudhri said administrative burdens can be significant for some providers, and plans are looking at ways to reduce them. He said some plans are setting up referral clinics or connecting small clinics with support services so they can remain viable rather than merging with larger organizations. Jones said plans are working to leverage the networks they have so that primary care providers have the support they need to integrate care. She said this allows behavioral health specialists to be used more effectively. She added that some plans use analytics to identify providers who are underrepresented demographically in the network or identify out-of-network providers who are serving a significant share of members.

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

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Draft: 1/5/23

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Tampa, Florida
December 14, 2022

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Tampa, FL, Dec. 14, 2022. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jane Beyer, Vice Chair (WA); Erin Klug (AZ); Kate Harris (CO); Kurt Swan (CT); Howard Liebers (DC); Andria Seip (IA); LeAnn Crow and Julie Holmes (KS); Mary Kwei (MD); Peter Brickwedde and Paul Hanson (MN); Carrie Couch (MO); David Dachs (MT); Ted Hamby (NC); Rachel Kriege (ND); David Bettencourt (NH); Ralph Boeckman (NJ); Paige Duhamel (NM); Daniel Bradford and Laura Miller (OH); Ashley Scott (OK); Lindsie Swartz (PA); Gwendolyn McGriff (SC); Jill Kruger (SD); R. Michael Markham (TX); Tanji J. Northrup (UT); Julie Fairbanks (VA); Barbara Belling (WI); Erin K. Hunter (WV); and Tana Howard (WY). Also participating were: Chris Struk (FL); and Kevin Beagan (MA).

1. Heard Presentations on Parity Issues from Health Insurers

Anshu Choudhri (Blue Cross Blue Shield Association—BCBSA) spoke about health insurers' opportunities for improving behavioral health access and complying with MHPAEA. He said that insurers face provider shortages in building networks. Nonetheless, he provided examples of insurers in Michigan and North Carolina that have added behavioral health providers to their networks. He said efforts are particularly focused on youth mental health and health equity. He said patient-centered medical homes have been a method for integrating mental health services with primary care.

Choudhri said health insurers are taking steps to address workforce challenges. He said insurers are trying to get creative in contracting by using value-based contracts, changing reimbursement levels, and encouraging contracts with downside risk for providers. He said insurers are working to refine contracts and using vendors to build out networks, as well as adding new provider types, like social workers and counselors, to networks. He said plans are working to support existing providers and to encourage primary care providers to offer mental health treatments.

Choudhri offered suggestions for state and federal regulators to improve MHPAEA reviews. He observed that MHPAEA governs health insurers' processes, not outcomes. He said insurers want additional clarity, consistency, and help in understanding what they should provide to show they are doing the right thing. He requested additional examples of compliance and non-compliance and alignment of compliance practices across state and federal regulations. He said plans would benefit from having a full list of nonquantitative treatment limitations. He said plans are still working to comply with requirements under the federal Consolidated Appropriations Act, 2021, so the time is not right for additional requirements.

Meghan Stringer (AHIP) provided additional perspective from health insurers on improving mental health coverage and access. She said AHIP's board has adopted a set of mental health principles and advocacy priorities. She summarized the results of a survey AHIP conducted among health insurance providers on mental health. She said that mental health provider networks are growing and that reimbursements are rising, with the number of mental health providers increasing by nearly 50% on average over the last three years. She said all plans that responded to the survey offer tele-behavioral health services. She said most plans are training and supporting primary care providers in offering mental health services, assisting enrollees in finding mental health appointments, and using specialized care managers who follow up after emergency or inpatient care.

Stringer said that case management practices differ among insurers and that different regulators have taken different views on whether a particular practice is a non-quantitative treatment limitation. She said an annual list

of non-quantitative treatment limitations (NQTLs) would be helpful, either a full list or a list of all the NQTLs that regulators have requested information on in the prior year. She said this would promote common understanding and collection of the right data.

Stringer emphasized that parity does not require the same treatment limitations, only that the processes to decide the limitations be comparable and no more stringent than those for medical/surgical services. She said prior authorization practices vary by plan and that they consider different factors. She said MHPAEA includes some clear limitations and that plans have altered their requirements in response to the law, including by limiting prior authorization. She said that the process to determine reimbursement rates is governed by MHPAEA, not the rates themselves. She said insurers routinely review their payment rates to gauge compliance with MHPAEA, including measuring against other plans. She said payment audits occur when there is a coding discrepancy or when a service is provided without approval. She said records may be requested to determine if care is appropriate or to check medical management procedures. She said a small number of claims are audited and that plans do not have the capacity to audit every suspicious claim.

Stringer said progress has been made on mental health access, but more needs to be done. She said AHIP is committed to working with regulators and other stakeholders to improve mental health support.

Weyhenmeyer asked the speakers to define fraud, waste, and abuse. Choudhri said that fraud is willfully doing something fraudulent, waste is overusing services or deviating from best practices, and abuse is misrepresenting services. Stringer said it varies by plan, but one example is drug treatment programs that do not meet quality standards.

Brickwedde asked how plans have increased their number of mental health providers. Stringer said plans have focused on using telehealth and that some increase is due to rising payment rates. Brickwedde asked whether network adequacy standards should shift focus from time and distance to appointment wait times if care is shifting to telehealth. Choudhri said it would be interesting to revisit the standards so they are not as dependent on time and distance. Brickwedde and Harris asked how plans are tracking the data needed to measure enrollees' appointment wait times. The speakers said they would have to follow up at a later time.

Beyer asked whether providers in smaller practices have the capacity to participate in value-based payments. Choudhri said contracting models like value-based payments have greater participation from broader health systems rather than small providers. He said behavioral health providers often join when systems of care form, but quality measures for behavioral health are a challenge because they have not been developed.

Weyhenmeyer said releasing an exhaustive list of NQTLs would be difficult because there are many one-off issues that insurers include in their plans. Stringer said regulators should consider releasing a list of the NQTLs they discovered or looked at in the course of a year. Hanson noted that releasing a list could be considered rulemaking under some states' laws.

Having no further business, the MHPAEA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

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2023 Spring National Meeting
Louisville, Kentucky

PHARMACY BENEFIT MANAGER REGULATORY ISSUES (B) SUBGROUP

Wednesday, March 22, 2023

2:00 – 3:00 p.m.

Meeting Summary Report

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will meet March 22, 2023. During this meeting, the Subgroup plans to:

1. Adopt its 2022 Fall National Meeting minutes.
2. Hear an update on pharmacy benefit manager (PBM)-related federal legislative and regulatory activities.
3. Hear a legal update on PBM-related litigation.
4. Hear a discussion on recently enacted state laws regulating PBMs and their business practices.

Draft Pending Adoption

Attachment ?
Regulatory Framework (B) Task Force
3/22/23

Draft: 1/4/22

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup Tampa, Florida December 15, 2022

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met in Tampa, FL, Dec. 15, 2022. The following Subgroup members participated: TK Keen, Chair, Numi Rehfield-Griffith, Doug Hartz, Veronica Murray, and Ralph Magrish (OR); Laura Arp, Vice Chair (NE); Sarah Bailey (AK); Mark Fowler (AL); Crystal Phelps (AR); Paul Lombardo and Jared Kosky (CT); Howard Liebers (DC); Andria Seip (IA); Vicki Schmidt (KS); Daniel McIlwain, Rob Roberts, and Jonathan Abbott (KY); Chad Arnold and Joe Stoddard (MI); Norman Barrett Wiik (MN); Amy Hoyt and Carrie Couch (MO); David Dachs (MT); Robert Croom (NC); Ralph Boeckman and Erin Porter (NJ); Paige Duhamel (NM); Kelli Price (OK); Ana Paulina Gomez (PA); Scott McAnally (TN); Tanji J. Northrup (UT); Don Beatty and Stephen Hogge (VA); Ned Gaines and Molly Nollette (WA); Nathan Houdek, Rachel Cissne Carabell, and Jennifer Stegall (WI); Ellen Potter (WV); and Tana Howard (WY). Also participating were: Chris Struk (FL); Michelle B. Santos (GU); Chris Nicolopoulos (NH); and Cassie Brown (TX).

1. Adopted its Oct. 24 and Summer National Meeting Minutes

The Subgroup met Oct. 24 and Aug. 9. During these meetings, the Subgroup heard presentations from America's Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA), and the Pharmaceutical Care Management Association (PCMA) on issues from their perspective on the Subgroup's 2022 charge to develop a white paper to: 1) analyze and assess the role pharmacy benefit managers (PBMs), pharmacy services administrative organizations (PSAOs), and other supply chain entities play in the provision of prescription drug benefits; 2) identify, examine, and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements; rebating; and spread pricing, including the implications of the *Rutledge vs. PCMA* decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.

Beatty made a motion, seconded by Commissioner Houdek, to adopt the Subgroup's Oct. 24 (**Attachment ?-A**) and Aug. 9 (*see NAIC Proceedings – Summer 2022, Regulatory Framework (B) Task Force, Attachment Eight*), minutes. The motion passed unanimously.

2. Discussed its Work to Develop an Initial PBM White Paper Draft

Keen said the Subgroup just released a working draft of the PBM white paper. He said that the Subgroup's aim in developing the white paper was to have it focus on the current state of play as far as PBMs and PBM regulation and business practices are concerned, as well as not have it try to predict any future changes in such regulation or business practices. He said that over the next few months, the Subgroup plans to edit and refine the document before releasing an official draft for a 30-day public comment period, which includes adding language to the introduction and recommendation sections. Keen said the main purpose of this meeting is for the Subgroup to hear from the leaders of each of the white paper section drafting groups on their process for developing an initial draft of their section and its focus.

Gaines discussed Section B—Key Players in the Drug Pricing Ecosystem. He said Section B focuses on the main players in the prescription drug supply chain, including insurers, pharmaceutical manufacturers, PBMs, pharmacists, PSAOs and the interrelation of the parties in the chain and transaction costs. He said with respect to

the pharmaceutical manufacturers, Section B describes the various entities within this category—brand drug manufacturers, generic drug manufacturers, and biologic manufacturers. Gains said the subsection on pharmacies describes both chain pharmacies and independent pharmacies. He explained that there are a few subsections in Section B that the drafting group needs to write, but it plans to complete them soon and have NAIC staff incorporate them into the white paper draft the Subgroup will expose for public comment.

Rehfield-Griffith discussed Section C—Enforcement and Federal Preemption Issues. She said Section C examines the scope of federal preemption of state laws regulating PBMs under the federal Employee Retirement Income Security Act of 1974 (ERISA), Medicare Part D, and Medicaid, including the implications of recent court decisions and ongoing litigation, and implications for states considering enacting similar laws. She said the subsection on ERISA focuses mostly on the recent U.S. Supreme Court decision in *Rutledge* and how that decision provides some leeway for the states to regulate PBMs without being concerned about ERISA preemption, but states need to be careful in crafting such legislation because it is unclear how far the facts of *Rutledge* and the precedent of that case would extend to state laws that may not mirror the Arkansas law that was the subject of that case. Rehfield-Griffith said the Medicare Part D subsection discusses the *Mulready v. PCMA* case extensively and outlines the provisions in the Oklahoma law a federal district court found were preempted by ERISA. She said this subsection concludes that Medicare Part D preemption may remain an obstacle to state insurance regulation and that state insurance regulations are likely going to be preempted in areas where a standard has been directly articulated by the federal government, such as in the provisions related to Medicare Part D.

Rehfield-Griffith said the remaining subsection in Section C, which focuses on Medicaid, does not focus on any court cases because there is little case law or precedent in this area. She said the subsection describes how the Medicaid program is set up as a federal-state partnership, which differs in how both Medicare and ERISA are set up. Because of such a partnership, states have more leeway to regulate PBMs serving Medicaid carriers as long as those regulations do not conflict with the state's Medicaid structure and are consistent with the terms of a state's current Medicaid plan. She said this subsection concludes that unlike the potential for ERISA or Medicare Part D preemption, Medicaid preemption should not be a significant concern for states looking to regulate PBMs that service Medicaid managed care plans or other Medicaid health carriers. However, states should ensure that any changes in PBM regulation in the Medicaid space are consistent with the state's Medicaid plan or seek an appropriate plan amendment if they are not.

Stoddard discussed Section D, which examines PBM functional areas, including formulary design, rebates, pricing and contracting practices, vertical integration and consolidation, pharmacy network adequacy, and the licensing of the different entities involved in the prescription drug supply chain. He discussed the main points of each of these areas as written in the subsection. He explained that the pricing and contracting practices subsection does not include any language related to mandatory arbitration as had been contemplated in the white paper outline because no one in the section drafting group had any information on this. He said the section drafting group is open to including such language if anyone in the Subgroup has this information or could clarify what this means.

Abbott discussed Section E—State Laws that Operate in the Supply Chain. He said Section E discusses the role of PBMs in the prescription drug supply chain and state laws enacted regulating PBMs and PBM business practices because of this expanding and evolving role. He described the Section E drafting group's approach and research used in writing the section, including examining different state laws and recent updates to those laws. He noted that recently there has been a push on both the state and federal level to enact laws requiring PBMs to provide more transparency in their business practices, such as disclosure of prescription drug pricing, cost information related to rebates, payments and fees collected from pharmaceutical manufacturers, insurers, and pharmacies.

Draft Pending Adoption

Attachment ?
Regulatory Framework (B) Task Force
3/22/23

Jolie H. Matthews (NAIC) said she would be speaking on behalf of the leader of the Section F drafting group. She said Section F concerns federal interest in PBMs and PBM business practices. The section focuses on the Federal Trade Commission's (FTC's) recently announced study on PBMs. She said the Section F drafting group developed the language for Section F using information found through targeted online searches for articles on the subject. The Section F drafting group summarized the information found in the articles to include in Section F.

Price discussed Section G—Key Jurisprudence. She said Section G focuses on the three cases, to date, that have shaped state PBM laws and regulations—the *Rutledge* case, the *PCMA v. Wehbi* case, and the *Mulready* case. She explained that to some extent, Section G repeats some of the same information provided in Section C. Price discussed the details, arguments, findings, and key takeaways for each of the cases as detailed in Section G.

Arp reminded the Subgroup members and other stakeholders that the PBM white paper draft is just a draft, not an official draft the Subgroup is exposing for public comment. She said the purpose of providing the draft for this meeting is to let Subgroup members and other stakeholders know that the Subgroup is working diligently to complete its charge and the status of this work now before exposing an official draft for public comment. Keen asked for comments.

Carl Schmid (HIV+Hepatitis Policy Institute) expressed support for the Subgroup's work to date, particularly the work the Subgroup has been doing to hear from a wide range of stakeholders on issues related to the Subgroup's work to develop the PBM white paper. He said the NAIC consumer representatives look forward to providing comments on the draft white paper once the Subgroup exposes it for public comment. Schmid noted that the current working draft includes little information on the impact—good or bad—of PBMs and their business practices, such as mail-order service requirements or high cost-sharing requirements on certain prescription drugs for consumers. He reiterated that the NAIC consumer representatives stand ready to assist the Subgroup with addressing these initial concerns. Kris Hathaway (AHIP) also expressed support for the Subgroup's work to date related to the PBM white paper. She suggested, however, that the Subgroup expand the current working draft to incorporate and examine high prescription drug costs and issues related to such high costs. J.P. Wieske (Horizon Government Affairs) suggested that the Subgroup include a discussion in the white paper on the NAIC's previous work related to PBMs, such as the work done in revising the *Health Carrier Prescription Drug Benefit Management Model Act* (#22). Chris Petersen (Arbor Strategies LLC), speaking on behalf of the PCMA, said the PCMA shares some of the concerns of AHIP, particularly with the Subgroup potentially setting a 30-day public comment period for stakeholders to submit comments on the official PBM white paper draft. He suggested a longer public comment period, such as 60 days, would be more appropriate given the white paper's complexity.

3. Discussed Next Steps

Keen reiterated that the Subgroup plans to make additional edits to the PBM white paper working draft. Following this work, the Subgroup will release an official draft for a public comment period. Keen said he anticipates this will happen in January 2023. Noting that it is her last NAIC meeting, he also thanked Arp for her work as the Subgroup's vice chair.

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

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Draft: 11/9/22

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Virtual Meeting
October 24, 2022

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met Oct. 24, 2022. The following Subgroup members participated: TK Keen, Chair (OR); Laura Arp, Vice Chair (NE); Sarah Bailey (AK); Anthony L. Williams (AL); Beth Barrington (AR); Jessica Ryan (CA); Michael Shanahan and Kathy Belfi (CT); Howard Liebers (DC); Robert Koppin (IA); Craig VanAalst (KS); Sharon P. Clark and Daniel McIlwain (KY); Crystal Lewis (LA); Chad Arnold and Joe Stoddard (MI); Andrew Kleinendorst (MN); Amy Hoyt (MO); David Dachs (MT); Ted Hamby and Robert Croom (NC); Ralph Boeckman and Erin Porter (NJ); Paige Duhamel and Renee Blechner (NM); Kelli Price (OK); Michael Humphreys and Ana Paulina Gomez (PA); Katrina Rodon (SC); Michael Driver and Rhonda Bowling-Black (TN); Shelley Wiseman (UT); Julie Blauvelt (VA); Jennifer Kreitler (WA); Nathan Houdek and Jennifer Stegall (WI); Joylynn Fix (WV); and Bryce Hamilton (WY).

1. Heard a Presentation from AHIP

Kris Hathaway (America's Health Insurance Plans—AHIP) and Sergio Santiviago (AHIP) discussed the role of health insurance providers in keeping prescription drugs affordable. She focused her remarks on prescription drug costs. She explained how prescription drug prices and spending have increased over the years, growing at a rate that AHIP believes is unsustainable. She said an AHIP study found that in 2020, seven of the top 10 largest pharmaceutical companies spent more on marketing than on developing new drugs. She highlighted a 2020 Institute for Clinical and Economic Review (ICER) report, which was updated in 2022, that identified the top 10 drugs causing the greatest increase in drug spending and reviewed them for clinical evidence to justify the increases. She discussed five drugs the ICER reviewed that found no clinical reason for the drug price increase. She said prescription drug costs have decreased overall, but even small net price increases have large impacts on prescription drug spending nationally. She also noted the high costs of new drugs entering the market. She said anecdotally, it seems that recently enacted state prescription drug price transparency laws seem to be having some impact on prescription drug price increases.

Santiviago discussed the value of pharmacy benefit managers (PBMs) to health insurance providers in helping to contain costs. He said health insurance providers use PBMs to help contain costs by: 1) utilizing contract models with administrative fee payment structures and spread pricing; 2) using medication and drug management programs, such as PBM pharmacy and therapeutics (P&T) committees; and 3) developing pharmacy networks that include mail order pharmacy options and specialty pharmacies. He discussed how some of these cost containment tools, such as spread pricing and rebating, work to reduce costs and can reduce premiums in some cases. He also discussed the role of P&T committees in the development of formulary designs to help enrollees obtain safe and effective medications at the best value.

Santiviago discussed how these cost-saving tools are under attack from certain programs, such as drug manufacturer copay coupons. He also discussed how drug manufacturer rebates are not driving higher prescription drug price increases and how rebates benefit all consumers.

The AHIP presentation also included recommendations to the Subgroup related to the development of the white paper on PBM business practices. Those recommendations included suggesting that any policies included in the white paper consider both the individual consumer perspective and the overall cost to all people in the risk pool and health care system. AHIP also recommends the inclusion of all stakeholders in the process and that the white paper provide all perspectives on issues equally because each drug issue has multiple perspectives.

2. Heard a Presentation from the BCBSA

Randi Chapman (Blue Cross Blue Shield Association—BCBSA) focused her remarks on the roles of the various entities in the prescription drug supply chain, the BCBSA's policy positions related to prescription drug pricing and prescription drug financial assistance programs, and Blues plan initiatives to provide pharmacy benefits and member access to prescription drugs and affordable medications.

Chapman said the BCBSA agrees with state insurance regulators and many of the stakeholders who have presented to the Subgroup on the need to curb the high cost of prescription drugs. The BCBSA knows that each entity in the prescription drug supply chain, including payers, pharmacies, PBMs, and pharmacy services administrative organizations (PSAOs), play a role and share the responsibility of ensuring that consumers have access to the most effective and affordable medication. Chapman said given this, the BCBSA supports the Subgroup's direction to expand the white paper's scope to include an analysis and assessment of the roles of each supply chain player.

Chapman said the BCBSA supports state departments of insurance (DOIs) having oversight of PBMs rather than state boards of pharmacy or other provider-type state boards. She said the BCBSA also supports state prescription drug transparency laws, and it hopes the white paper includes a robust discussion of such transparency measures.

Chapman said because AHIP has already provided a thorough explanation of prescription drug costs, she would not discuss that issue in any detail. However, she noted that prescription drug manufacturers set the price of prescription drugs and administer patient assistance programs. She said in 2021, prescription drug manufacturers raised prices on 822 brand name drugs by an average of 4.6%. She said a Kaiser Family Foundation (KFF) analysis completed earlier this year showed that between July 2019 and July 2020, half of all Medicare Part D covered drugs and nearly half of the Medicare Part B covered drugs had price increases greater than inflation. She said another study found that 60% of adults between the ages of 18 and 64 recorded being prescribed at least one medication in the previous year, but 29% of them said they were not taking prescribed medication due to cost. She said stories like this one, and many others, show how the consistent rise in prescription drugs has a real and tangible impact on enrollees.

Chapman said because of this, the BCBSA supports improved prescription drug manufacturer price transparency, particularly in patient assistance programs offered by prescription drug manufacturers. She said in addition, the Blues plans and the BCBSA actively support transparency in their practices and are fully compliant with state and federal reporting requirements for claims and discounts. She said as AHIP alluded to, patient assistance programs help individual patients, but in effect, these programs hide the real costs of the drug and can prevent the utilization of generic drugs and spread costs across the system, which ultimately leads to higher premiums and higher costs overall.

Chapman said the Blues plans are looking at and initiating innovative solutions to support community-based approaches to ensure access to affordable medications. She provided examples of these approaches, such as prescription drug transparency with real-time cost information to providers and patients and outcomes-based agreements. She said overall, these approaches are trying to support their members' ability to make educated and informed choices with their providers about the prescription drugs they use and promote the affordability of those medications. She said the BCBSA believes prescription drug price transparency and quality information empowers consumers and ultimately drives larger changes in the prescription drug marketplace.

Chapman discussed the role PBMs play in the prescription drug supply chain, including the tools PBMs use to encourage patients, working with their physicians to select the safest and most effective drugs at the lowest possible price. She also discussed the BCBSA's position related to pharmacies and PSAOs. She said the BCBSA

believes specific types of pharmacy providers should not have financial advantages through mandated contract terms between pharmacies and PBMs or mandated coverage of drugs at acquisition cost. She also said the BCBSA believes further study is necessary to understand how PSAOs affect the prescription drug supply chain and what state actions are needed to lower prescription drug costs, and it urges the Subgroup to do this research when developing the white paper.

Allan Coukell (Civica) discussed how Civica is working with the BCBSA and several Blues plans to bring lower-priced generics to market. He said Civica entered into a partnership in 2020 with the BCBSA to create a new, nonprofit subsidiary, named CivicaScript, dedicated to lowering the cost of select, outpatient generic drugs. He said CivicaScript will develop and manufacture six to 10 common, but high-priced general prescription drug medicines, for which there is not enough market competition to drive down prices. He said Civica has about 10 prescription drug products in development; two of those drugs are expected to be marketed later this year.

Coukell focused his remarks on Civica's work related to generic insulin in both pen and vial form. He said in March 2022, the BCBSA and 12 Blue Cross Blue Shield (BCBS) companies announced a partnership with Civica to increase access to affordable insulin. He said Civica will produce three insulins and biologics corresponding to and interchangeable with brand name insulin. He said the cost of these generics to consumers will be no more than \$30 per vial or \$55 for a box of five pens starting in 2024.

Keen asked if the BCBSA owns Civica. Coukell said Civica is a standalone nonprofit organization. There are no equity owners. Coukell said CivicaScript is also a nonprofit organization, which was capitalized by health plans and other founding members. He said these founding members sit on the board, which also includes a PBM representative, but it is really a mission-driven organization. Keen asked about any hurdles to setting up such nonprofit organizations. Coukell said one major hurdle is obtaining tax-exempt status from the Internal Revenue Service (IRS) as a nonprofit prescription drug manufacturer due to the so-called "commerciality doctrine."

Acting Commissioner Humphreys said the Pennsylvania Capital Blue Cross announced plans to collaborate with the Mark Cuban Cost Plus Drug Company to help bring high-quality, low-cost prescriptions to its members. He asked Chapman if the BCBSA knows of any other companies contemplating such action. She said she would have to reach out to her colleagues to provide an answer, but she said she would be happy to follow up with him later. Santiviago said he believes initiatives and collaborations like Civica and the Mark Cuban Cost Plus Drug Company are a good thing because they bring more competition and supply, which can ultimately drive down prescription drug costs.

4. Heard a Presentation from the PCMA

Casey Mulligan (University of Chicago), presenting on behalf of the Pharmaceutical Care Management Association (PCMA), discussed key findings from his research related to the value of PBMs. He said a managed plan is more valuable than an unmanaged plan. A managed plan provides plan member benefits and net external benefits. He said his research shows that an estimated \$145 billion per year in net value is added by PBM prescription drug plan management. He explained how he arrived at this figure, including how part of this net value is achieved by better drug utilization and inducing providers, such as prescription drug manufacturers and pharmacies, to compete more vigorously. He also explained how prescription drug benefit management reduces drug prices while rewarding drug innovation.

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

Agenda Item #3

Hear an Update on the Center on Health Insurance Reforms' (CHIR's) Work
—*Maanasa Kona (CHIR, Georgetown University Health Policy Institute)*

Update on Georgetown CHIR's Recent and Forthcoming Work

National Association of Insurance Commissioners
Regulatory Framework (B) Task Force
March 22, 2023

Maanasa Kona, J.D.
Assistant Research Professor

Georgetown University Center on Health Insurance Reforms (CHIR)

Nationally recognized team of private insurance experts

- Part of McCourt School of Public Policy
- Legal & policy analysis
 - Federal and state regulation
 - Market trends
- Published reports, studies, blog posts
- Technical assistance

PHE Unwinding

- Secrets to a Successful Unwinding: Actions State-Based Marketplaces and Insurance Departments Can Take to Improve Coverage Transitions
- Continuity of Care - Maintaining Access to Services After Transitioning from Medicaid
- Bridging the Gap: Oregon's Proposal to Ease Coverage Transitions at the End of Public Health Emergency

Enrollment

- State-Based Marketplace Outreach Strategies for Boosting Health Plan Enrollment of the Uninsured
- Implementing the Family Glitch Fix on the Affordable Care Act's Marketplaces

Public Option Plans

- States Move Forward with Public Option Programs, but Differ in How They Select Insurance Carriers
- A Progress Report on Washington's Public Option Plans
- Nevada Actuarial Study Projects Significant Savings from Public Option Plans
- Upcoming: Continuing to monitor state implementation efforts and new state public option legislation

Improving Coverage

- The ACA's **Preventive Services** Benefit Is in Jeopardy: What Can States Do to Preserve Access?
- State **Telemedicine** Coverage Requirements Continue to Evolve
- A Review of State Efforts to Enforce **Mental Health Parity**: Lessons for Policymakers and Regulators
- **COVID Long Haulers** Still Struggle with Coverage and Care

Health Equity

- Continued monitoring and analysis of state action
- State Efforts to Reduce Diabetes Disparities Through Private Health Insurance Reforms
- Value for Whom? - Impact of Payers' Value Assessments on Health Equity
- Upcoming: Surveying State-Based Marketplaces' Language Access Policies and Practices

Implementation of the No Surprises Act

- NSA enforcement map
- How states are working with the federal government to implement the NSA
- Upcoming Publications:
 - Implementation of prohibitions against balance billing
 - Recent state action in response to NSA
 - Discussion of Federal IDR report

Cost Containment - ESI

- Four-Part Series Exploring ESI and Cost Containment Policy Options
- New project exploring the role ERISA plays in cost containment
 - ERISA 101: The United States' Hands-Off Approach to Regulating Employer Health Plans
 - Upcoming: Deeper dives into ERISA's fiduciary duties

Cost Containment - Facility Fees

- New investigation: Outpatient Facility Fees
 - Key concerns/justifications
 - Consumer vs. plan exposure
 - Data issues
 - State responses, expected impacts, and political barriers
- Report and recommendations to follow later this year

Other Reading

- Policy Options to Improve Access to Primary Care for Underserved Populations
- Upcoming: State Protections Against Medical Debt

Questions?

CHIR Publications:

www.chir.georgetown.edu

CHIRblog:

www.chirblog.org

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Agenda Item #4

Discuss Any Other Matters Brought Before the Task Force
—*Commissioner Sharon P. Clark (KY)*