Revised: 11/4/24

2024 Fall National Meeting
Denver, Colorado

REGULATORY FRAMEWORK (B) TASK FORCE
Sunday, November 17, 2024
11:30 a.m. – 12:30 p.m.
Gaylord Rockies Hotel—Aurora Ballroom C/D—Level 2

ROLL CALL

Glen Mulready, Chair	Oklahoma	Chlora Lindley-Myers	Missouri
Ann Gillespie, Vice Chair	Illinois	Eric Dunning	Nebraska
Mark Fowler	Alabama	Scott Kipper	Nevada
Lori K. Wing-Heier	Alaska	D. J. Bettencourt	New Hampshire
Peni Itula Sapini Teo	American Samoa	Justin Zimmerman	New Jersey
Ricardo Lara	California	Mike Causey	North Carolina
Michael Conway	Colorado	Jon Godfread	North Dakota
Andrew N. Mais	Connecticut	Judith L. French	Ohio
Karima M. Woods	District of Columbia	Andrew R. Stolfi	Oregon
Dean L. Cameron	Idaho	Michael Humphreys	Pennsylvania
Holly W. Lambert	Indiana	Larry D. Deiter	South Dakota
Doug Ommen	Iowa	Cassie Brown	Texas
Vicki Schmidt	Kansas	Jon Pike	Utah
Sharon P. Clark	Kentucky	Scott A. White	Virginia
Robert L. Carey	Maine	Mike Kreidler	Washington
Michael T. Caljouw	Massachusetts	Allan L. McVey	West Virginia
Grace Arnold	Minnesota	Nathan Houdek	Wisconsin

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

AGENDA

1. Consider Adoption of its Nov. 4 and Summer National Meeting Minutes —*Commissioner Glen Mulready (OK)* — 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—*TBD*

D. Pharmaceutical Benefit Management Regulatory Issues (B) Working Group—*Joylynn Fix (WV)*

3. Hear an Overview of Pharmacy Benefit Management (PBM) Transparency Initiatives—*Rob Nolan (AffirmedRX)*

4. Discuss Issues Related to the Implementation of the Federal Affordable Care Act's (ACA's) Section 1557 Final Regulation
—*Amy Killelea (Killelea Consulting LLC), Jalisa Clark (Georgetown University Law Center on Health Insurance Reforms [CHIR]),* and *Meghan Stringer (America's Health Insurance Plans [AHIP])*

5. Discuss Any Other Matters Brought Before the Task Force
—*Commissioner Glen Mulready (OK)*

6. Adjournment

Agenda Item #1

Consider Adoption of its Nov. 4 and Summer National Meeting Minutes
—Commissioner Glen Mulready (OK)

Draft: 11/7/24

Regulatory Framework (B) Task Force
Virtual Meeting
November 4, 2024

The Regulatory Framework (B) Task Force met Nov. 4, 2024. The following Task Force members participated: Glen Mulready, Chair (OK); Ann Gillespie, Vice Chair (IL); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Anthony Williams and Yada Horace (AL); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Debra Judy (CO); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented by Howard Liebers (DC); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler and Shannon Hohl (ID); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Angi Raley (KY); Michael T. Caljouw represented by Kevin Beagan (MA); Robert L. Carey represented by Robert Wake (ME); Chlora Lyndley-Myers (MO); Mike Causey represented by Ted Hamby and Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); D.J. Bettencourt represented by Michelle Heaton (NH); Justin Zimmerman represented by David Wolf (NJ); Scott Kipper represented by Jeremy Christensen (NV); Judith L. French represented by Laura Miller (OH); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Rachel Bowden and Debra Diaz-Lara (TX); Jon Pike represented by Shelley Wiseman and Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Ned Gaines (WA); Nathan Houdek (WI); and Allan L. McVey (WV). Also participating was: Andy Schallhorn (OK).

1. Adopted the Revisions to Model #171

Commissioner Mulready said the Task Force's first item of business is to consider adoption of the proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). He explained that in 2013, the former Affordable Care Act Model (ACA) Review (B) Working Group identified Model #171 and its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), as needing to be revised because of the federal Affordable Care Act (ACA). After completing revisions to other NAIC models with a higher priority, in 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup to revise Model #170 and Model #171. The Subgroup completed its work on Model #170 in late 2018. The full NAIC membership adopted those revisions in February 2019.

Commissioner Mulready said the Model #170 revisions removed provisions for certain types of health insurance products that would not be permitted because of the requirements of the ACA leaving only those products considered to be excepted benefits and, therefore, not subject to the ACA's requirements. He said the Subgroup also added short-term, limited-duration (STLD) plans to the model because there was no other vehicle available in which to incorporate such plans, and the Subgroup did not want to create a new model for them. Commissioner Mulready said the proposed revisions to Model #171 revise the model for consistency with Model #170. The revisions also add standards for STLD plans and clarify provisions on consumer disclosure and outline of coverage requirements. He said the Subgroup adopted the revisions on Oct. 17.

Commissioner Humphreys said the NAIC consumer representatives submitted a comment letter to the Task Force just prior to the start of the meeting suggesting that they could not support the proposed revisions due to a provision in Model #171 that allows carriers to exclude coverage for "mental or emotional disorders, alcoholism, and drug addiction" and "suicide (sane or insane), attempted suicide, or intentionally self-inflected injury." He expressed concern about the provision and given this concern, he said he could not support the proposed revisions. Commissioner Humphreys suggested that the Task Force and the Health Insurance and Managed Care

(B) Committee should discuss the issue, particularly as to mental health coverage, more broadly. He said a lot has changed with respect to mental health coverage since the ACA was enacted and since the time the Subgroup began discussing the Model #171 revisions. Commissioner McVey expressed support for having a broader conversation of the issue. He also said he would vote to adopt the proposed revisions to move the model forward to the Health Insurance and Managed Care (B) Committee to hold those discussions.

Commissioner Humphreys asked if the Subgroup discussed the NAIC consumer representatives' concerns. Commissioner Mulready said the Subgroup had an extensive discussion on this provision. He also reiterated that Model #171 sets minimum standards, which means states can go further. Schallhorn, as co-chair of the Subgroup, agreed with Commissioner Mulready's comments.

Chris Petersen (Arbor Strategies LLC) noted that when the Subgroup discussed the provision, it was pointed out that the federal Mental Health Parity and Addiction Equity Act (MHPAEA) does not apply to excepted benefits coverage. He said there was also a concern expressed that mandating such coverage would require reopening Model #170. Petersen expressed support for moving the model forward for the Health Insurance and Managed Care (B) Committee's consideration and, if the Task Force decides it is appropriate, discussing the issue the NAIC consumer representatives' issue independently.

Jackson Williams (Dialysis Patient Citizens—DPC) said the proposed revisions to Model #171 represent a missed opportunity to bring greater value to consumers on products notorious for being of low value. He expressed disappointment that the Subgroup did not consider his proposals to address the issue.

J.P. Wieske (Horizon Government Affairs) said it is important to keep in mind that the products regulated under Model #170 and Model #171 are medically underwritten. As such, mandating mental health coverage could have the unintended consequence of limiting product availability. He also said Model #170 would have to be reopened.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) restated the NAIC consumer representatives' comments included in its letter, including that the provision in Model #171 allowing a permitted exclusion for mental health coverage is not only out-of-step with advances in the mental health field, but also it is at odds with the NAIC's commitment to mental health parity and meaningful response to the opioid crisis. She also said that the landscape regarding mental health coverage has changed even since last year given the recently issued federal final rules implementing the ACA's Section 1557 nondiscrimination provisions. Culp said the NAIC consumer representatives believe the issue is not settled and that there needs to be further discussion. She asked about the process for reopening Model #170. Jolie H. Matthews (NAIC) said the Health Insurance and Managed Care (B) Committee would have to approve a Request for NAIC Model Law Development to reopen Model #170. She highlighted a few of the requirements necessary for such approval. Culp said the NAIC consumer representatives disagree with the comments suggesting that Model #170 would need to be reopened.

Deborah Steinberg (Legal Action Center—LAC) said that at the time the Subgroup discussed this issue, as other NAIC consumer representatives have stated, there were no mental health and substance use disorder experts included in the discussion. She said that as a mental health and substance use disorder expert, she would appreciate the opportunity to speak on the issue and include others with similar expertise as part of the discussion given the importance of recognizing these as health conditions. Amy Killelea (Killelea Consulting LLC) expressed support for Culp's and Steinberg's comments. She also said that as stated in the NAIC consumer representatives' comment letter, because the ACA's Section 1557 nondiscrimination protections apply to any excepted benefit products that receive federal assistance, directly or through a parent company, the permitted exclusion provision for mental health coverage in Model #171 is also likely illegal under federal law for a subset of these products. She urged the Task Force to take a closer look at the potential impact of the ACA's Section 1557 nondiscrimination provisions on the proposed revisions.

William Schiffbauer (Schiffbauer Law Office) said that adding mental health benefits to excepted benefit products could make them look more like comprehensive major medical coverage, which is what the Subgroup has been trying to avoid throughout the drafting process. He also acknowledged that the ACA's Section 1557 discrimination provisions apply to products that receive federal funds, but he said the excepted benefit products regulated under Model #170 and Model #171 do not receive federal funds. Wieske noted that if the permitted exclusion for mental or emotional disorders, alcoholism, and drug addiction was removed from Model #171, that would not result in coverage for those conditions. He said Model #170 would have to be revised to require coverage.

Commissioner McVey made a motion, seconded by Heaton, to adopt the revisions to Model #171 (Attachment ?-A). The motion passed with the following states present and voting in favor of the motion: Alaska, Connecticut, Idaho, Iowa, Kansas, Kentucky, Maine, Massachusetts, Missouri, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin. The following states voted against the motion: Colorado and Pennsylvania. The following states abstained: Indiana and Ohio.

2. Adopted its 2025 Proposed Charges

Commissioner Mulready said that prior to this meeting, NAIC staff distributed the Task Force's 2025 proposed charges for comment with a public comment period ending Oct. 24. The Task Force received one comment from Virginia suggesting that the Task Force add "excepted benefit products" to charge #1F. He said that in addition to this change, the other substantive change from the 2024 charges is the deletion of the charge for the Accident and Sickness Insurance Minimum Standards (B) Subgroup because it has completed its charge.

Gaines made a motion, seconded by Commissioner McVey, to adopt the Task Force's 2025 proposed charges (Attachment ?-B). The motion passed unanimously.

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

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Draft Pending Adoption

Draft: 8/19/24

Regulatory Framework (B) Task Force
Chicago, Illinois
August 13, 2024

The Regulatory Framework (B) Task Force met in Chicago, IL, Aug. 13, 2024. The following Task Force members participated: Glen Mulready, Chair (OK); Ann Gillespie, Vice Chair, represented by Erica Weyhenmeyer (IL); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by John Buono (AL); Michael Conway represented by Kate Harris and Debra Judy (CO); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented by Howard Liebers (DC); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Shaun Orme (KY); Robert L. Carey represented by Robert Wake and Marti Hooper (ME); Chlora Lyndley-Myers represented by Amy Hoyt (MO); Mike Causey represented by John Hoomani (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson and Maggie Reinert (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Judith L. French represented by Laura Miller (OH); Michael Humphreys represented by Shannen Logue (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by R. Michael Markham, Debra Diaz-Lara, and Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup, Ryan Jubber, and Shelley Wiseman (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Ned Gaines (WA); Nathan Houdek represented by Rebecca Rebholz and Jennifer Stegall (WI); and Allan L. McVey represented by Joylynn Fix (WV). Also participating was: Patrick Smock (RI).

1. Adopted its July 1 and Spring National Meeting Minutes

The Task Force met July 1 and adopted by e-vote its 2024 revised charges, which amend the 2024 charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup.

Swanson made a motion, seconded by VanAalst, to adopt the Task Force's July 1 (Attachment One) and March 16 (*see NAIC Proceedings – Spring 2024, Regulatory Framework (B) Task Force*) minutes. The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

Gaines made a motion, seconded by Logue, to adopt the following reports: 1) the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its July 29 (Attachment Two), July 15 (Attachment Three), June 24 (Attachment Four), April 22 (Attachment Five), April 8 (Attachment Six), and March 25 (Attachment Seven) minutes; 2) the Employee Retirement Income Security Act (ERISA) (B) Working Group; 3) the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its March 17 (Attachment Eight) minutes; and 4) the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its June 7 (Attachment Nine) and May 2 (Attachment Ten) minutes. The motion passed unanimously.

3. Heard a Presentation from CHIR on Facility Fees

Rachel Swindle (Center on Health Insurance Reforms—CHIR) discussed outpatient facility fee billing reforms and options for the states to address the issue. She explained that facility fees are a second fee that hospitals charge in addition to the health care professional's bill. She said that entities charging such fees assert that the fees are to cover hospital overhead costs. Swindle described the issues involved in charging facility fees, such as consumer out-of-pocket cost exposure and the lack of transparency in billing and ownership. She also discussed potential

solutions, including: 1) site-neutral payment; 2) billing transparency; 3) public reporting; and 4) consumer notification requirements.

Swindle provided an overview of state outpatient facility fee reforms, explaining that some states, such as Colorado, Connecticut, Maryland, and Washington, have implemented multiple strategies to address the issue. She highlighted a few of those state reforms: 1) facility fee prohibitions; 2) requiring billing transparency; and 3) public oversight. Swindle also identified states that have implemented certain outpatient facility fee reforms. She discussed additional CHIR resources and publications that have been developed on outpatient facility fees.

4. Discussed *Loper Bright* and Potential Implications on Health Insurance-Related Regulations

William G. Schiffbauer (Schiffbauer Law Office) provided an overview of *Loper Bright Enterprises v. Raimondo* and *Relentless v. Department of Commerce* (collectively referred to as *Loper Bright*) rulings, which overturned the so-called "Chevron Doctrine." He also discussed its potential implications on federal health insurance-related regulations.

Schiffbauer explained that the Chevron Doctrine stems from a ruling in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.* (*Chevron*), which required federal courts to defer to a federal agency's reasonable interpretation where statutory text is ambiguous or silent. He said the case involved a challenge to a federal agency rule under the federal Administrative Procedure Act (APA). In its ruling, the court established a two-step analysis for federal courts to follow when conducting judicial reviews of such challenges. Schiffbauer said the Chevron Doctrine adopted a presumption of an implied delegation of interpretative authority to a federal agency without reference to any provision in the APA.

Schiffbauer explained how the *Loper Bright* ruling overturned the Chevron Doctrine and its two-step analysis. He said that in overturning the Chevron Doctrine, the majority opinion stated that *Chevron* defies the command of the APA that the reviewing court, not the agency whose action it reviews, is to decide all relevant questions of law and statutory interpretation. *Chevron* requires a court to ignore, not follow, the reading the court would have reached had it exercised its independent judgment, as required by the APA.

Schiffbauer highlighted several health insurance-related regulations, including the federal Affordable Care Act's (ACA's) Section 1557 federal regulations, the ACA's cost-sharing and deductible regulations, and Medicare hospital payment rules that could be affected by the overturning of the Chevron Doctrine. He suggested that moving forward, federal agency rules upheld in prior court decisions using *Chevron* may still be challenged under the APA and de novo review by a federal court. He noted that the Supreme Court of the U.S. has already vacated several appellate court *Chevron* decisions pending review and remanded them for further consideration under *Loper Bright*. Schiffbauer suggested that state agencies might examine judicial review provisions and deference case law under their state administrative procedure acts and consider the lessons of *Loper Bright*.

5. Heard a Presentation from BPC and AHIP on the New Collaborative Multi-Stakeholder Initiative PHtP

Anand Parekh (Bipartisan Policy Center—BPC) and Kate Berry (America's Health Insurance Plans—AHIP) discussed Promoting Health Through Prevention (PHtP), a new collaborative multi-stakeholder initiative. Parekh explained that AHIP and a coalition of preeminent public and private health organizations launched PHtP to encourage people to get the recommended preventive services available with no out-of-pocket cost under the ACA because preventive services save lives. He discussed the current uptake for certain preventive services and how there is room for improvement. The lack of patient education is a major factor contributing to the low uptake of preventive services, and PHtP aims to address this issue. Parekh described how participants in the PHtP initiative are using multiple communication approaches to raise awareness about the importance of preventive services.

Berry discussed the health organizations participating in the PHtP initiative. She described the PHtP's ongoing actions, including: 1) expanding participation; 2) identifying strategies/timing for additional communications; 3) conducting targeted outreach for different populations and/or types of screenings; and 4) exploring fundraising to support broader advertising and outreach. She also highlighted opportunities for the states and related stakeholder engagement by promoting the MyHealthfinder tool and leveraging existing social media tools.

Commissioner Mulready asked where to find the MyHealthfinder tool, which Berry explained can be accessed at *https://health.gov/myhealthfinder*. Commissioner Mulready noted that PHtP released a press release announcing the new initiative. He asked about other ways state insurance regulators and other stakeholders could promote the initiative. Berry said the PHtP has social media messages and other white-label media she would be happy to share.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2024 Summer Meeting/RFTF 8-13-24 MtgMin.docx

Agenda Item #2

Consider Adoption of its Subgroup and Working Group Reports
—Commissioner Glen Mulready (OK)

- *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 —TBD*
- *Pharmaceutical Benefit Management Regulatory Issues (B) Working Group—Joylynn Fix (WV)*

Virtual Meetings

ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS (B) SUBGROUP
October 17, 2024 / September 9, 2024

Summary Report

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Oct. 17 and Sept. 9, 2024. During these meetings, the Subgroup:

1. Discussed the comments received on the May 5 and Sept. 24 drafts of proposed revisions to Section 9—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

2. Adopted the proposed revisions to Model #171.

Draft: 10/28/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
Oct. 17, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Oct. 17, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Christina Jackson (FL); Amy Hoyt and Camille Anderson-Weddle (MO); Martin Swanson (NE); Heidi Clausen (UT); Christine Menard-O'Neil and Jamie Gile (VT); and Ned Gaines (WA).

1. Adopted Revisions to Model #171

The Subgroup continued its discussion of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). Jolie H. Matthews (NAIC) said Brenda J. Cude (NAIC consumer representative) submitted additional comments suggesting more revisions to Section 9—Required Disclosure Provisions. She said most were clarifying, non-substantive suggested revisions; however, one suggested revision is more substantive. Cude suggested that for consistency with other provisions in Section 9, language should be added to Section 9I and Section 9J to outline coverage provisions for limited scope dental coverage and limited scope vision coverage, respectively. The Subgroup reviewed NAIC staff's suggested language to address Cude's comments (Attachment ?-A). After discussion, the Subgroup accepted the suggested language. The Subgroup also accepted Cude's clarifying, non-substantive suggested revisions.

Swanson made a motion, seconded by Gaines, to adopt the proposed revisions to Model #171 (Attachment ?-B). The motion passed unanimously.

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

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Draft: 9/27/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
Sept. 9, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Sept. 9, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Amy Hoyt and Camille Anderson-Weddle (MO); Eric Dunning (NE); Heidi Clausen (UT); and Anna Van Fleet and Jamie Gile (VT).

1. Discussed Additional Comments Received on Draft Revisions to Model #171

The Subgroup continued its discussion of the comments submitted by Robert Wake (ME) and Brend Cude (NAIC Consumer Representative) on the May 3 draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) (*see NAIC Proceedings – Summer 2024, Regulatory Framework (B) Task Force, Attachment Four-A*), beginning with Section 9A(4)—Required Disclosure Provisions for other fixed indemnity coverage. Cude suggests for Section 9A(4) through Section 9A(12) deleting drafting notes requiring specific phrases and sentences be made prominent in the disclosures and adding that language to the substantive provisions. The Subgroup accepted those suggested revisions.

The Subgroup discussed and accepted Wake's non-substantive, clarifying suggested revisions to Section 9A(16) and Section 9A(17). The Subgroup discussed and accepted Wake's suggestion to delete the last sentence in both Section 9A(18) and Section 9A(19) because it duplicates requirements outlined in Section 9A(2). The Subgroup discussed and accepted Wake's suggested non-substantive, clarifying suggested revisions to Section 9A(20). Consistent with its decisions for Section 9A(4) through Section 9A(12), the Subgroup also accepted Cude's suggested revisions to Section 9A(21) to delete the drafting note and move the language in the drafting note to the substantive provision.

The Subgroup next discussed Section 9A(22), which requires insurers to provide a Buyer's Guide approved by the commissioner to individuals applying for specified disease insurance. In her comments, Cude questions whether such a guide exists. After discussion, the Subgroup asked NAIC staff to add a drafting note to Section 9A(22) stating that the Section 9A(22) only applies if the state has such a guide.

The Subgroup next discussed Section 9B(1)—Outline of Coverage Requirements. In her comments, Cude questioned whether the language in Section 9B(1) requiring an insurer to deliver an outline of coverage to an applicant prior to sale was accurate given the requirements of Section 6B and Section 6C of the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170). After discussion, the Subgroup agreed to delete the words "prior to sale" in Section 9B(1) to resolve the issue.

The Subgroup next discussed Wake's and Cude's non-substantive, clarifying suggested revisions on Section 9C through Section 9J. These provisions outline the requirements for the outline of coverage for the types of coverages regulated under the revised Model #171. The Subgroup accepted all the suggested revisions. The Subgroup also agreed to add a drafting note to Section 9F—Specified Disease or Specified Accident Coverage (Outline of Coverage) suggesting that states review their regulations to determine if they have the Buyer's Guide to Specified Disease Insurance referenced in Section 9F(1) before requiring insurers to provide the guide to consumers for them to read.

The Subgroup next discussed Wake's non-substantive, clarifying suggested revisions to Section 10—Requirements for Replacement of Individual Supplementary and Short-Term Health Insurance Coverage. After discussion, the Subgroup accepted the suggested revisions.

Jolie H. Matthews (NAIC) said the Subgroup has discussed all the Wake and Cude comments on the proposed revisions to Model #171 and no additional comments have been received. She said she will distribute a final draft of the proposed revisions to Model #171 reflecting the Subgroup's discussions to date for the Subgroup to consider adoption during a meeting sometime in October.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/Accident and Sickness Subgrp/Accident and Sickness Ins Min Stds Subgrp 9-9-24 MtgMin.docx

2024 Fall National Meeting
Denver, Colorado

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) (B) WORKING GROUP
Monday, November 18, 2024
11:30 a.m. – 12:15 p.m.

Meeting Summary Report

The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group will meet Nov. 18, 2024. During this meeting, the Working Group plans to:

1. Discuss the federal mental health parity final rule.

2. Adjourn into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues relating to federal legislative and regulatory matters) of the NAIC Policy Statement on Open Meetings.

Draft: 8/19/24

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Chicago, Illinois
August 14, 2024

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Chicago, IL, Aug. 14, 2024. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jane Beyer, Vice Chair (WA); Crystal Phelps (AR); Debra Judy (CO); Kurt Swan (CT); Elizabeth Nunes (GA); Andria Seip (IA); Julie Holmes (KS); Mary Kwei (MD); T.J. Patton (MN); Jo LeDuc (MO); Robert Croom and Tracy Biehn (NC); Chrystal Bartuska (ND); Michelle Heaton (NH); Alejandro Amparan (NM); Kyla Dembowski (OH); Ashley Scott (OK); Shannen Logue (PA); Jill Kruger (SD); Matthew Tarpley (TX); Ryan Jubber and Shelley Wiseman (UT); Julie Fairbanks (VA); Rebecca Rebholz (WI); Joylynn Fix (WV), and Jill Reinking (WY).

1. Heard Presentations on Clinical Guidelines for Behavioral Health Care

A. MCG Health

Ravi Sitwala (MCG Health) provided background on the history of MCG Health and its parent company, Hearst Health. He said MCG Health has more than 6,000 clients, including the majority of health plans, more than 3,000 hospitals, and many state and federal agencies. For behavioral health specifically, he cited hundreds of provider organizations, health plans, and hospitals as users. He said MCG Health guidelines are continually updated to keep current with the standard of medical care, with thousands of new articles reviewed and new citations added to the latest edition. He described a three-step process for developing guidelines, including searching medical literature, reviewing sources for quality and relevance, and grading the available evidence. He said behavioral health guidelines are written by a board-certified psychiatrist and reviewed by external, active professionals. He said MCG Health is the only nationally recognized, independently published source for clinical criteria since it is not owned by a health insurer or providers.

Donna Baker-Miller (MCG Health) added that MCG Health guidelines are subscription-based, so MCG Health is not paid based on whether claims are approved or denied. Sitwala said MCG Health care guidelines align with those from specialty societies like the American Society of Addiction Medicine (ASAM). He noted that MCG Health guidelines are specifically crafted to support substance use disorder (SUD) management. He said MCG Health supports a single workflow that allows clinicians to integrate references to other guidelines in one location. He pledged to share MCG Health guidelines with state insurance regulators.

B. Optum

Chrissy Finn (Optum) and Sarah Johnson (Optum) described the InterQual clinical guidelines. Finn said the guidelines are intended to ensure patients get the right care at the right time in the right setting, efficiently. She said inappropriate care, slow adoption of evidence, increasing complexity, and unexplained variance in care contribute to inefficiency. She described InterQual criteria as an innovative technology used by thousands of hospitals and hundreds of health plans and government payers. She said InterQual develops evidence-based criteria in the same way for physical health and behavioral health. She said content development follows a rigorous cycle, including research, critical appraisal, clinical review, peer review and validation, and quality assurance and release. Johnson said InterQual criteria support mental health parity and proactively direct to the next level of care. She said the criteria incorporate content like the ASAM Criteria.

C. LOCUS

Dr. Michael Flaum (American Association for Community Psychiatry—AACP) presented on the Level of Care Utilization System (LOCUS) family of tools. He asked Working Group members about their current level of familiarity with LOCUS, and members responded that they had minimal familiarity. He said LOCUS has been under development since the 1990s and now includes tools that cover treatment for children, adolescents, and early childhood. He said LOCUS has two major components: evaluation parameters with six dimensions and a level of care continuum with seven ordered categories of service intensity. He said a LOCUS report can be completed in less than 10 minutes in a process that can be interactive, collaborative, and iterative. He said ratings can change over a short period of time, for example, when a patient has changes in their level of stress or support. He described the major goal of LOCUS as promoting a common language among people served, providers, payers, and policymakers. Flaum said LOCUS strives for transparency and clarity. He said LOCUS should be seen as complementary with other sources of clinical guidelines, like MCG Health or InterQual.

D. ASAM

Maureen Boyle (ASAM) presented on the ASAM Criteria, Fourth Edition. She said the ASAM Criteria is the most widely used set of standards for determining the appropriate level of care for SUDs. She said dozens of health plans license the Criteria for medical necessity, and 15 states require commercial payers to use the Criteria for medical necessity. She said the overdose crisis drives its growing adoption, expanded coverage under the Affordable Care Act (ACA), mental health parity regulations, and other factors.

Boyle identified the core components of the ASAM Criteria as the level of care assessment, decision rules, and the patient's placement in the continuum of care. She said the fourth edition added a new dimension of person-centered considerations to the existing dimensions, which include intoxication and withdrawal, biomedical conditions, psychiatric conditions, substance use risks, and the recovery environment. She said the continuum of care includes levels from outpatient to medically managed inpatient. The decision rules recommend the least intensive level of care where the patient can be safely and effectively treated. She said the Criteria are intended to be integrated, patient-centered, holistic, and oriented to chronic care. Boyle said the ASAM Criteria are supported by a number of implementation tools that aid in the education of users, assessment, and decision support. She mentioned training resources, ASAM software developed in partnership with InterQual, and service request forms that allow providers to structure information and summarize treatment plans and progress.

Beyer asked how MCG Health and InterQual guidelines deal with situations when the most appropriate level of care is unavailable due to a provider shortage. Sitwala said the guidelines would take a patient to the next level of care. He said one of the considerations in the guidelines is what facilities are available. He said an additional benefit of the guidelines is that they provide an outline of evidence-based care that may be helpful for providers when more specialized providers are unavailable. Johnson said a lack of provider availability is a real problem. She said InterQual guidelines are screening guidelines that do not indicate a final decision. She said a health plan would make a final decision that takes provider availability into account. Finn said users of InterQual implement the guidelines very differently from each other. Flaum said using a common standard allows benchmarking across systems. He said under LOCUS, a health plan would be expected to fund a higher level of care when the most appropriate level is unavailable. Boyle said ASAM allows for stepping up a request to a higher level when a certain level is unavailable.

Fix asked whether clients of MCG Health are contractually permitted to adjust the guidelines. Sitwala said MCG Health guidelines are not algorithms that decide whether a user should or should not do something. He said the guidelines collect evidence and allow payers to make their own judgments. He said payers may customize the

guidelines, but when they do, the payer cannot say they are applying MCG Health guidelines to make a decision. Finn said InterQual content is no longer considered InterQual content once a payer updates it; it is then considered custom content.

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, to continue work on its goals.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/MHPAEAWG Min 8.14.24.docx

2024 Fall National Meeting
Denver, Colorado

PHARMACEUTICAL BENEFIT MANAGEMENT REGULATORY ISSUES (B) WORKING GROUP
Monday, November 18, 2024
1:00 – 2:00 p.m.

Meeting Summary Report

The Pharmaceutical Benefit Management Regulatory Issues (B) Working Group will meet Nov. 18, 2024. During this meeting, the Working Group plans to:

1. Hear presentations on "Pharmacy Benefit Managers (PBMs) and How They Function."

2. Discuss providing potential assistance to the Producer Licensing Uniformity (D) Working Group to create a new section on PBM Licensure Best Practices and Uniform Standards in the *State Licensing Handbook.*

Agenda Item #3

Hear an Overview of Pharmacy Benefit Management (PBM) Transparency Initiatives
—Rob Nolan (AffirmedRX)

AffirmedRx
PUBLIC BENEFIT CORPORATION

PBMs & Current Regulatory Landscape

An Overview of PBM Transparency Initiatives

Rob Nolan, Chief Compliance Officer
November 17, 2024

Introduction

Introduction

- Brief overview of Pharmacy Benefit Managers (PBMs)
- Importance of transparency in PBM operations
- What is a Public Benefit Corporation (PBC)
- Objectives of the presentation

Importance of Compliance

- Ensures ethical and legal operations
- Protects against compliance and regulatory risk
- Maintains trust with stakeholders and the public

Public Benefit Corporation (PBC) PBMs

What is a Public Benefit Corporation (PBC)?

- A PBC is a type of for-profit corporation that includes a specific public benefit purpose in addition to profit-making.
- PBCs are legally required to consider the impact of their decisions on society and the environment.

PBC PBMs:

- Mission Alignment: PBC PBMs focus on providing transparent and ethical drug pricing while ensuring access to medications for underserved populations.
- Examples: Some PBMs have adopted the PBC model to emphasize their commitment to public health and ethical practices.

Benefits:

- Enhanced trust with stakeholders, partners, and the public.
- Ability to attract socially conscious investors.
- Improved public image and reputation.

What are Pharmacy Benefit Managers (PBMs)?

Pharmacy Benefit Managers (PBMs) are third-party administrators of prescription drug programs for health plans, employers, and other payers.

They act as intermediaries between insurers, pharmacies, and drug manufacturers to manage prescription drug benefits.

Key Functions

- Formulary Management
- Negotiating Drug Prices
- Utilization Management
- Establishing Pharmacy Networks
- Processing and Paying Prescription Drug Claims

Pharmacy Benefit Managers Impact

Economic Impact:

- PBMs play a significant role in the healthcare system, managing the prescription drug benefits for over **266 million Americans.**
- They are involved in the management of **80%** of all prescriptions filled in the United States.

Controversies and Criticisms:

- **Lack of Transparency:** PBMs have been criticized for their opaque pricing and rebate practices, which can lead to higher costs for patients.
- **Rebate Retention:** There are concerns that PBMs retain a significant portion of manufacturer rebates instead of passing the savings on to patients.
- **Market Power:** The consolidation of PBMs has led to a few large companies dominating the market, raising concerns about competition and pricing practices.

The Need for Transparency

- **Issues with Current PBM Practices:**
  - Opaque pricing and rebate structures
  - Potential conflicts of interest
  - Lack of accountability
- **Impact on Stakeholders:**
  - Patients: Higher out-of-pocket costs and limited access to medications
  - Pharmacies: Financial strain due to low reimbursement rates
  - Healthcare System: Increased overall healthcare costs
- **Calls for Reform:**
  - Advocacy from patient groups, healthcare providers, and policymakers
  - Legislative efforts to increase transparency and accountability

Transparency Initiatives

Legislative Efforts:

- State and federal laws aimed at increasing PBM transparency
- Examples: California's SB 17 and, the Federal Drug Pricing Transparency Act

Industry-Led Initiatives:

- Voluntary measures by PBMs to disclose pricing and rebate information
- Adoption of standards set by organizations like the National Council for Prescription Drug Programs (NCPDP)

Examples of Transparency Measures:

- Disclosure of rebate amounts and pricing models
- Reporting requirements for PBM practices

Benefits of Transparency

Improved Patient Outcomes:

- Access to Affordable Medications: Transparency helps patients understand medication costs, leading to informed choices and lower out-of-pocket expenses
- Better Adherence to Treatment Plans: Affordable medications improve adherence, resulting in better health outcomes
- Enhanced Trust in Healthcare Providers: Transparency fosters trust between patients and providers

Fairer Pricing and Reduced Costs:

- Reduction in Drug Prices: Competitive pricing driven by transparency
- Elimination of Hidden Fees: Patients pay only the actual cost of medications

Enhanced Trust and Accountability:

- Increased Accountability of PBMs: Transparency holds PBMs accountable for their practices
- Empowerment of Patients: Clear information empowers patients to make better healthcare decisions

Benefits of Transparency

Patient Testimonials

- Sarah's Story: Medication costs jumped from $50 to $500 per month due to PBM tier changes.
- Michelle's Experience: Paid $60 for a prescription that cost $40 without insurance.
- John's Challenge: Forced to switch to less effective insulin due to formulary changes.

Real-World Case Studies

- Case Study 1: California's SB 17
- Background: Requires advance notice of significant price increases.
- Impact: Greater scrutiny of drug pricing practices.

Case Study 2: FTC Investigation:

- Background: Investigation into PBM practices.
- Impact: Highlighted the need for more stringent regulations.

Market Concentration: The three largest PBMs manage nearly 80% of all prescriptions filled in the United States.

Specialty Drugs: From 2017 to 2022, 55% of 30-day equivalents for specialty drugs were filled by PBM-affiliated specialty pharmacies.

Legislative Efforts: Recent legislative efforts require PBMs to file annual reports with the FTC, increasing transparency about how they set drug prices and manage rebates.

These case studies, testimonials, and data points highlight the significant impact of PBM practices on patients and underscore the urgent need for transparency and reform.

Benefits of Transparency

Improved Patient Outcomes

- **Access to Affordable Medications**
- **Better Adherence to Treatment Plans**
- **Enhanced Trust in Healthcare Providers**

Fairer Pricing and Reduced Costs

- **Reduction in Drug Prices**
- **Elimination of Hidden Fees**

Enhanced Trust and Accountability

- **Increased Accountability of PBMs**
- **Empowerment of Patients**

Challenges and Barriers

Resistance from PBMs and Stakeholders:

- Concerns about proprietary business information
- Potential loss of competitive advantage

Implementation Difficulties:

- Complexity of integrating transparency measures into existing systems
- Costs associated with compliance and reporting

Balancing Transparency with Business Interests:

- Ensuring transparency without compromising propriety information
- Finding a balance that satisfies all stakeholders

Future Directions

Emerging Trends in PBM Transparency:

- Increased use of technology to enhance transparency (e.g., blockchain)
- Greater emphasis on patient-centered care and value-based pricing

Potential Impact of New Technologies:

- Blockchain for secure and transparent transaction records
- AI and data analytics for better pricing and utilization management

Ongoing Legislative and Regulatory Efforts:

- Continued push for federal and state legislation to enforce transparency
- Increased oversight and regulation of PBM practices

Future Trends in PBM Compliance

- **Emerging Trends:**
- AI and machine learning in corporate compliance.
- Increasing legal and regulatory scrutiny.

- **Preparing for the Future:**
- Staying ahead of legal and regulatory changes.

Future Directions

PBM Reverse Auctions:

- **New Jersey:** Implemented a PBM reverse auction process, which has significantly reduced the state's prescription drug spending by creating a competitive marketplace where PBMs bid for contracts.
- **Colorado:** Recently enacted legislation to adopt a similar reverse auction model, expected to generate substantial savings.

Ongoing Legislative and Regulatory Efforts:

- Some PBMs have adopted fully transparent, fee-based models that pass through rebates directly to consumers, avoiding hidden fees and ensuring that savings are shared.

State Transparency Laws:

- **Oregon:** Requires drug manufacturers to notify the state of significant price increases and mandates annual transparency reports from PBMs.
- **Maine:** Enforces transparency in the drug supply chain, requiring detailed reporting on profits and pricing methodologies

Regulatory Efforts:

- **21 States:** Have enacted laws requiring transparency in drug pricing and PBM practices, aiming to reduce consumer costs and increase accountability.

Conclusion

Recap of Key Points:

- Importance of PBM transparency for fair pricing and improved patient outcomes
- Overview of current transparency initiatives and their impact
- Challenges and future directions for PBM transparency

Importance of Continued Efforts:

- Need for ongoing advocacy and legislative action
- Role of stakeholders in promoting transparency and accountability

Call to Action:

- Encourage stakeholders to support transparency initiatives
- Advocate for policies that ensure fair and equitable access to medications

Q&A Session:

Agenda Item #4

Discuss Issues Related to the Implementation of the Federal Affordable Care Act's (ACA's) Section 1557 Final Regulation—***Amy Killelea (Killelea Consulting LLC), Jalisa Clark (Georgetown University Law Center on Health Insurance Reforms [CHIR]), and Meghan Stringer (America's Health Insurance Plans [AHIP])***

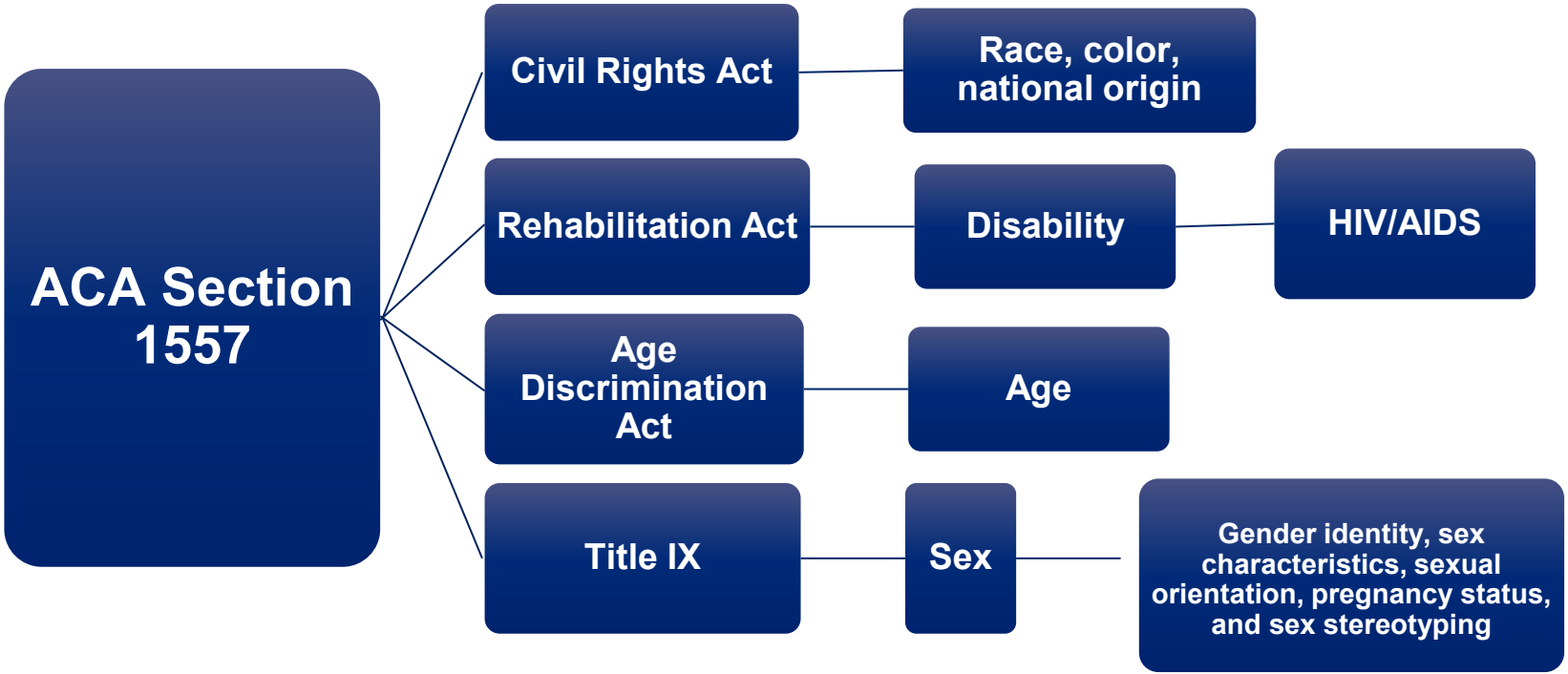
Section 1557 Non-Discrimination and What They Mean for Medigap (and other Excepted Benefits)

NAIC Fall Meeting 2024

Presented by: Amy Killelea and Jalisa Clark

NAIC
National Association of Insurance Commissioners

Section 1557: Nondiscrimination in “Health Programs and Activities”



Does 1557 Apply to Medigap Plans and Other Excepted Benefits?

- **Yes,** the ACA statutory language is clear on this
- Section 1557 applies broadly to "**any health program or activity, any part of which is receiving Federal financial assistance**" 42 U.S. Code § 18116
- 1557 protections apply to **all operations** of the entity receiving federal financial assistance, even lines of business that do not directly receive the federal financial assistance
- The application of **civil rights laws** to all operations of an entity receiving federal financial assistance is not new and did not originate with section 1557

Does 1557 Apply to Medigap Plans and Other Excepted Benefits? (cont.)

1557 protections apply to **all operations** of the entity receiving federal financial assistance, even lines of business that do not directly receive the federal financial assistance

For example:

- Issuers that receive APTCs with legal entities that offer STLDIs
- Issuers that receive APTCs and offer Medigap plans
- Issuers that offer Medicare Part D plans and Medigap plans

Question for OCR: What test or criteria will OCR apply to determine when entities are legally separate from a recipient of federal financial assistance?

2024 Final Rule: Discriminatory Benefit Design

The insurance practice may not be based on unlawful animus or bias, or constitute a pretext for discrimination

- Cost sharing
- Medical necessity definitions
- Narrow networks
- Drug formularies
- Adverse tiering
- Benefit substitution
- Marketing practices
- Utilization management
- Exclusions
- Visit limits
- Waiting periods
- Service areas
- Coercive wellness programs
- Provider reimbursement rates

Potential Discrimination in Excepted Benefits

Market	Enrollment	Premiums	Plan design
Medigap **Short-term limited duration insurance (STLDI) plans** **Fixed indemnity (including accident or critical illness policies)**	Exclusions based on disability, age, sex, or race? Limited access to certain plan options based on age or disability? Waiting period for coverage based on disability?	Premium rating based on issue-age, attained-age, health status, including conditions covered under section 504 of the Rehabilitation Act as a disability, or sex?	Note: Medigap plans have standardized plan designs Exclusions or limits on benefits or services from coverage based on a person's disability, age, sex, or race? Post-claims underwriting to deny coverage for services used to treat someone with a disability?)

How Does 1557 Apply to Medigap and other Excepted Benefits Plans?

The text of the ACA nor the final 1557 regulation include a list of per se discriminatory practices.

If a plan design is determined discriminatory, the covered entity may **provide a legitimate, nondiscriminatory reason for the plan's benefit design.** OCR will carefully consider the evidence presented and determine whether the reason is legitimate and not pretext for discrimination.

OCR will also consider if:

1. Compliance will make the plan unaffordable or force the issuer to stop selling the plan altogether
2. Modifying a plan to comply with section 1557 would result in a fundamental alteration to their health program or activity

What about Underwriting?

Million dollar question!

There are different interpretations as to whether the rule prohibits underwriting based on a protected class in Medigap and other excepted benefit plans.

Here's one interpretation of how OCR may review plans:

- A Medigap plan that underwrites plans for people under 65 based on disability and charges people with a disability a higher premium, could warrant a discrimination claim that the practice is based on animus or bias against this protected class
- The Medigap plan could answer that claim by offering evidence that the underwriting practice is not based on bias toward a protected class, it is based on a legitimate business reason to charge this population more in premiums
- OCR would then have to determine if that business reason is legitimate, and they might look to whether evidence is presented that removing underwriting based on this protected class would send the plan into a death spiral or not and would weigh the business interests against the interest of protecting people with disabilities from higher premiums

What about Other Potentially Discriminatory Practices?

- Refusal to accept third-party payments from charitable or government programs that provide assistance to people with disabilities (e.g., HIV)
- Denying or canceling coverage based on a disability
- Charging people higher premiums based on gender

Section 1557 Enforcement

- Section 1557 is primarily enforced by the HHS Office of Civil Rights (OCR)
- Complaints are submitted directly to OCR, and OCR will conduct a fact-specific inquiry to determine whether the practice is discriminatory
- State plan review and certification processes include assessment of whether products sold in the state comply with both state and federal laws
- In the past, states have also collaborated with OCR when section 1557 complaints are filed against state-regulated insurance plans to share information

Section 1557 Litigation Round up

- Section 1557 is the **law of the land**
- On July 3, 2024, three federal district courts in Texas, Mississippi, and Florida issued rulings halting the enforcement of the rule's **gender identity protections**
- While the Florida court's ruling applies only in Florida, the Mississippi and Texas decisions apply nationwide
- HHS has appealed

Regulator Considerations

- Make changes to Model 171 Accident and Sickness Insurance Minimum Standards to ensure it aligns with federal non-discrimination law
- Assess Medigap and other excepted benefits markets and the extent to which enrollment, premiums, and plan designs exclude or limit coverage based on age, disability, sex, or race
- Consult with consumer groups and other experts on how excepted benefits markets impact consumers based on age, disability, sex, and race
- Develop guidance for regulated entities on how section 1557 impacts products regulated by the state

Implementation of Section 1557 Final Rule on Excepted Benefits Products

Meghan Stringer

Vice President, Product & Commercial Policy

November 17, 2024

AHIP Supports the Final Rule's Protections against Discrimination

- Every American deserves access to high-quality, affordable health care, regardless of race, color, national origin, sex, gender identity, sexual orientation, age, or disability.
- AHIP firmly believes in this commitment, and we strongly support the overarching goal to promote equal access to health care.
- We also support federal law protections that prohibit discrimination and ensure that care is available and accessible to every American and applaud HHS' efforts to promote health equity and reduce health care disparities.

Excepted Benefits Products

- Four categories of products that are “excepted” from the Affordable Care Act (ACA) and other health coverage mandates as long as they meet certain requirements. Examples:
  - Cover additional benefits not included in major medical plans (dental, vision, Medicare Supplement)
  - Specifically designed not to coordinate with other coverage and pay benefits regardless of whether the medical event triggering benefits is covered under another plan (fixed indemnity, specified disease)
- Excepted benefits products provide value to millions of Americans.

Excepted Benefits Products

- Medicare Supplement (Medigap)
- Supplemental Health (Hospital or other Fixed Indemnity, Specified Disease/Critical Illness, Accident-Only)
- Disability Income
- Long Term Care

Excepted Benefits Products

Guaranteed Renewability

- Many excepted benefits products are **guaranteed renewable** products.
  - Unless the policyholder cancels the policy (or fails to pay their premium), the carrier cannot cancel the policy or change the benefits of the plan.
- When a guaranteed renewable product is created and filed for sale in a state, the rates are structured to reflect the **long-term nature** of the policy, rather than a rate that reflects a one-year estimation of expected costs.

Keeping Premiums Affordable

- Benefits provided by excepted benefits products are **funded solely from the premiums** paid by policyholders.
- Risk pool stability is a priority focus for plans and necessary for consumers; if the risk pool becomes unbalanced (adverse selection), premiums could increase drastically.

Applying 1557 to Excepted Benefits Products from Covered Entities

Federal Guidance Is Critical

- There is currently little clarity with respect to compliance and how plans should approach the administration of the products, including benefit design and premium structuring.
- The Final Rule could drastically increase premiums and create compliance burdens and an unlevel playing field that could lead to fewer insurers offering these products.
- Consumers who rely upon affordable Excepted Benefit products for financial security would be negatively affected.

Outstanding Questions Remain

- How do the Final Rule's Age Act exceptions impact age rating for Excepted Benefits products, especially Medigap?
- What are the rules for using gender as a rating factor?
- How will OCR evaluate "unaffordability" and "fundamental alteration" as applied to plan benefit designs and underwriting?

Federal Guidance is Necessary

- Neither covered entities nor state regulators have the information to answer these outstanding questions.
- Trying to implement the final rule amid this level of uncertainty would cause severe and potentially unnecessary disruptions in the market and create confusion among consumers.
- Instead, AHIP asks that state regulators wait until OCR provides guidance to answer the questions posed by regulators and covered entities.

AHIP Resources

- AHIP's Comments on the Section 1557 Proposed Rule (October 3, 2022)
- Final Rule (May 5, 2024)
- Medigap
  - State of Medicare Supplement Coverage
  - State One-Pagers
  - Satisfaction Survey
- Supplemental
  - Satisfaction Survey
  - Industry Survey
- Disability Income
  - Consumer Satisfaction Survey
  - Guide to Disability Income Insurance
- Long Term Care
  - State-to-State 2023 (Study)
- Dental
  - Satisfaction Survey
- Vision
  - Satisfaction Survey
- General Resources
  - Coverage@Work: Supplemental Coverage

Thank You

Meghan Stringer

Vice President, Product and Commercial Policy

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Agenda Item #5

Discuss Any Other Matters Brought Before the Task Force
—Commissioner Glen Mulready (OK)