NATIONAL MEETING
SUMMER / CHICAGO

Revised date: 7/24/24

2024 Summer National Meeting
Chicago, Illinois

REGULATORY FRAMEWORK (B) TASK FORCE
Tuesday, August 13, 2024
11:30 a.m. – 12:30 p.m.
McCormick Place Convention Center—S102—Level 1

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 "Ben" 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
Amy L. Beard	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
Kevin P. Beagan	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 July 1 and Spring National Meeting Minutes — Attachment One
   —*Commissioner Glen Mulready (OK)*

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

3. Hear a Presentation on Facility Fees—*Rachel Swindle (Center on Health Insurance Reforms [CHIR] at Georgetown University's McCourt School of Public Policy)*

4. Discuss *Loper Bright Enterprises v. Raimondo* and *Relentless v. Department of Commerce* (collectively "*Loper")* and Potential Implications on Health Insurance-Related Regulations —*William G. Schiffbauer (Schiffbauer Law Office)*

5. Hear a Presentation on the New Collaborative Multi-Stakeholder Initiative "Promoting Health Through Prevention (PHtP)"—*Kate Berry (America's Health Insurance Plans [AHIP]) and Anand Parekh (Bipartisan Policy Center)*

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

7. Adjournment

Agenda Item #1

Consider Adoption of its July 1 and Spring National Meeting Minutes
—Commissioner Glen Mulready (OK)

Draft: 7/2/24

Regulatory Framework (B) Task Force
E-Vote
July 1, 2024

The Regulatory Framework (B) Task Force conducted an e-vote that concluded July 1, 2024. The following Task Force members participated: Glen Mulready, Chair (OK); Ann Gillespie represented by Erica Weyhenmeyer, Vice Chair (IL); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler (AL); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods (DC); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Amy L. Beard represented by Alex Peck (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Kevin P. Beagan (MA); Robert L. Carey represented by Robert Wake (ME); Chlora Lyndley-Myers represented by Jo LeDuc (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Scott Kipper (NV); Judith L. French represented by Laura Miller (OH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Jodi Frantz (PA); Larry D. Deiter (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Ned Gaines (WA); Nathan Houdek (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its 2024 Revised Charges

The Task Force conducted an e-vote to consider adoption of its 2024 revised charges, which amend the 2024 charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup (Attachment ?-A). The motion passed unanimously.

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 7-1-24 E-Vote MtgMin.docx

Draft Pending Adoption

Draft: 3/26/24

Regulatory Framework (B) Task Force
Phoenix, Arizona
March 16, 2024

The Regulatory Framework (B) Task Force met in Phoenix, AZ, March 16, 2024. The following Task Force members participated: Glen Mulready, Chair, and Andy Schallhorn (OK); Dana Popish Severinghaus represented by Erica Weyhenmeyer, Vice Chair (IL); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Sanjeev Chaudhuri (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 Stephen Flick (DC); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Amy L. Beard represented by Alex Peck and Meghann Leaird (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Shaun Orme (KY); Gary D. Anderson represented by Kevin Beagan (MA); Robert L. Carey represented by Marti Hooper (ME); Chlora Lyndley-Myers represented by Jo LeDuc, Amy Hoyt, and Carrie Couch (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska and Karri Morris (ND); Eric Dunning represented by Martin Swanson, Maggie Reinert, and Michael Muldoon (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Scott Kipper represented by Nick Stosic and Jonathan Wycoff (NV); Judith L. French represented by Kyla Dembowski (OH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Shannen Logue (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup, Ryan Jubber, Shelley Wiseman, and Heidi Clausen (UT); Scott A. White represented by Julie Blauvelt and Jackie Myers (VA); Mike Kreidler represented by Ned Gaines and Jane Beyer (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey represented by Joylynn Fix (WV). Also participating was: Patrick Smock (RI).

1. Adopted its 2023 Fall National Meeting Minutes

Weyhenmeyer made a motion, seconded by Keen, to adopt the Task Force's Dec. 1, 2023, minutes (*see NAIC Proceedings – Fall 2023, Regulatory Framework (B) Task Force*). The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

Swanson made a motion, seconded by Kruger, to adopt the following reports: 1) the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Feb. 26 (Attachment One), Feb. 12 (Attachment Two), and Jan. 29 (Attachment Three) 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 Dec. 2, 2023 (Attachment Four) minutes; and 4) the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. The motion passed unanimously.

3. Received an Update on the Accident and Sickness Insurance Minimum Standards (B) Subgroup's Work

Schallhorn updated the Task Force on the work of the Accident and Sickness Insurance Minimum Standards (B) Subgroup to revise the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). He said the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup in 2016 to revise the *Accident and Sickness Insurance Minimum Standards Model Act (*#170*),* and its companion model, Model #171, to address the models' provisions for certain types of health insurance plans that are no longer permitted under the federal Affordable Care Act (ACA).

Schallhorn said the Accident and Sickness Insurance Minimum Standards (B) Subgroup completed the revisions to Model #170 in late 2018, renaming it the *Supplementary and Short-Term Health Insurance Minimum Standards*

Model Act to reflect its revised provisions. The Executive (EX) Committee and Plenary adopted the revised model in February 2019. Following the adoption of the revised Model #170, the Subgroup turned its attention to revising Model #171 for consistency with the ACA and the revised Model #170.

Schallhorn said the Subgroup met throughout 2019, but because of the COVID-19 pandemic and other resource issues, the Subgroup did not meet in 2020. He said the Subgroup resumed meeting in June 2021 and has been meeting on a regular basis since to discuss the comments received on Model #171. In fall 2023, the Subgroup completed its review of the initial comments received on Model #170 and released a draft of proposed revisions to Model #171 for a public comment period, which ended on Dec. 1, 2023.

Schallhorn said that in developing the proposed revisions, the Subgroup extensively discussed potential provisions to the model on short-term, limited-duration (STLD) plans. He explained that the Subgroup added STLD plans to Model #170 because, at the time, there was no other vehicle to include such plans, and the Subgroup did not want to develop a new NAIC model solely for them, and because they were added to Model #170, Model #171 needed to include provisions establishing minimum standards for benefits for them. Schallhorn said that, in response to its request for comments, the Subgroup received comments from several stakeholders. He said the Subgroup has been meeting since January to discuss the comments received. Schallhorn said the Subgroup intends to complete its review of the comments within the next few months. Then it will forward the revised model to the Task Force for its consideration.

4. Discussed Embedded Insurance Code Provisions for HSAs

Jeffrey Klein (American Bankers Association [ABA] Health Savings Account [HSA] Council) discussed embedded insurance code provisions protecting HSAs. He highlighted 2023 state legislative activity using embedded insurance code provisions to carve out or exempt HSAs from certain benefit mandate/limited cost-sharing bills and copayment accumulator bills to protect the ability of HSA account holders to continue to use their HSA. Klein also discussed the ABA HSA Council's 2024 state advocacy initiatives and priorities, which include working with states to expand the number of states that have enacted embedded insurance code provisions. Currently, eight states have such provisions.

Klein said the ABA HSA Council has one ask of the Task Force, which is for the Task Force to work with state departments of insurance (DOIs) and other interested parties to adopt embedded insurance code provisions to protect HSAs. Klein said adopting such legislation prevents unintended consequences and protects HSAs of well-intended state benefit mandate and cost-sharing legislation and proposals advocated by patient advocacy groups and other interested parties. Klein also noted that such provisions provide "legislative economy" considering the hundreds of individual state benefit mandate bills considered each year in state legislatures.

5. Discussed Draft 2024 Revised Proposed Charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

Jolie H. Matthews (NAIC) said that prior to the Task Force's meeting, NAIC staff distributed draft 2024 revised proposed charges (Attachment Five) for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup for initial Task Force discussion during this meeting. She said the charges reflect discussions between the Task Force chair, Task Force vice chair, and NAIC staff. She explained that the charges envision the Subgroup transitioning to a working group because it would have continuing work that would not be finished at year-end.

Matthews explained that the charges are based, in part, on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's recommendations, which were initially included in its white paper *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation* and charges from other NAIC groups, such as the Health Innovations (B) Working Group and the Mental Health Parity and Addiction Equity (MHPAEA) (B) Working Group.

She highlighted a few of the charges, including a charge suggesting the Subgroup's successor working group consider any necessary updates to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22).

The Task Force discussed the charges and next steps. Some Task Force members suggested that it would be premature for the Subgroup's successor group to consider potential review and any necessary updates to Model #22 given the evolving nature of the issues related to pharmacy benefit managers (PBMs) and the prescription drug ecosystem. In addition, some Task Force members suggested that because Model #22 has not been adopted in its entirety by any state, it would not be appropriate to consider updating it.

Carl Schmid (HIV+Hepatitis Policy Institute), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives submitted a comment letter to the Task Force expressing strong support for the draft revised 2024 proposed charges. Chris Petersen (Arbor Strategies LLC) speaking on behalf of the Pharmaceutical Care Management Association (PCMA), said the PCMA does not believe it is appropriate to include a charge suggesting the successor working group review and consider updates to Model #22 because it would be premature, and, as already discussed, no state has adopted it in its entirety. He noted that, as discussed in its comment letter to the Task Force, the PCMA supports having the Subgroup's successor working group focus on all aspects of the pharmaceutical supply chain.

After additional discussion, the Task Force set a 30-day public comment period ending April 19 to receive comments on the draft 2024 revised proposed charges. Commissioner Mulready announced that for 2024, Fix has agreed to chair the Subgroup's successor working group, and Ashley Scott (OK) would continue as vice chair.

6. Heard Information on World Hypertension Day

J.P. Wieske (Horizon Government Affairs), representing Jazz Pharmaceuticals, provided information to the Task Force on World Hypertension Day, which is May 17. He explained that Jazz Pharmaceuticals focuses on innovation to transform the lives of patients and their families. Jazz Pharmaceuticals is dedicated to developing life-changing medicines for people with serious diseases—often with limited or no therapeutic options—so they can live their lives more fully.

Wieske said that Jazz Pharmaceuticals is seeing an increasing number of high-sodium medications and as such, it wanted to bring awareness of hypertension—what it is, who is at risk, how it can be prevented and managed, and which medications can affect blood pressure levels—to state DOIs and provide information on World Hypertension Day and a sample press release.

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

Virtual Meetings

ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS (B) SUBGROUP
July 29, 2024 / July 15, 2024 /June 24, 2024 / April 22, 2024 / April 8, 2024 / March 25, 2024

Summary Report

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 29, July 15, June 24, April 22, April 8, and March 25, 2024. During these meetings, the Subgroup:

1. Completed its discussion of the Dec. 1, 2023, comments received on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

2. Distributed for final review a May 3, draft of proposed revisions to Model #171 reflecting the Subgroup's discussions.

3. Discussed comments received on the May 3, draft of proposed revisions to Model #171.

Draft: 8/2/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
July 29, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 29, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Stephen Flick (DC); Carson Gaines (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson and Maggie Reinert (NE); Andreea Savu (SC); Heidi Clausen and Shelley Wiseman (UT); and Anna Van Fleet and Jamie Gile (VT).

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

Before beginning its discussion of the comments submitted by Wake 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 ?-A*), the Subgroup reviewed Bowden's revisions to Section 8E(4) (Attachment ?-A). Bowden said the revisions reflect the Subgroup's discussion during its July 15 meeting. She said that in addition, she suggests that the Subgroup consider moving the language defining "home health care agency" in Section 8E(4)(k)(i) to Section 6—Policy Definitions. After discussion, the Subgroup accepted Bowden's revisions to Section 8E(4) and her suggestion to move the definition of "home health care agency" to Section 6. The Subgroup also agreed to correct a spelling error and delete the word "chux," which is a product brand name for disposable absorbent pads, and replace it with "disposable absorbent pads."

The Subgroup next discussed Wake's comments on Section 8H(8)—Short-Term, Limited-Duration Health Insurance Coverage concerning the notice requirements necessary when rescinding a policy. After discussion, the Subgroup agreed to clarify this provision by adding language separating the rescission notice requirements from the cancellation notice requirements to require a carrier to provide "a notice of rescission to an insured in writing with an appeal period of [thirty (30) days]." The Subgroup discussed Wake's comments and suggested revisions to the drafting note for Section 8H. After discussion, the Subgroup accepted Wake's suggested revision of adding a new sentence at the beginning of the drafting note. The Subgroup decided to delete the remainder of the drafting note language and requested NAIC staff add language alerting the states that they should review any relevant federal regulations establishing requirements for short-term, limited-duration (STLD) coverage that could differ from the state's requirements.

The Subgroup next discussed Wake's suggested revisions to Section 9A(1)—Required Disclosure Provisions. Wake suggested revising this provision to clearly state that the disclosures required under Section 9 may be modified as needed for accuracy and clarity "and only with the approval of the commissioner." The Subgroup accepted his suggested revision. The Subgroup also accepted Wake's non-substantive revisions to Section 9A(2). The Subgroup discussed Wake's suggested revisions to the drafting note for Section 9A(2). After discussion, the Subgroup accepted his suggested revisions but decided not to accept the suggested revisions that would have added language suggesting that the states should review "any applicable NAIC models" that may have provisions on readability and accessibility.

The Subgroup next discussed Wake's suggestions to delete the drafting note for Section 9A(3) requiring the disclosure of hospital indemnity coverage, make the phrase "fixed dollar benefits" prominent, and add the language to the substantive provision itself. The Subgroup accepted the suggested revision.

The Subgroup next discussed how the federal notice and disclosure requirements for hospital indemnity and other fixed indemnity coverage would work with state notice and disclosure requirements for such coverage. The Subgroup concluded that given the issue's complexity and other factors, such as current and future litigation related to the federal rules establishing the notice and disclosure requirements, it would not be practical to include the federal language. During the discussion, it was suggested that the Subgroup consider adding drafting notes to the relevant provisions alerting the states to the issue.

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

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Draft: 7/31/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
July 15, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 15, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Carson Gaines (FL); Camille Anderson-Weddle and Amy Hoyt (MO); Martin Swanson and Maggie Reinert (NE); Shari Miles (SC); Heidi Clausen and Shelley Wiseman (UT); Mary Block and Jamie Gile (VT); and Ned Gaines (WA).

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

The Subgroup continued its discussion of the comments submitted by Robert Wake (ME) on the May 3 draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) beginning with the comments on Section 8A(11)—Supplementary and Short-Term Health Insurance Minimum Standards for Benefits (*see NAIC Proceedings – Summer 2024, Regulatory Framework (B) Task Force, Attachment ?-A*). Jolie Matthews (NAIC) said Wake's comments on Section 8A(11) question the meaning of the language "irrespective of total disability," whether it means the policy must pay accidental death and dismemberment benefits even if the insured is NOT totally disabled or whether the policy must pay accidental death and dismemberment benefits if the insured IS totally disabled. She said the language is existing Model #171 language. The Subgroup discussed the comments. After discussion, the Subgroup decided to leave the language unchanged because it felt the language was clear. It requires a carrier to pay accidental death and dismemberment benefits regardless of whether the insured is totally disabled, and if the insured has disability income protection coverage and is totally disabled, the carrier must pay benefits in accordance with the terms of that policy because they are two separate policies and two separate provisions.

The Subgroup next discussed Wake's comments on Section 8C(1)—Disability Income Protection Coverage. The Subgroup discussed the comments noting that Wake made similar comments to Section 8A(2)(d). After discussion, the Subgroup agreed to delete the words "to receive Social Security benefits" for consistency with the revision made to Section 8A(2)(d). The Subgroup next discussed the comments on Section 8C(3). The Subgroup agreed that the suggested revisions clarified the language. The Subgroup next discussed Wake's comments on Section 8E(2)(h)—Specified Disease Coverage. The comments suggest revising the provision to clarify which NAIC model should be specifically referenced with respect to "the NAIC uniform provision." The Subgroup accepted the suggested revisions. The Subgroup also accepted clarifying revisions to Section 8E(2)(j) and Section 8E(2)(l). The Subgroup next discussed Wake's comments on Section 8E(2)(m) suggesting that the word "facility" is the wrong word to use with respect to hospice care. After discussion, the Subgroup decided to delete the word "facility" and replace it with "provider."

The Subgroup next discussed Wake's suggested revisions to Section 8E(4). Wake suggests reorganizing Section 8E(4) to clarify which types of benefits in a cancer-only policy are subject to the copayment provisions in Section 8E(4)(h). The Subgroup discussed the suggested revisions. After discussion, the Subgroup agreed to reorganize the language based on Wake's comments and the Subgroup's discussion. Bowden volunteered to provide language reflecting the Subgroup's discussion for its review during its next meeting on July 29.

The Subgroup next discussed Wake's comments on Section 8E(6)(a) suggesting that the existing Model #171 language in this provision is nonsensical. After discussion, the Subgroup agreed to correct the language by deleting the words "on behalf of insured persons." The Subgroup discussed and accepted Wake's suggested clarifying

revisions to Section 8E(6)(b). The Subgroup discussed Wake's comments on the drafting note for Section 8E(6)(b), questioning the inclusion of skin cancer as a specific example of a specified disease a commissioner can approve as an exception to requiring equal coverage for all subtypes of a specified disease. The Subgroup accepted his suggestion to delete the reference to skin cancer.

The Subgroup discussed and agreed to accept Wake's revised Section 8G(1)—Limited Benefit Health Coverage suggestion to revise the provision to use the statutory term "limited benefit health coverage." The Subgroup also accepted Wake's suggestion to use the word "policies" instead of "plans" for accuracy when referring to limited long-term care insurance in the drafting note for Section 8G(2).

The Subgroup next discussed Wake's suggested revisions to the drafting note for Section 8G. The Subgroup agreed that revisions should be made for accuracy. William Schiffbauer (Schiffbauer Law Office) agreed to send NAIC staff the suggested revisions.

The Subgroup next discussed Wake's comments on Section 8H—Short-Term Limited-Duration Health Insurance Coverage. The Subgroup accepted Wake's non-substantive, clarifying revisions to Section 8H(1), Section 8H(2), Section 8H(4)(b), Section 8H(4)(d), and Section 8H(5). The Subgroup discussed Wake's comments on Section 8H(6) that suggest the Subgroup consider deleting the last sentence which specifies the amount a carrier must refund a consumer when a plan is rescinded. The Subgroup accepted his suggested revisions. The Subgroup also accepted Wake's corresponding suggested revisions to Section 8H(6)'s drafting note.

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

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Draft: 7/18/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
June 24, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met June 24, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Robert Wake (ME); Amy Hoyt (MO); Maggie Reinert (NE); Andreea Savu (SC); Heidi Clausen and Shelley Wiseman (UT); and Anna Van Fleet and Jamie Gile (VT).

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

The Subgroup discussed additional comments from Wake on the May 3 draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) beginning with the comments on Section 3A—Applicability and Scope (Attachment ?-A). Wake explained that for clarity, he suggests adding the words "residents of" this state instead of "in" this state. He also suggests adding the word "offered." After discussion, the Subgroup accepted his suggested revisions. Additionally, Wake suggests deleting the words "unless otherwise specified is included in the definition of 'short-term health insurance' under the Act." The Subgroup accepted the suggested revision. Wake also suggests non-substantive revisions to Section 3C(3) to the reference to the U.S. uniformed services health care program, TRICARE. The Subgroup accepted the suggested revisions.

The Subgroup next discussed Wake's comments on whether to include a definition of "short-term, limited duration insurance" in Section 5C—Definitions. Wake expressed concern that the definition appears to be more of a minimum standard rather than a definition. After discussion, the Subgroup decided to revise Section 5C to provide a cross-reference to the definition for this term in Model #171's companion model act, *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170).

The Subgroup next agreed to accept Wake's suggestion to delete the word "rehabilitory" in Section 6C(2)—Policy Definitions in the policy definition of "hospital" and replace it with "rehabilitative." The Subgroup next discussed Wake's comments on the last sentence in the policy definition of "physician" in Section 6I(1). Wake expressed concern that the language would require insurers to recognize certain types of providers as physicians. The Subgroup discussed his comments. After discussion, the Subgroup agreed to add at the end of the first sentence the words "and may not be defined more narrowly than applicable state licensing laws" and delete the last sentence. The Subgroup also agreed to add a new subsection, which Bowden suggested, to the end of Section 7—Prohibited Policy Provisions stating: "A policy shall not limit an insured's choice of health care provider if the provider is licensed or otherwise qualified under state law and the services to be provided are within the health care provider's scope of practice."

The Subgroup next discussed Wake's comments on the inconsistent use of the term "workers' compensation" throughout the model. NAIC staff agreed to review the model to ensure the references to the term are consistent.

The Subgroup next discussed Wake's comments on Section 7D suggesting that it be revised to add the words "the following permitted exclusions" for clarity. The Subgroup agreed to make the suggested revisions. The Subgroup also agreed to make the same revision to the drafting note for Section 7D(2). Additionally, the Subgroup agreed to make non-substantive revisions to Section 7D(5) and Section 7D(6). The Subgroup next discussed Wake's comments on Section 7D(7) concerning the provision on chiropractic care. Jolie Matthews (NAIC) pointed out that this provision is existing language in Model #171 except for the proposed revision clarifying that the provision

refers to “chiropractic” care. After discussion, the Subgroup decided to leave the language unchanged. The Subgroup next discussed Wake’s comments Section 7D(12) suggesting that it be revised to include the language in the proposed drafting note to clearly state the limitations of the territorial limitation exclusion. The Subgroup accepted the suggested revisions.

The Subgroup next discussed and accepted Wake’s suggested non-substantive revisions to Section 7E and Section 7F.

The Subgroup next discussed Wake’s suggested revisions for Section 8A—Supplementary and Short-Term Health Insurance Minimum Standards for Benefits. He suggests reorganizing and revising Section 8A(2)(c) and Section 8A(2)(d) for clarity. Matthews noted that some of the language is existing language in Model #171. The Subgroup discussed the suggested revisions. After discussion, the Subgroup agreed to make the clarifying revisions, including reorganizing the provisions.

The Subgroup discussed and accepted Wake’s clarifying revisions to the drafting note for Section 8A(2) and Section 8A(3). The Subgroup also discussed and accepted Wake’s clarifying revisions to Section 8A(6), Section 8A(7), and Section 8A(8).

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

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Draft: 5/7/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
April 22, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met April 22, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Christina Jackson (FL); Martin Swanson (NE); Tanji J. Northrup, Heidi Clausen, and Shelley Wiseman (UT); Anna Van Fleet, Mary Block, and Jamie Gile (VT); and Ned Gaines (WA).

1. Discussed the Dec. 1, 2023, Comments Received on Draft Revisions to Model #171

The Subgroup continued its discussion of the Dec. 1, 2023, comments submitted on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), beginning with the Schiffbauer Law Office's suggestion to delete the work "available" in Section 9A(1)—Required Disclosure Provisions and replace it with "provided." William Schiffbauer (Schiffbauer Law Office) said he suggests this revision because he believes the word "available" is ambiguous and the word "provided" is clearer. He said for Section 9A(2)(d), he also suggests for clarity replacing the words "in close proximity" and replacing it with "directly above." After discussion, the Subgroup accepted the first suggested revision to replace the word "available" with "provided" in Section 9A(1). The Subgroup discussed the potential consequences of replacing "in close proximity" with "directly above" in Section 9A(2)(d). During the discussion, Subgroup members discussed how such a change would work with the recently adopted federal consumer disclosure requirements and whether it would be feasible. After additional discussion, the Subgroup decided not to accept the suggested revision because it might not be feasible to implement and would limit flexibility.

The Subgroup next discussed the Schiffbauer Law Office comments on Section 9C(2)—Hospital Indemnity or Other Fixed Indemnity Coverage (Outline of Coverage). Schiffbauer said he suggests revising the language to match the disclosure language for this product in Section 9A(3) and (4). Jolie H. Matthews (NAIC) explained that the language in Section 9C(2) does not mirror the language in Section 9A(3) and (4) because the provisions are structured differently. The Subgroup discussed the suggested comment. After discussion, Schiffbauer withdrew his comments.

The Subgroup next discussed the Schiffbauer Law Office comment's on Section 9E(2)—Accident Only Coverage (Outline of Coverage) suggesting the Subgroup add "or injury" because it would tie this provision back to the definition of "injury" in Section 6D—Policy Definitions. The Subgroup discussed the suggested revision. After discussion, the Subgroup decided not to accept it because Section 9E(2) includes language stating that "accident only coverage pays for benefits for covered injuries." Given this, adding "or injury" is unnecessary.

The Subgroup next discussed the Schiffbauer Law Office comments on Section 9F(2)—Specified Disease or Specified Accident Coverage (Outline of Coverage). Schiffbauer said he suggests revising the language to match the disclosure language for this product in Section 9A(3) and (4). Matthews said the suggested comments on this section are like those for Section 9C(2). After discussion, the Subgroup asked NAIC staff to review the language for consistency.

Matthews said the Subgroup has discussed all the Dec. 1, 2023, comments on the proposed revisions to Model #171 and no additional comments have been received. She said she will distribute a final draft of proposed revisions to Model #171 reflecting the Subgroup's discussions to date. She said stakeholders will have at least two weeks to review the final draft prior to the Subgroup holding a meeting to consider adoption of the revised model.

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

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Draft: 4/29/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
April 8, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met April 8, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Christina Jackson (FL); Martin Swanson and Maggie Reinert (NE); Heidi Clausen and Shelley Wiseman (UT); and Jamie Gile (VT).

1. Discussed the Dec. 1, 2023, Comments Received on Draft Revisions to Model #171

Before continuing its discussion of the Dec. 1, 2023, comments submitted on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), the Subgroup reviewed proposed revisions to Section 8A intended to reflect the Subgroup's discussion of the term "spouse" during its March 25 meeting. Jolie H. Matthews (NAIC) said that as discussed during the March 25 meeting, she added a drafting note to Section 8A(1) and Section 8(A)(3) where the term "spouse" is used directing states to review the use of the term "spouse" and replace it or add additional terms in accordance with state law or regulations. She explained that there was an existing proposed drafting note for Section 8A(3) concerning the addition of the terms "married couple" and "civil union couple." Matthews said she revised that drafting note to reflect the Subgroup's discussion of the term "spouse" in Section 8A(1). After discussion, the Subgroup accepted the suggested revisions.

The Subgroup continued its discussion of the Dec. 1, 2023, comments beginning with the Schiffbauer Law Office's suggestion to add additional language to the drafting note in Section 8B(2). William Schiffbauer (Schiffbauer Law Office) said he suggests the Subgroup adds a sentence to the drafting note explaining that state insurance regulators can address consumer confusion about the coverage excepted benefit products provide by requiring insurers to not offer, market, or sell these products as a substitute for, or an alternative to, comprehensive major medical coverage and requiring consumer disclosures that this type of coverage is supplementary insurance. After discussion, the Subgroup accepted the suggested revision.

The Subgroup next discussed the Schiffbauer Law Office's suggested clarifying revisions to the drafting notes at the end of Section 8B by: 1) deleting the word "supplemental" and replacing it with "supplementary;" 2) deleting the word "resemble" and replacing it with "could be mistaken for;" and 3) deleting the word "developed" and replacing it with "offered." After discussion, the Subgroup accepted the suggested revisions.

The Subgroup next discussed the NAIC consumer representatives' comments on Section 8C—Disability Income Protection Coverage. Lucy Culp (The Leukemia & Lymphoma Society—LLS) said the NAIC consumer representatives suggest incorporating the language in the drafting note for Section 8C(2) into the subsection's substantive provisions. She said the NAIC consumer representatives also suggest clarifying the language in Section 8C(3). The Subgroup agreed that the drafting note language should be incorporated into Section 8C(2). After discussion, the Subgroup agreed to revise Section 8C(2) to read as follows: "(2) Contains an elimination period no greater than: (a) Fifty percent (50%) of the benefit period in the case of a coverage providing a benefit of one hundred and eighty (180) days or less; (b) Ninety (90) days in the case of a coverage providing a benefit of one hundred and eighty (180) days to one year; (c) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or (d) Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury." To clarify Section 8C(3), the Subgroup also agreed to delete the word "maximum."

The Subgroup next discussed the Schiffbauer Law Office's suggestion to add the word "injury" to Section 8D—Accident Only Coverage for consistency with other provisions in the revised model. After discussion, the Subgroup accepted the suggested revision.

The Subgroup next discussed the NAIC consumer representatives' and Schiffbauer Law Office's suggested revisions to Section 8E—Specified Disease Coverage. The NAIC consumer representatives suggest clarifying Section 8E(1) by adding a cross-reference to paragraph (2). The Subgroup accepted the suggested revision. The Schiffbauer Law Office suggests the same revisions to the drafting note for Section 8E(6)(a) as those made to the drafting note for Section 8B(2). The Subgroup accepted the suggested revisions.

The Subgroup next discussed the Schiffbauer Law Office's suggested revisions to the drafting note for Section 8G—Limited Benefit Health Coverage. The first suggested revision seeks to clarify the language in the drafting note's second sentence, which discusses situations when excepted benefit-type products may be combined with other types of products. After discussion, the Subgroup decided not to accept the suggested revision because the suggested language seemed more confusing than clarifying. The Subgroup accepted the second revision, which added the same language the Subgroup agreed to add to the drafting notes for Section 8B(2) and Section 8E(6)(a).

The Subgroup next discussed the comments received on whether it should retain the proposed language in Section H—Short-Term, Limited-Duration Health Insurance Coverage establishing requirements for canceling a short-term, limited-duration (STLD) plan. During its initial discussions of this provision, the Subgroup preliminarily added the language but requested that NAIC staff flag it for future discussion after it completed its review of all the initial comments received on the model. The Subgroup received two comments on this provision—the Health Benefits Institute (HBI) and the NAIC consumer representatives. Both the HBI and the NAIC consumer representatives suggest retaining the provision because it is an important consumer protection provision. The Subgroup agreed.

The Subgroup next discussed the NAIC consumer representatives' comments, alerting the Subgroup that the revised model does not include minimum standards for limited-scope vision coverage and limited-scope dental coverage. The Subgroup discussed the comments. During the discussion, the Subgroup noted that Section 5—Minimum Standards for Benefits of the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170), which is the companion model act to Model #171, does not provide for the establishment of minimum standards for these coverages and during the revision process for Model #170, no one suggested adding language to this provision to require the establishment of such standards.

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

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Draft: 4/4/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
March 25, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met March 25, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers and Stephen Flick (DC); Christina Jackson (FL); Camille Anderson-Weddle (MO); Maggie Reinert (NE); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet, Mary Block, and Jamie Gile (VT); and Ned Gaines (WA).

1. Discussed the Dec. 1, 2023, Comments Received on Draft Revisions to Model #171

The Subgroup continued its discussion of the Dec. 1, 2023, comments submitted on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) beginning with the NAIC consumer representatives' comments on Section 7D. Section 7D prohibits insurers from limiting or excluding coverage by type of illness, accident, treatment, or medical condition except as provided in the section. Lucy Culp (The Leukemia & Lymphoma Society—LLS) reiterated the NAIC consumer representatives' objection to the inclusion of "mental or emotional disorders, alcoholism, and drug addiction" and "suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury" as allowable limitations or exclusions from coverage for any type of supplemental or short-term policies. The Subgroup discussed the NAIC consumer representatives' comments. During the discussion, some Subgroup members noted that the removal of the permitted limitation or exclusion of coverage for "mental or emotional disorders, alcoholism, and drug addiction" or "suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury" for these products could adversely impact the availability and affordability of such products for consumers. The Subgroup discussed how Vermont does not permit these limitations or exclusions for disability products. After additional discussion, the Subgroup decided to leave Section 7D unchanged.

The Subgroup next discussed Section 7E. Section 7E allows insurers to issue waivers that exclude or limit coverage for certain preexisting conditions or extra hazardous activities. The NAIC consumer representatives suggest deleting Section 7E because they find it unnecessary and at odds with the Subgroup's purpose, which is to set minimum standards. The NAIC consumer representatives suggest the Subgroup adopt minimum standards and not permit insurers to offer waivers limiting or excluding coverage under Section 7E. The Subgroup discussed the comments submitted regarding Section 7E. The American Council of Life Insurers (ACLI) suggests retaining Section 7E because if the Subgroup removes it, then most likely, consumers with preexisting conditions will be denied coverage completely rather than the consumer obtaining coverage except for the preexisting disease, physical condition, or extra hazardous activity that is subject to the waiver. America's Health Insurance Plans (AHIP) also suggests retaining Section 7E because, without such a provision, there would be nothing in Model #171 outlining the structure or use of waivers or for the consumer disclosure and acceptance of such a waiver. After additional discussion, the Subgroup decided to retain Section 7E.

The Subgroup next discussed the use of the term "spouse" in Section 8A. During its previous discussions of this provision, the Subgroup discussed the use of the term "spouse" and possible alternative terms to use in its place, considering the varying interpretations and meanings of the term from state to state. After extensive discussion, the Subgroup decided to retain the term "spouse" and add a drafting note suggesting that the states, when reviewing the language in Section 8A, insert replacement or additional terms in accordance with the state's laws or regulations.

The Subgroup next discussed whether to move Section 8A(10), which is a provision permitting insurers to include in a policy a provision related to recurrent disabilities, to another section in Model #171. During its previous discussions of this provision, the Subgroup had initially considered moving Section 8A(10) to another section in Model #171 related to disability policies because it seemed to be applicable only to those types of policies. The Subgroup discussed the comments received on this issue. The comments from the ACLI and AHIP suggest leaving Section 8A(10) in its current place in Model #171 because its provisions could apply to other types of policies in addition to disability policies. After additional discussion, the Subgroup decided to leave Section 8A(10) in its current place.

The Subgroup next discussed Schiffbauer Law Office's suggestion to delete "triggered by" in Section 8B(1) and replace it with "as a result of." William Schiffbauer (Schiffbauer Law Office) explained that he is suggesting this revision to be consistent with other proposed revisions in Model #171. After discussion, the Subgroup accepted his suggested revision.

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

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2024 Summer National Meeting
Chicago, Illinois

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) (B) WORKING GROUP
Wednesday, August 14, 2024
11:30 a.m. – 12:30 p.m.

Meeting Summary Report

The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group will meet Aug. 14, 2024. During this meeting, the Working Group plans to:

1. Hear presentations on clinical guidelines for behavioral health care.

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: 3/27/24

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Phoenix, Arizona
March 17, 2024

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Phoenix, AZ, March 17, 2024. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jane Beyer, Vice Chair (WA); Crystal Phelps (AR); Gio Espinosa (AZ); Cara Cheevers and Debra Judy (CO); Kurt Swan (CT); Stephen Flick (DC); Elizabeth Nunes (GA); Andria Seip (IA); Julie Holmes (KS); Mary Kwei (MD); T.J. Patton (MN); Teresa Kroll (MO); Robert Croom and Ted Hamby (NC); Chrystal Bartuska and Karri Morris (ND); Ralph Boeckman and Erin Porter (NJ); Viara Ianakieva (NM); Kyla Dembowski (OH); Ashley Scott and Landon Hubbart (OK); Caroline Boehm (PA); Jill Kruger (SD); Rachel Bowden (TX); Heidi Clausen and Shelley Wiseman (UT); Julie Fairbanks (VA); Rebecca Rebholz (WI); Joylynn Fix (WV), and Jill Reinking (WY).

1. Heard Presentations on Opioid Use Disorder and Medication for Opioid Use Disorder

Weyhenmeyer said that state insurance regulators perform detailed analysis of coverage policy and claims data, but they lack health care providers' knowledge of diseases like opioid use disorder and effective treatments for it. She said expert physician speakers would help educate the Working Group on the effects of opioid use disorder and the evidence that supports treatment for the disorder.

Dr. Jesse Ehrenfeld (American Medical Association—AMA) said the overdose epidemic is a critical issue for the nation. He said patients with mental illness and substance use disorder need the help of parity laws that are intended to protect them. He shared data on the rising numbers of overdose deaths and the large share of deaths caused by illicit fentanyl. He said more than 100,000 people die per year due to the epidemic of overdose.

Dr. Ehrenfeld described resources from the AMA on opioids, including reports on pregnant women and justice-involved individuals, a toolkit for policymakers, and a report with statistics on the epidemic. He reviewed key trends in opioid use disorder, including reduced opioid pain prescriptions, the end of barriers to prescribing like the X waiver, the success of naloxone, and remaining barriers to care like prior authorization. He said the AMA is happy to work with state insurance regulators to strengthen state or federal parity laws if regulators do not believe they grant sufficient authority. He urged states to impose significant monetary penalties on health plans for parity violations.

Dr. Ehrenfeld said that workforce challenges exist for mental health, but in comparison to medical crises like cardiac arrest, mental health treatment is not immediate and does not have appropriate follow-up. He said medical decisions are not questioned by health plans when the decisions follow the standard of care. He said that too often, health plans have no problem denying or delaying care for mental health conditions.

Dr. Marcus Bachhuber (Center for Evidence-based Policy) presented on medications for opioid use disorder. He described the effects of opioid use as doses increase and the increasing occurrence of withdrawal for patients. He said substance use disorders share many features with other chronic medical illnesses, such as periods of remission and relapse.

Dr. Bachhuber reviewed treatments for opioid use disorder. He said there was an early recognition that opioid use is different from other drug use disorders. He noted the history of treatments, including municipal morphine

clinics, methadone clinics, and the development of buprenorphine and injectable naloxone. He showed the effects of medications on the opioid receptors in the brain.

Dr. Bacchuber said that medication treatment for opioid use disorder is effective and lifesaving and that treatment retention is similar to other chronic conditions. He said methadone and buprenorphine generally have similar outcomes and that naltrexone requires a patient to undergo withdrawal before treatment. He said the three medications are delivered to different patients in different settings depending on the clinical circumstances, and there is not one optimal treatment for everyone.

Dr. Bacchuber covered the rules for prescribing the three medications and their dose and quantity limits. He said limitations on duration of therapy can disrupt treatment and put patients at risk for overdose death.

Dr. Bacchuber said state insurance regulators have used parity exams to compare health plans' coverage of medications to opioid use disorder with coverage for opioids for treatment of pain, as well as with other medications. He said states have found differences such as excluding methadone, applying different prior authorization requirements, or placing all medications on a high tier.

Dr. Bacchuber shared additional resources on the three medications, including from the Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM), and the Center for Evidence-based Policy.

Beyer said state Medicaid programs often use information from the Center for Evidence-based Policy for setting coverage standards and that the same information can support the work that state insurance regulators do in mental health parity.

Seip asked whether generic equivalents exist for the drugs Dr. Bacchuber discussed. He said methadone is a generic, there are generic forms of buprenorphine, and only the brand form of naltrexone is approved for the treatment of opioid use.

2. Discussed Other Matters

Joe Feldman (Cover My Mental Health) said he is working to learn more about consumer complaints to state insurance regulators. He asked members of the Working Group to share how consumers can use the services their state departments of insurance (DOIs) provide. He said he will present at the Summer National Meeting on obstacles that consumers face in accessing mental health services.

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.

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Virtual Meetings

PHARMACY BENEFIT MANAGER REGULATORY ISSUES (B) SUBGROUP
June 7, 2024 / May 2, 2024

Summary Report

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup June 7 and May 2, 2024. During these meetings, the Subgroup:

1. Discussed and heard from stakeholders who commented on its proposed revised 2024 charges.

2. Adopted its proposed revised 2024 charges, which included renaming the Subgroup as the "Pharmaceutical Benefit Management Regulatory Issues (B) Working Group."

3. Forwarded the proposed revised 2024 charges to the Regulatory Framework (B) Task Force for its consideration and adoption.

Draft: 7/1/24

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Virtual Meeting
June 7, 2024

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met June 7, 2024. The following Subgroup members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Kayla Erickson and Jeanne Murray (AK); Willard Smith (AL); Amy Seale (AR); Paul Lombardo (CT); Stephen Flick (DC); Sheryl Parker (FL); Andria Seip (IA); Erica Weyhenmeyer (IL); Vicki Schmidt (KS); Sharon P. Clark (KY); Chad Arnold and Joe Stoddard (MI); Norman Barrett Wiik (MN); Cynthia Amman and Amy Hoyt (MO); Robert Croom (NC); Cheryl Wolff (NE); Tim Stroud (NJ); Renee Blechner (NM); Jennifer Boyle, Kristina Magne, and Krista Porter (NY); TK Keen (OR); Jodi Frantz (PA); Elliott G. Webb (TN); Tanji J. Northrup (UT); Jennifer Kreitler and Ned Gaines (WA); Jennifer Stegall (WI); and Jill Reinking (WY).

1. Adopted its Revised 2024 Charges

Fix said that following the Subgroup's May 2 meeting during which the Subgroup discussed the comments received on its draft 2024 revised charges, the Subgroup met in regulator-to-regulator session to have an open and honest discussion, particularly on the draft 2024 revised charge 5C to review and consider revisions to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22). She said that during this discussion Subgroup members and interested regulators indicated a more urgent need to have the Subgroup develop standardized market conduct examination standards for pharmacy benefit managers (PBMs) rather than reviewing Model #22. Fix explained that many state insurance departments now have the authority to conduct PBM market conduct examinations, but there currently is no guidance to assist state insurance regulators in conducting such examinations. She noted that such examination standards would have to include flexibility to reflect differences in state law. She also noted that in developing these examination standards, the Subgroup will rely on its expertise as the subject matter experts on PBMs and the prescription drug ecosystem, but it would also rely on the market conduct examination expertise of some of its members as well as industry and other stakeholder input, which will be essential to the Subgroup's work.

Fix said that prior to this meeting, NAIC staff distributed the revised draft 2024 revised charges, deleting the proposed 2024 revised charge 5C, which was to review and consider revisions to Model #22, and adding a new proposed 2024 revised charge in its place to "develop a chapter for inclusion in the *Market Regulation Handbook* establishing examination standards for PBMs and related entities for referral and consideration by the Market Conduct Examination Guidelines (D) Working Group." She said the Subgroup received comments from America's Health Insurance Plans (AHIP) and the Pharmaceutical Care Management Association (PCMA).

Kris Hathaway (AHIP) said that as noted in its comment letter, AHIP had questions about the process and how the Subgroup envisioned working with the Market Conduct Examination Guidelines (D) Working Group as it develops the proposed new PBM market conduct examination standards chapter for the *Market Regulation Handbook*. She said that in addition, AHIP has concerns about standardizing the PBM examination standards given the different approaches states have taken. To address this concern, AHIP suggests adding the words "while remaining sensitive to variation in state approaches" to the draft 2024 revised charge 5C. In response to AHIP's first question about the process, Fix said she envisions the Subgroup developing the new chapter and referring it to the Market Conduct Examination Guidelines (D) Working Group for its consideration. She anticipates the Market Conduct Examination Guidelines (D) Working Group will accept the referral and the Subgroup's draft PBM market conduct examination standard chapter for its consideration, and after receipt, the Working Group will follow its normal process of exposing the document for comment and discussing any comments and suggested revisions during

open meetings prior to considering its adoption. Fix said she supported adding AHIP's suggested language to the revised draft 2024 revised charge 5C to reflect the different approaches states have taken.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the PCMA, said the PCMA appreciates the revisions to the draft 2024 revised charges. He said the PCMA welcomes the opportunity to work with the Subgroup as it moves forward with the charge 5C to develop PBM market conduct examination standards for inclusion in the *Market Regulation Handbook*. He noted the PCMA's experience in this area, particularly on what works and what does not work in the various states from a national perspective. Randi Chapman (Blue Cross and Blue Shield Association—BCBSA) said that although it did not submit written comments, the BCBSA wanted to provide comments during this meeting expressing its appreciation for the work the Subgroup has done to develop the draft 2024 revised charges. She said the BCBSA also looks forward to working with the Subgroup as it works to develop a PBM market conduct examination standards chapter.

After discussion, the Subgroup agreed to revise the draft 2024 revised charge 5C to add the language suggested by AHIP, which would have the charge read as follows: "As the subject matter experts and to promote uniformity across the states, while remaining sensitive to variation in state approaches, develop a chapter for inclusion in the *Market Regulation Handbook* establishing examination standards for PBMs and related entities for referral and consideration by the Market Conduct Examination Guidelines (D) Working Group."

Weyhenmeyer made a motion, seconded by Northrup, to adopt the draft 2024 revised charges (Attachment ?-A). The motion passed unanimously.

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

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Draft: 5/23/24

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Virtual Meeting
May 2, 2024

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met May 2, 2024. The following Subgroup members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Kayla Erickson and Sarah Bailey (AK); Anthony Williams and Yada Horace (AL); Amy Seale (AR); Paul Lombardo and Michael Shanahan (CT); Sheryl Parker and Samantha Heyn (FL); Andria Seip (IA); Erica Weyhenmeyer (IL); Craig VanAalst (KS); Daniel McIlwain (KY); Nina Hunter (LA); Chad Arnold, Tina Nacy, and Joe Stoddard (MI); Norman Barrett Wiik (MN); Chlora Lindley-Myers and Amy Hoyt (MO); Cheryl Wolff (NE); Renee Blechner (NM); Alice McKenney (NY); Ted Hamby (NC); TK Keen (OR); Shannen Logue and Sandy Ykema (PA); Elliott G. Webb (TN); Tanji J. Northrup, Heidi Clausen, and Shelley Wiseman (UT); Jennifer Kreitler (WA); Nathan Houdek and Jennifer Stegall (WI); and Jill Reinking (WY). Also participating was: Chrystal Bartuska (ND).

1. Discussed the April 19 Comments Received on its Draft Proposed Revised 2024 Charges

Fix said the purpose of this meeting is for the Subgroup to hear from stakeholders who submitted comments on the Subgroup's draft proposed 2024 revised charges (Attachment A). She said the Subgroup received comments from America's Health Insurance Plans (AHIP), the NAIC consumer representatives, the Healthcare Distribution Alliance (HDA), the National Association of Chain Drug Stores (NACDS), the National Community Pharmacists Association (NCPA); the North Dakota Insurance Department, and the Pharmaceutical Care Management Association (PCMA).

Samatha Burns (AHIP) said that, as discussed in its comment letter, AHIP recommends that the Subgroup remain a subgroup and not change to a working group. She said the term "working group" implies this will be a long-term commitment instead of gathering relevant information, completing the task, and ending within the next few years. Burns said AHIP also recommends specifically listing the supply chain entities—drug manufacturers and pharmacy services assistance organizations (PSAOs)—rather than the less prescriptive "stakeholders." She said this more descriptive listing will prompt Subgroup members to consider the various entities and potential topics to discuss for further education. Burns said AHIP recommends the proposed charge to review and consider revisions to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) be eliminated given the history related to the development and the NAIC membership's failure to adopt the proposed [State] Pharmacy Benefit Manager Licensure and Regulation Model Act. She noted that removing the charge does not preclude the Subgroup from discussing it. Deleting the charge merely eliminates the requirement for the Subgroup to review the model.

Will Dane (HDA) said the HDA believes the Subgroup's proposed 2024 revised charges provide a thoughtful approach to further the Subgroup's work as it transitions to the Pharmacy Benefit Management Regulatory Issues (B) Working Group and supports their adoption. He said the HDA stands ready to be a resource to the Working Group, as necessary, as it moves forward with its work.

Carl Schmid (HIV+Hepatitis Policy Institute), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives submitted a comment letter to the Regulatory Framework (B) Task Force for its consideration during its meeting at the Spring National Meeting expressing strong support for the draft revised 2024 proposed charges. He said that because Model #22 failed to include provisions directly regulating pharmacy benefit managers (PBMs) or specifically address the significant role that PBMs play in prescription drug benefit plan design and delivery, the NAIC consumer representatives strongly support its review and update to reflect the changing times since it was adopted. Schmid noted that although the states have taken differing steps in regulating

PBMs, consumers can benefit from and need an agreed-upon minimum level of protection by state insurance regulators.

Joel Kurzman (NCPA) said the NCPA is generally supportive of the proposed 2024 revised charges; however, based on its priorities, the NCPA suggests the Subgroup remain focused on PBMs rather than including other stakeholders in the prescription drug ecosystem and prioritize all its activities on the enforcement of existing PBM state insurance laws. He said the NCPA believes a focus on enforcement of existing PBM state laws is a topic most stakeholders can appreciate and brings practical value to state insurance regulators. Kurzman also said that if the Subgroup decides to revisit Model #22, the NCPA believes the most relevant possible addition would be a section establishing enforcement provisions. He noted that given the Subgroup's previous discussions related to the proposed [State] Pharmacy Benefit Manager Licensure and Regulation Model Act and the PBM white paper, the NCPA prefers the Subgroup focus on the other proposed 2024 revised charges, especially those pertaining to best practices, to assist state insurance regulators in overseeing and enforcing state PBM laws.

Sandra Guckian (NACDS) reiterated the NACDS's belief about the importance of PBM licensure and the state insurance regulatory environment. She said that while the emergence of greater regulation of PBM actions is essential, so too is a regulatory structure that adequately equips the states to respond to potential law violations, whether through fines or other civil penalties, license revocation, or both. Guckian said the Subgroup can establish such a regulatory structure by adding such provisions to Model #22. She said the NACDS also supports the NCPA's comments and urges the Subgroup to maintain its focus on PBMs, particularly enforcement of current PBM state insurance laws, to continue to help protect patients and patient access to pharmacies in communities nationwide.

Bartuska said the North Dakota Insurance Department suggests the Subgroup consider revising the proposed 2024 revised charge concerning its potential review of Model #22 to remove the words "and consider any necessary updates to" and "out of" and substitute the words "due to." She said that with these suggested revisions, the proposed 2024 revised charge would read: "Review the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) due to the emergence of greater regulation in the prescription drug ecosystem." She said the North Dakota Insurance Department believes these suggested revisions remove the pressure on the Subgroup to feel compelled to offer updates to Model #22 when its focus should be on a thorough review of the model during the remainder of the year.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the PCMA, said the PCMA believes it is important for the Subgroup to expand its focus to look at all the stakeholders in the prescription drug supply chain and their relationship with each other to identify all the factors possibly affecting the cost of prescription drugs. He said that as stated in its comment letter, the PCMA does not believe it is appropriate to include a charge suggesting the Subgroup's successor working group review and consider updates to Model #22 because it would be premature, and, as already discussed, no state has adopted it in its entirety. Petersen also said Model #22 does not contemplate regulating PBMs. He said given these concerns, the proposed 2024 revised charge concerning the potential review of Model #22 should be deleted.

Seip asked Petersen why the PCMA believes the Subgroup's focus should be expanded to include all stakeholders in the prescription drug supply chain. Petersen said the PCMA believes expanding the Subgroup's focus to include all the stakeholders would allow it to better understand all the factors that go into the cost of prescription drugs. He said the PCMA believes PBMs reduce the cost of drugs, while other stakeholders in the prescription drug supply chain suggest PBMs increase the cost. Petersen said that if the Subgroup focuses its work on all the parties to the transaction, it will be able to see what portion of costs are attributed to each party. He said the Subgroup needs to understand how the entire prescription drug supply chain works and how each part impacts prescription drug costs. Seip asked Petersen for the source of the graphic included in the PCMA's April 18 comment letter stating

that prescription drug manufacturers and pharmacies retain 90% of each dollar that enters the prescription drug ecosystem. Petersen said he did not have that information but would follow up with the Subgroup.

Charise Richard (Pharmaceutical Research and Manufacturers of America—PhRMA) said that although PhRMA did not submit written comments on the Subgroup's proposed revised 2024 charges, she wants the Subgroup to know that PhRMA supports the Subgroup's efforts to better understand PBM practices and their central role in the prescription drug supply chain. She noted PhRMA's disappointment that the PBM white paper omitted several patient-centered solutions to the issues being discussed. She said that, despite this, PhRMA hopes that over time, the Subgroup will find solutions that better help patients to afford their prescriptions.

Weyhenmeyer expressed support for redesignating the Subgroup as a working group. She explained that in assisting to develop the Subgroup's proposed 2024 revised charges, the Subgroup would mirror the work of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group and have ongoing work on a complex issue of interest to all the states for which it will serve as a forum and provide an opportunity for state insurance regulator and stakeholder discussion and ongoing education. Wolff expressed support for the North Dakota Insurance Department comments about reviewing Model #22. She said Nebraska's PBM laws were a carefully crafted compromise among all the parties. Given this, she does not foresee Nebraska changing its PBM laws based on revisions to an NAIC model.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/PBM Regulatory Issues Subgrp/PBM Reg Issues MtgMin 5-2-24.docx

Agenda Item #3

Hear a Presentation on Facility Fees—*Rachel Swindle (Center on Health Insurance Reforms [CHIR] at Georgetown University's McCourt School of Public Policy)*

Outpatient Facility Fee Billing Reforms: Options for States

Health Insurance and Managed Care Committee:
Regulatory Framework (B) Task Force
-NAIC August 2024-

Rachel Swindle
Research Fellow

GEORGETOWN UNIVERSITY
McCourt School of Public Policy
CENTER ON HEALTH INSURANCE REFORMS

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

What are Facility Fees?

- A second fee that hospitals charge in addition to a health care professional's bill.
- Asserted to cover hospital overhead costs.
- Increasingly accompany routine medical care as hospital ownership over outpatient physician practices becomes the norm.

Facility Fee Reform Options

Issues to tackle:

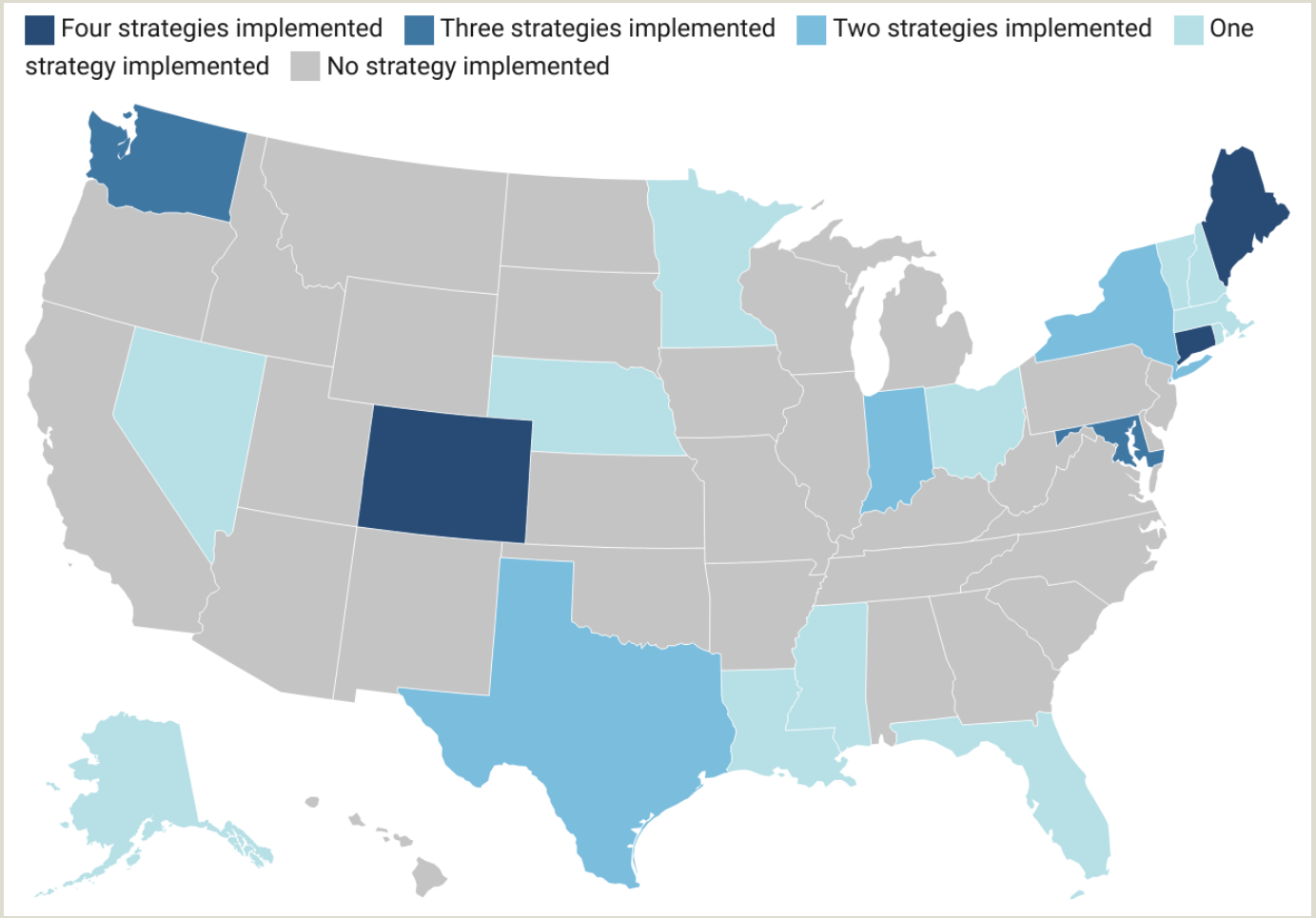
- Consumer out-of-pocket cost exposure
- Rising spending
- Lack of transparency in billing and ownership

Potential solutions

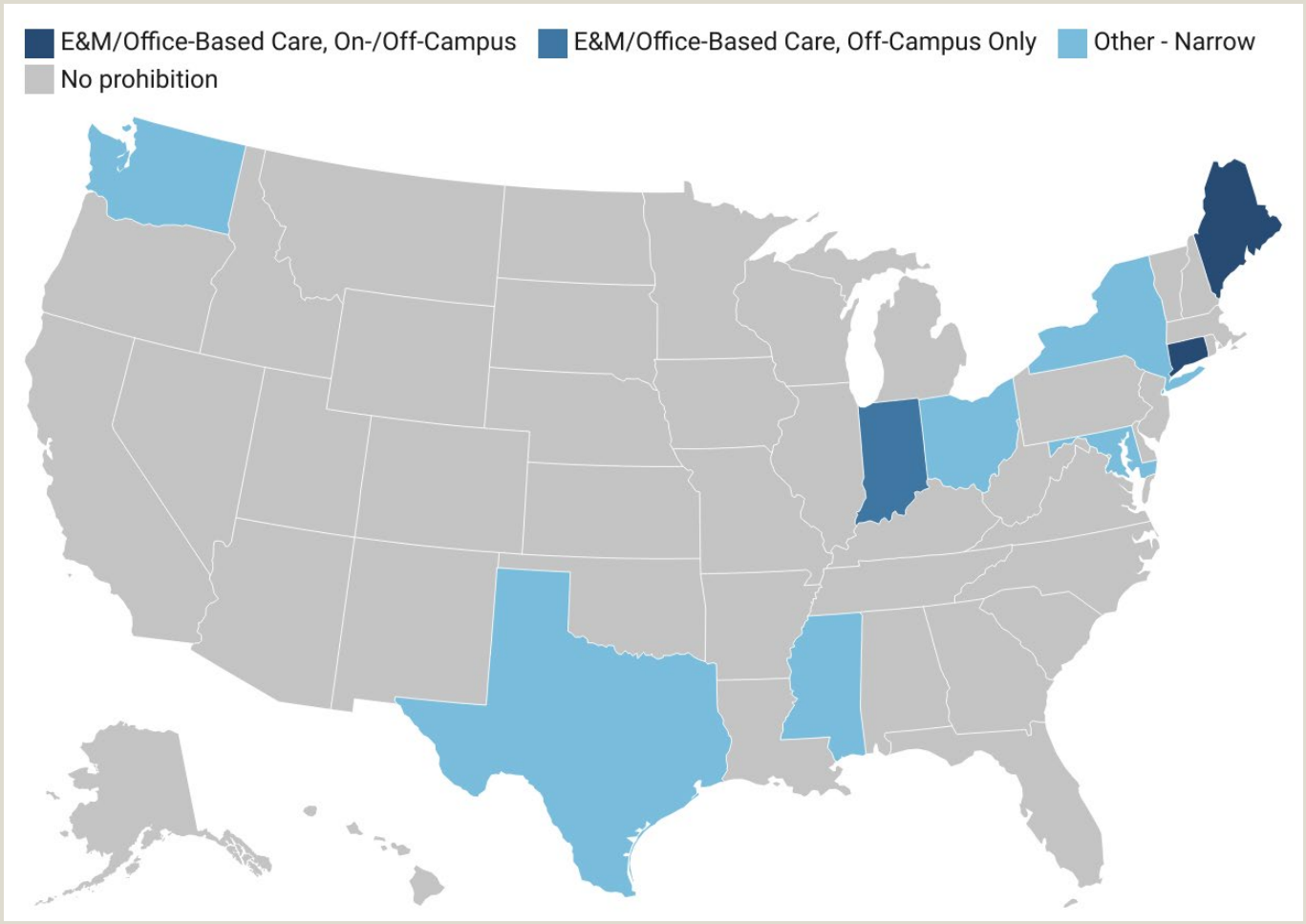
- Site-neutral payment
- Facility fee billing ban
- Billing transparency
- Public reporting
- Cost-sharing protections
- Consumer notification requirements

See how different policies measure up on our Cheat Sheet for Policymakers

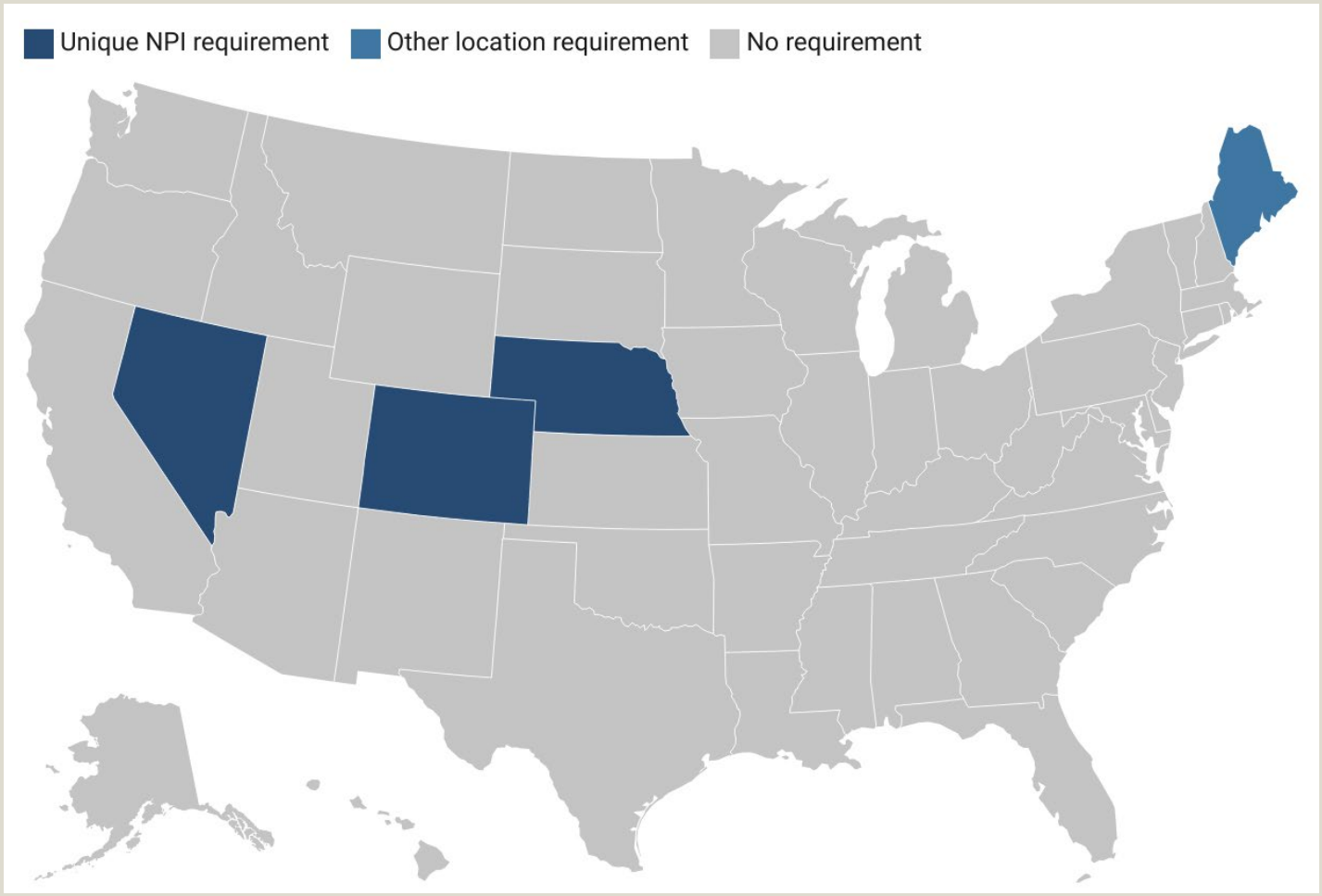
Overall Picture of State Reforms



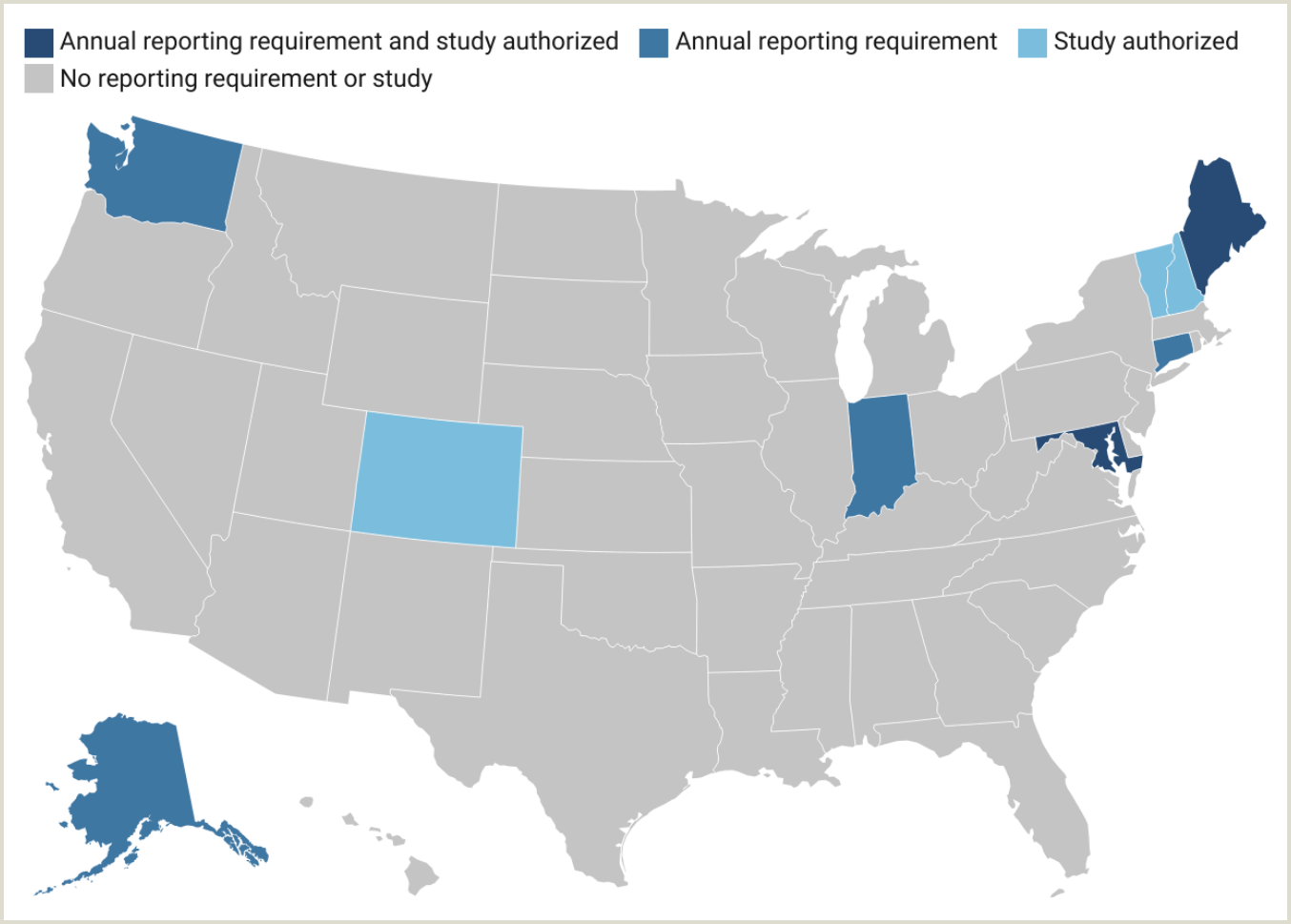
Facility Fee Prohibitions



Billing Transparency



Public Oversight



State Uptake By Reform

Reform	State Uptake
Site-Neutral Payment	0: (Proposals in development)
Facility Fee Billing Ban	9: CT, IN, MD, ME, MS, NY, OH, TX, WA
Billing Transparency	4: CO, ME, NE, NV
Public Reporting	9: AK, CO, CT, IN, MD, ME, NH, VT, WA
Cost-Sharing Protections	2: CO, CT
Consumer Notification Requirements	12: CO, CT, FL, LA, MA, MD, ME, MN, NY, RI, TX, WA

Questions?

More on Outpatient Facility Fees:

https://facilityfeereform.chir.georgetown.edu/

Other CHIR Publications:

www.chir.georgetown.edu

CHIRblog:

www.chirblog.org

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westhealth

GEORGETOWN UNIVERSITY McCourt School of Public Policy
CENTER ON HEALTH INSURANCE REFORMS

November 2023

Outpatient Facility Fee Reform Strategies

A Cheat Sheet on Key Goals and Strategies for Policymakers

Policymakers have several options for reforming hospital outpatient billing practices to better protect consumers, reduce health care costs, and increase transparency. These goals and the strategies outlined below are not mutually exclusive and may be pursued as a complementary package.

Policies to protect patients are emerging incrementally.

As hospitals acquire or otherwise affiliate with physician practices, they can charge facility fees—**a second fee in addition to a health care professional's bill**—for outpatient care. This practice results in higher spending, which increases premiums and out-of-pocket costs for consumers without improving quality.

Policymakers are responding with a variety reforms, with states leading the way.

- States are **prohibiting hospitals from charging fees for certain outpatient services**, such as evaluation and management services or preventive care, **or care provided in certain outpatient settings**, such as off-campus office practices, on the basis that these services and settings do not draw on significant facility resources.
- States are seeking to **shield consumers from out-of-pocket costs** by requiring health plans to treat facility fees as covered benefits, limiting consumer cost-sharing for these charges, and requiring providers and insurers to **disclose facility fee to consumers**.
- States are **improving their data on facility fee payments and practice ownership** to better understand facility billing. These efforts can facilitate policy change, bolster effective implementation and oversight of reforms, and support private payer actions to respond to facility fee billing.
- Federal policymakers have initiated similar payment reforms by requiring Medicare to make "site neutral" payments—the same price for the same service, regardless of setting—for outpatient services in some circumstances and introduced proposals to **set site-neutral payment caps for certain outpatient services in the commercial market**.

STATES LEADING THE WAY

Colorado

Colorado requires hospital outpatient departments and other hospital-owned or affiliated locations to acquire and use unique National Provider Identifiers (NPI) and expanded its law in 2023 to address ownership transparency and establish a steering committee to study additional reforms.

Connecticut

Connecticut leads the country in the scope and comprehensiveness of its facility fee reforms, including laws that prohibit facility fees for certain services, require public reporting on facility fee charges, protect consumers from out-of-pocket costs, and require facilities to disclose fees to consumer in advance of medical appointments and at the point of service.

Indiana

In 2023, Indiana enacted a law prohibiting large non-profit hospitals from charging facility fees for certain services and requiring hospitals to report on facility fee charges.

What about ERISA?

ERISA limits states' authority to regulate employer-sponsored health plans, but states retain broad authority to regulate health care providers, including what hospitals and other providers may charge for services, what they must report to states, and what they must tell consumers about health care charges.

Facility Fee Reform Strategies: A Closer Look

STRATEGY 1: Site-Neutral Payment Caps

Prohibit hospital-owned and -affiliated facilities from charging facility fees for specified outpatient services **AND** cap provider reimbursement for these services (e.g., at a percentage of Medicare rates or the median price insurers pay independent physician offices in the same area).

STRATEGY 2: Facility Fee Billing Prohibitions

Prohibit hospital-owned and -affiliated facilities from charging facility fees for specified outpatient services, such as those that can be safely and effectively provided outside of a hospital-setting.

STRATEGY 3: Billing & Ownership Transparency

Require hospital-owned and -affiliated providers to acquire and include unique National Provider Identifiers specific to the location of care on all claims. Monitor health care provider affiliations and acquisitions.

STRATEGY 4: Outpatient Facility Fee Reporting Requirements

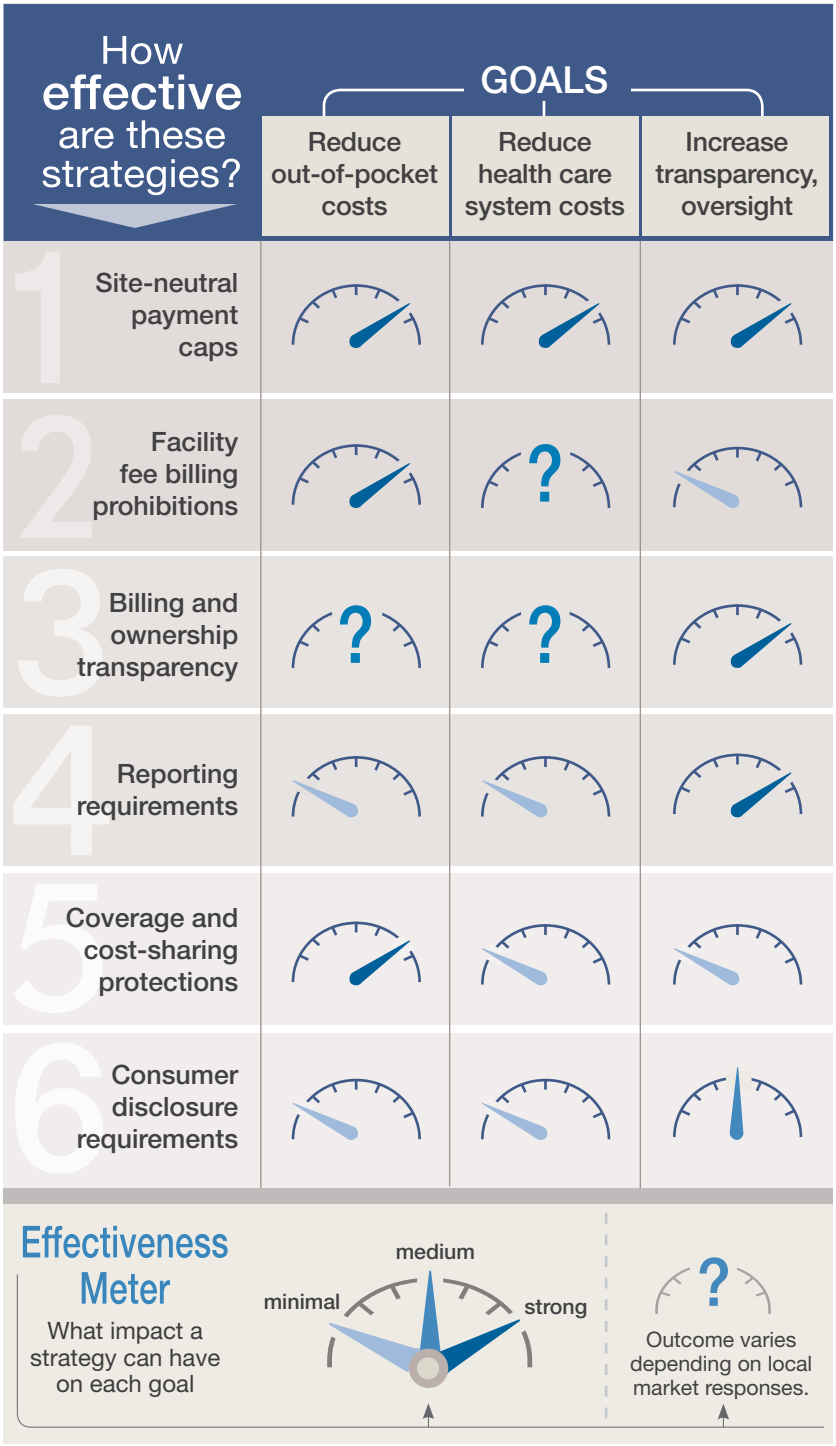
Require hospitals to report on outpatient facility fee billing, including the locations charging facility fees and the revenue from those fees, as well as the volume and amounts of facility fees by service, payer, and location.

STRATEGY 5: Coverage and Cost-Sharing Protections

Require state-regulated insurance policies to cover and limit consumer cost-sharing for outpatient facility fees.

STRATEGY 6: Consumer Disclosure Requirements

Require health care providers and state-regulated insurers to notify consumers before charging outpatient facility fees, including through physical signs and written and oral communications.



Want to learn more?

For more detailed information on state actions to regulate outpatient facility fee billing, see the recent report and issue brief from the Center on Health Insurance Reforms (CHIR) and West Health.

Policymakers and advocates considering facility fee reforms are encouraged to contact CHIR experts for technical assistance at FacilityFeeTA@georgetown.edu.

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Regulating Outpatient Facility Fees:

States Are Leading the Way to Protect Consumers

BY CHRISTINE H. MONAHAN, KAREN DAVENPORT, RACHEL SWINDLE, AND CAROLINE PICHER

July 2023

In recent years, health care consumers, payers, and policymakers have brought attention to the growing prevalence of hospital outpatient facility fees in the United States. As hospitals and health systems expand their ownership and control of ambulatory care practices, they are typically charging new facility fees for services delivered in these outpatient settings. Consumers, too, are facing greater financial exposure to these charges as insurance deductibles increase and payers develop new benefit designs that increase patients' exposure to cost-sharing, particularly in hospital outpatient settings.

Consequently, state policymakers, spurred on by consumer advocacy groups and a budding contingent of employers and business groups, are pursuing reforms that would limit hospitals' ability to charge outpatient facility fees and/or better protect consumers from such bills.

This issue brief explores why and how many states are taking on the regulation of outpatient facility fees. Its findings are informed by an analysis of current laws and regulations across 11 study states—**Colorado, Connecticut, Florida, Indiana, Maine, Maryland, Massachusetts, New York, Ohio, Texas,** and **Washington**—and more than 40 qualitative interviews with key stakeholders and experts between November 2022 and April 2023. For a more in-depth examination of this issue, a companion report is available here.

Key Findings:

- Concern is growing that hospital outpatient facility fees are adding to consumers' and employers' health care costs—both through higher out-of-pocket charges and rising insurance premiums.

- States have been at the forefront of protecting consumers from unwarranted outpatient facility fees in the commercial market. The five reforms most commonly adopted by states are described in Table 1. These include:
  1. Prohibitions on facility fees;
  2. Out-of-pocket cost protections for consumers;
  3. Consumer disclosure requirements;
  4. Hospital reporting requirements; and
  5. Provider transparency requirements.

- Despite strong opposition from hospitals, state action to constrain outpatient facility fees is clearly gaining momentum.

Why Action on Facility Fees Is Needed

Facility fees are the charges institutional health care providers, such as hospitals, bill ostensibly to cover their operational expenses for providing health care services. Hospitals submit these charges separately from the professional fees physicians and certain other health care practitioners, such as nurse practitioners, physician assistants, and physical therapists, charge to cover their time and expenses. Traditionally, public and private payers pay more in total for the same services provided in a hospital—including, importantly, hospital-owned outpatient departments—than care provided in an independent physician's office or clinic.

This payment differential both encourages and exacerbates the effects of vertical integration in the U.S. health care system, as hospitals and health systems increasingly acquire physician practices and other outpatient health care providers. When a hospital acquires or otherwise affiliates with a practice, ambulatory services provided at the practice often newly generate a second bill, the facility fee, on top of the professional fees the practitioners charge. As hospitals expand their control over more physician and other outpatient practices, they can also exert greater power in their negotiations with commercial health insurers and extract even higher charges.

> We are very worried about the prices that facility fees impose on the consumer, the carrier, and ultimately the premium."
>
> **— STATE HEALTH INSURANCE REGULATOR**

The growth in outpatient facility charges increases overall health care spending, resulting in higher premiums. Our research also suggests that insurance benefit designs are increasing consumers' direct exposure to these charges. Rising deductibles, which can subject consumers to several hundred dollars or more in facility fee charges for a single outpatient service, appear to be one factor. Even when a consumer has met their insurance deductible, a separate facility fee from the hospital, on top of a professional bill, may trigger additional cost-sharing obligations for the consumer, such as a separate co-insurance charge on the hospital bill. Commercial insurers also may impose higher cost-sharing on patients for receiving hospital-based care.

Consumers are often caught off guard by outpatient facility fee charges and may question why they are getting billed by a hospital for a run-of-the-mill visit to the doctor. Hospitals maintain that they need to impose these charges because of the extra costs they incur and services they provide—such as round-the-clock staffing, nursing and other personnel costs, and security—even though individual patients may not pose any additional costs or use the hospital's services. In contrast, payers and a range of policy experts view facility fee billing as a way hospitals leverage their market power and take advantage of the United States' complex and opaque payment and billing systems to increase revenue.

> You pay for the courtesy of going to the building owned by the hospital."
>
> **— FORMER STATE OFFICIAL**

Table 1. Outpatient Facility Fee Requirements in 11 Study States

	Regulatory Reform				
STUDY STATE	**1. Prohibition on Facility Fees** State prohibits providers from charging facility fees for specified procedures and/or care settings	**2. Out-of-Pocket Cost Protections** State limits consumers' financial exposure to outpatient facility fees in specified circumstances	**3. Consumer Disclosure Requirements** State requires specified providers and/or insurers to disclose that outpatient facility fees may be charged and/or the expected amount of outpatient facility fee charges or cost-sharing obligations, as applicable	**4. Hospital Reporting Requirements** State requires that hospitals make annual or one-time disclosures to the state on outpatient facility fee-related data	**5. Provider Transparency Requirements** State requires that health care providers register with national or state databases to better monitor where care is provided and/or who is providing care
COLORADO		No balance billing for facility fees for preventive services*	Hospitals and hospital-owned facilities,* freestanding emergency departments (EDs)	One-time study	Unique national provider identifier for off-campus locations
CONNECTICUT	Evaluation and management services on-* and off-campus, telehealth	No separate copayment on off-campus outpatient facility fees	Hospitals and hospital-owned facilities, insurers	Annual reporting	
FLORIDA			Hospitals and hospital-owned facilities, freestanding EDs		
INDIANA	Off-campus office settings owned by non-profit hospitals*			Annual reporting	
MAINE**	On- and off-campus office settings				
MARYLAND	Telehealth, COVID-19 testing and monoclonal antibodies		Hospitals and hospital-owned facilities	Annual reporting	
MASSACHUSETTS			Hospitals and hospital-owned facilities, insurers		Provider registry on ownership and affiliation
NEW YORK	Preventive services		Hospitals and hospital-owned facilities		
OHIO	Telehealth				
TEXAS	Drive-thru services at freestanding EDs		Freestanding EDs, insurers		
WASHINGTON	Telehealth (audio-only)		Hospitals and hospital-owned facilities	Annual reporting	

* Legislation has been enacted but requirement has not yet gone into effect. ** Maine recently enacted a bill to establish a task force to study facility fee billing and make a report to the legislature with recommendations. It also requires the state's all payer claims database to annually report on facility fee payments based on otherwise available data beginning in January 2024.

State Strategies to Regulate Outpatient Facility Fee Billing

While federal lawmakers and regulators have begun reining in payment discrepancies based on the site of care under Medicare, states are at the forefront of tackling outpatient facility fee billing in the commercial sector. Our analysis of the laws and regulations currently on the books in 11 study states demonstrates the range of reforms available (Table 1). Specifically, we identify five types of reforms states are beginning to adopt: (1) prohibitions on facility fees; (2) out-of-pocket cost protections; (3) consumer disclosure requirements; (4) hospital reporting requirements; and (5) provider transparency requirements. At the same time, our research shows how much more states can still do, both with respect to strengthening existing reforms to be more protective of consumers and adopting additional types of reforms.

1. Prohibitions on Outpatient Facility Fees: Stopping Charges Before They Happen

Several study states have prohibited facility fee charges in some circumstances, although the scope of these laws varies significantly. **Connecticut, Indiana,** and **Maine** have gone the furthest, prohibiting facility fees for selected outpatient services typically provided in an office setting. Some states have targeted more specific services, including telehealth services **(Connecticut, Maryland, Ohio,** and **Washington)**, preventive services **(New York)**, and Covid-19 related services **(Maryland, Texas,** and, during the public health emergency period, **Massachusetts).**

Maine's law is the oldest facility fee prohibition among the study states. It specifies that all services provided by a health care practitioner in an office setting—"a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility"—must be billed on the individual provider form. A Maine health care provider confirmed that this law means hospitals cannot charge facility fees for office-based care, even when provided in a hospital-owned practice. This provider has narrowly interpreted the scope of services to which the law applies, however. As such, they do not charge facility fees for Evaluation and Management (E&M) services,[1] but do charge facility fees for more complex procedures or services where a physician is not directly involved at the point of care, like infusion therapy to treat cancer and other illnesses. **Indiana** uses the same office-setting framework in its recently enacted law, which will go into effect July 1, 2025, and more narrowly prohibits facility fee billing for off-campus facilities owned by non-profit hospitals. **Connecticut** currently bars hospital-owned or -operated facilities from charging facility fees for outpatient E&M and assessment and management (A&M) services at off-campus locations. Beginning July 1, 2024, this prohibition will extend to on-campus locations as well, excluding emergency departments and certain types of observation stays.

In interviews, stakeholders emphasized that prohibitions on outpatient facility fees can provide significant financial protection to consumers, who otherwise may need to pay a significant portion, if not all, of a facility fee charge, depending on their insurance coverage. The impact on insurance premiums may be more muted, however, as hospitals with market power may make

[1] Evaluation and Management (E&M) services are non-procedural services where health care practitioners diagnose and treat illnesses, injuries and other conditions. Examples of E&M services include diagnosing a sinus infection and prescribing antibiotics, or an office visit focused on managing an ongoing and complex condition such as diabetes.

up for the lost revenue by securing higher rates for other services in their negotiations with commercial payers. (This is different from Medicare, where the government sets payment rates for health care providers.)

2. Out-of-Pocket Cost Protections: Limiting Consumer Charges for Facility Fees

Two study states have adopted relatively narrow restrictions that limit consumers' exposure to out-of-pocket costs while continuing to allow hospitals to charge facility fees in at least some circumstances. **Connecticut** prohibits insurers from imposing a separate copayment for outpatient facility fees provided at off-campus hospital facilities (for services and procedures for which these fees are still allowed to be charged) and bars health care providers from collecting more than the insurer-contracted facility fee rate when consumers have not met their deductible. More narrowly, health care providers in **Colorado** will not be allowed to balance bill consumers for facility fee charges for preventive services provided in an outpatient setting beginning July 1, 2024.

It is unclear to what extent coverage requirements such as state benefit mandates and the essential health benefit package require coverage of facility fees when the underlying service is covered. Multiple state insurance regulators suggested in interviews they had not previously considered this question. While coverage requirements would protect consumers from balance billing of facility fees when they receive care at an in-network facility, some interviewees cautioned that such rules could encourage health care providers to increase the frequency and amount of facility fee charges where they apply.

3. Consumer Disclosure Requirements: Notifying Consumers About Outpatient Facility Fee Charges

All but two study states require health care providers—typically hospitals and hospital-owned facilities and sometimes freestanding emergency departments—and/or health insurers to notify consumers that they may be charged a facility fee in certain circumstances. For example, **Connecticut** and, as of July 1, 2024, **Colorado** require providers to disclose certain information about their facility fee billing practices upon scheduling care, in writing before care, via signs at the point of care, and in billing statements. Upon acquiring a new practice, hospitals in these states also must notify patients that they may be charged new facility fees. Other study states have adopted a subset of these requirements, such as requiring disclosures before care is provided and/or in signage at the facility. Some states require consumers to be more proactive, requiring only that information about facility fee charges be available online or provided upon request by hospitals and/or health insurers.

Interviewees generally did not believe that these disclosures would drive many consumers to seek care in settings that do not impose facility fees, observing that consumers tend to prioritize their existing provider relationships and seek care where their providers refer them. They did think disclosures can reduce consumer confusion when they receive a facility fee bill, however. Some interviewees also suggested that consumer disclosure requirements could generate broader support for reforms by increasing awareness of the extent of facility fee billing.

4. Hospital Reporting Requirements: Disclosing How Much Hospitals Charge and Receive in Outpatient Facility Fees

Five study states have adopted public reporting requirements to better understand how much hospitals charge and receive for outpatient care. Four of these states—**Connecticut, Indiana, Maryland,** and **Washington**—have enacted annual reporting requirements, while **Colorado** recently required a study that includes collecting facility fee data from hospitals (among other sources) with a report due in the fall of 2024.[2]

The value of public reporting requirements depends on what information the state collects. More detailed information, broken down by facility, payer, and service, will offer policymakers a deeper and more nuanced understanding of the scope of facility fee billing and trends over time. Agencies charged with collecting this data also must have the authority, capacity, and will to ensure hospitals comply and to effectively analyze the data.

> Connecticut's law has been good from the exposure standpoint, on what the real problems are, specifically the opacity of facility fees and the lack of a rational basis for what the charges are."
>
> **— FORMER STATE OFFICIAL**

5. Provider Transparency Requirements: Who Is Providing Care Where?

Colorado and **Massachusetts** have taken steps to bring more transparency to the questions of where care is being provided and by whom. Unfortunately, existing claims data often conceal the specific location where care was provided and the extent to which hospitals and health systems own and control different health care practices across a state. This makes it challenging for payers, policymakers, and researchers to effectively monitor and respond to outpatient facility fee charges.

In an effort to understand where care is provided, **Colorado** requires every off-campus location of a hospital to obtain a unique identifier number (referred to as a national provider identifier or NPI) and include that identifier on all claims for care provided at the applicable location. Federal lawmakers and other states are considering similar proposals. One challenge **Colorado** has faced, however, is tracking the affiliations between different locations, all now represented by unique NPIs. A recently enacted law requires **Colorado** hospitals to report annually on their affiliations and acquisitions, which may help address this gap. **Massachusetts** does not have a unique NPI requirement but maintains a provider registry that includes information on provider ownership and affiliations among other data, enabling the state to better monitor trends in consolidation and integration.

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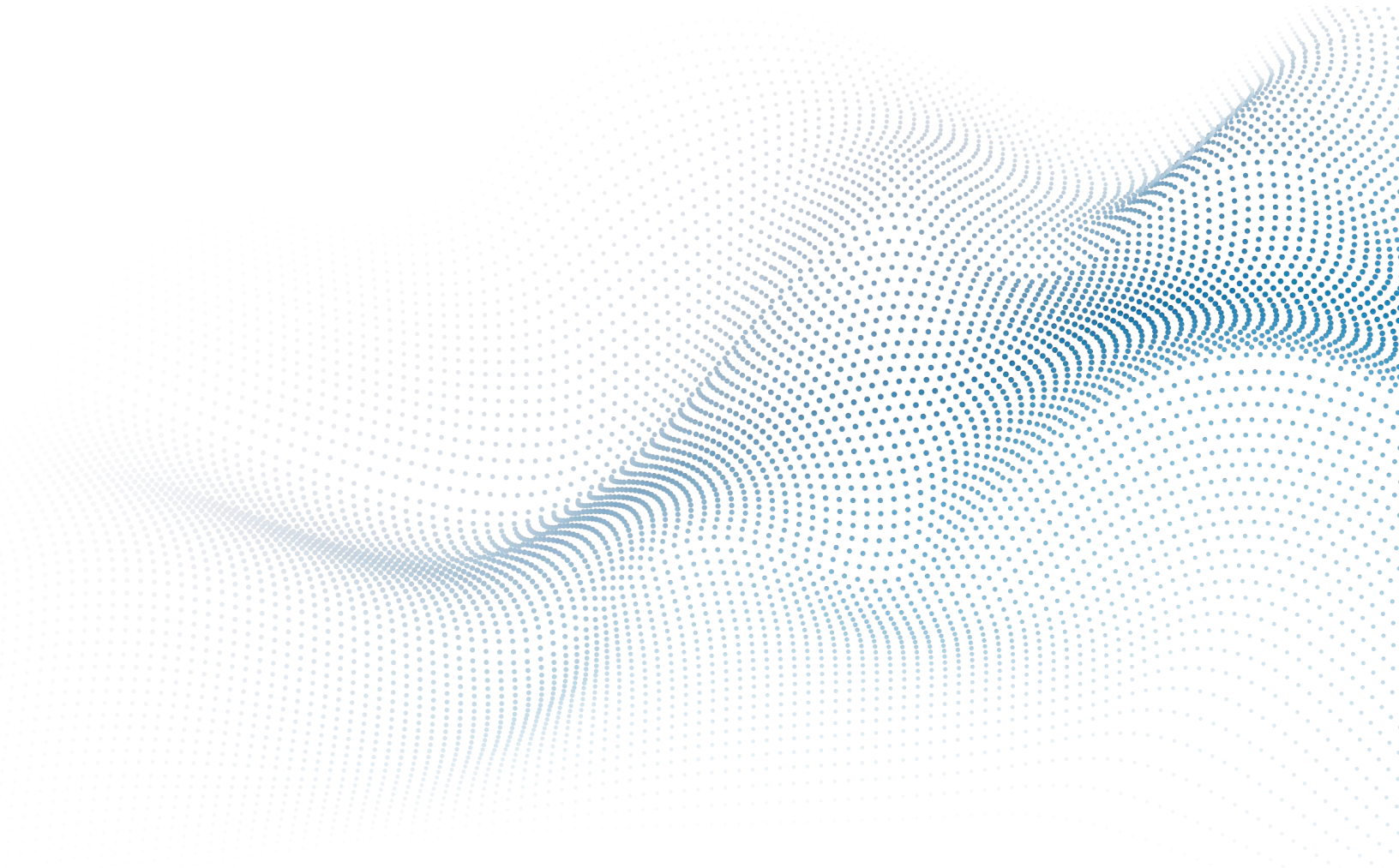
[2] Similar to Colorado, Maine recently enacted a bill to establish a task force to study facility fee billing and make a report to the legislature with recommendations. Unlike Colorado's law or other laws discussed in this section, however, Maine's law does not require any new reporting by hospitals, although it also requires the state's all payer claims database to annually report on facility fee payments based on otherwise available data beginning in January 2024.

Looking Ahead: Growing Momentum Despite Hospital Pressure

The hospital industry remains a powerful force, leveraging significant influence over policymakers, regulators, and other stakeholders to stifle reforms that would reduce their revenue or restrict their operations. Yet interviews revealed that cracks are forming in hospitals' defenses as momentum grows for reform. Hospitals are facing public criticism on a range of issues, from their facility fee charges, to debt collection practices, and for exploiting their non-profit tax status. The growing prevalence of facility fees specifically, and the financial toll they can take on unsuspecting consumers, is catching the eye of journalists, regulators, and policymakers. As more information on hospital prices and costs come to light through public and private transparency initiatives, the employer community also is increasingly engaging on the issue of outpatient facility fees and other issues affecting the cost of health care for their businesses and their employees. And states are building their internal capacity to tackle these topics, including establishing new offices and expanding the authority of existing departments to look at health care costs and affordability.

These forces are generating broad interest in tackling hospital pricing generally, and outpatient facility fee charges in particular. While addressing these issues is no small challenge, it is a challenge more and more policymakers and stakeholders are willing to tackle.



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For additional sources relied on for this issue brief, please see our companion report.

About

GEORGETOWN UNIVERSITY McCourt School of Public Policy **CENTER ON HEALTH INSURANCE REFORMS**

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Agenda Item #4

Discuss *Loper Bright Enterprises v. Raimondo* and *Relentless v. Department of Commerce* (collectively "*Loper Bright")* and Potential Implications on Health Insurance-Related Regulations —*William G. Schiffbauer (Schiffbauer Law Office)*

LEAVING CHEVRON BEHIND:

LOPER BRIGHT FULLY RESTORES JUDICIAL REVIEW UNDER THE ADMINISTRATIVE PROCEDURE ACT

NAIC Summer National Meeting
Regulatory Framework (B) Task Force
Chicago, Illinois
August 13, 2024

By
William G. Schiffbauer, Esq.

Overview

Loper Bright Enterprises v. Raimondo
Relentless, Inc. v. Department of Commerce
Collectively *Loper Bright*

Challenge to a federal requirement for herring fishermen to have and pay for on-board observers.

The District Court noted silence in the statutory text but deferred to the agency interpretation citing the *Chevron* doctrine. The Appeals Court upheld that ruling.

June 28, 2024, the U.S. Supreme Court overruled 6 to 3 the *Chevron* doctrine that stood for forty (40) years.

What is the *Chevron* Doctrine?

Originated in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc. (1984).*

Involved an EPA "stationary source" regulation and whether specific pollution emitting equipment in a plant was a regulated source. The statute was silent.

Required Federal Courts to defer to an agency's reasonable interpretation where statutory text is ambiguous or silent.

What is the *Chevron* Doctrine?

Involved judicial review in the case of challenges to agency rules under the federal Administrative Procedure Act (APA). Established a two-step analysis by a federal court.

Adopted a presumption of an implied delegation of interpretative authority to the agency without reference to any provision of the APA..

What is the *Chevron* Doctrine?

Step One. Discern whether Congress had directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter.

Step Two. Where the statute is silent or ambiguous with respect to the specific issue the court must defer to the agency if the agency offered a permissible construction of the statute even when the reviewing court reads the statute differently.

What is the *Chevron* Doctrine?

Statutory ambiguity indicates an implied congressional delegation of interpretative authority.

Agencies have more expertise than courts to interpret statutes they administer.

Agencies are politically accountable and therefore have more claim to make public policy than courts.

What Does the APA Text Say?

Section 706. Scope of Review. The reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of terms of an agency action.

The reviewing court shall hold unlawful and set aside agency action found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accord with the law, in excess of statutory jurisdiction, authority, or limitation.

Majority Opinion

The APA requires courts to exercise their independent judgment in deciding whether an agency has acted within its statutory authority.

Courts may not defer to an agency interpretation of the law simply because a statute is ambiguous.

Article III of the Constitution assigns the federal Judiciary final interpretation of the laws as the peculiar province of the courts.

Majority Opinion

Citing *Skidmore v. Swift* (1944) the Court explained that the interpretations and opinions of an agency give it the power to persuade, but not the power to control.

The APA codifies the proposition that courts decide legal questions by applying their own judgment, and courts, not agencies, decide all relevant questions of law.

Majority Opinion

A statute may well provide that an agency is authorized to exercise a degree of discretion expressly to give meaning to a particular term or to fill up the details.

Where a best reading by the court is that it delegates discretionary authority the reviewing court must independently interpret and effectuate the will of Congress.

Majority Opinion

The reviewing court must also consider whether the delegation by Congress is constitutional by policing the boundaries of the delegated authority.

The reviewing court must also ensure that the agency has engaged in reasoned decisionmaking within the boundaries of the delegated authority.

Majority Opinion

The Supreme Court has not deferred to an agency interpretation under *Chevron* since 2016 however, many lower courts continue to apply it while others bypass the doctrine.

Chevron has been a rule in search of a justification. It is a fictional presumption and invention of congressional intent that was unmoored from the APA's demand.

Majority Opinion

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.

Majority Opinion

Statutory ambiguity or silence cannot be read as congressional intent that an agency, as opposed to a court, must resolve the resulting interpretative questions.

Statutes, no matter how impenetrable do in fact, and must, have a single best meaning that is fixed at the time of enactment.

Majority Opinion

The better presumption is that Congress expects courts to do their ordinary job of interpreting statutes, with due respect for the views of the Executive Branch.

Courts interpret statutes based on the traditional tools of statutory construction and not based upon individual policy preferences.

Majority Opinion

Prior cases that relied on the *Chevron* doctrine are not overruled. Overruling *Chevron* does not constitute a "special justification" for overruling prior holdings.

Dissenting Opinion (Justice Kagan). Congress knew there would be ambiguities and there is presumed to be an implied delegation to agencies. The APA does not prescribe a *de novo* standard of review.

Health Insurance Regulations

Chevron Lesson: *Central United Life v. Burwell (2016)* involved Federal Tri-Agencies attestation rule that exceeded statutory text. Federal courts stopped at Step One.

Loper Bright Lesson: *Manhattan Life v. HHS* (Pending) involves Federal Tri-Agencies notice rule issued without statutory text and without APA required adequate notice.

Health Insurance Regulations

Loper Bright Lesson: *Tennessee v. Becerra* (2024) involves ACA Section 1557 regulation defining "sex" discrimination. APA review by federal District Court cites "no deference".

Other rules: ACA Section 1557 "all operations" regulation; Medicare hospital payments; drug pricing; ACA cost sharing and deductibles; Anti-Kickback safe harbors.

Conclusions

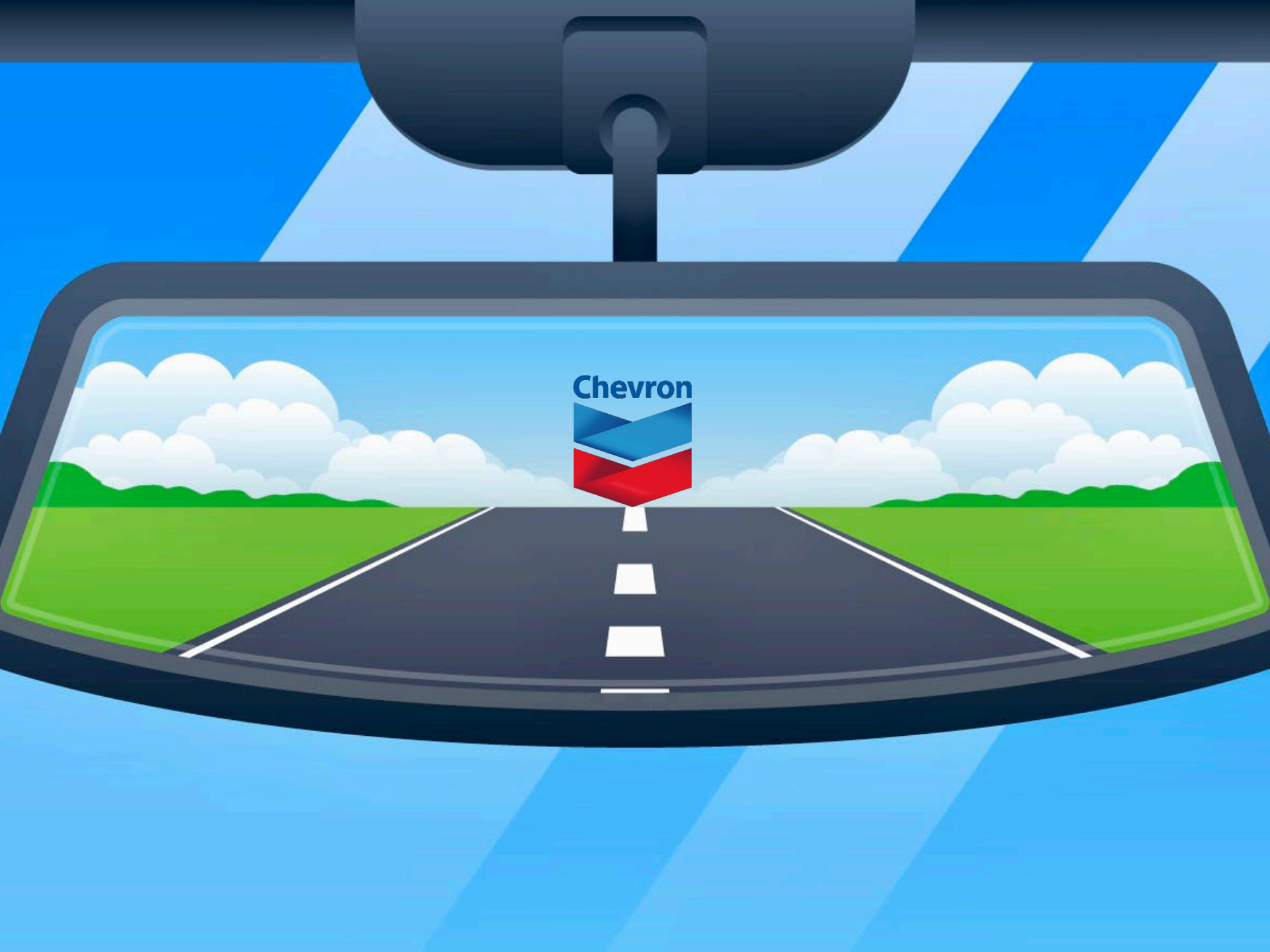
Going forward agency rules upheld in prior court decisions using *Chevron* may still be challenged under the APA and *de novo* review by a federal court.

The Supreme Court has already vacated several appellate court *Chevron* decisions pending review and remanded them for further consideration under *Loper Bright*.

Conclusions

The Congress must legislate more explicitly using less ambiguity and ensure that any delegation to an agency does not amount to amending a statute by regulation.

State agencies might examine the judicial review provisions and *deference* case law under their state administrative procedure acts and consider the lessons of *Loper Bright*.


Chevron

Agenda Item #5

Hear a Presentation on the New Collaborative Multi-Stakeholder Initiative "Promoting Health Through Prevention (PHtP)"—*Kate Berry (America's Health Insurance Plans [AHIP]) and Anand Parekh (Bipartisan Policy Center)*

Promoting Health Through Prevention

Anand Parekh, MD, Bipartisan Policy Center

Kate Berry, AHIP

Promoting Health Through Prevention

New Public/Private Multistakeholder Coalition. AHIP and a coalition of preeminent public and private health organizations launched **Promoting Health Through Prevention** to encourage people to get the recommended preventive services available with no out-of-pocket cost under the Affordable Care Act because preventive services save lives.

Opportunities for improvement in uptake of preventive services. For example, approximately 80% of adults are up-to-date with screenings for heart disease, 60-70% are current with cancer screenings, and only 30-40% are being screened or referred for substance use and mental health conditions.

Multiple communications approaches. Participants are raising awareness about the importance of preventive services, including MyHealthfinder, an HHS web-based tool, through their various communication channels (press release, social media, newsletters, etc.).

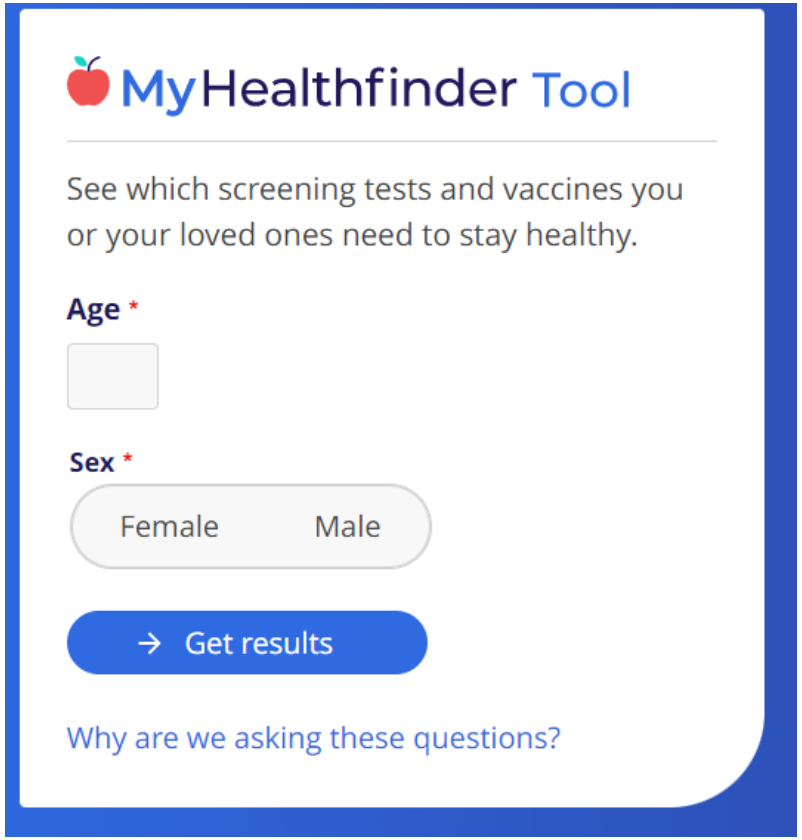
Promoting Health Through Prevention - Participants

Promoting Health Through Prevention - Ongoing Actions

- Continue to expand participation
- Identify strategies/timing for additional communications (e.g., back to school, open enrollment)
- Conduct targeted outreach for different populations and/or types of screenings
- Measure impact in short- and long-term
- Explore fundraising to support broader advertising, outreach

Opportunities for States and Related Stakeholder Engagement

- Promote MyHealthfinder tool
- Leverage existing social media toolkit



If you are interested in learning more about this campaign, please contact the AHIP staff!

AHIP, Public and Private Organizations Launch Promoting Health Through Prevention (PHtP) to Raise Awareness, Boost Uptake of Preventive Health Services

Press Release

Published Jun 18, 2024 • by AHIP

WASHINGTON, D.C. – (June 18, 2024) – AHIP and a coalition of preeminent public and private health organizations are launching Promoting Health Through Prevention (PHtP), a coordinated campaign to promote the availability of preventive services for no out-of-pocket cost under the Affordable Care Act.

Proactive screenings for cancer, behavioral health conditions, and heart disease, among other conditions, can help keep Americans of all ages healthy and identify potential problems early.

“Every American should know what preventive services and screenings are recommended and available to them with no cost sharing under their health insurance coverage,” **said Mike Tuffin, President and CEO of AHIP.** “We welcome this opportunity to partner with leading stakeholders to help educate consumers about their preventive care benefits.”

Uptake of preventive services varies. For example, approximately 80% of adults are up-to-date with screenings for heart disease, 60-70% are current with cancer screenings, and only 30-40% are being screened or referred for substance use and mental health conditions.

“Our nation’s foremost health policy priority must be prevention,” said **Dr. Anand Parekh, chief medical advisor of the Bipartisan Policy Center**, who helped catalyze the formation of the coalition. “One significant way to enhance Americans’ health is to increase the uptake of high-value evidence-based clinical preventive services, which can help detect diseases early.”

The coalition will use multiple communications channels and draw attention to several tools and services to educate Americans about the importance of preventive services, including the use of MyHealthfinder, developed by the Office of Disease Prevention and Health Promotion within the U.S. Department of Health and Human Services.

"Rates of access to preventive health services and primary care visits, which were already well below ideal levels prior to the pandemic, have yet to rebound fully. This is especially worrisome among certain racial and ethnic communities whose rates were concerningly low," explained **RDML Paul Reed, MD, Deputy Assistant Secretary for Health Director, Office of Disease Prevention and Health Promotion**. "To address such alarming trends – with the attendant risk for delayed or missed diagnoses – we need more partnerships like this one to help improve health literacy and preventive services access."

Participating organizations include: the Agency for Healthcare Research and Quality (AHRQ), American Academy of Family Physicians (AAFP), the Blue Cross Blue Shield Association, the Centers for Disease Control and Prevention (CDC), Cigna Healthcare, Elevance Health, GuideWell, Highmark Health, Humana, Kaiser Permanente, Mental Health America, the National Alliance of Healthcare Purchaser Coalitions, National Association of Community Health Centers, NCQA, the Office of Disease Prevention and Health Promotion (ODPHP), Quartz Health Solutions, and the VBID Center at the University of Michigan.

About AHIP

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

Agenda Item #6

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