REGULATORY FRAMEWORK (B) TASK FORCE
Saturday, December 7, 2019
11:30 a.m. – 1:00 p.m.
JW Marriott Austin—Lone Star Ballroom A-C—Level 3

ROLL CALL

Michael Conway, Chair Colorado Chlora Lindley-Myers Missouri
Scott A. White, Vice Chair Virginia Bruce R. Ramge Nebraska
Jim L. Ridling Alabama John Elias New Hampshire
Lori K. Wing-Heier Alaska John G. Franchini New Mexico
Elizabeth Perri American Samoa Mike Causey North Carolina
Allen W. Kerr Arkansas Jon Godfread North Dakota
Ricardo Lara California Glen Mulready Oklahoma
Stephen C. Taylor District of Columbia Andrew Stolfi Oregon
David Altmaier Florida Jessica Altman Pennsylvania
Dean L. Cameron Idaho Raymond G. Farmer South Carolina
Doug Ommen Iowa Larry Deiter South Dakota
Vicki Schmidt Kansas Kent Sullivan Texas
Nancy G. Atkins Kentucky Todd E. Kiser Utah
Eric A. Cioppa Maine Mike Kreidler Washington
Al Redmer Jr. Maryland James A. Dodrill West Virginia
Gary Anderson Massachusetts Mark Afable Wisconsin
Steve Kelley Minnesota Jeff Rude Wyoming
Mike Chaney Mississippi

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

AGENDA

1. Consider Adoption of its Oct. 2 and Summer National Meeting Minutes
   —Commissioner Michael Conway (CO)

2. Consider Adoption of its Subgroup and Working Group Reports
   a. Accident and Sickness Insurance Minimum Standards (B) Subgroup
      —Commissioner Glen Mulready (OK) and Melinda Domzalski-Hansen (MN)
   b. ERISA (B) Working Group—Robert Wake (ME)
   c. HMO Issues (B) Subgroup—Commissioner Scott A. White (VA) and Don Beatty (VA)
   d. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
      —Commissioner Andrew Stolfi (OR) and TK Keen (OR)

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

4. Hear a Presentation on the Implementation of the Consumer Purchasing Model in Summit County, CO
   —Tamara Progue-Drangstveit (Peak Health Alliance)

5. Hear a Presentation on Health Care Cost Trends and Affordability Recommendations
   —Leanne Gassaway (America’s Health Insurance Plans—AHIP)
6. Discuss Any Other Matters Brought Before the Task Force—Commissioner Michael Conway (CO)

7. Adjournment
Agenda Item #1

Consider Adoption of its Oct. 2 and Summer National Meeting Minutes
—Commissioner Michael Conway (CO)
The Regulatory Framework (B) Task Force met via conference call Oct. 2, 2019. The following Task Force members participated: Michael Conway, Chair (CO); Scott A. White, Vice Chair (VA); Lori K. Wing-Heier represented by Sarah Bailey and Jacob Lauten (AK); Jim L. Ridling represented by William Rodgers (AL); Allen W. Kerr represented by William Lacy and Mel Anderson (AR); Ricardo Lara represented by Sheirin Ghoddoucy (CA); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Cynthia Banks Radke (IA); Dean L. Cameron represented by Fernanda Vallejo (ID); Vicki Schmidt represented by Julie Holmes (KS); Gary Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Steve Kelley represented by Candace Gergen (MN); Chlora Lindley-Myers represented by Carrie Couch and Jessica Schrimpf (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Ross Hartley (ND); Bruce R. Range represented by Martin Swanson (NE); Glen Mulready represented by Ron Kreiter (OK); Andrew Stolfi represented by Gayle Woods (OR); Jessica Altman (PA); Raymond G. Farmer represented by Kendall Buchanan (SC); Larry Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser represented by Jaakob Sundberg and Heidi Clausen (UT); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); James A. Dodrill represented by Ellen Potter and Joylynn Fix (WV); and Jeff Rude (WY).

1. **Adopted its 2020 Proposed Charges**

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

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

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

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The Regulatory Framework (B) Task Force met in New York, NY, Aug. 3, 2019. The following Task Force members participated: Michael Conway, Chair (CO); Scott A. White, Vice Chair, represented by Don Beatty (VA); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Steve Ostlund (AL); Allen W. Kerr represented by Mel Anderson (AR); Ricardo Lara represented by Tyler McKinney (CA); Stephen C. Taylor represented by Howard Liebers (DC); David Altmaier represented by Craig Wright (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Vicki Schmidt represented by Julie Holmes (KS); Nancy G. Atkins represented by John Melvin (KY); Gary Anderson represented by Matthew Veno and Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Steve Kelley represented by Melinda Domzalski-Hansen (MN); Chlorla Lindley-Myers represented by Angela Nelson and Mary Mealer (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrysal Bartuska (ND); Bruce R. Ramge represented by Martin Swanson and Laura Arp (NE); John G. Franchini represented by Paige Duhamel (NM); Glen Mulready represented by Cuc Nguyen (OK); Andrew Stolfi represented by TK Keen (OR); Jessica Altman represented by Katie Dziurec (PA); Raymond G. Farmer represented by Diane Cooper and Gwen Fuller McGriff (SC); Larry Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Rachel Bowden (TX); Mike Kreidler represented by Molly Nollette (WA); and Mark Afable represented by Nathan Houdre and Jennifer Stegall (WI). Also participating were: Derek Oestreicher (MT); Troy Oechsner (NY); and Marie Ganim (RI).

1. **Adopted its May 15 and Spring National Meeting Minutes**

The Task Force met May 15 and April 6. During its May 15 meeting, the Task Force took the following action: 1) adopted amended 2019 charges to add a charge for the HMO Issues (B) Subgroup to, “[r]evise provisions in the Health Maintenance Organization Model Act (#430) to address conflicts and redundancies with provisions in the Life and Health Insurance Guaranty Association Model Act (#520);” and 2) adopted the HMO Issues (B) Subgroup’s Request for NAIC Model Law Development to revise Model #430 consistent with its 2019 charge.

Mr. Ostlund made a motion, seconded by Mr. Keen, to adopt the Task Force’s May 15 (Attachment One) and April 6 (see NAIC Proceedings – Spring 2019, Regulatory Framework (B) Task Force) minutes. The motion passed unanimously.

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

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

Ms. Domzalski-Hansen said the Subgroup met July 8 and June 17. During these meetings, the Subgroup discussed its approach to revising the provisions of the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170). She said the Subgroup decided to use a NAIC working draft of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) as a starting point for the Subgroup’s work to revise Model #171 and review and discuss potential revisions to this working draft section-by-section. She said the Subgroup also discussed adhering to certain general guidelines as it works to revise Model #171, such as not reopening issues discussed and settled during the Subgroup’s work revising Model #170 and not including topics not included in Model #170.

Ms. Domzalski-Hansen said the Subgroup also discussed initial comments received from several stakeholders, including the American Council of Life Insurers (ACLI), America’s Health Insurance Plans (AHIP), the Association for Community Affiliated Plans (ACAP), the Blue Cross Blue Shield Association (BCBSA), and the Coalition to Preserve Health Plan Choices (HPC), on revising Model #171. She said those comments reflected several themes and suggestions for the Subgroup’s focus on revising Model #171, including: 1) excepted benefits or supplemental coverage is different from short-term, limited-duration (STLD) plan coverage; 2) updating Model #171’s terminology; 3) developing disclosures for each type of coverage; and 4) developing standards for group and individual coverage, and distinguishing between the two types of coverage, as necessary.

Ms. Domzalski-Hansen said the Subgroup set a public comment period ending July 30 to receive comments on Sections 1–5 of Model #171. The Subgroup plans to begin its review and discussion of the comments received following the Summer National Meeting.
Ms. Mealer made a motion, seconded by Mr. Keen, to adopt the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its July 8 (Attachment Two) and June 17 (Attachment Three) minutes. The motion passed unanimously.

b. ERISA (B) Working Group

Mr. Wake said the ERISA (B) Working Group met Aug. 3. During this meeting, the Working Group adopted its April 6 minutes see NAIC Proceedings – Spring 2019, Regulatory Framework (B) Task Force, Attachment Four. He said the Working Group also discussed association health plans (AHPs), including state legislative and regulatory activity addressing multiple employer welfare arrangements (MEWAs). He also noted that the Working Group is continuing to hold regulator-to-regulator conference calls with the U.S. Department of Labor (DOL) concerning the AHPs and the federal rule. He said the Working Group heard that the MEWA Association of America will be holding its first annual meeting during the Fall National Meeting, and state insurance regulators and interested parties are invited to attend. He said the Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

Ms. Nollette made a motion, seconded by Ms. Dzurec, to adopt the report of the ERISA (B) Working Group (Attachment Four). The motion passed unanimously.

c. HMO Issues (B) Subgroup

Mr. Beatty said the HMO Issues (B) Subgroup met June 24, May 16 and April 29. During these meetings, the Subgroup adopted its 2019 charge. The Subgroup also adopted a Request for NAIC Model Law Development to revise Model #430 consistent with its 2019 charge. He noted that the Subgroup’s Request for NAIC Model Law Development is scheduled to be considered for adoption by the Executive (EX) Committee at the Summer National Meeting. He said the Subgroup also discussed initial comments related to its work to revise Model #430 consistent with its 2019 charge, and it agreed on a potential work plan for moving forward with its work. He said the Subgroup plans to begin its work via conference call after the Summer National Meeting.

Ms. Mealer made a motion, seconded by Mr. Swanson, to adopt the report of the HMO Issues (B) Subgroup, including its June 24 (Attachment Five), May 16 (Attachment Six), and April 29 (Attachment Seven) minutes. The motion passed unanimously.

d. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

Mr. Keen said the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup met July 18. During this meeting, the Subgroup heard a presentation from NAIC staff on the history of pharmacy benefit managers (PBMs) and their functions and role. The presentation also included a discussion of state and federal legislation, laws regulating PBMs and their business operations, and legal challenges to state PBM laws. He said the presentation also discussed NAIC PBM activities to date, including the Subgroup’s appointment and its 2019 charge to consider developing a new NAIC model to establish a licensing or registration process for PBMs. As part of its 2019 charge, the Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency. Mr. Keen said the Subgroup will continue its information-gathering sessions via conference call in August.

Ms. Nollette made a motion, seconded by Ms. Duhamel, to adopt the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its July 18 minutes (Attachment Eight). The motion passed unanimously.

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

Justin Giovannelli (Center on Health Insurance Reforms—CHIR, Georgetown University Health Policy Institute) provided an update on the CHIR’s work related to the federal Affordable Care Act (ACA) and other issues of interest to state insurance regulators. He discussed the CHIR’s work related to the balance billing issue, particularly with respect to state activity, as reflected in a July CHIR report, supported by the Commonwealth Fund, “States Are Taking New Steps to Protect Consumers from Balance Billing, But Federal Action Is Necessary to Fill Gaps.” He also cited a recent report analyzing New York’s 2014 law on surprise billing. He said the CHIR’s analysis of the law’s impact to date is that it appears to have had significant benefits for consumers, but gaps remain with respect to self-funded plans.

Mr. Giovannelli also discussed a recent report in Health Affairs, “Successfully Splitting The Baby: Design Considerations For Federal Balance Billing Legislation,” which provides lessons and considerations for both federal and state policymakers with
Draft Pending Adoption

respect to developing balance billing legislation. He said the CHIR has launched a new technical assistance project, supported by the Laura and John Arnold Foundation, on the balance billing issue for state and federal policymakers.

Mr. Giovannelli also discussed the CHIR’s work analyzing state activity with respect to regulating products, such as AHPs, STLDP, and health care sharing ministries, outside the ACA-compliant individual market. Lastly, he discussed state reforms, particularly through the ACA’s Section 1332 waiver process, to improve the affordability of comprehensive coverage in the individual market. He also noted the resources the CHIR has for state insurance regulators, including its publications and blog.

Commissioner Conway asked if, with respect to affordability of coverage in the individual market, the CHIR has studied subsidies. Mr. Giovannelli said the CHIR is still in the early stage of its analysis, but it is looking at legislation passed in California that increased subsidies. He said he believes that this increase could have a positive impact. He also noted reinsurance, which many states have used to reduce premium through the Section 1332 waiver process, to address affordability.

Ms. Duhamel asked if the CHIR has researched what Massachusetts has done through its wrap program with respect to affordability. Mr. Giovannelli said the CHIR has not specifically looked at Massachusetts, but he said this would be something that the CHIR can think about for a future project.

4. Heard a Presentation on the Montana PBM Legislation

Mr. Oestreicher discussed the history, purpose and provisions of Senate Bill 71 (SB71) to address issues related to PBMs, which passed in Montana but was ultimately vetoed. He said before drafting SB71, he considered two questions: 1) why prescription drug costs are so high; and 2) what state insurance departments can do to combat rising drug costs. He said to answer these questions, the Montana Department of Insurance (DOI) focused on obtaining information relevant to these questions from PBMs. He said after receiving this information, the Montana DOI focused on ways it could address the broken system. He said different approaches were considered, but ultimately, it was decided to develop a bill using the DOI’s current regulatory authority over health insurers to address the issue. He said SB71 comprised a list of best practices for insurers to include in their PBM contracts: 1) prohibit spread pricing; 2) require that all rebates be passed through the insurer; and 3) utilize rebate savings to directly lower premiums. He also discussed the opposition to SB71, which included claims that SB71 would: 1) prohibit mail order pharmacies; 2) increase administrative cost and manufacturer drug prices; and 3) cause insurers to violate the minimum loss ratio (MLR) under the ACA.

Mr. Oestreicher noted that the National Academy for State Health Policy (NASHP) adopted SB71 as model legislation. He said Maine recently enacted legislation, LD 1504, which is based on SB71. He pointed out that Maine’s legislation included a unique approach to spread pricing by permitting an insurer to allow spread pricing while requiring the insurer to account for the “spread” as an administrative cost for the purposes of the ACA’s MLR. He said the U.S. Senate Committee on Health, Education, Labor and Pensions (HELP) included provisions from SB71 in The Lower Health Care Costs Act of 2019 (S. 1895), Section 306. He also discussed continuing legal and regulatory actions against the Montana DOI.

Commissioner Godfrey asked if SB71 would have required additional staffing resources. Mr. Oestreicher said the Montana DOI did not anticipate having to hire additional staff because SB71 relied on its regulatory authority over health insurers to enforce its PBM-related requirements. Mr. Keen asked if SB71 created a private right of action. Mr. Oestreicher said it did not. Mr. Oechsner asked Mr. Oestreicher if he thought prohibiting PBMs from spread pricing meant they would find another way to make up for the loss of this money. Mr. Oestreicher said he did think that was a possibility, which is why SB71 provided a global solution to address the issue of high prescription drug prices, not just relying on prohibiting spread pricing.

Commissioner Conway asked if the Montana DOI considered the cost-sharing component with respect to SB71’s pass-through provision. Mr. Oestreicher said the Montana DOI considered whether it should reduce premium or cost-sharing. He said ultimately, it decided to reduce premium.

5. Heard a Panel Presentation on State Activities Related to Mental Health Parity

The Task Force heard a panel presentation on state activities related to mental health parity. Andrew Sperling (National Alliance on Mental Illness—NAMI) said he believes the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPEA) has been successful, but there remain issues, particularly with respect to non-quantitative treatment limits (NQTLs). He noted that the MHPEA does not preempt state laws. He also noted that challenges remain with respect to enforcement because enforcement relies largely on complaints. He also said certain groups are trying to develop an accreditation tool to address some of these issues and challenges.
Debra Judy (Colorado Consumer Health Initiative) highlighted Colorado’s mental health parity activities. She discussed Colorado’s newly created Office of the Ombudsman for Behavioral Health Access (Office). She said the position operates independently and interacts directly with patients, families, providers, advocates and other stakeholders on complaints, concerns, and complex challenges related to behavioral health prevention, treatment and recovery. She said the Office is tracking stakeholder complaints and issues with the provision of mental health and substance use disorder services, and it will release its first report next year. However, because the Office started in 2018, the complaint data and other data in the report is probably not going to be robust. Ms. Judy also discussed the recent passage of Colorado’s “Behavioral Health Care Coverage Modernization Act” to address issues related to coverage of behavioral, mental health, and substance use disorder services under private health insurance and the state medical assistance program (Medicaid). She also discussed other activities, such as developing worksheets to assist with insurer compliance. She also urged the states to conduct market conduct examinations to gauge compliance. She discussed additional challenges, such as network adequacy. She noted that because of these network adequacy issues, consumers face challenges in obtaining initial appointments and follow up appointments. She said she anticipates the new Colorado helping with these challenges.

Laura Colbert (Georgians for a Healthy Future) said the states fall on a spectrum with respect to their activities on mental health parity. She said Georgia is at the initial stages, but it is making efforts to increase its activity in this area. She highlighted Georgia’s activities toward this goal: 1) participating in interagency work groups; 2) gathering data; and 3) more open communication with consumers and consumer groups.

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

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Agenda Item #2

Consider Adoption of its Subgroup and Working Group Reports

—Commissioner Michael Conway (CO)
Conference Calls

ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS (B) SUBGROUP

Summary Report

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 25, Nov. 19, Nov. 4, Oct. 28, Oct. 7 and Sept. 16, 2019. During these calls, the Subgroup:

1. Discussed the comments received by the July 30 public comment deadline on Sections 1-5 of Model #171. The Subgroup plans to complete its review and discussion of the comments received following the Fall National Meeting.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup
Conference Call
November 25, 2019

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

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

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

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

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

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

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

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

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

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The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 19, 2019. The following Subgroup members participated: Melinda Domzalski-Hansen, Co-Chair (MN); Debra Judy (CO); Howard Liebers (DC); Chris Struk (FL); Robert Wake (ME); Camille Anderson-Weddle and Carrie Couch (MO); Martin Swanson (NE); Katie Dzurec (PA); Shari Miles (SC); Rachel Bowden (TX); Anna Van Fleet (VT); Andrea Philhower and Michael Bryant (WA); and Nathan Houdek and Jennifer Stegall (WI).

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

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

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

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

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

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

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

Drafting Note: This language is used in multiple policy forms that may pay benefits differently e.g. on per incident or per service basis. States may want to establish minimum policy standards that differ based on how the benefit is to be paid by the insurer and the type of policy.
The Subgroup discussed the Health Benefits Institute’s suggested revisions to Section 5I. Mr. Bryant questioned the language in Section 5I concerning the maximum number of days and asked if there was a way to simplify the language. Ms. Domzalski-Hansen questioned the addition of the brackets noting that including brackets would add variability to the language instead of establishing minimum standards for insurers with respect to the policies covered under Model #171. After additional discussion, the Subgroup decided to delete Section 5I and move its provisions to Section 7—Supplementary and Short-Term Health Minimum Standards for Benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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Accident and Sickness Insurance Minimum Standards (B) Subgroup
Conference Call
October 28, 2019

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

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

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

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

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

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

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

The Subgroup next discussed Section 5H, which defines the term “nurse.” Ms. Lueck said the NAIC consumer representatives suggest revising Section 5H to include a reference to “advance practice nurse.” She said this additional language is consistent with current terminology. The Subgroup agreed to accept the suggested revision.

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

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
Accident and Sickness Insurance Minimum Standards (B) Subgroup
Conference Call
October 7, 2019

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 7, 2019. The following Subgroup members participated: Glen Mulready, Co-Chair (OK); Melinda Domzalski-Hansen, Co-Chair (MN); Eric Unger (CO); Chris Struk (FL); Jeff Zewe (LA); Robert Wake (ME); Mary Mealer and Molly White (MO); Gayle Woods (OR); Katie Dzurec and Michael Humphreys (PA); Kendall Buchanan (SC); Jaakob Sundberg and Heidi Clausen (UT); Anna Van Fleet (VT); Andrea Philhower (WA); and Julie Walsh (WI).

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

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

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

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

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

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

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

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

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

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

No comments were received on Section 2—Authority.

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

Ms. Mealer said the Missouri DOI suggests deleting the word “also” in its comments on Section 3A because the word is unnecessary. The Subgroup agreed to accept the suggested revision. Mr. Bryant said the Washington DOI suggests adding the word “supplementary” to the term “hospital indemnity or other fixed indemnity” because Model #171 does not apply to all hospital indemnity plans, such as comprehensive hospital indemnity plans. Mr. Petersen said that based on the revisions to Model #170, Model #171 has been restructured to apply to supplementary plans. He said that in addition, Model #170 does not define “supplementary hospital indemnity.” After discussion, Mr. Bryant withdrew the Washington DOI’s comment.

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

No comments were received on Section 4—Effective Date.

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

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

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

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

HMO ISSUES (B) SUBGROUP
November 21, 2019 / September 16, 2019

Summary Report

The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 21 and Sept. 16, 2019. During these calls, the Subgroup:

1. Exposed for comment the Virginia Insurance Bureau’s recommendations for revising the *Health Maintenance Organization Model Act* (#430) for public comment period ending Oct. 15 to address inconsistencies and redundancies with the provisions in the *Life and Health Insurance Guaranty Association Model Act* (#520).

2. Discussed the Virginia Insurance Bureau’s revised recommendations for revising Model #430 and the Maine Department of Insurance’s (DOI) comments on the revised recommendations.

3. Adopted a motion to accept the Maine DOI’s approach for revising Model #430. The Subgroup plans to review and discuss an initial draft of revisions to Model #430 reflecting the Maine DOI’s approach via conference call after the Fall National Meeting.
The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 21, 2019. The following Subgroup members participated: Don Beatty, Chair (VA); Dayle Axman (CO); Toma Wilkerson (FL); Ryan Gillespie (IL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson (NE); Ron Pastuch (WA); Jennifer Stegall (WI); and Joylynn Fix (WV).

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

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

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

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

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

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

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

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

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The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Sept. 16, 2019. The following Subgroup members participated: Don Beatty, Chair, and Raquel Pino (VA); Dayle Axman (CO); Toma Wilkerson (FL); Eric Anderson (IL); Robert Wake (ME); Chlora Lindley-Myers and Mary Mealer (MO); Martin Swanson (NE); Ron Pastuch (WA); Nathan Houdek and Jennifer Stegall (WI); and Joylynn Fix (WV).

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

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

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

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

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

The Subgroup exposed the Bureau’s recommendations for a public comment period ending Oct. 15.

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

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Conference Call

PHARMACY BENEFIT MANAGER REGULATORY ISSUES (B) SUBGROUP
December 2, 2019 / October 3, 2019 / August 29, 2019 / August 22, 2019 / August 15, 2019

Summary Report

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Dec. 2, Oct. 3, Aug. 29, Aug. 22 and Aug. 15, 2019. During these calls, the Subgroup:

1. Heard presentations from various stakeholders, including representatives from health insurers, pharmaceutical manufacturers, pharmacy benefit managers (PBMs), academia and consumers. The Subgroup conducted these information-gathering sessions to help to inform its discussions on next steps to carry out its 2019 charge to consider developing a new NAIC model to establish a licensing or registration process for PBMs. As part of its 2019 charge, the Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.

2. Discussed its next steps in making progress on its 2019 charge during a regulator-to-regulator session pursuant to paragraph 8 (consideration of strategic planning issues relating to federal legislative and regulatory matters or international regulatory matters) of the NAIC Policy Statement on Open Meetings.
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
October 3, 2019

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

1. Heard a Presentation on the Kentucky PBM License Process

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

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

Mr. O’Connor said that due to the broad definition of PBM, the Kentucky DOI has licensed more entities than it originally anticipated. He said that for 2019, Kentucky has 45 active PBM licenses. He said that during the licensing process, the Kentucky DOI found that many PBMs did not have documented policies and procedures for provisions in the Kentucky law concerning the maximum allowable cost (MAC) appeals process and transparency requirements, which resulted in delays in the licensing process. He noted that the Kentucky DOI has had personnel expertise and resource challenges in implementing the PBM law.

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

2. Heard a Presentation on the Arkansas PBM Law

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

Mr. Ryan said that to implement the law, the Arkansas DOI established a new position, PBM coordinator, carved out from its legal division. He discussed the challenges the Arkansas DOI has encountered with respect to the MAC complaints. He also discussed possible future Arkansas legislation involving pharmacy services administrative organizations (PSAOs).
Ms. McKendell asked if the Arkansas DOI handled the MAC complaints or some other state agency. Mr. Ryan said the Arkansas DOI handles the complaints in-house. He said appeals related to the NADAC could be handled differently. Mr. Wake asked Mr. Ryan if he could provide a copy of the Arkansas PBM regulation with the Subgroup and interested state insurance regulators. Mr. Ryan said he would send a link to NAIC staff for distribution.

3. Heard a Presentation on the Montana PBM Law

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

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

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

4. Heard a Presentation on the New Mexico PBM Legislation

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

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

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

5. Heard a Presentation on the Oregon Law

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

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

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

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

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Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
August 29, 2019

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Aug. 29, 2019. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Sarah Bailey and Jacob Lauten (AK); William Rodgers and Anthony L. Williams (AL); Marjorie Farmer (AR); Bruce Hinze (CA); Howard Liebers (DC); Cynthia Banks Radke and Johanna Nagel (IA); Vicki Schmidt (KS); John Melvin (KY); Jeff Zewe (LA); Mary Kwet (MD); Chad Arnold (MI); Andrew Kleinendorst (MN); Mary Mealer and Molly White (MO); Derek Oestreicher (MT); Gale Simon (NJ); Renee Blechner (NM); Katie Dzurec, Karen M. Feather and Sandra L. Ykema (PA); Vickie Trice (TN); Eric Lowe (VA); Ron Pastuch (WA); Nathan Houdek and Jennifer Stegall (WI); Joylynn Fix and Ellen Potter (WV); and Denise Burke (WY). Also participating was: Matthew Veno (MA).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. **Heard a Presentation on PBMs and their Impact on Access and Affordability from the NASTAD**

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

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

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

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

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
August 22, 2019

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Aug. 22, 2019. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Chris Murray and Sarah Bailey (AK); Jerry Workman and Anthony L. Williams (AL); Ryan James (AR); Bruce Hinze (CA); Andria Seip (IA); Vicki Schmidt (KS); Patrick O’Connor (KY); Jeff Zewe (LA); Mary Kwei (MD); Joseph Stoddard (MI); Melinda Domzalski-Hansen and Krisi Bohn (MN); Molly White (MO); Marilyn Bartlett (MT); Gale Simon (NJ); Renee Blechner (NM); Katie Dzurec, Karen M. Feather and Sandra L. Ykema (PA); Michael Humphreys (TN); Don Beatty and Yolanda Tennyson (VA); Jennifer Kreitler (WA); Nathan Houdek and Jennifer Stegall (WI); and Joylynn Fix and Ellen Potter (WV). Also participating were: Matthew Veno (MA); and Jesse O’Brien (OR).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
Draft: 8/26/19

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
August 15, 2019

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

1. Heard Presentations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
Agenda Item #3

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

National Association of Insurance Commissioners
Regulatory Framework (B) Task Force
December 7, 2019

Justin Giovannelli, J.D., M.P.P.
Associate Research Professor
Regulating Coverage Products Outside the ACA-Compliant Individual Market

- State oversight of health care sharing ministries (publication forthcoming from the Commonwealth Fund).

- Regulatory approaches may include:
  - Active oversight to determine ongoing compliance with state law safe harbors
    - Also: requiring demonstration of compliance at front-end (registration)
  - Requiring data showing how HCSMs operate
    - Enrollment
    - Marketing materials
    - Financial info sufficient to assess members’ risk of facing unpaid claims
  - Consider what role, if any, producers should have in facilitating HCSM enrollment
Regulating Coverage Products Outside the ACA-Compliant Individual Market

- **Multiple Employer Welfare Arrangements**
  - CHIR recently published thousands of pages of DOL investigative records regarding MEWAs that were obtained in response to a 2018 FOIA request
  - Materials and a summary table are here:
    - chirblog.org/the-mewa-files/
  - Additional analysis of these files is forthcoming

- With support from the Commonwealth Fund, we continue to track and analyze state regulatory approaches to **MEWAs** and **short-term, limited duration insurance** in the wake of the federal rule changes
State Reforms Affecting the Individual Market

- Developments under the Section 1332 waiver program
- Actions to improve the affordability of comprehensive coverage
  - Supported by the Commonwealth Fund
- ACA marketplace transitions
  - Supported by the Robert Wood Johnson Foundation

Future research:
- Reinsurance
- More on broader 1332s and other state coverage reforms, STLDI, and balance billing
- Standardized health plans
- State strategies re: the SHOP
Technical Assistance and Support

- Ongoing state technical assistance regarding insurance regulatory matters through the **State Health and Value Strategies Program**
  - Supported by the Robert Wood Johnson Foundation

- Assistance for state and federal policymakers regarding regulatory approaches to **balance billing**
  - Supported by the Laura and John Arnold Foundation
Resources

• CHIR Publications and blog
• Commonwealth Fund state action and Section 1332 waiver tracking
• State Health and Value Strategies resources
• Balance billing resource center

Justin Giovannelli
Associate Research Professor
(202) 687-4954
Justin.Giovannelli@georgetown.edu
Agenda Item #4

Hear a Presentation on the Implementation of the Consumer Purchasing Model in Summit County, CO—*Tamara Progue-Drangstveit (Peak Health Alliance)*
We’re Better Together.

The Case for Locally-Led Health Insurance
Peak’s alliance model provides existing community-based efforts with access to expertise and resources while maintaining local control.
- Non-profit purchasing collaborative
- Governed by the local community
- Enabled by Colorado statute 10-16-1000-1015
The Traditional Model

Insurers Negotiate Prices with Hospitals and Providers

Insurers Set Prices Consumers Will Pay Based on Negotiation with Providers

Employers and Individuals Enroll

Chart design in collaboration with CHI
The Peak Model

1. Gather Community Buy-In and Support
2. Collect and Analyze Local Claims Data
3. Negotiate Rates Directly with Hospitals & Providers
4. Solicit Bids from Carriers for Group & Individual Markets
5. Employers & Individuals Enroll in Peak-Designed and Negotiated Plans

Chart design in collaboration with CHI
The Summit County Challenge
# Summit County Claims Analysis

## Inpatient Services

<table>
<thead>
<tr>
<th>Minimum Cost/Day</th>
<th>Number of Admissions</th>
<th>% of Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>434</td>
<td>195.6%</td>
</tr>
<tr>
<td>$500</td>
<td>389</td>
<td>220.6%</td>
</tr>
<tr>
<td>$1,000</td>
<td>354</td>
<td>233.5%</td>
</tr>
<tr>
<td>$2,000</td>
<td>302</td>
<td><strong>247.4%</strong></td>
</tr>
</tbody>
</table>

## Professional Services

% of Medicare: 197%

## Outpatient Place of Service

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>% of Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgery Center</td>
<td>395.1%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>841.9%</td>
</tr>
<tr>
<td>Other Outpatient</td>
<td>336.1%</td>
</tr>
<tr>
<td>Combined</td>
<td><strong>504.7%</strong></td>
</tr>
</tbody>
</table>
## Putting Savings to Work

<table>
<thead>
<tr>
<th>Service/Procedure</th>
<th>Peak Rates (total including copays etc.)</th>
<th>Discount from Average PPO Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal Delivery (Mom only, up to 2 days)</td>
<td>$5,716 per case</td>
<td>20-30%</td>
</tr>
<tr>
<td>C-Section Delivery (Mom only, up to 4 days)</td>
<td>$12,511 per case</td>
<td>5-10%</td>
</tr>
<tr>
<td>Normal newborn (Baby only)</td>
<td>$1,144 per day</td>
<td>55-65%</td>
</tr>
<tr>
<td>Laparoscopic appendectomy</td>
<td>$11,831 per case</td>
<td>45-55%</td>
</tr>
<tr>
<td>Treatment of tibial shaft fracture (broken leg)</td>
<td>$11,831 per case</td>
<td>&gt;70%</td>
</tr>
<tr>
<td>MRI scan</td>
<td>$600</td>
<td>15-25%</td>
</tr>
<tr>
<td>CT scan</td>
<td>$450</td>
<td>25-35%</td>
</tr>
<tr>
<td>Mammogram</td>
<td>$156</td>
<td>45-55%</td>
</tr>
<tr>
<td>Emergency Department Level 1</td>
<td>$530 per case</td>
<td>60-70%</td>
</tr>
</tbody>
</table>
Finding Solutions for Families

- Centura has offered Peak the lowest rates of any carrier or TPA in Colorado
- No discounts off billed charges—everything has a set price
- Independent analysis shows Peak’s negotiated rates between 250-300% of Medicare
- Risk-bearing carriers believe this is significant enough to have dropped rates by at least 20%
Benefit designs similar or better to current coverage in Summit County

Peak-negotiated provider networks

Better Preventative Health Benefits

Products are more comprehensive

The same kind of insurance people are used to buying
Broadening Our Approach
There’s Still Work to Be Done in Colorado

- Garfield County: 423% (291% inpatient)
- Archuleta: 200% (67%)
- La Plata: 421% (232%)
- Routt: 291% (190%)

Source: CIVHC/RAND
We’re sharing our vision for partnerships with other communities and the infrastructure that can make it work.

2021 Counties

- Grand
- Garfield
- La Plata
- San Juan
- Dolores
- Chaffee
- Lake
- Montezuma
Core Values

- Protect Local Health Care
- Recognize unique challenges of rural health care
- Empower consumers and communities
- Use data, not anecdotes
- Prioritize collaboration

We’re sharing our vision for partnerships with other communities and the infrastructure that can make it work.
Thank You.
peakhealthalliance.org
tamara@peakhealthalliance.org
Agenda Item #5

Hear a Presentation on Health Care Cost Trends and Affordability Recommendations
—Leanne Gassaway (America’s Health Insurance Plans—AHIP)
Health Care Cost Trends and Affordability Recommendations

Protecting Patients, Lowering Costs

Leanne D Gassaway, MHA
Senior Vice President, State Affairs and Policy, AHIP

December 7, 2019
Austin, TX

Who is AHIP?

America’s Health Insurance Plans (AHIP) is the national association whose members provide coverage and health-related services that improve and protect the health and financial security of consumers, families, businesses, communities and the nation.
Health Insurance Providers = 360° View

MEDICAL & BEHAVIORAL
- Design Plans and Benefits
- Improve Care & Outcomes
- Reduce Costs
- Build Networks

PHARMACY
- Coverage Policies

Consumer Outreach & Education
- Targeted Efforts to Enroll Existing Eligibles
- Expanded Wellness Benefits

Lower Drug Prices
End Surprise Medical Bills
Eliminate 3rd Party Payments
Expand Telehealth

Offer premium savings
- Reinsurance
- State Premium Discounts
- Tax Parity
- Repeal HIT & Cadillac Tax
- Expand HSA Options

Resource: AHIP, 12 Solutions to Lower Premiums, November 2018.
The Impact of High Prescription Drug Prices

Why Curbing Drug Costs Is Critical

Source: https://www.ahip.org/health-care-dollar/
Out-of-Control Drug Prices: Four themes

Broken Market
Sustainable Spending
Excessive Price Increases
High Launch Prices

Broken and Distorted Pharmaceutical Market

Government-granted monopolies via patent system and market exclusivity provisions in federal law

Market Dysfunction (via problematic marketing, legal, and regulatory practices)

HIGH PRICES HIGHER COSTS

- Coupons, Co-pay Cards
- Patent Games
- DTC, Product Detailing
- Pay for Delay
- Orphan Drug Act Abuses
- Product Hopping
- Dosing Strategies
- Generics, Biosimilar Barriers
- Off-label Promotion
- Coverage Mandates

PATIENTS
Rx Spending Growing at Unsustainable Rates

U.S. spending on prescription medicines is projected to reach over $600 billion by 2022

58% increase
4-7% CAGR

$600 billion (2022)
$453 billion (2017)
$380 billion (2014)

Source: Medicine Use and Spending in the U.S. - A Review of 2017 and Outlook to 2022, IQVIA Institute, April 2018

Excessive Price Increases on New & Older Therapies

Multiple Sclerosis Drugs Cost Much More Today than When Introduced

<table>
<thead>
<tr>
<th>FDA Approval</th>
<th>Price Increase</th>
<th>Cost in 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1993)</td>
<td>30% per year</td>
<td>$91K</td>
</tr>
<tr>
<td>(2004)</td>
<td>$8,300 - $11,000</td>
<td>$82K</td>
</tr>
<tr>
<td>(2016)</td>
<td>$83,000+</td>
<td>$88K</td>
</tr>
</tbody>
</table>

Average cost in 1990s
Average price increase for some drugs over two decades
Average cost in 2017 for all MS therapies

Source: Huff, Charlotte; “MS Drugs: Expensive, Often Lifelong, and Not Cost-Effective;” Managed Care Magazine; Sept 30, 2018
Costliest Price Hikes Not Supported by New Clinical Evidence

The Institute for Clinical and Economic Review (ICER) published its first annual report on Unsupported Price Increases (UPI) of prescription drugs in the United States. ICER ultimately determined that evidence for 7 of the 9 drugs was not adequate to support a claim of additional clinical benefit.

Net price increases for these 7 drugs were responsible for increasing total U.S. drug spending by more than $5.1 billion from 2017-2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Humira® (adalimumab, AbbVie)</td>
<td>19.1%</td>
<td>15.9%</td>
<td>$1,857</td>
</tr>
<tr>
<td>Rituxan® (rituximab, Genentech)</td>
<td>17.0%</td>
<td>23.6%</td>
<td>$806</td>
</tr>
<tr>
<td>Lyrica® (pregabalin, Pfizer)</td>
<td>28.3%</td>
<td>22.2%</td>
<td>$688</td>
</tr>
<tr>
<td>Truvada® (tenofovir disoproxil fumarate, Gilead)</td>
<td>14.3%</td>
<td>23.1%</td>
<td>$550</td>
</tr>
<tr>
<td>Neulasta® (pegfilgrastim, Amgen)</td>
<td>14.6%</td>
<td>13.4%</td>
<td>$489</td>
</tr>
<tr>
<td>Cialis® (tadalafil, Eli Lilly)</td>
<td>26.2%</td>
<td>32.5%</td>
<td>$403</td>
</tr>
<tr>
<td>Tecfidera® (dimethyl fumarate, Biogen)</td>
<td>16.7%</td>
<td>9.8%</td>
<td>$313</td>
</tr>
</tbody>
</table>

High Drug Prices: Is it the R&D?

Our Industry’s Market-Oriented Solutions

Real Competition
- Create a robust biosimilars market
- Creates, BLOCKING, Reduce red tape and abuses to limit generic and biosimilar entry
- Revisit orphan drug incentives
- Revisit guaranteed periods of market exclusivity

Open & Honest Rx Pricing
- Publish Rx prices, true R&D costs, and price increases
- Limit third-party schemes
- Evaluate DTC impact
- Extend manufacturer liability into Part D catastrophic benefit

Paying for Value
- Inform patients on effectiveness and value
- Expand value-based formulary programs
- Reduce regulatory barriers to value-based pricing
## State Solutions Encouraged

### Drug Transparency to Consumers
- Drug companies to report when, how much and why their drug costs are increasing
- \( \text{TX HB 2536 (2019); OR HB 4005 (2018); CA SB 17 (2017), NV SB 539/SB 262 (2016/2018)} \)

### Drug Transparency to Providers
- Pharma drug reps should include the cost of the drug when marketing to providers
- \( \text{LA SB 59 (2017)} \)

### State Enforcement
- State AGs should continue to investigate price anomalies like shadow pricing and price gouging
- \( \text{CA AB 824 (2019)} \)

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## Reduce Surprise Medical Bills
What Is a Surprise Medical Bill?

1 in 5 Americans covered by health insurance will receive a surprise medical bill from a doctor who treated them, even though the hospital itself is part of their network.

Why?

- Many doctors are independent contractors that work at the hospital, but not for the hospital.
  - That means that hospitals can be in a health insurance provider’s network, but the doctors at the hospital might not.
- Many health insurance providers cover much of the cost for services performed by an out-of-network (OON) provider.
  - However, because OON providers are not in a contractual agreement with the health plan, there is nothing to stop the provider from sending bills to patients when a plan does not pay the full amount they charge.

Surprise Medical Bills Raise Costs

5.8x Anesthesiologists charge, on average, 5.8 times the Medicare reimbursement rate
4.5x Radiologists charge 4.5 times the Medicare rate
4x Pathologists charge 4 times Medicare
4x Emergency medicine physicians charge 4 times the Medicare rate

Figure 4. Average Contracted Payment Rates Relative to Medicare Rates for Selected Specialties

Surprise Medical Bills and Networks

- **Surprise medical billing does not occur because of narrow networks**
  - The frequency of surprise medical billing is only marginally higher in individual market plans than in HMOs, PPO, or POS plans for large employers\(^*\)

- **Health insurance providers are required by law to meet either federal or state standards for network adequacy**
  - The law requires that private health plans have robust provider networks and regular verification of their continued compliance

- **Health insurance providers develop networks to negotiate better value and lower costs for the patients they serve**

- **Health insurance providers negotiate payment rates that fairly and reasonably compensate providers**
  - Increasingly with models that reward doctors for delivering higher value care at lower costs.

- **Network providers agree not to bill patients for more than the amount agreed upon between the insurance provider and doctor, protecting patients**


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Private Equity Exploits Patients Seeking Care

- **About 2/3 of U.S. hospitals outsource emergency care** to private physician-staffing companies, many of which are owned by private equity firms.

- Envision (EmCare) and TeamHealth – dominant players in this sector – are owned by private equity firms KKR and Blackstone Group.

- By 2013, these **private equity-owned staffing firms had captured 30% of the market** and private equity ownership of doctors’ groups has continued to grow.
  - One study found that in the case of EmCare, “out-of-network billing rates increase dramatically in the months after [it] takes over a staffing contract” and **physician charges increase on average by $556, a 96% increase** – “expos[ing] patients to increased cost sharing and financial risk.” The study found that EmCare’s entrance into a hospital increased out-of-network rates by 81.5%, while TeamHealth’s entrance drove up rates by almost 33%.

Private Equity Investing in Niche Areas

The business model of private equity is geared to drive up the costs of patient care.

“Emergency medical practices are a perfect buyout target for private equity managers because demand does not decline when prices go up.”


Laws Can Protect Patients and Preserve Networks

- California AB 72 (2016) set a benchmark at locally negotiated market reimbursement rate for OON care.
  - Doctors are paid either the insurer’s average contracted rate or 125% of the Medicare reimbursement rate (whichever is higher);
  - patients do not receive an additional bill above and beyond that amount for their in-network cost-sharing.

- A recent study examined 11 health plans, representing 96% of covered lives in the fully insured commercial market in California.

- The data show that after adoption of California’s surprise billing legislation, the number of physicians in provider networks was 16% HIGHER than the level prior to the law going into effect.

<table>
<thead>
<tr>
<th>Physician Type</th>
<th>In-network Providers, 2017-2019, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Physicians</td>
<td>116%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>110%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>110%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>118%</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>126%</td>
</tr>
<tr>
<td>Pathology</td>
<td>101%</td>
</tr>
</tbody>
</table>

Benchmark v. Arbitration

• A Congressional Budget Office score of Senate options to protect patients from surprise medical bills found that setting a **benchmark payment rate** would save the most money – **$25 billion** – over 10 years.

• This scored higher than options proposing arbitration, which scored **$17** and **$20 billion** over 10 years. The **administrative cost of arbitration** to health care providers and employers is estimated to be **$1 billion** over 10 years.
  - Arbitration does not address the root cause of surprise medical bills – exorbitant bills from certain specialty doctors. Because arbitration doesn’t tackle the problem, health costs will not be meaningfully reduced.
  - Arbitration places the onus for action on the patient or their health insurance provider, rather than protecting all patients by addressing the problem.
  - Even streamlined arbitration involves costs, time expenditures, and administrative burdens that can be avoided.


State Solutions to Protect Patients from Surprise Medical Bills

- **Ban balance billing** when a patient is involuntarily treated by an OON provider
  - Emergency and Non-Emergency
- **Require health insurance providers** to reimburse OON physicians at a market-driven, fair and reasonable amount (benchmark rate)
  - Cannot increase costs to patients (cost-sharing and premium impact)
- **Require states** to provide a backstop to assure fair application of the benchmark rate
  - Ensure that the “math” is right, not to determine a unique payment amount
- **Require hospitals, facilities, and health care providers** to give advance notice to patients of the network status of treating providers
Curb Inappropriate 3rd Party Payments

3rd Party Payments: Driving Up Premiums

- Medicare provides universal coverage for dialysis patients following a 90-day wait period for those uninsured or on Medicaid and after a further 30-month coordination period for those with group commercial coverage.

- In-network commercial payments for dialysis average $1,000-1,000/tx while Medicare and Medicaid payments average $260/tx.

- With the establishment of the ACA insurers now must underwrite individual policies for ESRD patients.

- The AKF is a non-profit 501(c)3 organization that accepts donations (per 2015 IRS form 990, 80% of AKF’s total $265m donations came from two redacted donors to provide financial assistance for ESRD patients to pay commercial premiums, Medigap premiums and cost-sharing).

- AKF current reports subsidizing 6,400 QHP policies which JP Morgan estimates drives nearly $1.7 billion of adverse selection.

State Solution: California AB 290

- Requires a health insurance provider to accept premium payments from specified 3rd-party entities (Ryan White program, Indian tribe, government program, family).
- Requires a financially interested entity (other than those entities listed above) making a 3rd-party premium payment to provide assistance for a full plan year, notify the enrollee prior to an OE period if financial assistance will be discontinued, annually inform applicants of other health care options, and agree not to steer/direct/advise a patient into/away from a specific coverage option or health plan.
- Prohibits entities from conditioning financial assistance on the use of a specific facility/provider.
- Prohibits entities that provide coverage for enrollees with ESRD from conditioning financial assistance on eligibility for/receipt of any surgery, transplant, procedure, drug, or device.
- Requires 3rd-party entity to disclose to plan/insurance provider the name of the enrollee before first premium payment is made and annually affirm compliance with above requirements. Establishes penalties if entity fails to disclose its 3rd-party payments, including health plan/insurance provider’s recovery of overpayment.
- Establishes calculations and limitations for reimbursement to a financially interested provider when a financially interested entity makes a premium payment.

Expand the Use of Telehealth
Telehealth Saves Money and Improves Care

- Telehealth has the potential to improve engagement between patients and providers; improve health care maintenance, especially for those with chronic conditions; and avoid unnecessary and costly acute care settings.
- While particularly useful for those in rural areas, seniors, and others with mobility concerns, telehealth services can make it easier for all patients to access care and connect with specialists from a computer or mobile device.
- Challenges to expansion of telehealth services include:
  - Numerous states have enacted laws and regulations governing telehealth for plans operating in the commercial market.
  - The disparities among state requirements related to provider licensure, site- and technology specific use, and reimbursement and/or payment parity, create many barriers to continued use and expansion of telehealth services.
- Estimates show that telehealth can save more than $6 billion annually.

State Solutions

- **Support establishment of multi-state licensure compacts.**
  - In many cases, providers can only offer services in a state where they are licensed. If a patient can only use an in-state doctor, this closes off doctors that would otherwise be available through national provider networks.
  - Allowing multi-state licensure compacts can promote expedited licensure for physicians and/or reciprocity for certain providers applying in multiple states, will increase the number of accessible services, and expand provider networks available to consumers.

- **Enhance flexibility** by not establishing state mandates related to reimbursement and/or payment parity, site-specific use, prior visit requirements, or specific technology use.
  - Inconsistent state laws and mandates can make providing access to telehealth services difficult for health insurance providers, particularly those that operate in multiple states.
  - State mandates to cover telehealth in specific ways and under specific requirements hinder flexibility to design benefits that meet the needs of consumers.

- **Designate telehealth as a means of satisfying network adequacy requirements.**
  - In a 2016 revised model law, NAIC included the use of telemedicine as an option to meet network adequacy standards.
  - Several states have passed laws or updated regulation to incorporate telehealth in their network adequacy requirements. As part of updating standards to allow greater use of telemedicine, states can identify guardrails to ensure telemedicine use is expanded for scenarios for which it is clinically appropriate.
Additional Recommendations

Offer Premium Savings

Section 1332 Waivers

• Allows states to waive key requirements of the ACA within certain guardrails:
  - Coverage
  - Affordability
  - Comprehensiveness
  - Deficit Neutrality

• The ACA requirements states may seek to waive include:
  - Qualified Health Plan Requirements, Essential Health Benefits, Abortion Requirements, and Definitions of Individual, Small/Large Employer
  - Exchange Requirements
  - Cost-Sharing Reductions
  - Premium Tax Credits
States with Section 1332 Waivers

Increase Participation to Balance Risk & Achieve Coverage Goals
Outreach & Education re: Existing Coverage Options

**Support investments in robust advertising and marketing campaigns for enrollment.**

- A stable individual market requires broad participation (healthy and sick, young and old).
- Stability comes when consumers enroll for a full plan year and continually maintain 12 months of coverage, as opposed to enrolling only when they need care.
- Marketing, outreach, and education are critical to ensure all consumers are aware of the open enrollment timelines and coverage options.

**Example – New Mexico (Urban Institute Findings)*:**

- 187,000 uninsured without coverage
- 55,000 are eligible but unenrolled in Medicaid
- 43,000 are eligible for subsidies on the Exchange but not enrolled

* Source: NM Human Services Department Presentation, November 12, 2019 by Cabinet Secretary David R. Scrase, MD and Chief Innovation Officer Abuko D Estrada, JD. Accessible at https://www.nmlegis.gov/handouts/LHHS%2020112119%20Item%202%20Presentation%20to%20LHHS%20Coverage%20and%20Affordability%20Initiatives.pdf

State Based Solution for FFM States

- At the option of a state participating in the FFM, transfer a portion of the FFM user fee to the state to conduct outreach, education, and marketing.
  - Health insurance providers who participate on the federal exchange are required to pay a user fee of 3% (2020) of premiums.
  - While CMS has not provided transparency into allocation of these funds, the user fee is intended to be used to support marketing and outreach activities, amongst other federal exchange functions.
  - CMS should identify user fees that can be allocated to support state marketing and outreach activities. States that opt to receive these funds may use them to carry out a defined list of marketing and outreach activities.
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Appendix
What do voters think about Surprise Medical Bills?

Coalition Against Surprise Medical Billing partnered with Morning Consult to release results of a recent poll that demonstrate voters want action from Congress on surprise medical billing – and they want it done in the right way.

- 3 in 5 voters (61%) would be more likely to vote for a candidate in the 2020 election if they promised to protect patients from surprise medical bills.
- 2 in 3 voters (65%) say it is very important for surprise medical billing legislation to lower health insurance premiums.
- A large majority of voters (71%) would be frustrated if Congress did not pass legislation to regulate the role of private equity companies in surprise medical billing.

What do voters think about High Drug Prices?

- Following the August Recess, 70 percent of Americans ranked lowering prescription drug prices as a “top priority” for Congress.
- A recent Gallup poll found that Americans rank Big Pharma as the most poorly regarded U.S. industry – below oil and gas, big banks and even the federal government.
- Over 90 percent of Americans “are in favor of various proposals designed to reduce the prices of prescription drugs including making it easier for generic drugs to come to market.”

Agenda Item #6

Discuss Any Other Matters Brought Before the Task Force

—Commissioner Michael Conway (CO)