REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force Aug. 4, 2020, Minutes
- Regulatory Framework (B) Task Force Feb. 20, 2020, Minutes (Attachment One)
  - Regulatory Framework (B) Task Force Revised 2020 Charges (Attachment One-A)
- Accident and Sickness Insurance Minimum Standards (B) Subgroup Dec. 16, 2019, Minutes (Attachment Two)
- ERISA (B) Working Group July 31, 2020, Minutes (Attachment Three)
- HMO Issues (B) Subgroup July 13, 2020, Minutes (Attachment Four)
  - HMO Issues (B) Subgroup June 11, 2020, Minutes (Attachment Four-A)
  - *Health Maintenance Organization Model Act* (#430) Draft Dated July 13, 2020 (Attachment Four-B)
- MHPAEA (B) Working Group July 28, 2020, Minutes (Attachment Five)
  - MHPAEA (B) Working Group June 24, 2020, Minutes (Attachment Five-A)
    - MHPAEA (B) Working Group June 5, 2020, Minutes (Attachment Five-A1)
      - MHPAEA (B) Working Group March 19, 2020, Minutes (Attachment Five-A1a)
      - MHPAEA (B) Working Group March 9, 2020, Minutes (Attachment Five-A1b)
- Pharmacy Benefit Manager Regulatory Issues (B) Subgroup July 16, 2020, Minutes (Attachment Six)
  - Pharmacy Benefit Manager Model Draft Dated July 6, 2020 (Attachment Six-A)

Draft Pending Adoption

Draft: 8/18/20

Regulatory Framework (B) Task Force
Virtual Summer National Meeting
August 4, 2020

The Regulatory Framework (B) Task Force met Aug. 4, 2020. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Ramge, Vice Chair (NE); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Steve Ostlund and Yada Horace (AL); Alan McClain (AR); Ricardo Lara represented by Tyler McKinney (CA); Karima M. Woods (DC); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Robert H. Muriel represented by Kate Morthland (IL); Vicki Schmidt represented by Justin McFarland and Craig Van Aalst (KS); Sharon P. Clark represented by DJ Wasson (KY); Gary Anderson represented by Kevin Beagan (MA); Eric A. Cioppa (ME); Steve Kelley represented by Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread (ND); Chris Nicolopoulos represented by Maureen Belanger (NH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser represented by Tanji Northrup and Jaakob Sundberg (UT); Scott A. White represented by Julie Blauvelt and Don Beatty (VA); Mike Kreidler (WA); Mark Afable represented by Nathan Houdek (WI); and James A. Dodrill (WV).

1. Adopted its Feb. 20 and 2019 Fall National Meeting Minutes

The Task Force met Feb. 20 and Dec. 7, 2019. During its Feb. 20 meeting, the Task Force appointed the MHPAEA (B) Working Group and adopted its 2020 proposed charges.

Ms. Kruger made a motion, seconded by Commissioner Godfread, to adopt the Task Force's Feb. 20 (Attachment One) and Dec. 7, 2019, (*see NAIC Proceedings – Fall 2019, Regulatory Framework (B) Task Force*) minutes. The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

Director Ramge made a motion, seconded by Mr. Trexler, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Dec. 16, 2019, minutes (Attachment Two); the ERISA (B) Working Group (Attachment Three); the HMO Issues (B) Subgroup, including its July 13 minutes (Attachment Four); the MHPAEA (B) Working Group (Attachment Five); and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its July 16 minutes (Attachment Six). The motion passed unanimously.

Commissioner Conway said in adopting the HMO Issues (B) Subgroup report, the Task Force is not adopting the proposed revisions to the *Health Maintenance Organization Model Act* (#430). He said the Task Force will meet via conference call in September to consider adoption of the proposed revisions.

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

Justin Giovannelli (Center on Health Insurance Reforms—CHIR, Georgetown University Health Policy Institute) provided an update on the CHIR's work related to the federal Affordable Care Act (ACA) and other issues of interest to state insurance regulators. He highlighted the work the CHIR has been doing related to the COVID-19 pandemic. He said the CHIR has set up a tracking map and database concerning state decisions related to coverage requirements during the pandemic. He said the CHIR has written several issue briefs related to the COVID-19 pandemic. With the support of the Robert Wood Johnson Foundation (RWJF), the CHIR recently issued a research brief trying to gain insight into the insurer perspective regarding coverage decisions during the pandemic. The research brief is based on interviews conducted between late April and June with 25 executives from health insurance plans.

Mr. Giovannelli said the CHIR is continuing its work to track and analyze state regulatory approaches to short-term, limited-duration (STLD) plans in the wake of recent federal rule changes with respect to these products. He said the CHIR is also continuing to track state reforms affecting the individual market, including state actions involving the ACA's section 1332 waiver program and improving the affordability of comprehensive coverage. He said the CHIR anticipates publishing an issue brief examining state reinsurance programs developed under the section 1332 waiver program. He said initial findings have shown that state reinsurance programs have had a positive effect in terms of creating individual market stability because such programs make coverage more affordable for individuals not eligible for premium subsidies. He suggested that state insurance

regulators may want to consider looking beyond reinsurance programs and/or looking at options to provide additional individual market stability that might work in tandem with state reinsurance programs to provide stability and benefits to all market participants, including those who are receiving premium subsidies.

Mr. Giovannelli discussed the CHIR's ongoing state technical assistance regarding insurance regulatory matters with the support of the RWJF through its State Health and Value Strategies Program. He also highlighted the CHIR's assistance, provided with the support by the Laura and John Arnold Foundation (LJAF), to state and federal policymakers regarding regulatory approaches to balance billing.

Commissioner Conway said Colorado enacted legislation last year providing additional funding to allow the Colorado Department of Insurance (DOI) to look at ways to use its reinsurance program in tandem with other initiatives to provide additional individual market stability. He expressed interest in having additional discussions with the CHIR and other experts on this topic.

4. Heard a Panel Presentation on HCSMs

Mr. Giovannelli provided an overview of health care sharing ministries (HCSMs). He discussed consumer confusion involving HCSMs. He said although HCSMs are careful to say they are not insurance, to consumers, they look like traditional health insurance coverage for a number of reasons, including: 1) the use of defined benefit packages; 2) monthly payment requirements similar to premiums; 3) the use of provider networks; and 4) cost-sharing requirements, such as deductibles, copayment and co-insurance limits. In addition, he said some HCSMs use insurance brokers to sell their plans, and they have marketing campaigns that describe HCSM plans as a replacement for insurance or suggest that consumers can rely on HCSMs for financial protection. He highlighted some examples from HCSM advertising and marketing materials illustrating these concerns and why consumers may be led to believe HCSM plans are traditional health insurance plans.

Mr. Giovannelli discussed potential harms to consumers and the individual health insurance market related to HCSMs, such as: 1) misaligned expectations that their claims will be paid; and 2) risk segmentation and undermining the traditional health insurance market. He also discussed the current regulatory framework for HCSMs, noting that neither the federal mandate exemption under the ACA nor any other federal provision preempts state regulatory authority over HCSMs, and that states can, and some do, set standards for HCSMs, which they enforce.

Mr. Giovannelli offered several regulatory options regarding the regulation of HCSMs, including: 1) active, ongoing oversight to ensure compliance with state standards, such as including demonstration of compliance at the front-end through a registration requirement; 2) prohibiting HCSMs from offering financial incentives for enrollment; and 3) prohibiting marketing materials that suggest that an HCSM is operating in a financially sound manner or that it has had a successful history of meeting subscribers' financial or medical needs.

Joel Noble (Samaritan Ministries) described Samaritan Ministries' approach to meeting its members' health care needs. He said Samaritan Ministries coordinates and connects members to care for the whole need with prayer, encouragement and financial support. Samaritan Ministries believes health care needs are multi-dimensional—emotional and spiritual—as much as physical and financial. Samaritan Ministries has been operating for just over 25 years. Currently, over $30 million is shared each month among over 270,000 members nationwide.

Mr. Noble discussed Samaritan Ministries' best practices, found at *https://www.samaritanministries.org/bestpractices*, that it believes all HCSMs should follow. The best practices suggest that an HCSM should: 1) act primarily as a facilitator for the bearing of medical burdens through the voluntary medical burden-sharing process, which does not include the pooling of funds; 2) not assume any transfer of medical risk form its members or make any guarantee of payment for any member medical expenses; 3) conform with the statutory definition of a qualifying HCSM, as required under the ACA; 4) not require its members to apply for government assistance or state aid as part of the ministry's sharing; 5) ideally not use health insurance agents or brokers to enroll members into the ministry; and 6) clearly communicate in its marketing and advertising materials that the HCSM is not an insurance company. The sharing of medical costs is completely voluntary, and members maintain their legal responsibility to pay their medical bills irrespective of whether they receive payment from the voluntary actions of other members of the ministry through the sharing process.

Mr. Noble said Samaritan Ministries values transparency, and it would not find it burdensome to report information annually if a state mandates such a requirement for HCSMs. He explained that Samaritan Ministries routinely shares financial and other information with state agencies, upon request, and its members. However, he expressed concern with non-insurance entities, such as HCSMs, registering with a state DOI because HCSMs are section 501(c)(3) charities, and they should not be subject

to any portion of the insurance code. As a charity, HCSMs should be regulated by the state attorney general's office, and they should be subject to the same state laws that apply to other charities. However, Mr. Noble acknowledged that state DOIs do receive calls from consumers about HCSMs. To address this, he suggested that any information a HCSM shares with the state attorney general's office should be shared with the state DOI.

Commissioner Conway discussed problems that Colorado has had with the marketing by some HCSMs that lead consumers to believe that they are offering a traditional insurance product. He asked Mr. Noble why Samaritan Ministries' best practices do not specifically address this issue by specifically suggesting that an HCSM should not use insurance terms in their marketing materials. Mr. Noble said an HCSM's marketing material should make it clear that the HCSM product is not an insurance product and not use insurance terms. He said Massachusetts has included in its HCSM regulations a prohibition on the use of confusion language and the use insurance terms like "coverage" or "deductible." He agreed with Commissioner Conway's concerns related to this issue.

Mr. Sundberg asked Mr. Noble if Samaritan Ministries used actuaries to set the level of monthly members sharing. Mr. Noble said Samaritan Ministries does not use actuaries. He said Samaritan Ministries looks at health care trends and monitors health care costs. Commissioner Conway asked what Samaritan Ministries uses to price the product if it does not employ actuaries. Mr. Noble said because the sharing is member-to-member, Samaritan Ministries is dealing with medical bills after they have been incurred. He said actuaries make assumptions about future events and set premium rates based on those assumptions. HCSMs are dealing with actual medical events after they have happened. Mr. Noble said Samaritan Ministries deals with this situation by including a pro rata provision in its member agreements, such that if the sharing needs exceed the monthly shares, then the sharing is at a pro rata rate. He explained that if such a short fall occurs three times in a row, then under Samaritan Ministries' guidelines, its members can vote to increase their monthly share amounts to address the current shortfall and avoid future shortfalls.

Commissioner Conway asked Mr. Noble about Samaritan Ministries' position on the payment of commissions to individuals who enroll people into its HCSM products. Mr. Noble said Samaritan Ministries does not support the payment of commissions because it could lead to possible fraudulent and deceptive practices surrounding enrollment that could be harmful to consumers.

5. Heard a Discussion on Premium Holidays, Early MLR Rebate Payments, and Adjustments to Cost-Sharing Benefits as a Result of Fewer Claims Filings in 2020 Due to COVID-19

Jason Levitis (Levitis Strategies LLC) said as many know, the COVID-19 pandemic has led to a substantial reduction in commercial health insurance claims, partly because consumers are avoiding non-urgent health care. He said some health insurers, particularly in the Medicare market, have responded with premium holidays or rebates. He said with respect to premium holidays and rebates, many state insurance regulators have been supportive of providing rebates and premium holidays to consumers, but it is unclear whether federal rules permit it, particularly with respect to individuals receiving coverage through the health insurance exchanges. He noted that the federal Centers for Medicare & Medicaid Services (CMS) have said subject to the states allowing it, pre-payment of medical loss ratio (MLR) rebates are allowed as an avenue for providing premium discounts; but again, the issue is how to apply it and its implications for those receiving coverage through the health insurance exchanges in light of advanced premium tax credits (APTCs). He said if the CMS does not address the premium holiday and rebating issue, then insurers could be receiving too much money when the rebate lowers the premium amount due; and consumers may be on the hook for paying back the excess amount when they file their taxes. He posed several questions that the CMS needs to consider in issuing any guidance to address this issue, including: 1) the financial impact on consumers; 2) the potential administrative burden on consumers; and 3) the impact on carriers.

Randy Pate (Center for Consumer Information and Insurance Oversight—CCIIO) discussed the CMS's current work related to the COVID-19 health emergency. He said while focusing on the health emergency, the CMS and the CCIIO are also focusing on the upcoming open enrollment period for 2021, and they are continuing their focus on increasing competition in the individual market and lowering premiums to make health care coverage more affordable. Mr. Pate said while he was speaking, the CMS just released guidance on a new temporary policy that will allow issuers to offer temporary premium reductions for individuals with 2020 coverage in the individual and small group markets. The guidance can be found at *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Premium-Credit-Guidance.pdf*. Mr. Pate provided a general overview of the guidance provisions, noting that it touches on the questions Mr. Levitis posed, such as how the premium reductions will be reported to the Internal Revenue Service (IRS). Mr. Pate said the guidance requires that the premium reduction be a fixed percentage and be prospective only. He also said that he anticipates future rulemaking to address some of the questions that Mr. Levitis raised.

Commissioner Conway asked about carriers who have already provided rebates or premium holidays. Mr. Pate said these carriers should submit the template to the CMS outlining what they have done, which the CMS will review. He said he anticipates the CMS providing flexibility to these insurers. Commissioner Conway asked Mr. Pate what he anticipates will be included in future rulemaking that he anticipates the CMS issuing. Mr. Pate said future rulemaking will most likely address risk adjustment issues.

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

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Draft: 2/24/20

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

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

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

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

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

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

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

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Draft: 2/19/20
Adopted by the Health Insurance and Managed Care (B) Committee – TBD
Adopted by the Regulatory Framework (B) Task Force – Feb. 20, 2020

2020 REVISED CHARGES

REGULATORY FRAMEWORK (B) TASK FORCE

The mission of the Regulatory Framework (B) Task Force is to: 1) develop NAIC model acts and regulations for state health care initiatives; and 2) consider policy issues affecting state health insurance regulation.

Ongoing Support of NAIC Programs, Products and Services

1. The **Regulatory Framework (B) Task Force** will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2020.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the ERISA (B) Working Group, monitor, analyze and report developments related to association health plans (AHPs).
   F. Monitor, analyze and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

2. The **Accident and Sickness Insurance Minimum Standards (B) Subgroup** will:
   A. Review and consider revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

3. The **ERISA (B) Working Group** will:
   A. Monitor, report and analyze developments related to the federal Employee Retirement Income Security Act (ERISA), and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate and coordinate with the states and the U.S. Department of Labor (DOL) related to sham health plans.
   C. Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.
   D. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) and modify it, as necessary, to reflect developments related to ERISA. Report annually.

4. The **HMO Issues (B) Subgroup** will:
   A. Revise 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).

5. The **MHPAEA (B) Working Group** will:
   A. Monitor, report and analyze developments related to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate and coordinate best practices with the states, the DOL and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
   C. Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to MHPAEA.

D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC *Market Regulation Handbook*.

6. The **Pharmacy Benefit Manager Regulatory Issues (B) Subgroup** will:
   A. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.

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

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Draft: 1/2/20

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

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

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

Ms. Domzalski-Hansen said the purpose of today's conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), beginning with Section 5L, the definition of "preexisting condition." She reminded the Subgroup of its discussion of Section 5L during its Nov. 25 conference call.

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

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

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

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

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

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

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

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

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

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

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Draft: 8/6/20

ERISA (B) Working Group
Virtual Summer National Meeting
July 31, 2020

The ERISA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call July 31, 2020. The following Working Group members participated: Robert Wake, Chair (ME); Steve Ostlund (AL); Jim Brader (AR); Kate Harris and Jason Lapham (CO): Howard Liebers (DC); Angela Burke Boston (IA); Mark McClaflin and Craig Van Aalst (KS); Grace Arnold and Jonathan Kelly (MN); Camille Anderson-Weddle, Danielle K. Smith and Carrie Couch (MO); Laura Arp (NE); Alexia Emmermann (NV); Laura Miller (OH); Cuc Nguyen (OK); Travis Jordan (SD); Raja Malkani, Rachel Bowden and David Bolduc (TX); Tanji Northrup (UT); Molly Nollette (WA); and Richard Wicka (WI). Also participating were: Sarah Bailey (AK) Bruce Hinze and Sheirin Ghoddoucy (CA); Fleur McKendell (DE); James Dunn III (FL); Arlene Ige and Jason Asaeda (HI); Weston Trexler and October Nickel (ID); Elizabeth Nunes (IL); Claire Szpara (IN); Glynda Daniels and Mary Kwei (MD); Karen Dennis (MI); Mike Chaney (MS); Diana Sherman (NJ); Paige Duhamel (NM); Colleen Rumsey (NY); Tashia Sizemore (OR); Katie Dzurec (PA); Thomas Baldwin, Daniel Morris and Ryan Basnett (SC); Brian Hoffmeister and Bill Huddleston (TN); Julie Blauvelt (VA); Marcia Violette and Jill Rickard (VT); Greg Elam and Ellen Potter (WV); and Denise Burke and Amanda Tarr (WY).

1. Adopted its 2019 Fall National Meeting Minutes

Mr. Wicka made a motion, seconded by Ms. Arp, to adopt the Working Group's Dec.7, 2019, minutes (*see NAIC Proceedings – Fall 2019, Regulatory Framework Task Force, Attachment Eight*). The motion passed unanimously.

2. Discussed the Working Group's Focus for 2021

Mr. Wake said the single item on the Working Group's open agenda was to discuss what projects the Working Group might want to focus on in the coming year. He said that the Working Group had discussed developing a best practices document for state regulation of multiple employer welfare arrangements (MEWAs) and association health plans (AHPs), both fully insured and self-funded. He said up to this point, there was not clear support to pursue this task pending the appeal of the District Court for the District of Columbia ruling in *New York v. U.S. Department of Labor*, which vacated critical portions of the U.S. Department of Labor's (DOL) final rule on AHPs.

Mr. Wake also mentioned the *Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation* (#220). This model was developed by the ERISA (B) Working Group and adopted by the NAIC in 2010. It has not been adopted in the states, but Mr. Wake suggested that it might be worth taking another look at this model to see if it contains any tools that could be helpful to states as they look to address illegal MEWAs. Mr. Wake explained that the genesis for Model #220 is that often licensed entities, whether deliberately or unwittingly, are involved with sham health plans. Model #220 is designed to require licensed persons and entities to establish and follow responsible procedures to identify and report illegal health insurers. Jennifer Cook (NAIC) also mentioned that at about the same time that this model was adopted, the Working Group developed an insurer and producer bulletin, as well as a consumer alert, on the same topic. Ms. Cook offered to distribute them to the Working Group.

Mr. Wake asked for feedback on the idea of looking at Model #220. Ms. Seip asked about the harm that Model #220 is designed to address. Mr. Wake said the harm is that people will be defrauded by illegal and unlicensed health plans, and by having licensed entities undertake the procedures in Model #220, consumers will be protected from entities offering fraudulent or otherwise illegal health care coverage. Mr. Lapham said when legitimate players in the market align themselves with questionable, or illegitimate, entities, those bad actors capitalize on the respectability of the legitimate entities and are able to influence not only their potential customers, but also state insurance regulators investigating an entity. Ms. Arp said that provider networks often contract with multiple entities, both fully insured and self-insured, some legitimate, others not and some in between. She said it would certainly make investigating some of these entities a lot easier if there was a way to see a list of the entities a provider network has relationships with. Mr. Wake said that often carriers rent out their networks to self-funded plans and sometimes can have hundreds of clients, so they will not necessarily know exactly who all of them are, but they should have some kind of vetting process in place. He said he would be interested in hearing from the industry about what best practices might be and what state insurance regulators might be able to learn from that. Mr. Wake mentioned that the M-

1 filings have turned out to be hugely helpful in identifying entities operating in a state without that state's knowledge. Mr. Wake pointed out that finding illegal health plans can be complicated. He mentioned a case in Maine where a nationwide plan advertised that it had the best provider network, except that the network did not actually have any providers in Maine. Or a plan that advertises that it does not have any copays or deductibles, but it does not have any coverage either. He explained that he mentions these cases to illustrate that there is not always a single answer to what is a complicated, multi-faceted problem of illegal and fraudulent health plans.

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

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Draft: 7/21/20

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

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

1. Adopted its June 11 Minutes

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

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

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

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

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

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

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Draft: 6/18/20

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Adopted by the Health Insurance and Managed Care (B) Committee - TBD
Adopted by the Regulatory Framework (B) Task Force - TBD
Adopted by the HMO Issues (B) Subgroup – July 13, 2020

Draft: 7/6/20
Revisions to Model #430

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

Table of Contents

Section 1. Short Title

This Act may be cited as the Health Maintenance Organization Act of [insert year].

Section 2. Purpose and Intent

The purpose of this Act is to provide for a system of regulation for health maintenance organizations that is fair and efficient, and promotes the continued solvency of health maintenance organizations. This Act is designed to operate in conjunction with and as a companion to other state laws that establish standards for the regulation of health maintenance organizations, such as [insert state law equivalent to the ~~Managed Care Plan Network Adequacy~~*Health Benefit Plan Network Access and Adequacy Model Act*, the *Quality Assessment and Improvement Model Act*, the *Health Care Professional Credentialing Verification Model Act*, the *Utilization Review and Benefit Determination Model Act*, the *Health Carrier Grievance Procedure Model Act*, the *Health Carrier External Review Model Act*, the *Health Information Privacy Model Act*, the *Unfair Trade Practices Model Act*, the Unfair Claims Settlement Practices Model Act, the *Insurance Holding Company System Regulatory Act* and the *Risk-Based Capital (RBC) for Health Organizations Model Act*].

Drafting Note: This model act presumes the existence of state laws that are based on the listed NAIC model acts described in this section. States that have not already adopted these laws should consider adopting them to ensure that a comprehensive system of regulation for health maintenance organizations is in place.

Drafting Note: Former Section 14—Continuation of Benefits and Section 20—Uncovered Expenditures provide consumer protections for health maintenance organization enrollees in the event of a health maintenance organization insolvency in the absence of guaranty association protection for health maintenance organization enrollees. Those sections (along with Section 3HH, defining the term "uncovered expenditures") have been repealed to reconcile this Act with the *Life and Health Insurance Guaranty Association Model Act* (#520), which was amended in 2017 to make health maintenance organizations members of the guaranty association. States that continue to exclude health maintenance organizations from guaranty association membership should retain provisions, comparable to former Sections 3HH, 14 and 20, requiring health maintenance organizations to develop advance insolvency plans that include procedures to facilitate continuation of benefits after an insolvency, and to post deposits to secure any uncovered expenditures in excess of 10% of total health care expenditures. The language from former Section 14, former Section 20 and the former definition of "uncovered expenditures" in Section 3HH can be found in Appendix A. Former Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency was repealed as obsolete due to the provisions of the federal Affordable Care Act (ACA).

Section 3. Definitions

A. "Adverse determination" means a determination by a health maintenance organization or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health maintenance organization's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.

B. "Basic health care services" includes the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.

C. "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

D. "Coinsurance" means the percentage amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

Drafting Note: States that do not allow HMOs to impose a coinsurance requirement should not adopt this definition nor include the term when it is referenced throughout the model.

E. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction

of health maintenance organizations lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

F. "Copayment" means a specified dollar amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

G. "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

H. "Covered person" means any person eligible to receive covered benefits under the terms of a health benefit plan.

I. "Deductible" means the amount a covered person is responsible to pay out-of-pocket before the health maintenance organization begins to pay the covered expenses associated with treatment.

J. "Enrollee" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

K. "Evidence of coverage" means a statement that sets out the coverage and other rights to which the covered person is entitled under the health benefit plan and that may be issued by the health maintenance organization or by the group contract holder to an enrollee electronically or, upon request, in writing.

L. "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to a covered person who is totally disabled on the date of termination.

M. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

N. "Grievance" means a written complaint submitted by or on behalf of a covered person regarding:

(1) The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(2) Claims payment, handling or reimbursement for health care services; or

(3) Matters pertaining to the contractual relationship between a covered person and a health maintenance organization.

O. "Group contract" means a contract for health care services, which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

P. "Group contract holder" means a person, other than an individual, to which a group contract has been issued.

Q. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

R. "Health care professional" means a physician or other health care practitioner license, accredited or certified to perform specified health services consistent with state law.

S. "Health care provider" or "provider" means a health care professional or facility.

T. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

U. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, managed care organization, health maintenance organization, a nonprofit hospital or medical service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

Drafting Note: The term "hospital or medical service corporation," as used in the model act, is intended to apply to any nonprofit health, hospital or medical service corporation or similar organization. In order to include such organizations in this section, which are also commonly referred to as "Blue Cross Blue Shield-type" plans, each state should identify these organizations in accordance with its statutory terminology for such plans or by specific statutory citation. Some states also may have to amend other laws to bring these organizations within the scope of this section since the portions of state law applicable to these organizations may provide that no other portion of the insurance code applies to these organizations without a specific reference to the other provision.

V. "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for a covered person's responsibility for copayments, coinsurance or deductibles.

W. "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the enrollee.

X. "Insolvent" or "insolvency" shall mean that the health maintenance organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.

Y. "Intermediary organization" means a person, other than an individual, authorized to negotiate and execute provider contracts with health maintenance organizations on behalf of a group of health care providers or on behalf of a network, but does not include a provider or group of providers negotiating on its own behalf.

Z. "Network" means the group of participating providers providing services to a health maintenance organization.

AA. "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

BB. "Participating provider" means a provider that, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments, coinsurance or deductibles, from the health maintenance organization or other organization under contract with the health maintenance organization to provide payment in accordance with the terms of the contract.

CC. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or a combination of the foregoing.

DD. "Policyholder" means, for individual contracts, the individual in whose name the contract is issued, and for group contracts, the group contract holder.

EE. "Qualified actuary" means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the commissioner may require.

FF. "Replacement coverage" means the benefits provided by a succeeding carrier.

GG. "Risk bearing entity" means an intermediary organization that is at financial risk for services provided through contractual assumption of the obligation for the delivery of specified health care services to covered persons of the health maintenance organization.

~~HH. "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which a covered person may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.~~

~~**Drafting Note:** Subsection HH defines uncovered expenditures for use in Section 20. They will vary in type and amount, depending on the arrangements of the health maintenance organization. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the covered person even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.~~

~~H~~HH. "Utilization review" means a set of formal techniques utilized by or on behalf of the health maintenance organization designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Section 4. Applicability and Scope

This Act applies to all health maintenance organizations and risk bearing entities doing business in this state.

Section 5. Establishment of Health Maintenance Organizations

Option A:

A. Notwithstanding any law of this state to the contrary, any person other than an individual may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. No person shall establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this Act. A foreign corporation may qualify under this Act, subject to its registration to do business in this state as a foreign corporation under [insert reference to applicable state law] and compliance with all provisions of this Act and other applicable state laws.

Drafting Note: State laws differ as to whether a health maintenance organization is required to be a domestic corporation. This provision should be adopted if your state wants to permit a foreign corporation to qualify under this Act if it registers to do business in a state as a foreign corporation and complies with all provisions of this Act and other applicable state laws.

Option B:

A. Notwithstanding any law of this state to the contrary, any organization may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. A person shall not establish or operate a health maintenance organization in this state without obtaining a certificate of authority under this Act.

Drafting Note: State laws differ as to whether a health maintenance organization may be a foreign corporation. This option does not differentiate between foreign and domestic corporations. Whether or not to allow foreign corporations to become health maintenance organizations should be determined in light of a particular state's regulatory framework.

B. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall demonstrate, set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation,

articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) (a) A disclosure of the internal organizational structure identifying senior management employees;

(b) A disclosure of the external organizational structure identifying all parent, subsidiary and affiliate organizations; and

(c) If the applicant is a member of a holding company:

(i) Identification of the holding company; and

(ii) A copy of the most recent holding company Form B that includes current financial information for the ultimate controlling party;

(4) The applicant's federal identification number, NAIC number if applicable, corporate address and mailing address;

(5) (a) The names, addresses, official positions and biographical affidavit of the individuals who are to be responsible for the conduct of the affairs of the applicant, including, but not limited to all members of the board of directors, executive committee, and the principal officers accompanied by a completed release of information for each of these individuals, on forms acceptable to the commissioner; and

(b) A disclosure of any person owning or having the right to acquire five percent (5%) or more of the voting securities or subordinated debt of the applicant;

(6) A detailed plan of operation for [insert state name];

(7) A description of the applicant and its personnel, and, where applicable, its facilities, including, but not limited to, location, hours of operation and telephone numbers;

(8) A copy of:

(a) Any contract made or to be made between the applicant and an affiliated or unaffiliated person for managerial or administrative services, including, third party administrators, marketing consultants or persons listed in Paragraph (5); and

(b) Sample contract forms proposed for use between the applicant and persons providing health care services to covered persons, including, participating providers and intermediary organizations.

Drafting Note: Section ~~8~~11A of the ~~Managed Care Plan Network Adequacy~~*Health Benefit Plan Network Access and Adequacy Model Act* requires the filing of substantially similar information to the filing of sample provider contracts required in Paragraph (8)(b). States that have adopted the ~~Managed Care Plan Network Adequacy~~*Health Benefit Plan Network Access and Adequacy Model Act* should consider whether it is necessary to include a similar requirement in this Act as well.

(9) A copy of each type of evidence of coverage and identification card or similar document to be issued to the enrollees;

(10) A copy of each type of individual or group policy, contract or agreement to be used;

(11) A copy of all marketing materials;

(12) A copy, if applicable, of the most recent financial examination report made of the health maintenance organization within the previous three (3) years, certified by the insurance regulatory agency of the applicant's state of domicile;

(13) (a) A copy of the applicant's financial statements showing the applicant's assets, liabilities and sources of financial support, including a copy of the applicant's most recent audited financial statement that complies with [insert reference to state law equivalent to *Model Regulation Requiring Annual Audited Financial Reports*] and an unaudited current financial statement; or

(b) If the information in Subparagraph (a) of this paragraph is not applicable to the applicant, a list of the assets representing the initial net worth of the applicant;

Drafting Note: States should ensure that the state law equivalent to the *Model Regulation Requiring Annual Audited Financial Reports* is applicable to health maintenance organizations before referencing it in Paragraph (13)(a).

(14) A financial plan that provides a three-year projection of operating results, including:

(a) A projection of balance sheets;

(b) Income and expense statements anticipated from the start of operations until the organization has had net income for at least one year;

(c) Cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state;

(d) Detailed enrollment projections;

(e) The methodology for determining premium rates to be charged that has been certified by a qualified actuary; and

(f) A statement as to the sources of working capital as well as any other sources of funding;

(15) The names and addresses of the applicant's qualified actuary and external auditors;

(16) If the applicant has a parent company and the commissioner determines that additional solvency guarantees are necessary, the parent company's guaranty, on a form acceptable to the commissioner, that the applicant will maintain the minimum net worth required under this Act. If no parent company exists, a statement regarding the availability of future funds if needed;

(17) A description of the nature and extent of any reinsurance program to be implemented, including a detailed risk retention schedule indicating direct, assumed, ceded and net maximum risk exposures on any one risk;

(18) A demonstration that errors and omission insurance or other arrangements satisfactory to the commissioner will be in place upon the applicant's receipt of a certificate of authority;

(19) Information regarding the proposed fidelity bond required pursuant to Section ~~24B~~21B of this Act;

(20) If the applicant is a foreign corporation, a statement from the appropriate regulatory agency of the applicant's state of domicile stating that:

(a) The applicant is authorized to operate as a health maintenance organization in the state of

domicile;

(b) The regulatory agency has no objection to the applicant applying for a certificate of authority in this state; and

(c) The applicant is in good standing in the applicant's state of domicile;

(21) The name and address of the applicant's [insert state name] statutory agent for service of process, notice, or demand, or if not domiciled in this state, a power of attorney duly executed by the applicant, appointing the commissioner and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(22) A description of the proposed policies, standards and procedures for the management of health information, including proposed policies, standards and procedures that guard against the unauthorized collection, use or disclosure of protected health information, that complies with [insert reference to state law equivalent to the *Health Information Privacy Model Act*];

(23) A description of the proposed quality assessment and improvement activities that comply with [insert reference to state law equivalent to the *Quality Assessment and Improvement Model Act*] regarding the maintenance and improvement of the quality of health care services provided to covered persons;

(24) If the health maintenance organization will not operate statewide, a statement or map describing the service area;

(25) A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements;

(26) A description of the proposed network adequacy standards that assure the adequacy, accessibility and quality of health care that complies with [insert reference to state law equivalent to the ~~Managed Care Plan Network Adequacy~~*Health Benefit Plan Network Access and Adequacy Model Act*];

(27) A description of the proposed health care provider credentialing program in compliance with [insert reference to state law equivalent to the *Health Care Professional Credentialing Verification Model Act*];

(28) If the health maintenance organization will provide or perform utilization review services, a description of the proposed utilization review procedures that comply with [insert reference to state law equivalent to the *Utilization Review and Benefit Determination Model Act*] regarding the ongoing assessment and management of health care services;

(29) A description of the proposed internal grievance procedures that comply with [insert reference to state law equivalent to the *Health Carrier Grievance Procedure Model Act*] regarding the investigation and resolution of covered persons' complaints and grievances;

(30) A description of the proposed external review procedures that comply with [insert reference to state law equivalent to the *Health Carrier External Review Model Act*] regarding the external independent review of covered persons' grievances; and

(31) Any other information the commissioner may require.

Section 6. Issuance or Denial of Certificate of Authority

A. Within ninety (90) days of receipt of a completed application, the commissioner shall issue a certificate of authority when the commissioner is satisfied that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

(2) The name of the health maintenance organization is not the same as, or deceptively similar to, the name of a domestic insurer, or of a foreign or alien company authorized to transact business in this state, nor does the name of the health maintenance organization tend to deceive or mislead as to the authorization of the health maintenance organization to engage in a specific line of business;

(3) The health maintenance organization will provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments, coinsurance or deductibles; and

(4) The health maintenance organization is in compliance with the requirements of this Act.

B. A certificate of authority shall be denied only after the commissioner complies with the requirements of Section ~~29~~26 of this Act.

Section 7. Powers of Health Maintenance Organizations

A. The powers of a health maintenance organization include, but are not limited to, the following:

(1) The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and property reasonably required for its principal office or for purposes necessary to the transaction of the business of the organization;

(2) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts (provider, subscriber, etc.,) between affiliates or between the health maintenance organization and its parent;

(3) The furnishing of health care services through providers, provider associations, intermediary organizations or agents for providers which are under contract with or employed by the health maintenance organization;

(4) The contracting with a person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

(5) The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) The offering of other health care services, in addition to basic health care services. Non-basic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual;

(7) The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.

Drafting Note: States that allow health maintenance organizations to offer a point of services contract may wish to consider additional requirements for those organizations, including but not limited to, additional ongoing net worth and capital, additional deposits, more detailed annual and quarterly financial statement filings, limitations on out-of-plan expenditures and additional reinsurance coverage.

B. (1) A health maintenance organization shall file notice, with adequate supporting information, with the

commissioner prior to the exercise of any power granted in Subsection A(1), (2) or (4) that may affect the financial soundness of the health maintenance organization. The commissioner shall disapprove the exercise of power only if, in the commissioner's opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner does not disapprove within thirty (30) days of the filing, it shall be deemed approved.

(2) The commissioner may promulgate rules and regulations exempting from the filing requirement of Paragraph (1) those activities having a *de minimis* effect.

(3) Transactions between affiliated entities shall be subject to [insert reference to state law equivalent to NAIC *Insurance Holding Company System Regulatory Act*].

Section 8. Contract Requirements

A. Each group or individual contract holder is entitled to a group or individual contract within thirty (30) days of the effective date of a new or amended contract.

B. The contract shall not contain provisions or statements that:

(1) Are unjust, unfair, inequitable, misleading, or deceptive; or

(2) Encourage misrepresentation as defined by [reference to state law equivalent to the NAIC *Unfair Trade Practices Act*].

C. (1) The contract shall contain a clear statement of the following:

(a) Name and address of the health maintenance organization;

(b) Eligibility requirements;

(c) Benefits and services within the service area;

(d) Emergency care benefits and services;

(e) Out of area benefits and services (if any);

(f) Copayments, coinsurance, deductibles or other out-of-pocket expenses, the financial responsibility of the covered person and how the covered person's obligation is determined;

(g) Provider hold harmless provisions;

(h) Limitations and exclusions;

(i) covered person termination;

(j) covered person reinstatement (if any);

(k) Claims procedures;

(l) Utilization review procedures;

(m) Grievance procedures;

(n) Procedures for requesting independent external review;

(o) Continuation of coverage;

(p) Conversion;

(q) Extension of benefits (if any);

(r) Coordination of benefits (if applicable);

(s) Subrogation (if any);

(t) Description of the service area;

(u) Procedures for obtaining a provider directory;

(v) The existence of a formulary and procedures for obtaining a copy of the formulary list (if applicable);

(w) Entire contract provision;

(x) Term of coverage;

(y) Cancellation of group or individual contract holder;

(z) Renewal;

(aa) Reinstatement of group or individual contract holder (if any);

(bb) Grace period; and

(cc) Conformity with state law.

(2) An evidence of coverage may be filed as part of the group contract to describe the provisions required in Paragraph (1).

D. (1) In addition to the provisions required in Subsection C(1), an individual contract shall provide for a ten-day period to examine and return the contract and have the premium refunded.

(2) If services were received during the ten-day period, and the individual returns the contract to receive a refund of the premium paid, the individual must pay for those services.

E. The commissioner may adopt regulations establishing readability standards for individual and group contract forms.

Drafting Note: The commissioner may adopt standards in the NAIC *Life and Health Insurance Policy Language Simplification Act*.

Section 9. Risk Bearing Entity Registration and Contracting Requirements

A. Registration Requirements.

(1) All risk bearing entities shall register annually with the commissioner in this state unless already subject to state insurance regulation.

Drafting Note: A state may wish to exempt a risk bearing entity from the registration requirements of this subsection, or modify the provisions of this subsection as they apply to a risk bearing entity, where a risk bearing entity accepts risk exclusively from

a single health maintenance organization, provides direct care to covered persons of that health maintenance organization, and where detail of claims payments is available for examination from the health maintenance organization. A state may want to require the health maintenance organization to demonstrate to the commissioner that the contractual arrangement with the risk bearing entity will allow it to fulfill the provisions of its contract for the contract year. Health maintenance organizations contracting with risk bearing entities that are exempt from this subsection, or subject to modified registration requirements, should be subject to Subsections C and D of this section and Section ~~19~~18 of this Act.

(2) The registration shall be in a form approved by the commissioner and shall include:

(a) The name of the risk bearing entity;

(b) The business address of the risk bearing entity;

(c) The principal contact person for risk bearing entity;

(d) The names and positions of senior officers of risk bearing entity, including, President, Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Executive Vice Presidents, Treasurer and Secretary;

(e) A list of all entities on whose behalf the risk bearing entity has contracts or agreements to provide health care services;

(f) A matrix listing of all major categories of health care services provided by the risk bearing entity;

(g) An approximate number of total covered persons served in all the risk bearing entity's contracts or agreements;

(h) An annual audited Generally Accepted Accounting Principles (GAAP) financial statement;

(i) A list of all subcontractors of the risk bearing entity;

(j) Sample contract forms proposed for use between subcontractors and the risk bearing entity;

(k) A list of all stop loss arrangements; and

(l) Any other information or financial information requested by the commissioner.

(3) The commissioner may charge a registration fee sufficient to cover the cost of implementing this section.

(4) The risk bearing entity shall permit the commissioner to:

(a) Inspect the risk bearing entity's books and records; and

(b) Examine, under oath, any officer or agent of the risk bearing entity with respect to the use of its funds and compliance with the terms and conditions of its contracts to provide covered benefits under the health benefit plan.

(5) A risk bearing entity shall file with the commissioner a notice of any material modification of any matter or document furnished pursuant to this section, together with such supporting documents as are necessary to explain the modification.

B. Contracting Requirements

(1) Except as provided in Paragraph (2), a health maintenance organization shall not contract with a risk

bearing entity that has not registered in accordance with this section.

(2) The requirements of this section shall apply to any contract entered into, amended or renewed after the effective date of this section and shall apply to all contracts no later than two (2) years after the effective date of this section.

(3) A health maintenance organization shall:

(a) Unless already specified in the contract with the risk bearing entity, provide the following, upon request, to the risk bearing entity with which it contracts:

(i) At the time the contract is entered into, a written statement describing the amount or method of remuneration to be paid to the risk bearing entity. If any part of the remuneration is a calculated amount based on variable factors, the payment methodology upon which the calculated amount will be determined. The statement shall specify the services and expenses for which the risk bearing entity is financially liable in whole or part;

(ii) At the time payment is made, the basis of the calculation of that payment;

(iii) For health benefit plans in which the covered persons are assigned to the risk bearing entity under a capitated payment arrangement, a list of enrollees and payments due to the risk bearing entity, to be provided monthly if not already available to the risk bearing entity;

(iv) At the time the contract is entered into, a copy of the health maintenance organization's most recent annual statement filed with the NAIC;

(v) Once the contract is in effect, the quarterly or annual statement filed with the NAIC; and

(vi) Any other information requested by the commissioner.

(b) Include in its contracts with a risk bearing entity a provision that requires the risk bearing entity to provide to the health maintenance organization at the time a contract is entered into and annually thereafter:

(i) Annual audited GAAP report;

(ii) Documentation that satisfies the health maintenance organization that the risk bearing entity has sufficient ability to accept risk; and

(iii) Documentation that satisfies the health maintenance organization that the risk bearing entity has appropriate management expertise and infrastructure;

(c) Include in its contracts with a risk bearing entity a provision that requires the risk bearing entity to provide to the health maintenance organization a quarterly status report that includes:

(i) GAAP financial statements;

(ii) An aging report of the percentage of claims that have been paid, pended or denied, across all contracts with risk bearing entities; and

(iii) On a monthly basis, a report of the estimated reported claims and incurred but not reported claims liability of the risk bearing entity; and

(d) Require that a risk bearing entity with which the health maintenance organization contracts provide notice within thirty (30) days to the health maintenance organization of:

(i) Any changes involving the ownership structure of the risk bearing entity;

(ii) Financial or operational concerns regarding the financial viability of the risk bearing entity; or

(iii) Loss of registration.

(4) A health maintenance organization shall provide to the commissioner on a quarterly basis a list of all risk bearing entities with which it has an agreement or contract and the number of covered persons assigned or selected by each risk bearing entity, and any additional information the commissioner may require.

(5) A health maintenance organization shall include in its contracts with a risk bearing entity a provision that allows the commissioner, in the event that a risk bearing entity fails to comply with any provision of this Act, to assign for six (6) months, the risk bearing entity's contract with providers to furnish covered services.

C. Oversight Responsibility

(1) A health maintenance organization shall have procedures in place to notify the commissioner within a reasonable time that a risk bearing entity has materially failed to perform under its contract with the health maintenance organization. A health maintenance organization is not in violation of this paragraph if it acts in good faith in its attempt to comply. The commissioner may by rule enumerate more specific circumstances under which a report may be filed.

(2) A health maintenance organization shall maintain systems and controls for, including but not limited to, reviewing the information provided to the health maintenance organization by the risk bearing entity pursuant to this Act.

(3) Any information that has been provided to the commissioner by a health maintenance organization pursuant to this subsection is confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Act and as allowed by state law, regardless of whether the information is in the form of paper, is preserved on microfilm or is stored in computer readable form. If the information is disclosed pursuant this subsection, the health maintenance organization providing the notice shall not be liable for the disclosure or any subsequent use or misuse of the information. The health maintenance organization shall be entitled to claim any statutory privileges against disclosure that the entity that provided the information to the health maintenance organization is entitled to claim.

(4) Any person acting as a director, officer, employee, contractor or agent of a health maintenance organization, who, in good faith and without malice, makes any decision or takes any action to provide a notice of the type contemplated by this subsection shall not be subject to liability for civil damages or any legal action in consequence of that decision or action, nor shall the health maintenance organization, or any other director, officer, employee, contractor or agent be liable for the activities of the person.

(5) In the event that a health maintenance organization has been notified that the registration of a risk bearing entity has been terminated, revoked, non- renewed or forfeited for any reason, a health maintenance organization shall terminate its contract with the risk bearing entity unless specific permission is provided by the commissioner to maintain the contract at the request of both parties, or enter into an agreement pursuant to which the risk bearing entity ceases to bear risk. The commissioner may set conditions on any agreements between the risk bearing entity and the health

maintenance organization.

(6) This subsection is not intended to create a private right of action.

D. Continuity of Care.

Notwithstanding any agreement to the contrary, the health maintenance organization shall:

(1) Retain full responsibility on a prospective basis for the provision of health care services pursuant to any applicable health benefit plan; and

(2) At all times, be able to demonstrate to the satisfaction of the commissioner that the health maintenance organization can fulfill its non-transferable obligation to provide health care services to covered persons in any event, including the failure, for any reason, of a risk bearing entity.

E. Enforcement Against Risk Bearing Entities.

(1) If the commissioner determines that a risk bearing entity has not complied with any provision of this Act, the commissioner may terminate the risk bearing entity's registration, institute a corrective action against the risk bearing entity, or use any of the commissioner's other enforcement powers to obtain compliance with this Act.

(2) The commissioner shall, within five (5) business days, inform each health maintenance organization with which a risk bearing entity contracts, in writing:

(a) Of any corrective action undertaken by the commissioner against a risk bearing entity; and

(b) If the registration of a risk bearing entity has been revoked, non-renewed, forfeited or terminated.

(3) The commissioner may, in the event that a risk bearing entity fails to comply with any provision of this Act, require the assignment of the risk bearing entity's contract to furnish covered services for a period not to exceed six (6) months.

(4) The commissioner may assess fines on a risk bearing entity for every day that the entity has failed to meet the registration requirements of this section.

Section 10. Form and Rate Filing Requirements

Drafting Note: States that require prior approval of policy forms and premium rates should adopt Option A. States that have a system of file and use for policy forms and premium rates should adopt Option B.

Option A. Prior Approval

A. Subject to Subsections B and C, no group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form has been filed with and approved by the commissioner.

B. (1) Every form required by this section shall be filed with the commissioner not less than thirty (30) days prior to delivery or issue for delivery in this state. At any time during the initial thirty-day period, the commissioner may extend the period for review for an additional thirty (30) days. Notice of an extension shall be in writing. At the end of the review period, the form is deemed approved if the commissioner has taken no action. The filer must notify the commissioner in writing prior to using a form that is deemed approved.

(2) At any time, after thirty (30) days notice and for cause shown, the commissioner may withdraw

approval of a form, effective at the end of the thirty-day period.

(3) Whenever the commissioner disapproves a form or withdraws approval of a form, the commissioner shall notify the health maintenance organization in writing of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing.

C. (1) A health maintenance organization shall not use a premium rate until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the commissioner.

(2) Any schedule of premium rates or rating methodology submitted pursuant to this subsection shall clearly state any copayments, coinsurance or deductibles to be paid by the covered person.

(3) Either a specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of covered persons, provided that the premium applicable to a covered person shall not be individually determined based on the status of the covered person's health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

Drafting Note: States may wish to vary the type of information required to accompany a rate filing based on the type of rating mechanism in use. For instance, requiring that only the rating methodology for setting premium rates accompany the rate filing may be sufficient for experience rated groups, while requiring the rate filing to include both the schedule of rates and the rating methodology used to set the rates may be more appropriate for community rated or pooled groups. Regardless of whether a rating methodology or schedule of rates is required to accompany the rate filing, states should require that adequate supporting documentation be included.

(4) The commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of Paragraph (2) are met. If the commissioner disapproves the filing, the commissioner shall notify the health maintenance organization, in writing, of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. If the commissioner does not take action on the schedule or methodology within thirty (30) days of the date of the filing of the schedule or methodology, it shall be deemed approved.

D. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a form or rate filing made pursuant to this section.

Option B. File and Use

A. No group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form and rates have been filed with the commissioner at least thirty (30) days prior to its issuance or delivery.

B. (1) At any time, after its issuance and delivery, and for cause shown, the commissioner may disapprove the use of a form. The disapproval shall be effective thirty (30) days after the health maintenance organization receives the notice described in Paragraph (2).

(2) The commissioner shall notify the health maintenance organization, in writing, of the reasons for disapproval of the form. The notice shall inform the health maintenance organization that the health

maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. A written request for hearing shall stay the effect of the disapproval.

C. (1) A health maintenance organization shall not use a premium rate unless the premium rate or a methodology for determining the premium rate has been filed with the commissioner at least thirty (30) days prior to its use.

(2) The health maintenance organization shall certify that the rates meet the requirements of Paragraph (4).

(3) Any schedule of premium rates or rating methodology submitted pursuant to this subsection shall clearly state any copayments, coinsurance or deductibles to be paid by the covered person.

(4) A specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of covered persons, provided that the premium applicable to a covered person shall not be individually determined based on the status of the covered person's health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A qualified actuary or other qualified person acceptable to the commissioner must certify the appropriateness of the use of the methodology, based on reasonable assumptions, backed by adequate supporting information.

Drafting Note: States may wish to vary the type of information required to accompany a rate filing based on the type of rating mechanism in use. For instance, requiring that only the rating methodology for setting premium rates accompany the rate filing may be sufficient for experience rated groups, while requiring the rate filing to include both the schedule of rates and the rating methodology used to set the rates may be more appropriate for community rated or pooled groups. Regardless of whether a rating methodology or schedule of rates is required to accompany the rate filing, states should require that adequate supporting documentation be included.

(5) At any time after its implementation, and for good cause shown, the commissioner may disapprove the use of a specific rate or rating methodology. The commissioner shall notify the health maintenance organization, in writing, of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. A written request for a hearing shall stay the effect of the disapproval.

Section 11. Evidence of Coverage

A. (1) Every enrollee shall receive an evidence of coverage from the group contract holder or the health maintenance organization.

(2) The evidence of coverage shall not contain provisions or statements that are unfair, unjust, inequitable, misleading, deceptive, or that encourage misrepresentation as defined by [insert reference to state law equivalent to the NAIC *Unfair Trade Practices Act*].

(3) The evidence of coverage shall contain a clear statement of the provisions required in Section 8C of this Act.

B. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the commissioner of this state for approval.

Section 12. Marketing and Advertising Materials

A. The advertising and marketing materials of health maintenance organizations are subject to the requirements of [insert reference to state law equivalent to the NAIC *Advertisements of Accident and Sickness Insurance Model Regulation*].

B. The advertising and marketing materials of health maintenance organizations marketing Medicare supplement insurance are subject to the requirements of [insert reference to state law equivalent to the *NAIC Medicare Supplement Insurance Minimum Standards Model Act* and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act*].

C. The advertising and marketing materials of health maintenance organizations marketing long-term care insurance are subject to the requirements of [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Regulation*].

Section 13. Information to Enrollees and Covered Persons

A. A health maintenance organization shall provide, within thirty (30) days, notice to enrollees of any material change in the operation of the organization that will affect them directly.

B. (1) The health maintenance organization shall make written copies of provider directories available to enrollees upon enrollment and re-enrollment.

(2) The health maintenance organization shall provide written copies of provider directories to covered persons upon request.

(3) The health maintenance organization shall provide the directory and any updates to enrollees, in writing or by electronic means, in accordance with the terms of its contract.

C. (1) A health maintenance organization shall notify covered persons of the termination of the primary care provider who currently provides health care services to that covered person.

(2) A health maintenance organization shall establish a method to permit a covered person, at the option of the covered person, to receive notice in writing or by electronic means, of the termination of the primary care provider who currently provides health care services to that covered person.

(3) The health maintenance organization shall provide assistance to the covered person in transferring to another participating primary care provider.

D. The health maintenance organization shall establish a method to permit a covered person, at the option of the covered person, to obtain information in writing or by electronic means, on how services may be obtained, where additional information on access to services may be obtained and a telephone number where covered persons may contact the health maintenance organization, at no cost to the covered person.

Drafting Note: For the purpose of this section any major change in the provider network is considered a material change.

~~**Section 14. Continuation of Benefits**~~

~~A. The commissioner shall require that each health maintenance organization have a plan for handling insolvency that provides for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.~~

~~B. In considering such a plan, the commissioner may require:~~

~~(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;~~

~~(2) Provisions in provider contracts that obligate the provider, after the health maintenance organization's insolvency, to provide covered services through the period for which premium has been paid to the health maintenance organization on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency will continue until their confinement in an inpatient facility is no longer medically necessary;~~

~~(3) Insolvency reserves;~~

~~(4) Acceptable letters of credit; or~~

~~(5) Any other arrangements to assure that benefits are continued as specified above.~~

Section ~~15~~14. Coordination of Benefits

A. Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two (2) or more group health insurance or health benefit plans.

B. If a health maintenance organization adopts coordination of benefits provisions, the provisions shall be consistent with [insert reference to state law equivalent to NAIC ~~Group~~ *Coordination of Benefits Model Regulation*] in general use in the state for coordinating coverage between two (2) or more group health insurance or health benefit plans.

C. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination consistent with [insert reference to state law equivalent to NAIC ~~Group~~ *Coordination of Benefits Model Regulation*], health maintenance organizations shall make payments for services that are:

(1) Received from non-participating providers;

(2) Provided outside their service areas; or

(3) Not covered under the terms of their group contracts or evidence of coverage.

Section ~~16~~15. Initial Net Worth and Capital Requirements

A. Before the commissioner issues a certificate of authority in accordance with Section 6 of this Act, an applicant seeking to establish or operate a health maintenance organization shall have the greater of:

(1) The amount of capital required under [insert reference in state law equivalent to the Risk-Based Capital (RBC) for Health Organizations Model Act];

(2) An initial net worth of $3,000,000; or

(3) At the commissioner's discretion, an amount greater than required under Paragraph (1) or (2), as indicated by a business plan and a projected risk-based capital calculation after the first full year of operation based on the most current NAIC Health Annual Statement Blank.

Section ~~17~~16. Ongoing Net Worth and Capital Requirements

A. A health maintenance organization shall maintain minimum net worth equal to the greater of $2,500,000 or the amount necessary to maintain capital required pursuant to [insert reference to state law equivalent to the *Risk-Based Capital for Health Organizations Model Act*].

B. The amount in Subsection A may be adjusted annually for inflation, at the commissioner's discretion.

Drafting Note: The following definition of "managed hospital payment basis" and formulation for ongoing net worth, based on the 1989 amended version of HMO Model Act, have been included for the benefit of states that have not adopted the *Risk-Based Capital for Health Organizations Model Act*:

"Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services. Examples of managed hospital payment basis agreements include but are not limited to payments on a DRG or per diem basis or where there is an agreement between a hospital and a health maintenance organization and which are under common ownership or control.

C. A health maintenance organization shall maintain a minimum net worth equal to the greater of $2,500,000; or an amount equal to the sum of:

(1) Eight percent (8%) of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

(2) Four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

Section ~~18~~17. Deposit Requirements

A. Unless otherwise provided in this section, a health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a market value of not less than $1,000,000.

B. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

C. All income from deposits shall be an asset of the health maintenance organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being deposited or substituted.

D. The deposit shall be used to protect the interests of the health maintenance organization's covered persons and to assure continuation of health care services to covered persons of a health maintenance organization that is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a rehabilitation, receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the liquidation act.

E. The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, commissioner, or other official body of the state or jurisdiction of domicile for the protection of all covered persons, wherever located, of the health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

Section ~~19~~18. Hold Harmless Provision Requirements for Covered Persons

A. Except for coinsurance, deductibles or copayments as specifically provided in the evidence of coverage, in no event, including but not limited to nonpayment by the health maintenance organization, insolvency of the health maintenance organization or breach of contract among the health maintenance organization, risk

bearing entity or participating provider, shall a risk bearing entity or participating provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization) acting on behalf of the covered person for covered services provided. No risk bearing entity or participating provider, nor any agent, trustee or assignee of the risk bearing entity or participating provider may maintain an action at law against a covered person to collect sums owed by the health maintenance organization.

B. All contracts among health maintenance organizations, risk bearing entities, and participating providers shall include a hold harmless provision specifying protection for covered persons. Any attempted waiver or amendment in a manner materially adverse to the interests of covered persons of a hold harmless provision shall be null and void and unenforceable.

C. The requirement of Subsection B shall be met by including a provision substantially similar to the following:

> "Provider agrees that in no event, including but not limited to nonpayment by the health maintenance organization or intermediary organization, insolvency of the health maintenance organization or intermediary organization, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization or intermediary organization) acting on behalf of the covered person for covered services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, copayments or services in excess of limits, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons."

D. (1) Any statement sent to a covered person shall clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(2) All contracts among health maintenance organizations, risk bearing entities, and participating providers shall require that all statements sent to covered persons clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(3) The notice requirements in this subsection shall be met by including in the statement to covered persons a provision substantially similar the following:

NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY AMOUNTS OWED BY YOUR HEALTH MAINTENANCE ORGANIZATION

E. Any violation of the provisions of this section shall constitute an unfair trade practice pursuant to [insert reference to state insurance fraud statute] and shall subject the health care provider to monetary penalties in accordance with [insert reference to state insurance fraud statute] and notification to the [insert reference to appropriate licensing entity for type of provider].

Drafting Note: States that do not authorize insurance departments to take action against providers should not adopt Subsection E and should consider other options such as contacting the state attorney general's office or other appropriate state official.

Drafting Note: States with consumer protection acts that provide covered persons with a private right of action should consider including a reference in Subsection E.

~~**Section 20. Uncovered Expenditures Deposit**~~

~~A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner,~~

with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of 120 percent of the health maintenance organization's outstanding liability for uncovered expenditures for covered persons in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

B. The deposit required under this section is in addition to the deposit required under Section 18 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

C. (1) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

(a) A substitute deposit of cash or securities of equal amount and value is made;

(b) The fair market value exceeds the amount of the required deposit; or

(c) The required deposit under Subsection A is reduced or eliminated.

(2) Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

D. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of covered persons of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

E. The commissioner may by regulation prescribe the time, manner and form for filing claims under Subsection D.

F. The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

Section 21. Open Enrollment and Replacement Coverage in the Event of Insolvency

A. Enrollment Period

(1) In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient

~~health care delivery resources to assure that health care services will be available and accessible to all of the group covered persons of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for these groups among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization's existing coverage that is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology and in accordance with state law.~~

~~(3) The commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees that are unable to obtain other coverage among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer the nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by the enrollee's type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.~~

~~B. Replacement Coverage~~

~~(1) "Discontinuance" shall mean the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.~~

~~(2) A health maintenance organization providing replacement coverage hospital, medical or surgical expense or service benefits within a period of sixty (60) days from the date of discontinuance of a prior health maintenance organization, shall immediately cover all covered persons who were validly covered under the previous health maintenance organization at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding health maintenance organization, regardless of any provisions of the contract relating to active employment, hospital confinement or pregnancy.~~

~~**Drafting Note:** Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in the group market, a succeeding carrier, including a health maintenance organization, is prohibited from including any nonconfinement rules in its plan of benefits and any actively-at-work rules provided in the succeeding carrier's plan of benefits must provide that absence from work due to any health status-related factor be treated as being actively-at-work.~~

~~(3) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding health maintenance organization's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those covered persons validly covered under the prior carrier's contract or policy on the date of discontinuance.~~

Section ~~22~~19. Investment Powers

With the exception of investments made in accordance with Section 7A(1) of this Act, the investment practices of a health maintenance organization shall be governed by [insert reference to state law equivalent to the NAIC *Health Maintenance Organization Investment Guidelines*].

Section ~~23~~20. Accounting Practices

Every health maintenance organization shall maintain its financial records in accordance with [insert reference to state law equivalent to NAIC *Accounting Practices and Procedures Manual*].

Section ~~24~~21. Fiduciary Responsibilities

A. A director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of the health maintenance organization shall be responsible for the funds in a fiduciary relationship to the health maintenance organization.

B. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on these employees and officers, directors and partners in an amount not less than $1,000,000 for each health maintenance organization or a maximum of $10,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or the sum prescribed by the commissioner.

Drafting Note: As an optional additional subsection, language may be included that would make the appropriate provisions of the state's insurance laws governing prohibitions or restrictions on activities of directors, officers and certain shareholders applicable to health maintenance organizations.

Section ~~25~~22. Annual and Quarterly Financial Statement Filing Requirements

A. (1) Every health maintenance organization shall file annual and quarterly financial statements, as provided in Paragraph (2), with the commissioner and with the National Association of Insurance Commissioners (NAIC).

(2) The annual statement shall be filed by March 1 for the preceding year and a quarterly financial statement by May, August and November 15 for the preceding quarter.

B. The annual and quarterly financial statements shall be prepared on the most current NAIC Health Annual Statement Blank in accordance with the NAIC Annual Statement Instructions and the NAIC *Accounting Practices and Procedures Manual*.

Section ~~26~~23. Reporting Requirements

A. (1) Every health maintenance organization shall annually, on or before March 1, file a report verified by at least two principal officers with the commissioner covering the preceding calendar year. The report shall be on forms prescribed by the commissioner.

(2) In addition, the health maintenance organization shall file by March 1, unless otherwise stated:

(a) Audited financial statements on or before June 1;

(b) A list of participating providers in a form approved by the commissioner; and

(c) (i) A description of the grievance procedures; and

(ii) The total number of grievances handled through these procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

B. (1) Unless otherwise provided in this Act, a health maintenance organization shall file notice with the commissioner within thirty (30) days of the effective date of a change, describing any material modifications to the documents required to be filed with the application for a certificate of authority as set forth in Section 5B(1) and (2) of this Act.

(2) Unless otherwise provided in this Act, a health maintenance organization shall file with the commissioner advance notice, or if advance notice is not practicable, notice filed as soon as possible, but in no event more than thirty (30) days after the effective date of a change, describing any material modifications to the health maintenance organization's operations as set forth in the information required by Section 5B of this Act that affects any of the following:

(a) The solvency of the health maintenance organization;

(b) The health maintenance organization's continued provision of health care services that it has contracted to provide;

(c) The manner in which the health maintenance organization conducts its business; or

(d) Any other matters the commissioner may prescribe by regulation.

C. The commissioner may require additional reports as necessary to carry out the commissioner's duties under this Act.

Section ~~27~~24. Powers of Insurers and [Hospital and Medical Service Corporations]

A. An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this Act. Notwithstanding any other law, which may be inconsistent, any two (2) or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care services by a health maintenance organization owned or operated by an insurer or its subsidiary.

B. Notwithstanding any provision of insurance and hospital or medical service corporation laws [citations], an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The covered persons of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

Section ~~28~~25. Examinations

A. The commissioner may make an examination of the affairs of a health maintenance organization, providers and risk bearing entities with which the health maintenance organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state, but not less frequently than once every five (5) years.

B. An examination conducted under this section shall be performed in accordance with the provisions of [insert reference to state law equivalent to the NAIC *Model Law on Examinations*].

C. The expenses of examinations under this section shall be assessed against the health maintenance organization being examined and remitted to the commissioner.

D. In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state provided that the provisions of [insert state law equivalent to Section 3C of the NAIC *Model Law on Examinations*] are satisfied.

Section ~~29~~26. Suspension or Revocation of Certificate of Authority

A. A certificate of authority issued under this Act may be suspended or revoked, and an application for a certificate of authority may be denied, if the commissioner finds that any of the conditions listed below exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 5 of this Act, unless amendments to those submissions have been filed with and approved by the commissioner;

(2) The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections 8 and 9 of this Act;

(3) The health maintenance organization does not provide or arrange for basic health care services;

(4) The health maintenance organization is unable to fulfill its obligations to furnish health care services;

(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to covered persons or prospective covered persons;

(6) The health maintenance organization has failed to correct any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired;

Drafting Note: States that have not adopted *Risk Based Capital for Health Organizations Model Act* should consider including a provision that provides for early warning and correction of insufficient net worth by a health maintenance organization.

(7) The health maintenance organization has failed to implement internal grievance procedures in compliance with [insert reference to state law equivalent to the *Health Carrier Grievance Procedure Model Act*];

(8) The health maintenance organization has failed to implement the external review procedures required by [insert reference to state law equivalent to the *Health Carrier External Review Model Act*];

Drafting Note: States that have adopted Options 1 or 2 of the NAIC *Health Carrier External Review Model Act* should not adopt this provision.

(9) The health maintenance organization, or any person acting on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(10) The continued operation of the health maintenance organization would be hazardous to its covered persons;

(11) The health maintenance organization has otherwise failed substantially to comply with this Act or any regulation adopted pursuant to this Act; or

(12) The health maintenance organization or applicant has violated any other provision of the state insurance code.

Drafting Note: States that have adopted an Administrative Procedures Act should adopt Option A. States that have not adopted an Administrative Procedures Act should adopt Option B.

Option A.

B. The provisions of the [insert reference to state Administrative Procedure Act] of this state shall apply to

proceedings under this section.

Option B.

B. (1) Suspension or revocation of a certificate of authority or the denial of an application pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail. The written order shall state the grounds, charges or conduct on which the suspension, revocation or denial or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty (30) days from the date of mailing of the order. If no written request is made, the order shall be final upon the expiration of the thirty (30) day period.

(2) If the health maintenance organization or applicant requests a hearing pursuant to this subsection the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail stating:

(a) A specific time for the hearing, which may not be less than twenty (20) days nor more than thirty (30) days after mailing of the notice of hearing; and

(b) A specific place for the hearing, which may be either in [location of regulatory body] or in the county where the health maintenance organization's or applicant's principal place of business is located.

C. (1) With respect to individual contracts, when the certificate of authority of a health maintenance organization is suspended, during the period of suspension, the health maintenance organization shall not:

(a) Enroll any additional covered persons except newborn children or other newly acquired dependents of existing covered persons; and

(b) Engage in any advertising or solicitation.

(2) With respect to group contracts, when the certificate of authority of a health maintenance organization is suspended, during the period of suspension, the health maintenance organization shall enroll additional enrollees and their eligible dependents and newly acquired eligible dependents of existing enrollees, including individuals who become newly acquired eligible dependents of an enrollee through marriage, birth or adoption or placement for adoption, who meet the requirements for special enrollment in accordance with [cite section of state law or regulation implementing the provisions of Section 2701(f) of the Public Health Service Act] or are otherwise eligible under the health benefit plan.

Drafting Note: Under Section 2701(f) of the Public Health Service Act, as amended by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for the group market, health maintenance organizations are required during special enrollment periods to enroll individual eligible employees and dependents of eligible employees and newly acquired dependents of already enrolled eligible employees, including individuals who become dependents through marriage, birth or adoption or placement for adoption. The language in Paragraph (2) is intended to reflect this requirement.

D. When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit further operation of the organization found to be in the best interest of covered persons, to the end that covered persons will be afforded the greatest practical opportunity to obtain continuing health care coverage.

E. A certificate of authority shall be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

Section ~~30~~27. Summary Orders and Supervision

A. Whenever the commissioner determines that the financial condition of a health maintenance organization is such that its continued operation might be hazardous to covered persons, creditors, or the general public, or that it has violated any provision of this Act, the commissioner may, after notice and hearing, order the health maintenance organization to take action reasonably necessary to rectify the condition or violation, including but not limited to one or more of the following:

(1) Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;

(2) Reduce the volume of new business being accepted;

(3) Reduce expenses by specified methods;

(4) Suspend or limit the writing of new business for a period of time;

(5) Increase the health maintenance organization's capital and surplus by contribution; or

(6) Take other steps the commissioner may deem appropriate under the circumstances.

B. For purposes of this section, the violation by a health maintenance organization of any law of this state to which the health maintenance organization is subject shall be deemed a violation of this Act.

C. The commissioner is authorized to adopt regulations to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to covered persons, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization. The standards shall be consistent with the purposes expressed in Subsection A.

D. The remedies and measures available to the commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of [insert reference to state law equivalent to Section 10 of the NAIC *Rehabilitation and Liquidation Model Act*].

Section ~~31~~28. Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations

A. A rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in [insert reference to state rehabilitation law], or when in the commissioner's opinion the continued operation of the health maintenance organization would be hazardous either to the covered persons or to the people of this state. Covered persons shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

B. For purpose of determining the priority of distribution of general assets, claims of covered persons shall have the same priority as established in [insert reference to state law relating to liquidation of insurers] for policyholders and beneficiaries of insureds of insurance companies. If a covered person is liable to a provider for services provided pursuant to and covered by the health benefit plan, that liability shall have the status of a covered person claim for distribution of general assets. A provider who is obligated by statute or agreement to hold covered persons harmless from liability for services provided pursuant to and covered by a health benefit plan shall have a priority of distribution of the general assets immediately following that of covered persons as described herein, and immediately preceding the priority of distribution described in [insert

reference to state liquidation procedures].

Section ~~32~~29. Penalties and Enforcement

A. In addition to or in lieu of suspension or revocation of a certificate of authority or the denial of an application pursuant to Section ~~29~~26 of this Act, the applicant or the health maintenance organization may be subjected to an administrative penalty of up to $[insert number] for each cause for suspension or revocation or application denial.

B. (1) If the commissioner shall for any reason have cause to believe that a violation of this Act has occurred or is threatened, the commissioner may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation; and, in the event it appears that a violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

(2) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section of this Act are satisfied.

C. Notwithstanding any other provisions of this Act, if a health maintenance organization fails to comply with the net worth requirement of this Act or fails to correct its net worth to bring it into compliance with the requirements of this Act, the commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its covered persons.

Drafting Note: In addition to the actions provided in this section that a commissioner may use to enforce a health maintenance organization's compliance with the provisions of this Act, some states may authorize the commissioner to issue an order to a health maintenance organization or a representative of the health maintenance organization to cease and desist from engaging in an act or practice that is violation of this Act. In addition, the commissioner may also be authorized to institute an action seeking to obtain injunctive or other relief if the health maintenance organization fails to comply with the order to cease and desist. When the commissioner is not granted such statutory powers, the language should be modified to provide for the legal steps to be taken by the attorney general or other appropriate state official.

Section ~~33~~30. Regulations

The commissioner may promulgate regulations to carry out the provisions of this Act. The rules and regulations shall be subject to review in accordance with [insert reference to state law relating to administrative rulemaking and review of rules].

Section ~~34~~31. Statutory Construction and Relationship to Other Laws

A. Except as otherwise provided in this Act or in other laws expressly referring to health maintenance organizations, provisions of the insurance law and provisions of hospital or medical service corporation laws shall not be applicable to a health maintenance organization granted a certificate of authority under this Act. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance law or the hospital or medical service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this Act.

B. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health care professionals.

C. Any health maintenance organization authorized under this Act shall not be deemed to be practicing medicine and shall be exempt from the provision of [insert reference to state law relating to the practice of medicine].

Section ~~35~~32. Filings and Reports as Public Documents

All applications, filings and reports required under this Act shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under Section ~~26~~23 of this Act, and any other information that is considered privileged or confidential under state or federal law.

Section ~~36~~33. Insurance Holding Company System Regulatory Act

All health maintenance organizations shall meet the requirements of [insert reference to state law equivalent to NAIC *Insurance Holding Company System Regulatory Act*].

Drafting Note: States that have not included health maintenance organizations within the scope of their state law equivalent to the NAIC *Insurance Holding Company System Regulatory Act* should not adopt this section.

Section ~~37~~34. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section ~~38~~35. Effective Date

This Act shall be effective [insert date].

APPENDIX A

Former Section 3HH, Section 14 and Section 20

Below are the sections deleted to reconcile the provisions of this model with the 2017 revisions to the *Life and Health Insurance Guaranty Association Model Act* (#520), which added health maintenance organizations as members of the guaranty association.

Section 3HH. Definition of Uncovered Expenditures

"Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which a covered person may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.

Section 14. Continuation of Benefits

A. The commissioner shall require that each health maintenance organization have a plan for handling insolvency that provides for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.

B. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider, after the health maintenance organization's insolvency, to provide covered services through the period for which premium has been paid to the health maintenance organization on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency will continue until their confinement in an inpatient facility is no longer medically necessary;

(3) Insolvency reserves;

(4) Acceptable letters of credit; or

(5) Any other arrangements to assure that benefits are continued as specified above.

Section 20. Uncovered Expenditures Deposit

A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of 120 percent of the health maintenance organization's outstanding liability for uncovered expenditures for covered persons in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

B. The deposit required under this section is in addition to the deposit required under Section 18 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

C. (1) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

(a) A substitute deposit of cash or securities of equal amount and value is made;

(b) The fair market value exceeds the amount of the required deposit; or

(c) The required deposit under Subsection A is reduced or eliminated.

(2) Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

D. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of covered persons of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

E. The commissioner may by regulation prescribe the time, manner and form for filing claims under Subsection D.

F. The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

Draft: 8/19/20

MHPAEA (B) Working Group
Virtual Summer National Meeting
July 28, 2020

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call July 28, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); Donna Lambert (AR); Erin Klug (AZ); Sheirin Ghoddoucy (CA); Cara Cheevers (CO); Kurt Swan (CT); Howard Liebers (DC); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Justin McFarland and Craig Van Aalst (KS); Kathleen A. Birrane and Theresa Morfe (MD); Andrew Kleinendorst (MN); Jeannie Keller (MT); Chrystal Bartuska and Sara Gerving (ND); Maureen Belanger (NH); Gale Simon (NJ); Margaret Pena (NM); Laura Miller (OH); Marie Ganim (RI); Shari Miles (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji Northrup (UT); Brant Lyons (VA); Barbara Belling (WI); James A. Dodrill, Tim Sigman and Joylynn Fix (WV); and Denise Burke (WY). Also participating were: Trinidad Navarro (DE); and Glen Mulready (OK).

1. Adopted its June 24 Minutes

The Working Group met June 24 to discuss the June 18 comments received on the draft quantitative treatment limitation (QTL) template and instructions.

Ms. Beyer made a motion, seconded by Ms. Northrup, to adopt the Working Group's June 24 minutes (Attachment Five-A). The motion passed unanimously.

2. Heard a Presentation on MHPAEA Compliance Work and Activities Involving Self-Funded Group Health Plans

Henry Harbin (The Bowman Family Foundation—BFF), consultant to the BFF, and Beth Ann Middlebrook (B. Middlebrook Consulting LLC) discussed the activities of the BFF to improve plan compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Dr. Harbin highlighted the work the BFF has been doing with Path Forward, which is a five-year initiative undertaken by a number of partners, including the National Alliance of Healthcare Purchaser Coalitions (National Alliance), the American Psychiatric Association (APA), and the APA Foundation Center for Workplace Mental Health. He said employers overwhelmingly identify the need to improve access to effective, affordable and timely behavioral health care as a top priority. He described the five key priorities of Path Forward, which includes: 1) improving in-network access to behavioral health specialists; 2) expanding screening and testing for mental health/substance use disorders (MH/SUD); and 3) ensuring MHPAEA plan compliance.

Dr. Harbin said Path Forward's main focus among its key priorities is improving access. He discussed Path Forward's efforts to improve access and its recommendations to employers to address the issue. He also discussed Path Forward's use of Regional Employer Stakeholder Engagement Teams (RESET Regions) to assist it with achieving improved access. He said Path Forward also sees itself as a partner with state departments of insurance (DOIs) and the U.S. Department of Labor (DOL) in improving MHPAEA plan compliance.

Ms. Middlebrook discussed the findings of the 2019 Milliman Report (Report). Based on claims data, the Report measured disparities in reimbursement rates and access to MH/SUD services with respect to employer-sponsored plans. Ms. Middlebrook also discussed the Mental Health Treatment and Research Institute's (MHTARI's) Model Data Request Form (MDRF), which is a tool for the collection of key data on certain MHPAEA plan compliance and network access issues that may exist for MH/SUD services.

Ms. Middlebrook explained that the MDRF contains specific, detailed instructions and definitions developed to elicit targeted, consistent and reliable responses from plans on quantitative measures for determining outcome disparities related to network adequacy and other non-quantitative treatment limitations (NQTLs). The MDRF requests data that measures the following: 1) disparities in out-of-network use for MH/SUD versus medical/surgical (M/S); 2) disparities in reimbursement rates for MH/SUD versus M/S providers; 3) disparities in denial rates for MH/SUD versus M/S services; and 4) the accuracy of network provider directories. Ms. Middlebrook discussed how some large private employers and states, such as Washington, have used the MDRF to assess these disparities and evaluate any red flags that may surface related to a plan's MHPAEA plan compliance.

Ms. Beyer explained how Washington used the MDRF through its market conduct examination authority to evaluate disparities, particularly with respect to NQTLs, based on the data collected from plans. She said Washington plans to publish an aggregate level report on the findings and recommendations form the University of Washington. NAIC staff will post the report on the Working Group's webpage.

Ms. Dzurec reminded Working Group members and interested parties about the purposes of establishing the Working Group. One such purpose is to have the Working Group facilitate information-sharing and discussion among state insurance regulators on the work they are doing related to MHPAEA plan compliance and share state best practices, such as what Ms. Beyer discussed related to Washington's work with the MDRF.

3. Heard a Presentation on State Legislative Trends in MHPAEA Reporting

Tim Clement (APA) discussed state legislative action with respect to MHPAEA plan compliance. He said there has been significant and growing state legislative efforts to improve MHPAEA plan compliance. Most of the legislation has focused on NQTLs. Mr. Clement said state legislation has also required market conduct examinations as part of the effort to achieve MHPAEA plan compliance. He discussed state legislation that has been enacted since 2018 and legislation currently pending, noting that his presentation includes links to the legislation.

Mr. Clement advised state insurance regulators to be prepared for legislation to be introduced in their states concerning MHPAEA plan compliance. He said to date, 14 states have introduced legislation, with 13 requiring NQTL stepwise analyses to determine MHPAEA plan compliance. He encouraged state insurance regulators to ensure that any such introduced legislation works for them and is in line with the state DOI staffing and funding resources. He suggested a number of potential technical suggestions and/or amendments that state insurance regulators may want to consider with respect to any legislation introduced, including: 1) effective dates; 2) reporting submission dates; 3) defining terms; 4) specifying that NQTL reporting be staggered rather than one reporting date; and 5) adding provisions for quantitative treatment limitation/financial requirement (QTL/FR) reporting. He also suggested that state insurance regulators should talk to their fellow regulators, particularly those states that are implementing, or have undertaken, significant MHPAEA activities.

4. Discussed Current MHPAEA Compliance Tools, How the States Can Leverage These Resources, and the Working Group's Next Steps

Ms. Dzurec discussed current MHPAEA plan compliance tools, including the MHPAEA chapter (Chapter) in the *Market Regulation Handbook*. She explained that in having this Chapter, she was able to cross-reference what is in the Chapter with the draft QTL template. She reiterated that the Working Group's work is to supplement the existing MHPAEA plan compliance tools, such as the Chapter, not replace them. She said she is still working to revise the draft QTL template based on the June 18 comments and her current work cross-referencing the draft QTL template with the Chapter.

Ms. Beyer discussed the Working Group's future work to develop NQTL compliance tools that the states can use to determine MHPAEA plan compliance. She asked for suggestions from Working Group members on what NQTL categories or types would be most helpful. Ms. Dzurec discussed what the Working Group has discussed to date about potential NQTL topics, such as reimbursement and network adequacy. She said the Working Group will continue this discussion in its upcoming meetings. She suggested that if any Working Group members have thoughts on specific NQTL topics the Working Group should work on to reach out to NAIC staff.

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

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Draft: 7/22/20

MHPAEA (B) Working Group
Conference Call
June 24, 2020

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call June 24, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); Mel Heaps (AR); Erin Klug (AZ); Sheirin Ghoddoucy (CA); Cara Cheevers (CO); Kurt Swan (CT); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Julie Holmes (KS); Erica Bailey (MD); Peter Brickwedde and Grace Arnold (MN); Jeannie Keller (MT); Ted Hamby (NC); Chrystal Bartuska and Sara Gerving (ND); Gale Simon and Ralph Boeckman (NJ); Brittany ODell (NM); Laura Miller (OH); Shari Miles (SC); Jill Kruger (SD); Rachel Bowden (TX); Heidi Clausen and Jaakob Sundberg (UT); Brant Lyons (VA); Barbara Belling (WI); Tim Sigman and Joylynn Fix (WV); and Denise Burke (WY). Also participating was: Laura Arp (NE).

1. Adopted its June 5 Minutes

The Working Group met June 5 to review and discuss the draft quantitative treatment limitation (QTL) template and instructions.

Ms. Beyer made a motion, seconded by Mr. Swan, to adopt the Working Group's June 5 minutes (Attachment Five-A1). The motion passed unanimously.

2. Heard an Update from the DOL on the Proposed 2020 MHPAEA Compliance Tool

Amber Rivers (U.S. Department of Labor—DOL) said the DOL's Employee Benefits Security Administration (EBSA) released a proposed 2020 self-compliance tool on June 19 intended to help improve compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and additional related requirements under the federal Employee Retirement Income Security Act (ERISA). The EBSA is requesting public comments on the self-compliance tool proposed revisions by July 24. Ms. Rivers said the proposed revisions update the current 2018 MHPAEA self-compliance tool. She said the proposed revisions generally fall into four categories: 1) integration of recent guidance; 2) revision of compliance examples; 3) best practices for establishing an internal compliance plan; and 4) warning signs. She said the DOL is hosting an MHPAEA listening event July 16 focusing on compliance issues. She urged Working Group members to attend.

3. Discussed the June 18 Comments Received on the Draft QTL/FR Template and Instructions

Ms. Dzurec said the Working Group received comments on the draft QTL and financial requirement (QTL/FR) template by the June 18 public comment deadline from the Association for Behavioral Health and Wellness (ABHW); America's Health Insurance Plans (AHIP); the American Medical Association (AMA); the Blue Cross Blue Shield Association (BCBSA); the Health Coalition in a joint comment submission from Anthem Inc., Cigna, CVS Health, Health Care Service Corporation (HCSC), and UnitedHealthcare; The Kennedy Forum; the Legal Action Center (LAC); the National Association of Health Underwriters (NAHU); the NAIC consumer representatives; the Parity Implementation Coalition (PIC); the Virginia Insurance Bureau; and URAC. She said she reviewed each comment letter, and during her review, she found that the comments generally fell into the following issue categories: 1) addressing plan networks; 2) grouping services; 3) certificate of coverage and schedule of benefits (SOB) cross reference requirements; 4) a limitation on the number of plans per template; and 5) the addition of non-quantitative treatment limitation (NQTL) elements. She discussed how she planned to address some of these issues in the next draft of the QTL/FR template and instructions, including clarifying in the instructions how plans should account for networks, such as preferred and non-preferred networks; clarifying how plans may be able to group certain services together if the elements are the same; and making the certificate of coverage and SOB cross-references optional.

Ms. Dzurec said some commenters also requested clarification on the states' use of the proposed QTL/FR template. She said Pennsylvania uses the template for market conduct examinations. However, she said the analysis needed to determine MHPAEA plan parity compliance is the same regardless of whether the template is used for form review or market conduct examinations. Kris Hathaway (AHIP) asked about the Working Group's timeline for completing the template. She noted that the states have other tools and templates to use to determine MHPAEA mental health/substance use disorder (MH/SUD) parity compliance, such as the MHPAEA chapter and tool in the NAIC *Market Regulation Handbook* (Handbook). She also expressed concern with the time it will take for a plan to complete the proposed QTL/FR template. Randi Reichel (Health Coalition)

expressed support for Ms. Hathaway's comments concerning the potential time needed for a plan to complete the proposed template. Ms. Reichel explained that plans are currently doing the analysis to comply with the MHPAEA MH/SUD parity requirements, but operationally the proposed template will require plans to manually input the required information, which could take a lot of time because it cannot be automated.

Ms. Arp discussed her work in developing the MHPAEA chapter and tool in the Handbook. She discussed how she envisioned the proposed QTL/FR template working with the MHPAEA chapter and tools and the merits of having such a template particularly for those states with limited resources to resolve red flags. Ms. Dzurec agreed that the states can use the draft QTL/FR template for that purpose and any other purpose a state feels is appropriate. She noted that she personally would like to use such a template at the beginning of any MHPAEA MH/SUD plan parity analysis because she has seen a lot of violations. She expressed concern that plans are not getting it right and consumers are being harmed.

Ms. Dzurec emphasized that consistent with the Working Group's charge, the draft QTL/FR template is meant to be supplemental to existing compliance tools. It is not intended to replace any of these existing compliance tools, including the MHPAEA chapter in the Handbook. She asked for comments.

Tim Clement (American Psychiatric Association—APA) said he understands industry concerns. However, he does not believe the draft QTL/FR template is overly burdensome. John Troy (BCBSA) expressed support for AHIP's and the Health Coalition's comments regarding their operational concerns with the draft QTL/FR template and its potential to be administratively burdensome for plans to complete. Pamela Greenberg (ABHW) reiterated the ABHW's concerns with the draft QTL/FR template outlined in its comment letter, including its use, the Working Group's process, flexibility in its use, and benefit services classifications. David Lloyd (The Kennedy Forum) agreed with Ms. Dzurec's comments concerning the errors that plans continue to make in their MHPAEA MH/SUD parity analyses and the impact of such errors on consumers.

Ms. Hathaway suggested that the draft QTL/FR template should be something the Market Regulation and Consumer Affairs (D) Committee should be involved in given the year-long project conducted by one of the Committee's working groups with respect to developing the MHPAEA chapter and tool in the Handbook. Ms. Dzurec explained the Working Group's next steps with respect to the draft QTL/FR template and the template's connection with the MHPAEA chapter and tool in the Handbook. She said after the Working Group completes its work on the template, it will not be formally voted on by the Regulatory Framework (B) Task Force or the Health Insurance and Managed Care (B) Committee. She reiterated that, consistent with the Working Group's charge, the template would be an additional resource the states can use, if they choose to do so, to determine MHPAEA MH/SUD plan parity compliance. The template would not supplant the MHPAEA chapter and tool in the Handbook. Ms. Dzurec said the draft template is just a deeper dive into the analysis required to determine MHPAEA plan parity compliance. She also explained that the template was never meant to be an NAIC supported or endorsed product. However, she cautioned that even it is not an NAIC supported or endorsed product, some states will still use it, and are currently using it, as part of their processes to determine MHPAEA plan parity compliance.

Ms. Beyer said the MHPAEA is a complex law and the analysis necessary to determine MHPAEA plan parity compliance is complex as well. She said state insurance regulators feel that they have a responsibility to consumers to ensure that they have access to the services they need. Ms. Cheevers expressed support for Ms. Dzurec's and Ms. Beyer's comments with respect to the proposed QTL/FR template being an additional tool states can use to dig deeper, particularly when there are red flags.

Ms. Dzurec said within the next few weeks, she will revise the draft QTL/FR template and instructions based on the comments received requesting clarity in some areas. She reiterated that after the Working Group completes its work, it will report on its work to the Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee for informational purposes only. Currently, she said the Working Group does not foresee the template being an NAIC supported or endorsed product. However, if the Task Force or the Committee decides that it should be, then the Working Group would go back to the beginning and use the NAIC's traditional process to work on it. Ms. Dzurec said after the Working Group completes its work on the QTL/FR template, it will begin work on the NQTL models determining what NQTL topics to include.

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

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Draft: 6/16/20

MHPAEA (B) Working Group
Conference Call
June 5, 2020

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call June 5, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); Mel Anderson and Zane Chrisman (AR); Erin Klug (AZ); Jessica Ryan (CA); Cara Cheevers (CO); Kurt Swan (CT); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Julie Holmes (KS); Erica Bailey (MD); Julia Lyng (MN); Jeannie Keller (MT); Ted Hamby (NC); Chrystal Bartuska and Sara Gerving (ND); Gale Simon and Ralph Boeckman (NJ); Paige Duhamel and Viara Ianakieva (NM); Laura Miller (OH); Courtney Miner (RI); Kendell Buchanan (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji Northrup (UT); Brant Lyons (VA); Barbara Belling (WI); Tim Sigman and Joylynn Fix (WV); and Tana Howard and Bill Cole (WY).

1. Adopted its March 19 and March 9 Minutes

The Working Group met March 19 and March 9 to discuss its 2020 activities.

Ms. Beyer made a motion, seconded by Ms. Kruger, to adopt the Working Group's March 19 (Attachment Five-A1a) and March 9 (Attachment Five-A1b) minutes. The motion passed unanimously.

2. Discussed the Draft Working Group Work Plan

Ms. Dzurec discussed her draft work plan for the Working Group's work related to complete two projects as additional resources and guidance for the states to use as part of their form reviews related to mental health/substance use disorder (MH/SUD) benefits parity requirements under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): 1) a quantitative treatment limit (QTL)/financial review (FR) template; and 2) non-quantitative treatment limit (NQTL) models. She said she anticipates the Working Group completing its work on the QTL/FR template by the end of June and sending it to the Regulatory Framework (B) Task Force. She said that because a state's use of this template is voluntary, she does not anticipate the Task Force adopting it.

Ms. Dzurec said that after the Working Group completes its work on the QTL/FR template, it will begin work on the NQTL models. She said that after the Working Group determines what NQTL topics to include in the models, she anticipates the Working Group possibly forming smaller drafting groups to separately work on each NQTL model topic and complete work on each of the NQTL model topics on a rolling basis before the end of the year. She also discussed the specific timelines for each project.

Ms. Dzurec asked for comments on the proposed work plan. There were no comments.

3. Reviewed the Draft QTL/FR Template

Ms. Dzurec said she reviewed the QTL/FR draft template. She said Pennsylvania has been using this template for its MHPAEA parity form reviews. She emphasized that a state's use of the template is voluntary, reiterating that its development is part of the Working Group's charge to create additional resources and guidance for the states with respect to MHPAEA parity compliance tools.

Ms. Dzurec described the template's uses, such as: 1) product development; 2) reporting; 3) form filing; and 4) market conduct examinations. She provided a step-by-step overview of how a state could use the template in its form review to determine plan MHPAEA parity compliance beginning with the input of plan information to the end of the form review. She explained the state's activities in the review as well as the insurer's activities, particularly with respect to covered services where the insurer would classify the covered services as medical/surgical services or MH/SUD services and the state would confirm that classification. She said the template does not permit an insurer to classify a covered service as both medical/surgical and MH/SUD. The covered services must be classified as one type of service or the other type of service, not both. She explained that when identifying limitations on a covered service, an insurer cannot include "medical necessity" as a limitation because for a service to be a covered service, it must be medically necessary. She said that at the end of the form review, the template

provides roles for the insurer and the state to adjust and correct any problematic areas that arise in the form review for the plan to comply with the MHPAEA parity requirements.

Ms. Dzurec requested comments. Ms. Beyer asked about the analysis required to determine MHPAEA parity compliance with respect to covered benefit plan limitations—copayments, coinsurance and deductibles. Ms. Dzurec confirmed that the analysis would be based on each QTL. Ms. Chrisman asked if there would be an issue with MHPAEA parity compliance if an MH/SUD benefit was more generous than a medical/surgical benefit. Ms. Dzurec said there would not be an issue with MHPAEA parity compliance in this situation because the federal regulations prohibit plans from imposing more restrictive requirements on MH/SUD benefits than medical/surgical benefits. This prohibition does not operate the other way.

Ms. Dzurec said the Working Group has set a public comment period ending June 18 to receive comments on the draft QTL/FR template. She urged stakeholders to submit comments in order to improve the draft and make it more efficient and helpful to the states as an additional tool in determining MHPAEA parity compliance.

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

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Draft: 5/13/20

MHPAEA (B) Working Group
Conference Call
March 19, 2020

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call March 19, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); William Lacy (AR); Erin Klug (AZ); Jessica Ryan (CA); Cara Cheevers (CO); Kurt Swan (CT); Colin Johnson (DC); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Julie Holmes (KS); Erica Bailey (MD); Candace Gergen (MN); Jeannie Keller (MT); Ted Hamby (NC); Sara Gerving (ND); Maureen Belanger (NH); Ralph Boeckman (NJ); Paige Duhamel and Viara Ianakieva (NM); Marie Ganim (RI); Shari Miles (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji Northrup (UT); Brant Lyons (VA); Barbara Belling (WI); Tim Sigman and Joylynn Fix (WV); and Denise Burke (WY). Also participating was: Laura Arp (NE).

1. Discussed Current and Potential MHPAEA Compliance State Tools

Ms. Dzurec said that currently there are two main Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) compliance tools available to the states: 1) the U.S. Department of Labor's (DOL's) compliance check list, which is updated every two years; and 2) the NAIC *Market Regulation Handbook's* (Handbook's) MHPAEA chapter. She asked the Working Group to consider the following questions: 1) how much detail is necessary for state insurance regulators to determine plan compliance with MHPAEA's parity requirements; 2) whether instructions on how to use these tools and any additional tools the Working Group develops would be useful; and 3) what is working and what is not regarding state insurance regulators determining plan parity compliance.

Ms. Dzurec asked the Working Group members to share their experiences with evaluating plan parity compliance. Ms. Cheevers said that in accordance with state requirements, Colorado receives a robust set of data from plans to evaluate compliance. She said the receipt of such data has presented some challenges; as a result, in some cases, Colorado has relied on self-attestation in determining plan compliance. She said the department of insurance (DOI) is looking at ways to prioritize and streamline the data it receives. Ms. Dzurec said Pennsylvania has similar issues with the amount of data it receives. She said this is an area the Working Group could address as part of its work related to nonquantitative treatment limits (NQTLs) guidelines to determine what information state insurance regulators need and what questions they should ask in determining plan parity compliance.

Ms. Arp said that when working on the MHPAEA chapter of the Handbook, the Market Conduct Examination Standards (D) Working Group took a surgical approach in establishing the examination requirements because it realized that state DOIs have limited staff to perform these analyses. She suggested that one way to find out if plans are complying with MHPAEA parity requirements is to reach out to providers. She said Nebraska took such an approach—talking to providers about what the Nebraska DOI would be looking for with respect to MHPAEA violations. Ms. Dzurec agreed that the Working Group could look at utilizing a similar approach, but taking care not to overburden providers in reporting this information to state DOIs. Ms. Arp suggested that to avoid this, the Working Group could consider reaching out to provider associations. Ms. Duhamel said New Mexico has taken a similar approach in its provider outreach efforts. She said it might be useful for the Working Group to create provider outreach materials for the states to use. Ms. Arp said Nebraska has created such materials, including a provider outreach presentation. Ms. Dzurec asked Ms. Arp to share Nebraska's provider outreach presentation with the Working Group. She suggested that any information the Working Group receives from such outreach could inform the Working Group's work on identifying which NQTLs the Working Group should focus on. She noted that claim reviews are also helpful in identifying NQTLs and monitoring plan in-operation compliance.

Uma Dua (Dua Enterprises) said the Working Group should consider developing an NQTL data tool for pharmacy benefits. Ms. Beyer said the Bowman Family Foundation (BFF) has developed a model data request form, which the Working Group may want to look at to determine what information state DOIs would want from plans to determine parity compliance. The Working Group discussed additional suggestions on what additional tools the Working Group could create to assist the states in determining plan parity compliance and providing uniformity in responses among carriers, such as developing a standardized side-by-side comparison template of medical/surgical (M/S) benefits and mental health of substance use disorder (MH/SUD) benefits and/or an excel spreadsheet with tabs that pertain to a certain area of mental health.

Matthew Litton (DOL) said the DOL recently issued its *2020 Report* (Report) to the U.S. Congress (Congress), as required by the MHPAEA, on compliance of group health plans and health insurance coverage offered in connection with such plans with the MHPAEA's requirements. He said the DOL is required to submit this Report every two years. He said the Report discusses the DOL's activities to further parity implementation since its 2018 Report to Congress. Most notably, the Report provides an overview of the DOL's partnership efforts across the federal agencies, as well as with plans, issuers, consumers, providers, states and other stakeholders. The Report details the DOL's intent to use the information gathered from these partnerships to develop a roadmap to compliance for the regulated community so that health plan participants and beneficiaries can realize the full benefits of the MHPAEA. Mr. Litton said the DOL also released its fiscal year (FY) *2019 Mental Health Parity and Addiction Equity Act Enforcement Fact Sheet*. He said the enforcement fact sheet summarizes the DOL Employee Benefits Security Administration's (EBSA's) and the federal Centers for Medicare and Medicaid's (CMS's) closed investigations and public inquiries related to MHPAEA during FY 2019.

Ms. Dzurec said that given the states' short-term focus on COVID-19 issues, she anticipated the Working Group's work to be slowed somewhat as it moves forward over the next few months. She said her goal is to create a project plan for the Working Group for the remainder of the year consistent with its charges.

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

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Draft: 3/13/20

MHPAEA (B) Working Group
Conference Call
March 9, 2020

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call March 9, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Mel Heaps (AR); Catherine O'Neil (AZ); Sheirin Ghoddoucy (CA); Cara Cheevers (CO); Kurt Swan (CT); Howard Liebers (DC); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie (IL); Julie Holmes (KS); Erica Bailey (MD); Sherri Mortensen-Brown and Peter Brickwedde (MN); Jeannie Keller (MT); Rosemary Gillespie (NC); Chrystal Bartuska and Sara Gerving (ND); Maureen Belanger (NH); Gale Simon (NJ); Paige Duhamel (NM); Marie Ganim (RI); Shari Miles and Kendell Buchanan (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji Northrup (UT); Yolanda Tennyson (VA); Jane Beyer (WA); Barbara Belling (WI); Joylynn Fix (WV); and Denise Burke (WY). Also participating was: Tashia Sizemore (OR).

1. Discussed the Working Group's 2020 Activities

Ms. Dzurec said the purpose of the Working Group's conference call is to discuss how the Working Group plans to proceed with its work and how it will operate moving forward. She said she anticipates the Working Group operating similarly to the ERISA (B) Working Group. The Working Group's main activity will be to review and develop tools for the states to use with respect to plan compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Ms. Dzurec requested suggestions from Working Group members and other stakeholders on what they believe the Working Group should focus on short-term and long-term consistent with the Working Group's 2020 charges.

Ms. Dzurec described some of the tools and resources currently available to the states to assist in MHPAEA plan compliance, including the U.S. Department of Labor's (DOL's) MHPAEA self-compliance tool and the MHPAEA chapter in the NAIC *Market Regulation Handbook*. She explained that the MHPAEA is not a mandate, but if a plan covers mental health and substance use disorder (MH/SUD) benefits, then the plan is prohibited from imposing limitations on such benefits that are less favorable than the limitations imposed on medical/surgical (M/S) benefits. She said that to determine plan compliance with this parity requirement, state insurance regulators are required to conduct a comparability analysis both at inception and in-operation.

Andrew Sperling (National Alliance on Mental Illness—NAMI) expressed support for the Working Group's appointment and its 2020 anticipated work. Tim Clement (American Psychiatric Association—APA) also expressed support for the Working Group's 2020 work, particularly its anticipated work related to in-operation plan parity compliance.

Ms. Dzurec requested comments on issues the states have encountered with plan parity compliance. Ms. Sizemore said Oregon has been having problems with third-party administrators (TPAs) not disclosing their underlying algorithms to support their assertions of parity and compliance with the MHPAEA. Health Insurance Commissioner Ganim said the Rhode Island Office of the Health Insurance Commissioner (OHIC) recently completed three market conduct examinations related to behavioral health coverage. She also said that state departments of insurance (DOIs) welcome input from providers related to parity issues they have encountered with plans. Ms. Dzurec agreed. She said the Working Group might want to consider developing some best practices for ways providers can provide such information to DOIs in such a manner that it is not burdensome to providers. Daniel Blaney-Koen (American Medical Association—AMA) expressed support for any efforts the Working Group undertakes related to provider reporting of plan parity compliance issues.

Ms. Bailey said there is a bill currently pending in the Maryland Legislature to establish reporting requirements related to non-quantitative treatment limits (NQTLs) and associated data. She suggested that the Working Group might want to consider developing best practices related to such reporting requirements. Several Working Group members noted passage of or consideration of legislation like Maryland's pending legislation, and they expressed support for the Working Group's efforts to develop resources for the states in this area as Ms. Bailey suggests. Mr. Clement said he would provide the Working Group with a copy of the APA's tracking of such legislation. Uma Dua (Dua Enterprises, Limited) suggested that the Working Group include a review of pharmacy benefits, particularly concerning pharmacy NQTLs and Pharmacy & Therapeutic (P&T) Committee actions in this area. Jeffrey M. Klein (McIntyre & Lemon) said the American Bankers Association's (ABA's) Health Savings Account (HSA) Council has been tracking state legislation related to behavioral services, and he warned the Working Group about potential compliance issues with high deductible health plans (HDHPs) and first dollar coverage for such services. Kris Hathaway (America's Health Insurance Plans—AHIP) expressed support for the Working Group's potential

work to develop best practices related to what data elements are most helpful to state insurance regulators to determine NQTL plan compliance.

Ms. Dzurec outlined the Working Group's potential short-term goals for further discussion during the Working Group's meeting at the Spring National Meeting. She volunteered to develop basic assumptions for the Working Group to use as it moves forward. She said the Pennsylvania DOI created an automated tool for the testing of quantitative treatment limits (QTLs) that she will share for discussion as another potential resource for the states in their analysis to determine plan parity compliance. Ms. Cheevers expressed support for having a uniform QTL tool for use among the states. Ms. Dzurec agreed, but reminded Working Group members that the intent is for the Working Group to develop resources and tools as an option for the states to use to supplement what they are already doing.

Ms. Dzurec said another short-term goal for the Working Group is to develop an NQTL process for the states to use when conducting their analyses to determine what red flags to look for, how to find them, what to do, and what questions to ask when a state finds them. She explained that the Working Group's options are limitless in this area, and she suggested that the Working Group select a few NQTLs to start with that are already under review and look for best practices. She said she anticipated each NQTL would be a separate document. She suggested the following NQTLs to review first: 1) reimbursement for MH/SUD providers; 2) fraud, waste and abuse actions that have resulted in NQTLs, such as substance use disorder laboratory work; 3) pharmacy; and 4) soft caps; i.e. not actual visit limits. Working Group members expressed support for Ms. Dzurec's suggested Working Group short-term goals. Ms. Sizemore said Oregon has been doing some work related to MH/SUD NQTL provider reimbursement that she would be happy to share with the Working Group when it is complete in a few months.

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

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Draft: 7/23/20

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

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

1. Discussed and Exposed a Draft PBM Model

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

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

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

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

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

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

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

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

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

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Draft: 7/6/20
A new model

Comments are being requested on this draft by Tuesday, Sept. 1, 2020. Comments should be sent by email only to Jolie Matthews at jmatthews@naic.org.

[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

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Section 1. Short Title

This Act shall be known and may be cited as the [State] Pharmacy Benefit Manager Licensure and Regulation Act.

Section 2. Purpose

A. This Act establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.

B. The purpose of this Act is to:

(1) Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;

(2) Promote the solvency of the commercial health insurance industry, the regulation of which is reserved to the states by the McCarran-Ferguson Act (15 U.S.C. §§ 1011 – 1015), as well as provide for consumer savings, and fairness in prescription drug benefits;

(3) Provide for powers and duties of the commissioner; and

(4) Prescribe penalties and fines for violations of this Act.

Section 3. Definitions

For purposes of this Act:

A. "Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

(1) Receiving payments for pharmacist services;

(2) Making payments to pharmacists or pharmacies for pharmacist services; or

(3) Both paragraphs (1) and (2).

B. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears.

C. (1) "Covered entity" means:

(a) A nonprofit hospital or medical service corporation, health insurer, health benefit plan or health maintenance organization;

(b) A health program administered by a department or a state in the capacity of a provider of health coverage; or

(c) An employer, a labor union or other group of persons organized in the state that provides health coverage to covered individuals who are employed or reside in the state.

(2) "Covered entity" does not include:

(a) A self-funded plan that is exempt from state regulation pursuant to federal law;

(b) A plan issued for coverage for federal employees; or

(c) A health benefit plan that provides coverage only for accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit health insurance policies and contracts.

D. "Covered person" means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.

E. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

F. "Other prescription drug or device services" means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:

(1) Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;

(2) Disbursing or distributing rebates;

(3) Managing or participating in incentive programs or arrangements for pharmacist services;

(4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;

(5) Developing and maintaining formularies;

(6) Designing prescription benefit programs; or

(7) Advertising or promoting services.

G. "Pharmacist" means an individual licensed as a pharmacist by the [state] Board of Pharmacy.

H. "Pharmacist services" means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.

I. "Pharmacy" means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.

J. (1) "Pharmacy benefit manager" means a person, business or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to covered persons who are residents of this state, for health benefit plans.

(2) "Pharmacy benefit manager" does not include:

(a) A health care facility licensed in this state;

(b) A health care professional licensed in this state; or

(c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager.

Section 4. Applicability

A. This Act shall apply to a contract or health benefit plan issued, renewed, recredentialed, amended or extended on or after the effective date of this Act, including any covered entity that offers pharmacy benefits through a third party.

Drafting Note: States may want to consider adding language to Subsection A above or Section 10—Effective Date providing additional time for pharmacy benefit managers to come into compliance with the requirements of this Act.

B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the requirements of this Act.

C. Nothing in this Act is intended or shall be construed to conflict with existing relevant federal law.

Section 5. Licensing Requirement

A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without obtaining a license from the commissioner under this Act.

B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers under this Act.

Drafting Note: States that are restricted in their rulemaking to only what is prescribed in statute may want to consider including in this section specific financial standards required for a person or organization to obtain a license to operate as a pharmacy benefit manager in this state.

C. A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the commissioner.

Drafting Note: States may want to consider reviewing their third party administrator statute if a state wishes to specify what documents must be provided to the commissioner to obtain a pharmacy benefit manager license in the state.

D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee of $[X].

E. The commissioner may refuse to issue a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

F. (1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations, including the payment of an annual license renewal fee of $[X] and completion of a renewal application on a form prescribed by the commissioner.

(2) Such renewal fee and application shall be received by the commissioner on or before [x] days prior to the anniversary of the effective date of the pharmacy benefit manager's initial or most recent license.

Section 6. Gag Clauses Prohibited

A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:

(1) The nature of treatment, risks or alternative thereto;

(2) The availability of alternate therapies, consultations, or tests;

(3) The decision of utilization reviewers or similar persons to authorize or deny services;

(4) The process that is used to authorize or deny healthcare services or benefits; or

(5) Information on financial incentives and structures used by the insurer.

B. A pharmacy or pharmacist may provide to a covered person information regarding the covered person's total cost for pharmacist services for a prescription drug.

C. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.

D. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefit manager's compliance with the requirements under this Act.

Section 7. Enforcement

A. The commissioner shall enforce compliance with the requirements of this Act.

B. (1) The commissioner may examine or audit the books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine compliance with this Act.

Drafting Note: States may want to consider including a reference to the cost of examinations in the *Model Law on Examinations* (#390).

(2) The information or data acquired during an examination under paragraph (1) is:

(a) Considered proprietary and confidential;

(b) Not subject to the [Freedom of Information Act] of this state;

(c) Not subject to subpoena; and

(d) Not subject to discovery or admissible in evidence in any private civil action.

Section 8. Regulations

A. The commissioner may adopt regulations regulating pharmacy benefit managers that not inconsistent with this Act.

B. The regulations adopted pursuant to Subsection A may include but are not limited to the following:

(1) Pharmacy benefit manager network adequacy;

(2) Prohibited market conduct practices;

(3) Data reporting requirements under state price-gouging laws;

(4) Rebates;

(5) Prohibitions and limitations on the corporate practice of medicine (CPOM);

(6) Compensation;

(7) Procedures for pharmacy audits conducted by or on behalf of a pharmacy benefit manager;

(8) Medical loss ratio (MLR) compliance;

(9) Affiliate information-sharing;

(10) Lists of health benefit plans administered by a pharmacy benefit manager in this state;

(11) Reimbursement lists or payment methodology used by pharmacy benefit managers;

(12) Clawbacks prohibited. A pharmacy benefit manager or representative of a pharmacy benefit manager may not make or permit any reduction of payment for pharmacist services by a pharmacy benefit manager or a covered entity directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including but not limited to, generic effective rates, brand effective rates, direct and indirect remuneration fees or any other reduction or aggregate reduction of payment;

(13) Affiliate compensation.

(a) “Pharmacy benefit manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one (1) or more intermediaries owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefit manager.

(b) A pharmacy benefit manager may not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmacist services; and

(14) Spread pricing prohibited.

(a) “Spread pricing" means the model of prescription drug pricing in which the pharmacy benefit manager charges a health benefit plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

(b) A pharmacy benefit manager is prohibited from conducting spread pricing in this state.

Drafting Note: Subsection B lists options for a state to consider in adopting regulations to implement the provisions of this Act. Not every option listed will be appropriate for every state.

Section 9. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of this Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 10. Effective Date

This Act shall be effective [insert date]. A person doing business in this state as a pharmacy benefit manager on or before the effective date of this Act shall have [six (6)] months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.

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