REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force March 22, 2023, Minutes
Accident and Sickness Insurance Minimum Standards (B) Subgroup March 13, 2023, Minutes (Attachment One)
Accident and Sickness Insurance Minimum Standards (B) Subgroup Feb. 27, 2023, Minutes (Attachment Two)
Accident and Sickness Insurance Minimum Standards (B) Subgroup Feb. 13, 2023, Minutes (Attachment Three)
Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group Feb. 24, 2023, Minutes (Attachment Four)
Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group Dec. 14, 2022, Minutes (Attachment Four-A)
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup March 22, 2023, Minutes (Attachment Five)
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup Dec. 15, 2022, Minutes (Attachment Five-A)
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup Oct. 24, 2022, Minutes (Attachment Five-A1)
The Regulatory Framework (B) Task Force met in Louisville, KY, March 22, 2023. The following Task Force members participated: Sharon P. Clark, Chair, represented by Shaun Orme (KY); Glen Mulready, Vice Chair, and Andy Schallhorn (OK); Lori K. Wing-Heier represented by Sarah Bailey (AK); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented by Howard Liebers (DC); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler and Shannon Hohl (ID); Amy L. Beard represented by Alex Peck (IN); Vicki Schmidt represented by Julie Holmes (KS); Gary D. Anderson represented by Kevin Beagan (MA); Timothy N. Schott represented by Robert Wake (ME); Mike Causey represented by Ted Hamby (NC); Eric Dunning represented by Martin Swanson and Maggie Reinert (NE); Chris Nicolopoulos represented by David Bettencourt (NH); Judith L. French represented by Laura Miller (OH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Katie Merritt (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Molly Nollette (WA); Nathan Houdek (WI); and Allan L. McVey represented by Erin K. Hunter (WV). Also participating were: Erica Weyhenmeyer (IL); Sarah Wohlford (MI); and Patrick Smock (RI).

1. **Adopted its 2022 Fall National Meeting Minutes**

Kruger made a motion, seconded by Swanson, to adopt the Task Force’s Dec. 13, 2022, minutes (see *NAIC Proceedings – Fall 2022, Regulatory Framework (B) Task Force*). The motion passed unanimously.

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

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

Schallhorn said the Accident and Sickness Insurance Minimum Standards (B) Subgroup met March 13, Feb. 27, and Feb. 13. He said that during these meetings, the Subgroup discussed the comments received on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), specifically, Section 8A—General Rules. He said the Subgroup also discussed its upcoming work to review the remaining provisions in Model #171 in the following order: 1) the remainder of Section 8, including revisiting the proposed new subsection on short-term, limited-duration (STLD) plans to discuss the Feb. 24 comments received on that section; 2) Section 7—Prohibited Policy Provisions; 3) revisit Section 5—Definitions and Section 6—Policy Definitions to reconcile any inconsistencies that may have arisen after the Subgroup’s review of the substantive provisions of Model #171; and 4) Section 9—Required Disclosure Provisions. The Subgroup hopes to finish its work to develop an initial draft of comments on Model #171 for public comment by the end of the year. Schallhorn said that in discussing the comments on this revised Model #171 draft, which will reflect all the Subgroup’s discussions related to the model revisions, the Subgroup plans to only entertain and consider comments that raise issues not previously discussed. The Subgroup’s goal is to have a revised Model #171 ready for consideration by the Task Force and the Health Insurance and Managed Care (B) Committee by early 2024, before the 2024 Spring National Meeting.

B. **ERISA (B) Working Group**

Wake said the Employee Retirement Income Security Act (ERISA) (B) Working Group will not be meeting during the Spring National Meeting, but he anticipates the Working Group meeting in person at the Summer National
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Meeting. Wake said the Working Group will most likely meet virtually prior to the Summer National Meeting to complete its work updating the NAIC chart on multiple employer welfare arrangements (MEWAs)/multiple employer trust (MET) and association plans. He said the Working Group continues to serve as a forum and facilitate discussions among state insurance regulators and federal regulators on issues involving ERISA plans and MEWAs. He said the Working Group also stands ready to assist the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup on any issues it encounters related to ERISA preemption issues as the Subgroup works on its white paper concerning pharmacy benefit managers (PBMs) and their business practices, including the implications of the Rutledge vs. Pharmaceutical Care Management Association (PCMA) decision and any subsequent decisions on such business practices.

C. MHPAEA (B) Working Group

Weyhenmeyer said the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group continues to serve as a forum and an opportunity for Working Group members and interested state insurance regulators to discuss MHPAEA enforcement and compliance issues. She said that since the 2022 Fall National Meeting, the Working Group met in regulator-to-regulator session and Feb. 24 to continue its discussion of parity issues with health insurers.

Weyhenmeyer said the Working Group is also continuing to monitor congressional activity related to mental health parity. She said that last year, the Working Group led the effort to write a letter in support of legislation that would provide grants to the states to assist them with mental health parity plan compliance determination, enforcement, and training. She said the legislation passed, but the U.S. Congress has not yet funded the grant program. She said the Biden Administration has included proposal funds for the grant program in its fiscal year 2024 budget. The Working Group is hopeful that this funding will remain in the final budget. Weyhenmeyer said the Working Group is anticipating an updated proposed rule related to mental health parity from the U.S. Department of Labor (DOL) and the federal Centers for Medicare & Medicaid Services (CMS). Once the proposed rule is published, she hopes to hold a Working Group meeting to discuss it and decide whether the NAIC should comment on it through the Government Relations (EX) Leadership Council.

Weyhenmeyer said the Working Group will meet March 23. During this meeting, the Working Group will hear a discussion of the Wit v. United Behavioral Health case, a potential landmark case setting a precedent for how care will be covered for individuals seeking treatment for mental health and addiction.

D. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

Keen said that since his last update, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup released a working draft of the proposed PBM white paper. He said the Subgroup discussed the draft paper’s outline during its meeting at the 2022 Fall National Meeting. Keen said the Subgroup is currently working on edits to the working draft, such as adding language to the Recommendation section and making any necessary non-substantive edits. After this is complete, the Subgroup plans to release an official draft of the white paper for public comment by the end of March or early April. Most likely, the Subgroup will set a 45-day public comment period. Keen said that following the end of the public comment period, the Subgroup plans to hold meetings to review the comments received and make changes to the draft based on those discussions. The Subgroup hopes to finish its work on the white paper prior to the 2023 Summer National Meeting and forward it to the Task Force for its consideration.

Keen said that during its March 22 meeting, the Subgroup adopted its 2022 Fall National Meeting minutes. He said the Subgroup heard an update on federal PBM-related legislative and regulatory activities. The Subgroup also heard a legal update on PBM-related litigation.
Keen made a motion, seconded by Nollette, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its March 13 (Attachment One), Feb. 27 (Attachment Two), and Feb. 13 (Attachment Three) minutes; the ERISA (B) Working Group; the MHPAEA (B) Working Group, including its Feb. 24 (Attachment Four) minutes; and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its March 22 (Attachment Five) minutes. The motion passed unanimously.

3. **Heard an Update on the CHIR’s Work**

Maanasa Kona (Center on Health Insurance Reforms—CHIR) provided an update on the CHIR’s work and various projects of interest to the Task Force. Kona said that in light of the upcoming end of the COVID-19 public health emergency (PHE) and the resulting Medicaid unwinding process, the CHIR recently released an issue brief called “Secrets to a Successful Unwinding: Actions State-Based Marketplaces and Insurance Departments Can Take to Improve Coverage Transitions.” She said a colleague of hers will discuss the issue in more detail during the Health Insurance and Managed Care (B) Committee’s March 23 meeting.

Kona said the CHIR has taken on a few projects related to qualified health plan (QHP) federal Affordable Care Act (ACA) marketplace enrollment, including an analysis of state-based marketplace (SBM) outreach strategies for boosting QHP enrollment of the uninsured and the process of implementing the family glitch fix on the ACA’s marketplaces. She said the CHIR also is examining state activities, such as those occurring in Washington and Nevada, related to public option programs. The CHIR plans to continue monitoring these activities and new state public option legislation.

Kona said the CHIR is examining what states are doing to improve coverage and recently released a few issue briefs highlighting state efforts in this area. She said the CHIR is continuing to monitor and analyze state action related to health equity. As part of this effort, the CHIR plans to publish a survey of SBMs’ language access and policy practices soon.

Kona said the CHIR continues to monitor the implementation of the federal No Surprises Act (NSA) and expects to issue publications soon on several issues related to the implementation process, including a one-year progress report. She said the CHIR recently launched a four-part series studying employer-sponsored insurance (ESI) and cost containment. Kona said the CHIR’s future work in this area includes investigating cost containment and outpatient facility fees. Another future CHIR project is a 50-state survey on state protections against medical debt.

Keen said Oregon and other states have encountered an issue with provider contracts expiring in the middle of a policy year, which is very disruptive to consumers. He asked Kona if the CHIR has examined this issue as part of their research and highlighted this as an issue of concern. Kona said the CHIR has researched issues related to provider contracts, but it has not specifically honed in or researched issues related to the mid-year expiration of such contracts. She said she would take this issue back to her colleagues at the CHIR as a potential future research project.

Commissioner Mulready explained that Oklahoma has seen access issues concerning consumers being able to obtain appointments with behavioral health providers in a timely fashion. He asked Kona if the CHIR has looked at this issue and, if so, whether she could recommend any best practices that other states may be doing to address the issue. Kona said the CHIR has studied the wait time issue with mental health parity as part of comparative analyses of non-quantitative treatment limitations (NQTLs). She said, however, that in examining this issue, it does not seem that any particular state has emerged as a leader in resolving this issue. She noted that California does have certain plan reporting requirements related to wait times for appointments, but the CHIR has not conducted an analysis of how it is working. She said the CHIR could possibly look at this as part of a future project.
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Having no further business, the Regulatory Framework (B) Task Force adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met March 13, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Chris Struk (FL); Robert Wake (ME); Camille Anderson-Weddele (MO); Martin Swanson (NE); Heidi Clausen (UT); Anna Van Fleet, Jamie Gile, and Mary Block (VT); and Ned Gaines (WA).

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

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

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

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

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

The Subgroup next discussed the Maine DOI’s suggestion to delete Section 7C. Section 7C prohibits an insurer from excluding coverage for a loss due to a preexisting condition for a period greater than 12 months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease, or physical condition or prior medical care and treatment and the preexisting
condition is not specifically excluded under the terms of the policy or certificate. After discussion, the Subgroup agreed to delete Section 7C because its provisions are folded into the revised language for Section 7A.

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

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

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

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

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

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
1. Continued Discussion of Section 8A of Model #171

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

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

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

The Subgroup next discussed Section 8A(8). The NAIC consumer representatives and the Vermont DOI both suggest revising this provision to delete outdated language, such as the reference to “mental retardation or
physical handicap” and replacing it with “intellectual or physical disability.” They also suggest deleting the reference to “incapacity” and replacing it with “disability.” After discussion, the Subgroup agreed to accept the suggested revisions.

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

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

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

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

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

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

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

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

The Subgroup next reviewed the Texas DOI’s comments on Section 8A(14). Bowden said she flagged this provision for the Subgroup for potential future discussion to add definitions for “policy period” and “benefit period” when it revisits Section 5—Definitions.
The Subgroup next discussed the Texas DOI’s suggestion to broaden and revise Section 8A(15) as follows: “A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or include unfair exclusions. For example, a policy providing coverage for fractures or dislocations may not provide benefits only for ‘full or complete’ fractures or dislocations.” After discussion, the Subgroup agreed to accept the suggested revision.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
February 13, 2023

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

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

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

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

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

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

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met Feb. 24, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jimmy Harris (AR); Erin Klug (AZ); Cara Cheevers (CO); Kurt Swan (CT); Howard Liebers (DC); Elizabeth Nunes (GA); Andria Seip (IA); Julie Holmes (KS); Mary Kwei (MD); Andrew Kleinendorst (MN); Cynthia Amman (MO); David Dachs (MT); Ted Hamby (NC); Chrystal Bartuska (ND); Maureen Belanger (NH); Ralph Boeckman (NJ); Cass Brulotte and Paige Duhamel (NM); Laura Miller (OH); Ashley Scott (OK); Lindsi Swartz (PA); Glynda Daniels (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Brant Lyons (VA); Barbara Belling (WI); Tim Sigman (WV); and Tana Howard (WY).

1. **Adopted Its 2022 Fall National Meeting Minutes**

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

2. **Discussed Parity Issues with Health Insurers**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Having no further business, the MHPAEA (B) Working Group adjourned.
Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Tampa, Florida
December 14, 2022

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

1. **Heard Presentations on Parity Issues from Health Insurers**

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

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

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

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

Stringer said that case management practices differ among insurers and that different regulators have taken different views on whether a particular practice is a non-quantitative treatment limitation. She said an annual list...
of non-quantitative treatment limitations (NQTLs) would be helpful, either a full list or a list of all the NQTLs that regulators have requested information on in the prior year. She said this would promote common understanding and collection of the right data.

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

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

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

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

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

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

Having no further business, the MHPAEA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.
The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met in Louisville, KY, March 22, 2023. The following Subgroup members participated: TK Keen, Chair (OR); Ashley Scott and Molly Clinkscales, Vice Chair (NE); Kayla Erickson (AK); Jimmy Gunn, Reyn Norman, and Anthony L. Williams (AL); Beth Barrington (AR); Paul Lombardo (CT); Howard Liebers (DC); Andria Seip (IA); Vicki Schmidt (KS); Daniel McIlwain (KY); Frank Opelka (LA); Anita G. Fox and Chad Arnold (MI); Amy Hoyt (MO); Matthew Eberhardt (MT); Ted Hamby (NC); Erin Porter and Ralph Boeckman (NJ); Paige Duhamel and Renee Blechner (NM); David Buono (PA); Scott McAnally (TN); Tanji J. Northrup (UT); Don Beatty (VA); Jennifer Kreitler and Ned Gaines (WA); Jennifer Stegall (WI); Erin K. Hunter (WV); and Jill Reinking (WY). Also participating was: Eamon G. Rock (NY).

1. **Adopted its 2022 Fall National Meeting Minutes**

Beatty made a motion, seconded by Commissioner Schmidt, to adopt the Subgroup’s Dec. 15, 2022, minutes (Attachment Five-A). The motion passed unanimously.

2. **Heard an Update on the PBM White Paper Status**

Keen said the Subgroup released a working draft of the proposed pharmacy benefit manager (PBM) white paper during its meeting at the 2022 Fall National Meeting. He said the Subgroup is working on edits to the working draft, such as adding language to the Recommendation section and making any necessary non-substantive edits. After this is complete, the Subgroup plans to release an official draft of the white paper for public comment by the end of March or early April. Keen said the Subgroup plans to set a 45-day public comment period. Following the end of the public comment period, the Subgroup plans to hold meetings to review the comments received and update the draft based on those discussions. He said the Subgroup hopes to finish its work on the white paper before the Summer National Meeting and forward it to the Regulatory Framework (B) Task Force for its consideration.

3. **Heard an Update on Federal PBM-Related Legislative and Regulatory Activities**

Brian R. Webb (NAIC) updated the Subgroup on recent federal PBM-related legislative and regulatory activities. He said the U.S. Senate (Senate) Committee on Commerce, Science, and Transportation passed the Pharmacy Benefit Manager Transparency Act of 2023 (S.127), which was sponsored by U.S. Sen. Maria Cantwell (D-WA) and U.S. Sen. Chuck Grassley (R-IA) on March 22. S.127 generally prohibits PBMs from engaging in certain practices when managing the prescription drug benefits under a health insurance plan, including charging the plan a different amount than the PBM reimburses the pharmacy. The bill also prohibits PBMs from arbitrarily, unfairly, or deceptively: 1) clawing back reimbursement payments; or 2) increasing fees or lowering reimbursements to pharmacies to offset changes to federally funded health plans.

Webb noted that S.127 provides that PBMs are not subject to these prohibitions if they: 1) pass along 100% of any price concession or discount to the health plan; and 2) disclose specified costs, prices, reimbursements, fees, markups, discounts, and aggregate payments received with respect to their PBM services. S.127 further requires PBMs to report annually to the Federal Trade Commission (FTC) certain information about payments received...
from health plans and fees charged to pharmacies. The FTC and state attorneys general are authorized to enforce the bill’s provisions. Webb explained that although this is a bipartisan bill, concerns have been raised by those accusing it of having the FTC involved in enforcing the legislation. He said he anticipates that S.127 will go to the Senate floor for a vote at some point; although, the exact timeline is unclear. If the Senate passes the bill, it is uncertain what will happen in the U.S. House of Representatives (House).

Webb said another bill of interest is the Prescription Pricing for the People Act of 2023 (S.113) introduced by Sen. Grassley, which passed the Senate Committee on the Judiciary on March 1. The bill requires the FTC to study the role of intermediaries in the pharmaceutical supply chain and merger activity. The FTC also must provide recommendations to increase transparency in the supply chain and prevent anticompetitive practices. Webb noted that like S.127, concerns involving the bill focus on the FTC’s role because of a feeling that the FTC is too political and untrustworthy.

Webb said NAIC staff will continue tracking both S.127 and S.113. He explained that because both bills are bipartisan, they could be incorporated into other Senate legislation or passed as standalone bills.

Webb said with respect to federal PBM-regulatory activity, in June 2022, the FTC launched a Section 6(b) of the Federal Trade Commission Act of 1914 (FTC Act) study to inquire into the prescription drug middleman industry, requiring the six largest PBMs to provide information and records regarding their business practices. He said the FTC’s investigation will closely examine how vertically integrated PBMs affect the availability and cost of prescription medications. He said as part of this investigation, the FTC issued mandatory orders to the six largest PBMs to submit to provide information and records regarding their business practices.

Webb said the inquiry is aimed at shedding light on several practices that have drawn scrutiny in recent years, including fees and clawbacks charged to unaffiliated pharmacies, methods to steer patients towards PBM-owned pharmacies, and the impact of rebates and fees from drug manufacturers on formulary design and the costs of prescription drugs to payers and patients. He said the FTC gave the PBMs 90 days to respond, but he has not seen any reports from the FTC reflecting the PBM responses. He said NAIC staff are working with FTC staff to see if the FTC would be available to participate in a regulator-to-regulator meeting with the Subgroup to discuss any findings they may have at this point in the study.

Webb said in addition to this Section 6(b) study, in June 2022, the FTC issued a “Policy Statement on Rebates and Fees in Exchange for Excluding Lower Cost Drug Products,” in which the FTC said this PBM business practice may violate anti-trust laws and bribery laws. The FTC intends to closely scrutinize the impact of rebates and fees on patients and payers to determine whether any of these provisions have been violated. In addition, it plans to monitor private litigation and file amicus briefs where it can aid courts in analyzing unlawful conduct that may raise drug prices. The FTC also plans to continue to study this issue to understand the full range of practices and implications.

Webb asked which NAIC staff could discuss with relevant Congressional committee staff, given the federal legislation and the recent U.S. Supreme Court decision in Rutledge vs. Pharmaceutical Care Management Association (PCMA) if the Subgroup is interested in pursuing trying to codify or clarify some of the issues related to the authority of state insurance regulators to regulate PBMs and their business practices. The Subgroup expressed support for Webb’s suggestion.
4. **Heard a Legal Update on PBM-Related Litigation**

Kay Noonan (NAIC) said as the Subgroup members and other stakeholders know, there has been a lot of PBM-related legislative activity by the states to address rising prescription drug costs. She noted the PCMA’s opposition to such legislation, which the PCMA asserts is preempted by the federal Employee Retirement Income Security Act of 1974 (ERISA), Medicare Part C program laws and regulations, and Medicare Part D program laws and regulations. She explained that the U.S. Supreme Court’s *Rutledge* decision potentially opened a pathway for states to regulate PBMs and their business practices. She discussed two major cases still pending in the courts—*PCMA v. Mulready* and *PCMA v. Wehbi*—considering the *Rutledge* decision, including their current litigation status and possible court decisions.

5. **Heard a Discussion from the States on Recently Enacted and Pending State PBM Legislation**

The Subgroup heard from various members and interested state insurance regulators on recently enacted and pending state PBM legislation. Beatty said in this year’s Virginia General Assembly session, two bills were introduced to include all self-funded plans in the definition of “carrier.” He said because of this proposed legislation, various stakeholders not previously involved in this issue, raised concerns. After discussion, the Virginia Joint Commission on Health Care (JCHC) was charged with conducting a study generally focusing on the *Rutledge* case and its implications and issuing a report on its findings. Beatty said he believes the idea of having the JCHC conduct this study and issue a report is to better educate legislators on the issues related to the *Rutledge* case and its impact on the ability of states to regulate PBMs and their business practices.

Seip updated the Subgroup on Iowa’s recently enacted PBM legislation. In this legislation, Iowa included a requirement that self-funding plans, defined as third-party payors, must comply with its provisions. She said based on this requirement, she has seen a big change in the reporting of information included in Iowa’s annual report concerning the collection of rebates and fees by plans, which previously only included such information from fully insured plans. She said this information is not public yet, but there is a big difference in the numbers. She said once the report is public, she would share it with the Subgroup.

Seip said Iowa is beginning to implement provisions of the law, including the provisions requiring the Iowa Department of Insurance (DOI) to collect complaints from pharmacies. She said the Iowa DOI has received many complaints, most focusing on the pharmacy being paid less than its drug acquisition cost. She said they have received a few complaints regarding the fees being charged. She said the Iowa DOI is turning its focus to examinations. She said she would be interested in what other states are doing in this area, how they implement this provision in their laws, and working together to figure out some best practices. Keen agreed and said he would work with NAIC staff to set up a future Subgroup regulator-to-regulator meeting to discuss examinations.

Rock provided an update on New York PBM-related legislation. He said in the Governor’s Executive Department proposed budget due April 1, there is a provision to provide the New York DOI with additional authority to regulate/register other prescription drug supply chain participants, such as pharmacy services administrative organizations (PSAOs), pharmacy switch companies, and rebate aggregators, as well as new requirements related to drug price disclosures of prescription drug manufacturers. He said for New York’s initial law, an 18-month implementation period was built in to allow time for the New York DOI to promulgate regulations, such as market conduct regulations, to implement its provisions. The New York DOI has had a number of open meetings discussing the proposed regulations and received many comments from stakeholders. He also noted that New York’s law gives the New York DOI the authority to conduct examinations. As such, he said he would support Iowa’s suggestion that the Subgroup hold a regulator-to-regulator meeting to discuss best practices in this area.
Duhamel discussed legislation just passed in New Mexico, which was introduced as co-payment accumulator legislation but later was amended to include provisions meant to lower the cost of prescription drugs. She said an additional amendment added provisions on federal Section 340B discrimination and new transparency and reporting requirements. She said she has not seen the final bill language, but she knows that based on the latest version of the bill, the New Mexico DOI will be busy this year working to implement the new law. Hoyt said based on Duhamel’s description, Missouri is seeing similar legislation being discussed in the state legislature. As such, she plans to follow what is going on in New Mexico as it works to implement the new law.

Lombardo discussed a bill just passed out of one of its committees that requires the Connecticut DOI to analyze the PBM distribution of prescription drugs and practices related to spread pricing, manufacturer rebates, and transparency and accountability. He said the proposed legislation also requires an examination of any impacts of ownership; governance; and vertical integration between PBMs, carriers, and pharmacies with respect to health care costs for consumers and any potential PBM anti-competitive practices in designing prescription drug formularies. He said he would keep the Subgroup apprised of what happens with the bill as it moves through the legislative process. He noted that Connecticut’s three largest domestic health insurers own the three largest PBMs. As such, if the bill is enacted, it could have a lot of significant implications. Keen asked about the timeline for the Connecticut DOI to complete its analysis if the bill passed without amendment. Lombardo said the bill requires the Connecticut DOI to finish its analysis and publish a report by Feb. 1, 2024. Beatty asked if the Connecticut DOI has calculated how much it will cost to conduct the analysis. Lombardo said based on internal discussions, the Connecticut DOI anticipates hiring an outside consulting firm to assist in the work, and it is working on developing a fiscal note reflecting this. He said the fiscal note is not intended to “kill” the bill, because the Connecticut DOI wants to conduct the analysis.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
Draft: 1/4/22

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

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

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

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

Beatty made a motion, seconded by Commissioner Houdek, to adopt the Subgroup’s Oct. 24 (Attachment Five-A1) and Aug. 9 (see NAIC Proceedings – Summer 2022, Regulatory Framework (B) Task Force, Attachment Eight), minutes. The motion passed unanimously.

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

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

Gaines discussed Section B—Key Players in the Drug Pricing Ecosystem. He said Section B focuses on the main players in the prescription drug supply chain, including insurers, pharmaceutical manufacturers, PBMs, pharmacists, PSAOs and the interrelation of the parties in the chain and transaction costs. He said with respect to
the pharmaceutical manufacturers, Section B describes the various entities within this category—brand drug manufacturers, generic drug manufacturers, and biologic manufacturers. Gains said the subsection on pharmacies describes both chain pharmacies and independent pharmacies. He explained that there are a few subsections in Section B that the drafting group needs to write, but it plans to complete them soon and have NAIC staff incorporate them into the white paper draft the Subgroup will expose for public comment.

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

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

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

Abbott discussed Section E—State Laws that Operate in the Supply Chain. He said Section E discusses the role of PBMs in the prescription drug supply chain and state laws enacted regulating PBMs and PBM business practices because of this expanding and evolving role. He described the Section E drafting group’s approach and research used in writing the section, including examining different state laws and recent updates to those laws. He noted that recently there has been a push on both the state and federal level to enact laws requiring PBMs to provide more transparency in their business practices, such as disclosure of prescription drug pricing, cost information related to rebates, payments and fees collected from pharmaceutical manufacturers, insurers, and pharmacies.
Jolie H. Matthews (NAIC) said she would be speaking on behalf of the leader of the Section F drafting group. She said Section F concerns federal interest in PBMs and PBM business practices. The section focuses on the Federal Trade Commission’s (FTC’s) recently announced study on PBMs. She said the Section F drafting group developed the language for Section F using information found through targeted online searches for articles on the subject. The Section F drafting group summarized the information found in the articles to include in Section F.

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

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

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

3. **Discussed Next Steps**

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

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
1. Heard a Presentation from AHIP

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

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

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

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

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

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

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

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

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

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

Chapman discussed the role PBMs play in the prescription drug supply chain, including the tools PBMs use to encourage patients, working with their physicians to select the safest and most effective drugs at the lowest possible price. She also discussed the BCBSA’s position related to pharmacies and PSAOs. She said the BCBSA
believes specific types of pharmacy providers should not have financial advantages through mandated contract terms between pharmacies and PBMs or mandated coverage of drugs at acquisition cost. She also said the BCBSA believes further study is necessary to understand how PSAOs affect the prescription drug supply chain and what state actions are needed to lower prescription drug costs, and it urges the Subgroup to do this research when developing the white paper.

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

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

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

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

4. Heard a Presentation from the PCMA

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

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