REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force Dec. 13, 2022, Minutes

- Regulatory Framework (B) Task Force Oct. 11, 2022, Minutes (Attachment One)
  - Regulatory Framework (B) Task Force 2023 Proposed Charges (Attachment One-A)
- Accident and Sickness Insurance Minimum Standards (B) Subgroup Dec. 5, 2022, Minutes (Attachment Two)
- Accident and Sickness Insurance Minimum Standards (B) Subgroup Nov. 28, 2022, Minutes (Attachment Three)
- Accident and Sickness Insurance Minimum Standards (B) Subgroup Nov. 14, 2022, Minutes (Attachment Four)
- Accident and Sickness Insurance Minimum Standards (B) Subgroup Oct. 31, 2022, Minutes (Attachment Five)
- Accident and Sickness Insurance Minimum Standards (B) Subgroup Oct. 18, 2022, Minutes (Attachment Six)
- Accident and Sickness Insurance Minimum Standards (B) Subgroup Sept. 29, 2022, Minutes (Attachment Seven)
- Accident and Sickness Insurance Minimum Standards (B) Subgroup Sept. 12, 2022, Minutes (Attachment Eight)
- Accident and Sickness Insurance Minimum Standards (B) Subgroup Aug. 29, 2022, Minutes (Attachment Nine)
- Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group (Attachment Ten)

Draft Pending Adoption

Draft: 12/21/22

Regulatory Framework (B) Task Force
Tampa, Florida
December 13, 2022

The Regulatory Framework (B) Task Force met in Tampa, FL, Dec. 13, 2022. The following Task Force members participated: Vicki Schmidt, Chair (KS); Sharon P. Clark, Vice Chair (KY); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Yada Horace (AL); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Jared Kosky (CT); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Amy L. Beard represented by Meghann Leaird (IN); Gary D. Anderson represented by Kevin Beagan (MA); Timothy N. Schott represented by Robert Wake (ME); Anita G. Fox represented by Sarah Wohlford (MI); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning, Laura Arp, and Maggie Reinert (NE); Chris Nicolopoulos represented by Maureen Belanger (NH); Russell Toal represented by Paige Duhamel (NM); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); 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 Ellen Potter (WV). Also participating was: Erica Weyhenmeyer (IL).

1. Adopted its Oct. 11 and Summer National Meeting Minutes

The Task Force met Oct. 11 and Aug. 10. During its Oct. 11 meeting, the Task Force took the following action: 1) decided not to consider revisions to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22). The revisions would have addressed a concern raised during a presentation from the Association for Accessible Medicines (AAM) about a provision in Model #22 on drug substitutions for certain biosimilar drugs at the Task Force's meeting at the Summer National Meeting; and 2) adopted its 2023 proposed charges.

Keen made a motion, seconded by Kruger, to adopt the Task Force's Oct. 11 (Attachment One) and Aug. 10 (*see NAIC Proceedings – Summer 2022, Regulatory Framework (B) Task Force*) minutes. The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

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

Arp said the Accident and Sickness Insurance Minimum Standards (B) Subgroup met Dec. 5, Nov. 28, Nov. 14, Oct. 31, Sept. 29, Sept. 12, and Aug. 29. She said during these meetings, the Subgroup discussed comments received on Section 8—Supplementary and Short-Term Minimum Standards for Benefits of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). The Subgroup completed its work on Section 8. Arp said the Subgroup discussed its upcoming work on Section 9—Required Disclosure Provisions. The Task Force requested comments with a public comment period ending Nov. 18 on this section and the remaining section in Model #171, Section 10—Requirements for Replacement of Individual Supplementary and Short-Term Insurance.

Because Arp would be resigning from the Nebraska Department of Insurance (DOI) at the end of the year and would no longer be attending national meetings as a representative of the DOI, Commissioner Schmidt recognized

and expressed appreciation for the work Arp has done for the Subgroup since she became its co-chair and the work she has done for other groups that report to the Task Force.

b. ERISA (B) Working Group

Wake said the Employee Retirement Income Security Act (ERISA) (B) Working Group has not met in open session since the Summer National Meeting, but it is continuing its work to update the NAIC chart on multiple employer welfare arrangements (MEWAs)/multiple employer trust (MET) and association plans and surveying the states regarding their stop loss laws in relation to level-funded 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, and it held a regulator-only meeting on Sept. 8 as part of this work. 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.

Wake also discussed an upcoming hearing in the U.S. Court of Appeals for the Eleventh Circuit related to an appeal from a district court's approval of a settlement of a consolidated multi-state, anti-trust class action against the Blue Cross Blue Shield Association (BCBSA) and its members. He said Oklahoma has taken the lead in drafting and submitting a multi-state amicus brief. He said the amicus brief does not address the merits of the settlement, but it urges the Eleventh Circuit Court in its decision to accurately describe the nature and regulatory status of stop loss insurance. He said several states have signed onto the brief. He urged any other states wishing to sign on as well to reach out to the Oklahoma DOI as soon as possible.

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. Given this, many of the Working Group's meetings since the Summer National Meeting have been in regulator-to-regulator session. Weyhenmeyer said the Working Group has also continued to dialogue with the federal agencies, the U.S. Department of Labor (DOL), and the federal Centers for Medicare & Medicaid Services (CMS) charged with implementing the federal mental health parity requirements.

Weyhenmeyer said the Working Group has met in person at each of the national meetings this year in addition to its regulator-to-regulator in-person and virtual meetings. She said the Working Group will be meeting Dec. 14 in an open session and a regulator-to-regulator session. In the open session, the Working Group will hear presentations on parity issues from America's Health Insurance Plans (AHIP) and the BCBSA.

Weyhenmeyer said as part of the Working Group's work this year, the Working Group held a series of regulator-to-regulator sessions to discuss potential changes to the mental health parity chapter of the *Market Regulation Handbook*. The Working Group finished its review and forwarded its suggested revisions to the Market Conduct Examination Guidelines (D) Working Group for its consideration. Weyhenmeyer said the Market Conduct Examination Guidelines (D) Working Group reviewed the MHPAEA (B) Working Group's suggested revisions and adopted them. The Market Regulation and Consumer Affairs (D) Committee adopted the revisions as well. The revised mental health parity chapter is available for state insurance regulators to use as part of their mental health parity compliance and enforcement efforts.

Weyhenmeyer said the Working Group is also continuing to monitor congressional activity related to mental health parity. She said the U.S. House of Representatives (House) passed legislation that would provide grants to the states to assist them with mental health parity plan compliance determination, enforcement, and training; but to date, there has not been any activity related to the legislation from the U.S. Senate (Senate). She said the Working Group is anticipating an updated proposed rule related to mental health parity from the DOL and the 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.

d. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

Keen said the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will meet Dec. 15. He said during this meeting, the Subgroup plans to consider adoption of its Oct. 24 and Summer National Meeting minutes. During its Oct. 24 meeting, the Subgroup continued its work on hearing presentations from various stakeholders on issues from their perspectives on the Subgroup's 2022 charge to develop a white paper to: 1) analyze and assess the role 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* decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.

Keen said yesterday, the Subgroup released a working draft of the PBM white paper. He said during its Dec. 15 meeting, the Subgroup will discuss its work on developing the working draft, including hearing from the leaders of each of the white paper section drafting groups on their process for developing an initial draft of their section. He emphasized that the draft is a working document. The Subgroup plans to edit and refine the document before releasing an official draft for public comment. Keen explained that the Subgroup aims to have the white paper focus on the current state of play as far as PBMs and PBM regulation and business practices, as well as not have it try to predict any future changes in such regulation or business practices.

Kosky made a motion, seconded by Keen, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Sept. 5 (Attachment Two), Nov. 28 (Attachment Three), Nov. 14 (Attachment Four), Oct. 31 (Attachment Five), Oct. 18 (Attachment Six), Sept. 29 (Attachment Seven), Sept. 12 (Attachment Eight), and Aug. 29 (Attachment Nine) minutes; the ERISA (B) Working Group; the MHPAEA (B) Working Group, including its Aug. 11 minutes (Attachment Ten); and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. The motion passed unanimously.

3. Heard a Presentation on a Potential Consumer Disclosure and Labeling Regime for Ancillary Health Products

Jackson Williams (Dialysis Patient Citizens—DPC) presented on "Addressing Low-Value Insurance Products Through Improved Consumer Information." The presentation is based on an article titled, "Addressing Low-Value Insurance Products with Improved Consumer Information: The Case of Ancillary Health Products," which is to be published in the Journal of Insurance Regulation (JIR).

Williams discussed how disclosure laws shape consumer information at three stages of the shopping process; i.e., first impression, pre-decision, and post-decision. He discussed how the current sales regime of products, such as short-term health insurance and supplemental health insurance products, favors the sellers of these products and leads to the marketing of insurance products offering low value to consumers. He suggested that state insurance regulators could address this by mandating a robust regime of disclosures and labeling, which he described as "comparative disclosures." He discussed currently mandated comparative disclosures for products, such as bourbon and orange juice and requirements under the federal Truth in Lending Act (TILA) that require the disclosure of an annual percentage rate to permit an apples-to-apples comparison of offers of credit and the so-

called "Monroney label," required under the federal Automobile Information Disclosure Act of 1958, to be affixed on new cars that facilitate the comparison of vehicle prices and attributes.

Williams said similar identity standards can be created for health insurance and critical illness insurance. He recommended that state insurance regulators: 1) prohibit the use of the term "health insurance" when the product has an actuarial value less than 60%; and 2) allow short-term health products to use alternate names, such as "mini-med" or "medical bill assistance plan," when the product does not offer that level of benefits. He also recommended the creation of a "unit price" for product comparisons, such as requiring the disclosure of loss ratio or a classification system for short-term products, such as MiniMed 1, MiniMed 2, or MiniMed 3 based on minimum coverage standards at each level.

Williams discussed additional recommendations, including establishing a uniform product summary for short-term insurance, creating a uniform product label with common scenarios by age group, and ensuring that representations are not misleading throughout the sales process or transaction.

Williams said his suggestions would structure the market to promote competition on price and quality. He said his approach avoids "command-and-control" regulations in favor of a light regulatory touch to facilitate informed consumer choices and lets market forces shape products.

4. Heard a Presentation on ICHRAs

Katherine Hempstead (Robert Wood Johnson Foundation—RWJF) provided an overview of individual coverage health reimbursement arrangements (ICHRA), including its potential for more consumer choice, its growth implications for the individual market, the challenges and barriers to its take-up by employers, and interest from brokers and health insurers. She said initially, there were high expectations with the U.S. Department of the Treasury (Treasury Department) projecting that 800,000 employers and 11 million workers would be using ICHRAs within five years after its creation in January 2020. A recent HRA Council report indicates rapid growth between 2020 and 2022 from a very low base, with ICHRA adoption more than tripling. Overall, however, the current take-up rate for ICHRAs is very low.

In discussing the challenges to ICHRAs, Hempstead described the many barriers affecting the rate of take-up by employers, such as: 1) the individual market often being more expensive than the small group market; 2) the lack of awareness among employers; 3) the lack of support from brokers; 4) opposition from some groups of employees and other stakeholders; and 5) ICHRAs must be purchased off-exchange to use pre-tax dollars. She cited two studies tracking the awareness, familiarity, and opinions of employers and employees about ICHRAs. The study findings indicated that employers are not offering ICHRAs because: 1) they do not understand them; 2) their broker did not recommend them; 3) they believe ICHRAs are too complicated to administer; 4) their employees are not interested; and 5) ICHRAs are not good for employees. Hempstead said other concerns with ICHRAs include: 1) the potential for adverse selection within the company; 2) it being hard to prevent consumers from buying "junk" coverage; and 3) "affordable" ICHRAs possibly being harmful to low-income workers.

Hempstead suggested a few policy recommendations to address some of these issues, including: 1) allowing a choice between group plans and ICHRAs; 2) requiring that ICHRAs be offered to all employees; 3) protecting workers from "junk" plans; and 4) conducting outreach and education to employers.

Seip asked Hempstead if she researched the rate of take-up of other types of health reimbursement arrangements (HRAs) in comparison to the take-up for ICHRAs to see if the differences, if any, could be attributed to the lack of sophistication and knowledge of this type of HRA by small employers versus large employers. Hempstead said the HRA Council's study did a comparison of ICHRAs with qualified small employer health reimbursement

arrangements (QSEHRAs). She has not conducted a study or comparison with other types of HRAs, but that could be something she could search for and provide additional information on later.

Duhamel asked if Hempstead's analysis takes into consideration the financial assistance available to consumers in the individual market health insurance exchanges. She explained that in New Mexico, the contributions small employers are offering to their employees to purchase coverage from the small employer do not match up to what an employee is eligible for and can receive through the purchase of a qualified health plan (QHP) on the health insurance exchange, particularly if the employee is eligible for advance premium tax credits (APTCs). She asked about Hempstead's thoughts on the usefulness of ICHRAs in expanding access to coverage under these circumstances when the QHP coverage an employee can receive, particularly those eligible for APTCs, will most likely be better than the coverage the employee would receive under the small employer plan with an ICHRA.

Hempstead agreed that given the current circumstances with the APTCs being extended, some employees, particularly low-wage employees, would be better off obtaining coverage through the individual market health insurance exchanges and not the small employer's plan with the ICHRA. She said she has heard anecdotally of some small employers offering ICHRA coverage that is intentionally only affordable to their high-wage employees so that their low-wage employees can obtain coverage through the individual market health insurance exchanges. She also said because of the APTCs and other types of subsidies that states may be offering, this could be one reason why ICHRAs are not being used and affecting its rate of take-up. Kruger agreed with Duhamel's comments about some small employers encouraging their employees to obtain coverage through the individual market health insurance exchanges because of the availability of APTCs, rather than the small employer offering coverage through the small group market. Hempstead said although she has not found a way to measure such a shift, she is sure it is happening.

5. Heard a Federal Update

Joe Touschner (NAIC) provided a federal update on issues of interest to the Task Force. He said there continues to be broad, bipartisan interest in legislation to improve the care and coverage of mental and behavioral health in the U.S. Congress (Congress). He explained that the states are the primary enforcers of the MHPAEA, but no federal funding is provided to assist states in enforcing it. He said the NAIC sent a letter to Congress in support of efforts to provide grant funds to states for the enforcement of the MHPAEA. He said as Weyhenmeyer noted, the House passed a bill, the Restoring Hope for Mental Health and Well-Being Act of 2022 (HR 7666), authorizing $10 million per year for five years for grants to states for MHPAEA enforcement; the Senate has not yet acted on the bill, but the legislation is part of the conversation in the current congressional lame duck session.

Touschner discussed telehealth and the potential for increased flexibility in its use. He noted that many of the changes expanding the use of telehealth are tied to the public health emergency (PHE), but there seems to be some support for maintaining some of these expanded uses after the PHE ends sometime next year, with the possibility of extending them until the end of 2023.

Touschner discussed the changes in congressional leadership on some of the key committees involved in health insurance legislation. He noted that even with these leadership changes, there seems to be continued interest in prescription drug issues and the marketing of health plans, particularly the marketing of Medicare Advantage plans.

Touschner said on the federal regulatory side, the CMS just released the Notice of Benefit and Payment Parameters for 2024 proposed rule. He said the CMS will provide a summary of that proposed rule during the Health Insurance and Managed Care (B) Committee's meeting on Dec. 14. He said the CMS recently sent out a request for information (RFI) concerning essential health benefits (EHBs) seeking information on how the benefits are described and how they are updated. He noted that there is a key role for state insurance regulators in how

these benefits should be described and how they should be updated. As such, it is likely that state insurance regulators will submit comments on the RFI and any proposed rule that results from the RFI. He said the NAIC and several state DOIs submitted comments on the proposed rule related to the non-discrimination provisions under Section 1557 of the federal Affordable Care Act (ACA). He anticipates the final rule being released soon. He said he anticipates the federal agencies charged with implementing the MHPAEA releasing a proposed rule concerning state mental health parity enforcement.

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

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Draft: 10/14/22

Regulatory Framework (B) Task Force
Virtual Meeting
October 11, 2022

The Regulatory Framework (B) Task Force met Oct. 11, 2022. The following Task Force members participated: Vicki Schmidt, Chair (KS); Sharon P. Clark, Vice Chair (KY); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Anthony L. Williams (AL); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Jared Kosky and Paul Lombardo (CT); Karima M. Woods represented by Howard Liebers (DC); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Kathy McGill (ID); Amy L. Beard represented by Scott Shover, Cory Best, and Meghann Leaird (IN); Gary D. Anderson represented by Kevin Beagan (MA); Timothy N. Schott represented by Robert Wake (ME); Anita G. Fox represented by Karen Dennis and Sarah Wohlford (MI); Grace Arnold represented by Galen Benshoof (MN); Chlora Lindley-Myers represented by Cynthia Amann and Amy Hoyt (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Laura Arp (NE); Chris Nicolopoulos represented by Michelle Heaton (NH); Marlene Caride represented by Chanell McDevitt (NJ); Russell Toal represented by Bogdanka Kurahovic (NM); Judith L. French represented by Laura Miller (OH); Glen Mulready (OK); Michael Humphreys (PA); Larry D. Deiter represented by Gretchen Brodkorb and Candy Holbrook (SD); Carter Lawrence represented by Toby Compton (TN); 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 Ned Gaines (WA); Nathan Houdek (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Discussed Revising Model #22

Commissioner Schmidt said before turning to the main agenda item for this meeting, which is to consider adoption of the Task Force's 2023 proposed charges, she wants to follow up on a matter from the Task Force's meeting at the Summer National Meeting. She said during that meeting, the Task Force heard a presentation from the Association for Accessible Medicines (AAM). The presentation included a request for the Task Force to consider revising the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) to address a concern the AAM has with a provision in the model concerning drug substitutions for certain biosimilar drugs. She said the Task Force agreed to consider the request but decided to form an ad hoc group of Task Force members to discuss and review the issue more thoroughly before taking any next steps to revise the model.

Commissioner Schmidt said following the Summer National Meeting, NAIC staff sent out an email to Task Force members and interested state insurance regulators asking for volunteers to serve on the ad hoc group. She said NAIC staff received one response to the email request for volunteers. Given this lack of response and interest in the issue, Commissioner Schmidt said she recommends that the Task Force take no further action. There was no objection to her recommendation.

2. Adopted its 2023 Proposed Charges

Commissioner Schmidt said prior to the meeting, NAIC staff distributed the Task Force's 2023 proposed charges. She said the Task Force received comments from the Dialysis Patient Citizens (DPC). Jackson Williams (DPC) said the DPC suggests adding a 2023 charge for the Task Force or the Accident and Sickness Insurance Minimum Standards (B) Subgroup to "examine and document recent changes in the markets for supplemental health products (e.g., specified disease, AD&D) and short-term, limited-duration products; identify areas of concern; consider proposals for reforms; and report findings of fact and recommendations for any appropriate interventions in these markets, including any that lie beyond the scope of Models #170 and #171." He said he is

suggesting this charge because the Subgroup, which is currently considering revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), is focused on revising Model #171 to address outdated language, and it is not looking to modernize the regulatory structure for these products. He believes the regulatory structure for these products needs to be modernized because the market and these products have changed since the adoption of Model #171 and its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170), in the 1990s. He discussed some of the market changes he believes are significant, such as the decline in loss ratios, which he said in some cases have declined by 20% or more, dropping below 50%, over the past decade.

Commissioner Clark asked Mr. Williams for clarification on what issues he is seeing with the supplemental plan market because she has not heard of any concerns. Mr. Williams reiterated his concerns about the decline in loss ratios for some of these products. He said there needs to be an analysis of this issue to understand why it is occurring. He also noted that these products in particular seem to be the target of fraudsters in how they are marketed to consumers.

Commissioner Schmidt said the Subgroup has had extensive discussions and has acknowledged that there are marketing issues with some of these products, particularly short-term, limited-duration (STLD) plans. She said the Subgroup has committed itself to addressing these issues as it moves forward with considering revisions to the notice and disclosure provisions in Model #171.

Ms. Arp expressed support for Commissioner Schmidt's comments about the planned work of the Subgroup. As co-chair of the Subgroup, she said the Subgroup believes looking at marketing issues is within the scope of the Subgroup's current charge, and the Subgroup has committed itself to taking on this work. She noted, however, that she does not agree with Mr. Williams' comments related to "modernizing" the supplemental market and the need to overhaul these products. She said the Subgroup has devoted significant time to discussing the types of supplemental products covered under Model #170 and Model #171 and their purpose and value for both the group market and the individual market. She also cited work being done and data being collected by other NAIC groups related to the supplemental plans and STLD plans. Commissioner Mulready expressed support for Ms. Arp's comments. He also noted the work being done by other NAIC groups, which would make Mr. Williams' suggested charge redundant and unnecessary.

Commissioner Clark made a motion, seconded by Commissioner Mulready, to adopt the Task Force's 2023 proposed charges (Attachment One-A). The motion passed unanimously.

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

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Draft: 9/22/22
Adopted by the Executive (EX) Committee and Plenary, Dec. __, 2022
Adopted by the Health Insurance and Managed Care (B) Committee, TBD
Adopted by the Regulatory Framework (B) Task Force, Oct. 11, 2022

2023 Proposed 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, or 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 2023.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (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 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) efforts 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.

REGULATORY FRAMEWORK (B) TASK FORCE *(continued)*

4. The **Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group** will:
   A. Monitor, report, and analyze developments related to the 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 the MHPAEA.
   D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the *Market Regulation Handbook*.
   E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

5. The **Pharmacy Benefit Manager Regulatory Issues (B) Subgroup** will:
   A. 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 v. Pharmaceutical Care Management Association (PCMA)* decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.
   B. Consider developing a new NAIC model to establish a licensing or registration process for PBMs. Based on issues identified in the white paper, 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: 12/7/22

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
December 5, 2022

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Dec. 5, 2022. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Rachel Bowden (TX); Tanji J. Northrup, Heidi Clausen, and Shelley Wiseman (UT); Anna Van Fleet, Jamie Gile, and Mary Block (VT); and Ned Gaines (WA).

1. Discussed Proposed Language for Section 8H of Model #171

The Subgroup continued its discussion of the NAIC consumer representatives' comments on Section 8H—Short-Term, Limited Duration Coverage of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). Lucy Culp (Leukemia & Lymphoma Society—LLS) discussed the NAIC consumer representatives' suggestion to add a provision establishing rescission and cancellation requirements for short-term, limited-duration (STLD) coverage. The Subgroup discussed the suggested language. After discussion, the Subgroup decided to preliminarily include such a provision with some revisions to the suggested language as follows: "A short-term limited duration health insurance plan cannot be rescinded by the carrier during the coverage period except if the insured fails to disclose a prior diagnosis of a health condition or if the insured intentionally fails to disclose the insured was covered under a short-term limited duration health insurance plan. If the plan is rescinded, the carrier must refund to the insured all payments less claims paid up to the total premium amount made by or on behalf of the insured prior to the rescission date or the expiration date of the short-term limited duration health insurance." The Subgroup also agreed to a drafting note to this provision to alert the states that the language concerning an insured's failure to disclose prior coverage under an STLD plan will need to be tailored to the state's laws and regulations concerning such disclosures of prior coverage. Additionally, the Subgroup agreed to add a drafting note explaining how to apply the language requiring the insurer to refund to the insured all payments paid to the insurer "less claims paid up to the total premium amount" made by or on behalf of the insured prior to the rescission date or the expiration date of coverage.

The Subgroup next discussed the NAIC consumer representatives' suggested language establishing cancellation requirements specifically for STLD coverage. Some Subgroup members expressed concern that if Model #171 includes specific language related to cancellation for STLD coverage that conflicts with the provisions of the language in state laws and regulations already applicable to STLD coverage, there could be confusion. After additional discussion, the Subgroup decided to preliminarily include the language, but possibly reconsider its decision depending on the number of states that already have language in their laws and regulations establishing general cancellation requirements for all coverages, including STLD coverage.

The Subgroup discussed the NAIC consumer representatives' suggested language for adding a provision requiring insurers to notify an insured 20 days prior to any cancellation or rescission date. Some Subgroup members expressed concern with including such a requirement, particularly setting a specific number of days to provide the notification. After discussion, the Subgroup agreed to preliminarily include the suggested language with brackets around the 20-day notification requirement, which would provide flexibility for those states with a different number of days. The Subgroup also agreed to add a drafting note explaining the rationale for the bracketed language.

The Subgroup discussed the NAIC consumer representatives' suggestion to add language concerning an individual's right of recovery under the contract when the individual makes false statements when applying for STLD coverage. The Subgroup decided it was not necessary to include the language, which seeks to codify common law as it relates to contracts.

The Subgroup discussed the NAIC consumer representatives' suggestion to add language establishing requirements for standard disclosure forms. The Subgroup decided that adding this language to Section 8H was unnecessary because of other state laws and regulations establishing such requirements, which apply to all types of coverages, including STLD coverage.

The Subgroup discussed the NAIC consumer representative's suggested drafting note outlining the different approaches the states have taken to regulate STLD products. The Subgroup decided to accept the drafting note.

2. Discussed Next Steps

Arp said she would work with NAIC staff to develop a draft of Section 8H reflecting the Subgroup's discussions. She said she sent NAIC staff and Schallhorn a copy of the disclosure chart that Nebraska uses, which she hopes will help jump-start the Subgroup's discussions beginning next year on the disclosure provisions in Model #171.

Arp also said she would be resigning from the Nebraska Department of Insurance (DOI) at the end of the year. As such, the Subgroup will be seeking a new Subgroup co-chair or a vice chair for 2023. She urged current Subgroup members and interested state insurance regulators to follow up with NAIC staff to volunteer for the position if they have an interest.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/Accident and Sickness Subgrp/Accident and Sickness Ins Min Stds Subgrp 12-5-22MtgMin.docx

Draft: 12/2/22

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
November 28, 2022

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Nov. 28, 2022. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Shari Miles (SC); Rachel Bowden (TX); Tanji J. Northrup, Heidi Clausen, and Shelley Wiseman (UT); Anna Van Fleet and Mary Block (VT); and Ned Gaines (WA).

1. Discussed Proposed Language for Section 8H of Model #171

The Subgroup continued its discussion of the comments received on Section 8H—Short-Term, Limited Duration Coverage of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). Bowden discussed the Texas Department of Insurance's (DOI's) comments. She said the Texas DOI thinks of short-term, limited-duration (STLD) coverage as being like short-term major medical insurance coverage, but in many instances, it is not specifically defined as such. She said that is why the Texas DOI suggests adding language to Section 8H stating, "an individual policy or group certificate of short-term, limited-duration insurance must provide benefits consistent with the minimum standards for the type of coverage offered." She next discussed the Texas DOI comments on guaranteed renewability, which include suggested language on how STLD plans should be marketed with respect to renewability and required disclosures to inform consumers about the duration of the initial term of the policy, the total maximum duration of the policy, and any renewal options. She explained that Texas passed legislation aligning its definition of STLD coverage with the federal definition. A provision in that legislation required the Texas DOI to develop and adopt disclosures for STLD coverage. She said the suggested language reflects provisions included in Texas' disclosure requirements. The Subgroup discussed the comments.

After discussion, the Subgroup agreed that some of the suggested language would be appropriate to consider for inclusion in an initial draft of Section 8H establishing minimum benefit requirements for STLD coverage, such as the initial duration of the coverage and whether the coverage is renewable. The Subgroup discussed the nuances related to the renewability of STLD coverage, including the Market Conduct Annual Statement's (MCAS's) definition of renewal and/or reissue for STLD coverage. The Subgroup agreed that other suggested language would be more appropriate for consideration for the disclosure provisions for this coverage. The Subgroup also agreed that it should consider language concerning the application of preexisting condition exclusion periods for this product in any disclosure language. The Subgroup acknowledged that the minimum benefit language it includes in Section 8H will have to provide flexibility and recognize that the states regulate STLD products in different ways.

Lucy Culp (Leukemia & Lymphoma Society—LLS) discussed the NAIC consumer representatives' comments on Section 8H. She said the NAIC consumer representatives' suggested language includes a comprehensive definition of "short-term, limited-duration insurance," with flexibility in the language to accommodate the differences in the states on the maximum duration of such coverage. The suggested language also includes provisions related to the issuance of such coverage during open enrollment periods for individual market health insurance coverage and qualified health plan (QHP) coverage through state and federal marketplace health insurance exchanges. Culp said the suggested language includes language establishing: 1) minimum standards for benefits; 2) the extension of coverage requirements while an insured is hospitalized; 3) plan, application, and disclosure form filing

requirements; 4) preexisting condition exclusion period requirements; and 5) rescission and cancellation provision requirements. The Subgroup discussed the comments.

Arp expressed support for the NAIC consumer representatives' suggested language for a definition of "short-term, limited-duration insurance," including the language targeting the issuance of such coverage by associations doing business in other states. The Subgroup discussed the suggested language that would prohibit an insurer from issuing STLD plan coverage if that coverage results in an insured being covered under the plan for more months than allowed by a state in any 12-month period. After discussion, the Subgroup agreed to consider adding the suggested language to Section 8H if the suggested language is revised as follows, "[in any 12-month period] to provide flexibility for those states with shorter maximum durations for STLD plan coverage."

The Subgroup discussed the NAIC consumer representatives' suggestion to prohibit the issuance of STLD plan coverage during individual market and QHP open enrollment periods to avoid consumer confusion and competition with federal Affordable Care Act (ACA)-compliant plans. After discussing the challenges of including such language and whether this issue could be addressed through disclosures, the Subgroup decided to defer a decision on whether to include it. The Subgroup next discussed the NAIC consumer representatives' suggestions to add filing requirements for STLD plan coverage. The Subgroup decided that this language is not necessary because filing requirements for all the products subject to Model #171 are included elsewhere, and STLD plan coverage should not be singled out.

The Subgroup decided that NAIC consumer representatives' minimum benefit language should not be included based on the Subgroup's previous discussions on its approach to establishing minimum benefits for STLD plan coverage. Arp pointed out a provision in the NAIC consumer representatives' suggested minimum benefit language concerning the extension of benefits while an insured is hospitalized for the Subgroup to discuss. She said she is unclear how such a provision would work when a state has a maximum duration on how long an individual can be covered under an STLD plan, and the extension of benefits under this circumstance could violate that maximum duration. The Subgroup discussed the issue, including whether language should be included in Section 8H, with references to state extension of benefit laws and their application to STLD plan coverage. The Subgroup did not reach a decision on whether to add such language, but it agreed to research whether there is model language on the topic and whether Model #171's companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170), would permit the addition of such language in Model #171.

The Subgroup next discussed the NAIC consumer representatives' preexisting condition exclusion period language. The Subgroup noted that during previous discussions of this term, it had decided to develop a separate definition for this term for STLD plan coverage. Given this, the Subgroup deferred discussion of the suggested language until it returns to the definition section and discusses what language to include for a definition of "preexisting condition exclusion period" for STLD plan coverage.

The Subgroup next discussed the NAIC consumer representatives' suggested language prohibiting the inclusion of waiting periods or probationary periods in STLD plan coverage plans and certificates. After discussion, the Subgroup agreed to preliminarily include the language, but revise it to prohibit an "issuer" from including a waiting period or probationary period.

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

Draft: 11/30/22

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
November 14, 2022

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Nov. 14, 2022. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Shari Miles (SC); Rachel Bowden (TX); Tanji J. Northrup, Heidi Clausen, and Shelley Wiseman (UT); Anna Van Fleet, Jamie Gile, and Mary Block (VT); and Ned Gaines (WA).

1. Discussed Proposed Language for Section 8H of Model #171

Before continuing its discussion of potential language to include in Section 8H—Short-Term, Limited Duration Coverage of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), the Subgroup discussed future meeting dates. After discussion, the Subgroup decided to meet on Nov. 28 and, if necessary, Dec. 5. The Subgroup also discussed an upcoming presentation Jackson Williams (Dialysis Patient Citizens—DPC) will be making during the Regulatory Framework (B) Task Force's meeting at the Fall National Meeting. Williams' presentation will focus on a potential consumer disclosure and labeling regime for ancillary health products, which is an issue of interest to the Subgroup because of its anticipated work on revising the consumer notice and disclosure provisions in Model #171.

Arp reiterated her suggested approach discussed during the Subgroup's Oct. 31 meeting to develop minimum benefit standards for short-term, limited-duration (STLD) plan coverage in Section 8H. She asked Subgroup members and interested state insurance regulators for comments. Subgroup members and interested state insurance regulators expressed support for her suggested approach.

The Subgroup discussed the Health Benefits Institute's (HBI's) comments related to minimum standards for STLD coverage in Section 8H. J.P. Wieske (Horizon Government Affairs), speaking on behalf of the HBI, said the HBI believes consumers should be able to expect a minimum standard of benefits for STLD plans that differentiate them from fixed indemnity coverage. He discussed the HBI's suggested language for minimum standards that most insurers are currently providing in the market concerning annual or lifetime limits, coinsurance percentages and family out-of-pocket maximum amounts. After discussion, the Subgroup agreed to incorporate the suggested language in the initial draft language for Section 8H. The Subgroup also discussed possible information that should be included in disclosures related to covered services detailing what is and is not a covered service and providing information on out-of-pocket maximums and annual lifetime limits.

The Subgroup next discussed the HBI's suggested language concerning preexisting condition exclusions and medical underwriting. Arp said the suggested language could overlap with language in Section 6—Prohibited Policy Provisions. Wieske explained why the HBI suggests language prohibiting an insurer from re-underwriting until all renewal periods elected for that coverage have ended. The Subgroup discussed the issue. After discussion, the Subgroup agreed to preliminarily accept the suggested language with one revision—deleting the word "coverage" and replacing it with the word "plan." The Subgroup also said that disclosures for these products should include clear statements regarding guaranteed renewability, how many times the policy can be renewed, and whether there is medical re-underwriting at renewal.

The Subgroup next discussed the HBI's comments suggesting that Section 8H include a provision to address network standards for those STLD plans that offer coverage through preferred provider networks. Wieske

explained that the HBI does not intend that such standards be the same for STLD plans as major medical insurance policies and federal Affordable Care Act (ACA) plans, but the HBI believes that if an STLD plan uses a preferred provider network to provide coverage that, as a minimum standard, the network is sufficient in number and types of providers to assure covered individuals' access to all covered health care services without unreasonable delay. The Subgroup discussed the comments. The Subgroup did not reach a definitive decision on whether to include any language in Section 8H on this issue, but generally, the Subgroup agreed that if an STLD plan offers a network benefit, or includes information about network benefits, insureds should be able to access that benefit. In addition, the Subgroup agreed that if any language is added in Section 8H related to network benefits, the language should probably also include information on any balance billing protections.

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

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Draft: 11/22/22

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
October 31, 2022

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Oct. 31, 2022. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Chris Struk and Shannon Doheny (FL); Camille Anderson-Weddle and Amy Hoyt (MO); Shari Miles (SC); Rachel Bowden (TX); Tanji J. Northrup and Shelley Wiseman (UT); Anna Van Fleet, Jamie Gile, Emily Brown, and Mary Block (VT); and Ned Gaines (WA).

1. Discussed Comments on Section 8E of Model #171

Before continuing its discussion of the Texas Department of Insurance (DOI) comments received on Section 8E—Specified Disease Coverage of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), Arp reminded the Subgroup and other stakeholders that the Subgroup is requesting comments on the remaining sections of Model #171 on or before Nov. 18. She also said that moving forward, the Subgroup's meetings will extend another 30 minutes to last no more than 90 minutes.

The Subgroup revisited its discussion of the Texas DOI comments suggesting that Section 8E(1)(g) clarify the applicability of utilization review requirements to medical necessity determinations under this provision. Arp said because the *Utilization Review and Benefit Determination Model Act* (#73) specifically applies only to health benefit plans and excludes excepted benefit plans, she said adding language to Section 8E(1)(g) requiring utilization review of medical necessity would cause a conflict. After discussion, the Subgroup decided to add a drafting note to this provision to alert states about the issue and to review their laws. The Subgroup also decided that it would revisit the issue if someone developed language for the Subgroup's consideration addressing the issue.

The Subgroup next discussed the Texas DOI's comments on Section 8E(2)(h) suggesting the Subgroup consider adding language noting that excepted benefits may not be "excess only" or otherwise condition benefits on the insured having other coverage. After discussion, the Subgroup decided to leave the provision unchanged because the current language addresses the issue. The Subgroup discussed the Texas DOI's comments for Section 8E(3)(b) and the introductory language for Section 8E(4). The Subgroup decided the suggested changes were not necessary.

The Subgroup next discussed the American Council of Life Insurers (ACLI), America's Health Insurance Plans (AHIP), and the NAIC consumer representatives' comments on Section 8F—Specified Accident Coverage suggesting deleting the specific dollar amounts and replacing them with a bracketed "x" to give states discretion to decide what dollar amounts are appropriate for their state. Consistent with its previous decisions related to similar suggestions, the Subgroup accepted the suggested revisions.

The Subgroup next discussed Section 8G—Limited Benefit Health Coverage. Arp said the NAIC consumer representatives suggest deleting Section 8G. She said the Subgroup cannot delete this provision because Section 5B of the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170), the companion model act to Model #171, requires Model #171 to establish minimum standards for limited benefit health coverage. Bowden discussed the Texas DOI's comments on Section 8G. She suggested that this provision is needed to provide discretionary authority to the states to approve supplementary products that do not meet the minimum benefit standards to be considered a specific type of supplementary products, such as a specified

disease product. After additional discussion, the Subgroup decided to leave the language in Section 8G unchanged. However, when the Subgroup starts reviewing and considering revisions to Model #171's disclosure provisions, the Subgroup will consider what type of information should be included in disclosures for limited benefit health products in order to provide consumers with sufficient information to make informed decisions on whether this product meets their needs and is appropriate for them to purchase.

Lucy Culp (Leukemia & Lymphoma Society—LLS) asked the Subgroup to consider delaying the Nov. 18 public comment deadline to receive comments on the remaining sections of Model #171. She said the NAIC consumer representatives would like to delay the public comment period until the Subgroup finishes its work on Section 8 because until the Subgroup completes its review, the NAIC consumer representatives are not sure what revisions have been made to Model #171 to date. Because of this, they believe they cannot submit fully informed comments on the remaining provisions, particularly the disclosure provisions. After discussion, the Subgroup decided not to extend the public comment period deadline because the Subgroup wants to immediately begin work on the comments received on the remaining Model #171 sections as soon as it finishes its work on Section 8 and Section 6—Prohibited Policy Provisions. The Subgroup directed NAIC staff to distribute the annotated comment chart reflecting the Subgroup's discussions to date on the comments received on Sections 1 through 8. NAIC staff will also distribute the current working draft of Model #171 reflecting the Subgroup's work up to February.

The Subgroup next discussed its potential approach to developing minimum benefit standards for short-term, limited-duration (STLD) coverage in Section 8H. Assuming the state allows this product to be sold in their market, Arp noted the differences among the states in how they regulate them. She said because of these differences, she believes the Subgroup should take a broad approach in developing minimum benefit standards for this coverage. For discussion during its next meeting, she suggested the Subgroup think about adding language to Section 8H linking the minimum benefit standards to the benefit requirements states have for these products, particularly those benefits required for major medical products before the enactment of the federal Affordable Care Act (ACA). The Subgroup discussed her suggestions, noting that whatever minimum benefit standards the Subgroup includes in Section 8H, they need to be coupled with the disclosure requirements for these products. The Subgroup plans to continue its discussion during its next meeting Nov. 14.

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

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Draft: 11/1/22

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
October 18, 2022

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Oct. 18, 2022. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Chris Struk and Shannon Doheny (FL); Camille Anderson-Weddle (MO); Shari Miles (SC); Rachel Bowden (TX); Heidi Clausen (UT); Anna Van Fleet, Jamie Gile, and Mary Block (VT); and Ned Gaines (WA).

1. Discussed Comments on Section 8E of Model #171

The Subgroup continued its discussion of the comments received on Section 8E—Specified Disease Coverage of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). The Subgroup discussed an issue from its Sept. 29 meeting on whether it needed to consider revisions to Section 8E to clarify hospice care and home health care. After extensive discussion, the Subgroup agreed to add the following language in a new subparagraph to Section 8E(4), which concerns cancer-only coverage: "Hospice services, as defined paragraph (2)(m) above, for cancer coverage."

The Subgroup next turned to the Texas Department of Insurance (DOI) comments on Section 8E. Bowden explained her rationale for suggesting that the Subgroup consider developing a definition of "disease." She acknowledged that developing such a definition would be difficult and as such, she would not push to have the Subgroup add the definition.

Bowden next discussed her comments suggesting that language be added to Section 8E to limit the number of specified diseases that may be covered because she has seen some policies that appear to be designed to be sold alongside an accident-only policy and marketed as comprehensive coverage. The Subgroup acknowledged that there is an issue with how these products may be marketed but decided not to add language to Section 8E to address. The Subgroup decided to address the issue when it started its review of disclosure provisions in Model #171.

The Subgroup next discussed Bowden's comments on Section 8E(1)(e) concerning the terms "waiting period" and "probationary period." Bowden said she suggests the Subgroup consider defining these terms. She said the Subgroup should also consider clarifying: 1) whether premium is being paid during the period; 2) whether a condition will be considered a preexisting condition if it arises during these periods; and 3) how these two types of periods interact. Arp noted that these terms are discussed in Section 7A—Prohibited Policy Provisions. The Subgroup discussed various ways these types of periods are applied. After discussion, the Subgroup did not take any action on the Texas DOI's comments, but the Subgroup agreed to return to these comments if it receives comments later that there is confusion on the meaning of these terms and how they are used by employers and for insurance purposes.

Bowden next discussed her comments on Section 8E(1)(f) suggesting the Subgroup clarify what happens if an individual after enrollment in a specified disease policy becomes eligible for Medicaid. The Subgroup discussed her comments. After discussion, the Subgroup decided that Bowden's concerns were addressed due to the Subgroup's acceptance of comments from the NAIC consumer representatives to add a drafting note to this provision clarifying this issue. In addition, because this provision specifically references "an application or

enrollment form" and because specified disease policy benefits cannot be coordinated with any other policy benefits, the Subgroup decided that the suggested language was not needed.

The Subgroup next discussed Bowden's suggestion that Section 8E(1)(g) clarify the applicability of utilization review requirements to medical necessity determinations under this provision. Bowden explained that Texas applies such requirements to all plans that use medical necessity language. However, the NAIC's *Utilization Review and Benefit Determination Model Act* (#73) specifically applies only to health benefit plans and excludes excepted benefit plans. She asked how other states handle this. Van Fleet said Vermont's utilization review requirements are restricted to managed care plans. Bowden asked about the options a consumer would have to resolve a medical necessity dispute if the state's utilization review requirements do not apply to specified disease plans. She also suggested the Subgroup consider adding a drafting note to highlight this issue and suggest the states consider applying their utilization review requirements to excepted benefit plans that have a medical necessity provision.

The Subgroup discussed her comments, noting that the dollar amounts involved in excepted benefit plans are typically low dollar amounts and as such, most likely, companies look at medical necessity differently for excepted benefit plans than for major medical plans. Bowden suggested adding language requiring specified disease plans that use prior authorization to follow the requirements of Model #73. The Subgroup discussed how such language could conflict with Model #73 because Model #73 specifically excludes excepted benefit plans from its requirements. After additional discussion, the Subgroup asked Bowden to draft language for the Subgroup's consideration during its next meeting.

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

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Draft: 10/13/22

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
September 29, 2022

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Sept. 29, 2022. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Chris Struk (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Shari Miles (SC); Rachel Bowden (TX); Heidi Clausen (UT); Anna Van Fleet, Jamie Gile, and Mary Block (VT); and Ned Gaines (WA).

1. Discussed Comments on Section 8E of Model #171

The Subgroup continued its discussion of the comments received on Section 8E—Specified Disease Coverage of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). After discussion, the Subgroup agreed to accept the NAIC consumer representatives' suggestion to delete the word "local" in Section 8E(4)(f). The Subgroup also agreed to add the language "nearest hospital able to appropriately treat the condition" for clarity. The Subgroup did not accept the NAIC consumer representatives' suggested revisions to Sections 8E(4)(g) and 8E(4)(h). After discussion, the Subgroup agreed to make the same revisions to Section 8E(i) related to durable medical equipment as it agreed to make to Section 8E(3)(a)(ix). The Subgroup did not accept the NAIC consumer representatives' suggested revisions to Section 8E(4)(j) because it believed the revisions to Section 8E(4)(f) address their concerns.

After discussion, the Subgroup agreed to delete the sentence in Section 8E(4)(k), which required a physician to certify that hospital confinement would have otherwise been required for the consumer to receive coverage for home health care.

The Subgroup discussed the difference between hospice care and home health care and the requirements necessary to receive coverage for such services. The Subgroup agreed to continue discussion of this issue and consider possible revisions to address it during its next meeting on Oct. 18.

The Subgroup discussed the NAIC consumer representatives' suggested revisions to add language to Section 8E(4) to require a cancer-only policy to include coverage for identifying and maintaining bone marrow donations. The Subgroup did not accept the suggested language because the NAIC consumer representatives' concern is addressed in other accepted revisions.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 8E(5)(a) to remove the dollar amounts and substitute that language with an "X," leaving it up to each state to set the dollar amount. The Subgroup accepted the suggested revisions. The Subgroup also accepted the suggested revisions to delete the reference to "one-half" and replace it with an "X" to allow each state to set the percentage for a fixed-sum payment for the hospital in-patient benefit. The Subgroup agreed to make a similar revision to Sections 8E(5)(b)(i) and 8E(5)(b)(ii). The Subgroup decided to accept the NAIC consumer representatives' suggested revision to Section 8E(5)(b) to delete the word "confinement" and substitute the words "receipt of care." The Subgroup did not accept the NAIC consumer representatives' suggestion to delete the language in Section 8E(5)(b), making the provision optional. In addition, because the Subgroup did not accept that language, the Subgroup did not accept the NAIC consumer representatives' suggestion to delete Section 8E(5)(b)(iv).

The Subgroup discussed the NAIC consumer representatives' suggested revisions to the drafting note in Section 8E(6)(a). After discussion, the Subgroup decided to revise the language as follows: "**Drafting Note:** Policies that

offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should avoid approving these policies in light of the fact that these policies are not intended to be comprehensive coverage and are not intended to be sold as such. Policies offering extremely low dollar amounts, however, may offer illusory coverage that may not be understood by consumers."

The Subgroup discussed but did not accept the NAIC consumer representatives' suggested revisions to Section 8E(6)(b), including its drafting note.

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

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Draft: 9/21/22

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
September 12, 2022

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Sept. 12, 2022. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Chris Struk (FL); Camille Anderson-Weddle and Amy Hoyt (MO); Rachel Bowden (TX); Shelley Wiseman (UT); and Anna Van Fleet and Jamie Gile (VT).

1. Discussed Comments on Section 8 of Model #171

The Subgroup continued its discussion of the comments received on Section 8E—Specified Disease Coverage of the Model Regulation to Implement the *Accident and Sickness Insurance Minimum Standards Model Act* (#171). After additional discussion, the Subgroup agreed to not accept the NAIC consumer representatives' suggestion to delete the reference to "reinstatement" in Section 8E(2)(e) because providing the option for carriers to reinstate a policy rather than cancelling a policy is more consumer friendly. The Subgroup also decided not to accept the NAIC consumer representatives' suggestion to add language to Section 8E(2)(m)(i) to add language and a drafting note clarifying the benefits that should be included in "a formal program of care" for the purposes of hospice care, such as the benefits covered in the Medicare hospice program. The Subgroup decided that adding this language detailing what benefits should be included for hospice care could have unintended consequences for consumers in accessing their policy benefits. The Subgroup discussed and agreed to accept the NAIC consumer representatives' suggested clarifying revisions to Section 8E(2)(m)(ii).

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 8E(3)(a)(ii) concerning the type of health care professional who can provide treatment to trigger a policy event allowing a consumer to access benefits. The Subgroup decided to revise the provision to state: "Treatment by a licensed physician, surgeon, or other health care professional acting within the scope of their license." The Subgroup also decided to add a drafting note for this provision alerting states to review their state laws to determine whether, in adopting this provision, the state should use the word "acting" or "performing."

The Subgroup continued its discussions of the NAIC consumer representatives' suggested revisions to Section 8E(a). The Subgroup took the following action: 1) revised Section 8E(3)(a)(iii) to reference a "licensed" nurse; 2) revised Section 8E(3)(a)(iv) to state: "Tests, procedures, and other medical services and supplies used in the diagnosis and treatment"; 3) accepted the suggestion to delete references to "local" in Section 8E(3)(a)(v); 4) accepted the suggestion to delete Section 8E(3)(a)(viii) because "iron lungs" are no longer used; and 5) revised Section 8E(3)(a)(ix) to delete the references to "braces, crutches and wheel chairs" and replace them with a reference to "durable medical equipment." The Subgroup did not accept the NAIC consumer representatives' suggestion to add language related to costs associated with transplants or their suggested changes to Section 8E(3)(a)(xi).

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 8E(4). The Subgroup agreed to make the same revisions to Section 8E(4)(a) as it made to Section 8E(3)(a)(ii). The Subgroup decided to accept the NAIC consumer representatives' suggestions concerning chemotherapy, but it decided it would be more appropriate to add that language to Section 8E(4)(e), which refers to drugs and medicines prescribed by a physician. The Subgroup decided not to add the suggested new language on palliative care services to Section 8E(4) because Subgroup members were concerned that adding such specificity could cause unintended consequences.

The Subgroup plans to continue its discussions of Section 8E during its next meeting on Sept. 29.

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

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Draft: 9/15/22

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
August 29, 2022

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Aug. 29, 2022. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Chris Struk (FL); Amy Hoyt (MO); Shari Miles (SC); Rachel Bowden (TX); Heidi Clausen and Tanji J. Northrup (UT); Anna Van Fleet, Jamie Gile, and Mary Block (VT); and Ned Gaines (WA).

1. Discussed its Future Work

Ms. Arp outlined the Subgroup's planned work over the next few months. She said after the Subgroup finishes its work on Section 8C—Disability Income Protection Coverage of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), she and Mr. Schallhorn plan for the Subgroup to complete its discussion and work on the following sections in this order: 1) the remainder of Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits; 2) Section 7—Prohibited Policy Provisions; 3) Section 5—Definitions and Section 6—Policy Definitions; and 4) Section 9—Required Disclosure Provisions.

Ms. Arp explained that as part of the Subgroup's work to complete its review and discussion of Section 8, the Subgroup would have to consider its approach to Section 8G—Limited Benefit Health Coverage, which seems to be a catch-all for supplementary products that do not fit into any other product category described in Section 8. Chris Petersen (Arbor Strategies LLC) said the Subgroup cannot eliminate Section 8G because Section 5—Minimum Standards for Benefits of the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170), Model #171's companion model act, requires Model #171 to include regulatory language establishing minimum benefits for limited benefit health coverage. Ms. Bowden said even though the Subgroup cannot delete Section 8G, the Subgroup could consider alternative language than what is currently in that subsection.

Ms. Arp said the Subgroup's next task will be to discuss language for the new Section 8H—Short-Term, Limited-Duration Health Insurance Coverage. She said the Subgroup has received comments on this new subsection. She suggested that the Subgroup review those comments. She also suggested that because the states have taken different approaches in regulating short-term, limited-duration (STLD) plans, the Subgroup may want to think about not including specific minimum standards for these types of plans, but instead include general language providing that if a state allows it—unless a state provides otherwise—these plans must include the same provisions and benefits major medical health insurance plans were required to include prior to the enactment of the federal Affordable Care Act (ACA) and any additional benefits a state may specially require. She asked the Subgroup to consider her suggestion and be ready to discuss it during a future Subgroup meeting.

2. Continued Discussion of Suggested Revisions to Section 8C of Model #171

The Subgroup *co*ntinued its discussion from its July 11 meeting on suggested revisions to Section 8C. Ms. Arp said Robert Wake (ME) submitted comments on the suggested revisions. She said for clarity and flexibility, Mr. Wake suggested deleting "weekly or monthly" in the introductory paragraph and replacing it with "no less than monthly." After discussion, the Subgroup agreed to add the language to the suggested revisions. Ms. Arp said Mr. Wake raised concerns about the definitional nature of this provision. The Subgroup deferred discussion of this issue until Mr. Wake could participate in the discussion and until the Subgroup discusses the definition sections.

The Subgroup next discussed adding a drafting note to Section 8C(1) explaining why the reference to page 62 was deleted. After discussion, the Subgroup agreed to add such a drafting note. The Subgroup also discussed adding a drafting note to Section 8C(2) concerning the length of the elimination period. After discussion, the Subgroup agreed to add a drafting note clarifying that the elimination period cannot exceed 50% of the benefit period.

3. Continued Discussion of Comments on Section 8 of Model #171

The Subgroup continued its discussion of the comments received on Section 8 beginning with Section 8D—Accident Only Coverage. Ms. Arp said the American Council of Life Insurers (ACLI), America's Health Insurance Plans (AHIP), and the NAIC consumer representatives submitted comments suggesting that the specific benefit dollar amounts be replaced with a bracketed "[X]" to permit the states to set what they believe is the appropriate benefit amount. The Subgroup agreed to accept this suggested revision.

The Subgroup discussed the Texas Department of Insurance's (DOI's) suggestion to add a drafting note to Section 8D explaining that accident-only coverage cannot include sickness or wellness benefits, and if an accident-only policy includes such benefits, the policy would potentially not be treated as an excepted benefit. The Subgroup discussed how this suggested revision could conflict with provisions in federal law and the NAIC models, allowing insurers to combine excepted benefit-type policies, and offer them to consumers as a package. The Subgroup also discussed issues with using the term "wellness" and confusion with benefits being provided on an expense-incurred basis. The Subgroup discussed whether the drafting note raises broader issues and touches on other products, not just accident-only coverage. The Subgroup deferred taking action on the Texas DOI suggested revision, but it acknowledged that it would possibly be appropriate in another section of Model #171 to include a drafting note on the issue of combining excepted benefit-type products to assist state DOI form filing reviewers.

Mr. Petersen suggested adding a drafting note at the end of Section 8 stating that Model #171 permits the combining of excepted benefit-type products described in this section. The drafting note could also state that combining other types of products not described in this section could cause the product not to be considered an excepted benefit-type product, and major medical insurance requirements may apply. Jack Friou (Tangent Point Solutions) suggested adding the potential drafting note to Section 8G. The Subgroup agreed to discuss Mr. Petersen's suggested drafting note when it discusses the comments received on Section 8G.

The Subgroup next discussed Section 8E—Specified Disease Coverage. The Subgroup agreed that it would accept the comments suggesting that the specific benefit amounts be deleted and replaced with a bracketed "[X]." Ms. Arp said the NAIC consumer representatives suggest additional revisions. Anna Schwamlein Howard (American Cancer Society Cancer Action Network—ACS CAN) said the NAIC consumer representatives suggest adding a drafting note to Section 8E(2)(f) clarifying that individuals who have already purchased a specified disease policy and become eligible for a Title XIX program would not prohibit the individual from utilizing the benefits of the policy. The Subgroup agreed to add the suggested drafting note.

The Subgroup next discussed the NAIC consumer representatives' suggestion to delete the reference to "short-term health insurance" in Section 8E(2)(d). After discussion, the Subgroup agreed to delete the reference as unnecessary because requirements for "short-term health insurance" will be established in another subsection in Section 8. The Subgroup next discussed the NAIC consumer representatives' suggestion to delete the reference to "reinstatement" in Section 8E(2)(e). The Subgroup discussed the reinstatement process to understand why a waiting or probationary period may be needed for a reinstatement. The Subgroup concluded that such a provision may need to apply to reinstatement because an individual is generally not medically underwritten when a policy is reinstated. After additional discussion, the Subgroup decided to defer deciding on this suggested revision until it could obtain additional information from industry.

The Subgroup next discussed the NAIC consumer representatives' suggestion to add the word "specified" and place brackets around "six (6)" in Section 8E(2)(k). Ms. Howard explained the NAIC consumer representatives' rationale for its suggestions. The Subgroup discussed the suggested revisions. Mr. Petersen suggested that instead of accepting the suggested revisions, the Subgroup should cross-reference the language in Model #170 concerning the definition of "preexisting condition." After additional discussion, the Subgroup did not accept the NAIC consumer representatives' suggested revisions for Section 8E(2)(k), particularly because adding "specified" could cause confusion.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 8E(2)(m)(i) to add language and a drafting note clarifying the benefits that should be included in "a formal program of care" for the purposes of hospice care, such as the benefits covered in the Medicare hospice program. The Subgroup did not decide on the suggested revisions but decided to discuss the suggested revisions further during its next meeting on Sept. 12.

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

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Draft: 8/24/22

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Portland, Oregon
August 11, 2022

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Portland, OR, Aug. 11, 2022. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jane Beyer, Vice Chair (WA); Erin Klug (AZ); Cara Cheevers, Kate Harris, and Debra Judy (CO); Kurt Swan (CT); Howard Liebers (DC); Donna Lambert and Chantel Allbritton (AR); Elizabeth Nunes (AZ); Andria Seip (IA); Craig VanAalst, LeAnn Crow, Kenneth Scott, and Tate Flott (KS); Mary Kwei (MD); Peter Brickwedde and Sara Payne (MN); Jo LeDuc, Carrie Couch, and Amy Hoyt (MO); Ted Hamby, Angela Hatchell, and Kathy Shortt (NC); Chrystal Bartuska (ND); Laura Arp (NE); David Bettencourt and Maureen Belanger (NH); Ralph Boeckman and Erin Porter (NJ); Paige Duhamel (NM); Daniel Bradford and Jana Jarrett (OH); Rebecca Ross and Ashley Scott (OK); Lindsi Swartz (PA); Glynda Daniels (SC); Candy Holbrook and Jill Kruger (SD); Rachel Bowden (TX); Heidi Clausen and Tanji J. Northrup (UT); Don Beatty, Julie Blauvelt, Julie Fairbanks, and Brant Lyons (VA); Barbara Belling and Diane Dambach (WI); Joylynn Fix and Erin K. Hunter (WV); and Tana Howard (WY). Also participating was: Weston Trexler (ID).

1. Heard an Expert Presentation on Parity Issues from The Kennedy Forum

David Lloyd (The Kennedy Forum) said he would discuss emergency services and the crisis hotline 988 that recently went live. He said there should be a continuum of services for responding to behavioral health crises or emergencies. The continuum includes crisis call centers, mobile crisis teams, and crisis stabilization services, or somewhere to go for observation. He said federal and state entities are working to build this continuum using various funding sources, but to date, commercial insurance has not been a part of the conversation.

Mr. Lloyd said that under the federal No Surprises Act (NSA), coverage of behavioral health emergency services in a facility is required. He said coverage in facilities should be the same as physical health emergencies, with no prior authorization or network limits. He said the NSA leaves open the question of mobile services, but the MHPAEA applies if the services are classified as emergency services.

Mr. Lloyd described Washington's guidance to require coverage of emergency behavioral health services across the continuum and said The Kennedy Forum agrees with the state's analysis.

Ms. Duhamel asked about emergency transportation for behavioral health crises and how they would be considered in MHPAEA analyses. Mr. Lloyd said other federal laws may be applicable, including the NSA and the federal Emergency Medical Treatment and Labor Act (EMTALA). He said plans would need to justify exclusion of emergency transportation if they do not cover it for mental health emergencies. Ms. Duhamel asked about independent free-standing emergency departments. Mr. Lloyd said coverage for emergency services at state-licensed facilities providing emergency services is required without regard to whether the emergency is due to physical or mental health.

2. Heard Presentations from Representatives of Mental Health Care Providers

Alan Nessman (American Psychological Association—APA) said psychologists have left insurance networks due to low payment and bad treatment from insurers. He said the big issues are network adequacy, payment parity, and harassment of psychologists.

Mr. Nessman said state insurance regulators should always seek quantitative measures because it is easier to be misleading in qualitative statements. He said payment should be measured based on actual amounts paid—not scheduled rates—and focus on the most commonly billed codes.

Connie Galietti (APA) said the 60-minute psychotherapy code has been paid the same as 45-minute codes by some insurers. She said some issuers have changed this, sometimes after inquires from the state insurance commissioner. She said insurers have sent letters or audited records of psychologists who use this code.

Mr. Nessman said network adequacy is not specifically listed in federal regulations as a non-quantitative treatment limitation (NQTL), but it is important to measure. He said specialties must be considered in network measurement and which providers are accepting new patients.

Ms. Galietti said psychologists must deal with excessive burden from insurers, which makes them want to leave insurer networks. She said psychologists have seen an increase in audits, sometimes prepayment, with uncertainty as to whether the same practices apply to medical services. She said credentialing delays can limit network participation, and some insurers require proprietary telehealth networks.

Ms. Klug asked for clarification on prepayment audits. Ms. Galietti said insurers seek to review the entire patient record before they process a claim. Mr. Nessman said it is reasonable to ask about symptoms or diagnosis, but not the entire patient record. Elyse Mowle (federal Centers for Medicare & Medicaid Services—CMS) asked about the letters insurers send referencing certain codes. Mr. Nessman said insurers send letters to psychologists to point out when they bill certain codes more often than peers. He said prepayment audits are more intrusive and can be repeated over time.

Roger Smith (American Association of Marriage and Family Therapists—AAMFT) said marriage and family therapists (MFTs) are licensed in all states and Washington, DC, and provide services to individuals, as well as couples and families. He said major issues therapists have identified include narrow networks with insufficient providers, low payment rates, and telehealth payments lower than in-person rates. He said other issues include denying treatment, clawing back payments, and family therapy codes not being recognized or paid lower by some insurers. He said a survey by the Washington affiliate of AAMFT raised issues with empaneling providers and limits on family therapy services.

Having no further business, the MHPAEA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

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