

Revised: 3/6/24

2024 Spring National Meeting  
Phoenix, Arizona

**REGULATORY FRAMEWORK (B) TASK FORCE**

Saturday, March 16, 2024

11:30 a.m. – 12:30 p.m.

Sheraton Phoenix Downtown—Valley of the Sun Ballroom C-E—Level 2

**ROLL CALL**

Glen Mulready, Chair	Oklahoma	Chlora Lindley-Myers	Missouri
Dana Popish Severinghaus, Vice Chair	Illinois	Eric Dunning	Nebraska
Mark Fowler	Alabama	Scott Kipper	Nevada
Lori K. Wing-Heier	Alaska	D. J. Bettencourt	New Hampshire
Peni “Ben” Itula Sapini Teo	American Samoa	Justin Zimmerman	New Jersey
Ricardo Lara	California	Mike Causey	North Carolina
Michael Conway	Colorado	Jon Godfread	North Dakota
Andrew N. Mais	Connecticut	Judith L. French	Ohio
Karima M. Woods	District of Columbia	Andrew R. Stolfi	Oregon
Dean L. Cameron	Idaho	Michael Humphreys	Pennsylvania
Amy L. Beard	Indiana	Larry D. Deiter	South Dakota
Doug Ommen	Iowa	Cassie Brown	Texas
Vicki Schmidt	Kansas	Jon Pike	Utah
Sharon P. Clark	Kentucky	Scott A. White	Virginia
Robert L. Carey	Maine	Mike Kreidler	Washington
Gary D. Anderson	Massachusetts	Allan L. McVey	West Virginia
Grace Arnold	Minnesota	Nathan Houdek	Wisconsin

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

**AGENDA**

1. Consider Adoption of its 2023 Fall National Meeting Minutes Attachment One  
—*Commissioner Glen Mulready (OK)*
2. Consider Adoption of its Subgroup and Working Group Reports
  - A. Accident and Sickness Insurance Minimum Standards (B) Subgroup  
—*Andrew Schallhorn (OK) and Rachel Bowden (TX)*
  - B. Employee Retirement Income Security Act (ERISA) (B) Working Group  
—*Robert Wake (ME)*
  - C. Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group  
—*Erica Weyhenmeyer (IL)*



3. Receive an Update on the Accident and Sickness Insurance Minimum Standards (B) Subgroup's Work—*Andrew Schallhorn (OK)*
4. Discuss Embedded Insurance Code Provisions Regarding Health Savings Accounts (HSAs)  
—*J. Kevin McKechnie (Executive Director, American Bankers Association [ABA] HSA Council) and Jeffrey M. Klein (ABA HSA Council)*
5. Discuss Draft Revised 2024 Charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's Successor Group—*Commissioner Glen Mulready (OK)*
6. Hear Information on World Hypertension Day—*J. P. Wieske (Horizon Government Affairs, representing Jazz Pharmaceuticals)*
7. Discuss Any Other Matters Brought Before the Task Force  
—*Commissioner Glen Mulready (OK)*
8. Adjournment

**Agenda Item #1**

**Consider Adoption of its 2023 Fall National Meeting Minutes**  
**—Commissioner Glen Mulready (OK)**

## Draft Pending Adoption

Draft: 12/7/23

Regulatory Framework (B) Task Force  
Orlando, Florida  
December 1, 2023

The Regulatory Framework (B) Task Force met in Orlando, FL, Dec. 1, 2023. The following Task Force members participated: Sharon P. Clark, Chair (KY); Glen Mulready, Vice Chair (OK); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Yada Horace (AL); 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 (ID); Amy L. Beard represented by Alex Peck, Meghann Leaird, and Claire Szpara (IN); Vicki Schmidt (KS); Gary D. Anderson represented by Niels Puetthoff (MA); Timothy N. Schott represented by Marti Hooper and Robert Wake (ME); Grace Arnold represented by Peter Brickwedde (MN); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Maggie Reinert and Michael Muldoon (NE); D.J. Bettencourt (NH); Justin Zimmerman represented by Paul Lupo (NJ); Judith L. French represented by Laura Miller (OH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Shannen Logue (PA); Larry D. Deiter represented by Jill Kruger and Travis Jordan (SD); Jon Pike (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Ned Gaines, Jane Beyer, and Lichiou Lee (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey represented by Joylynn Fix (WV). Also participating were: Erica Weyhenmeyer (IL); Carrie Couch and Camille Anderson-Weddle (MO); Paige Duhamel (NM); and Patrick Smock (RI).

### 1. Adopted its Sept. 29 and Summer National Meeting Minutes

The Task Force met Sept. 29 and took the following action: 1) adopted its 2024 proposed charges; and 2) adopted the white paper *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation* (PBM white paper).

Keen made a motion, seconded by Commissioner Mulready, to adopt the Task Force's Sept. 29 (Attachment One) and Aug. 13 minutes (see *NAIC Proceedings – Summer 2023, Regulatory Framework (B) Task Force*). The motion passed unanimously.

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

Kruger made a motion, seconded by Kosky, to adopt the following reports: 1) the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Oct. 2 (Attachment Two), Sept. 18 (Attachment Three), and Aug. 21 (Attachment Four) minutes; 2) the Employee Retirement Income Security Act (ERISA) (B) Working Group; 3) the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Aug. 14 (Attachment Five) minutes; and 4) the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. The motion passed unanimously.

### 3. Heard a Presentation from the HIV+Hepatitis Policy Institute on the Results and Impact of the Copay Accumulator Adjustment Programs Lawsuit

Carl Schmid (HIV+Hepatitis Policy Institute) discussed the results and impact of the copay accumulator adjustment programs lawsuit, which challenged a federal rule that allows health insurers to avoid counting the value of drug manufacturer copay assistance toward patients' out-of-pocket cost obligations. He discussed the U.S. District Court for the District of Columbia's Sept. 29 decision vacating the 2021 Notice of Benefit and Payment Parameters (NBPP) to the extent it permitted health plans to use a copay accumulator policy. Schmid said the court based its ruling on both the federal rule's contradictory reading of the same statutory and regulatory language and the fact

## Draft Pending Adoption

that the federal agencies implementing the rule had yet to offer a definitive interpretation of its language that would support their authorization of copay accumulators.

Schmid explained that the HIV+Hepatitis Policy Institute believes that by its decision, the court fully understood and stated how copay assistance and accumulators work in practice: 1) increase consumer costs; 2) increase manufacturer costs; 3) increase payments to insurers; and 4) is not a discount from the cost of the prescription drug. He said the court also did not accept the federal government's argument that the case was not justiciable. He said the court's decision did not address issues such as: 1) the Internal Revenue Service's (IRS') guidance on copay assistance and high deductible health plans (HDHPs) and health savings accounts (HSAs); and 2) insurers collecting more money than permitted under the federal Affordable Care Act's (ACA's) cost-sharing limits and double billing. Schmid discussed steps after the decision. He said that because the court did not stay its decision, the decision was immediately effective.

Schmid said that on Nov. 28, the federal U.S. Department of Health and Human Services (HHS) filed a notice of appeal with the U.S. Court of Appeals for the D.C. Circuit. In addition, the HHS also filed a motion to clarify the extent of the court's Sept. 29 decision. Specifically, the HHS requested the court confirm it was not required to enforce the 2020 NBPP, which prohibited copay accumulators except where a medically appropriate generic alternative is available.

Trexler asked what, if anything, state insurance regulators should be doing with respect to the decision. Schmid said it is important that the state departments of insurance (DOIs) enforce the decision because the court did not stay its decision.

#### 4. Heard a Presentation from the NABIP on "Cost: The Greatest Barrier to Access"

Jessica Brooks-Woods (National Association of Benefits and Insurance Professionals—NABIP) presented on "Cost: The Greatest Barrier to Access." She said that cost is one of the major issues keeping health insurance brokers up at night because the cost of health care affects access to such care. She said health care utilization is determined by the need for care, whether consumers know that they need care, whether they want to obtain care, and whether care can be accessed. Brooks-Woods noted the connection between the current health care cost trends and access to health care, even for those who have health insurance coverage. She said that according to the 2022 Commonwealth Fund Biennial Health Insurance Survey, about 29% of consumers with employer-based coverage and 44% of those with coverage purchased through the individual market and ACA marketplaces are underinsured.

Brooks-Woods explained that premiums are not the only cost affecting access to care. She said access to care is also affected by increasing out-of-pocket costs for consumers, particularly the differences between out-of-pocket maximums for in-network care and out-of-network care. She said that in an effort to reduce costs and continue to offer health insurance coverage to their employees, employers are increasingly shifting to and choosing to self-insure. Brooks-Woods offered a few suggestions to address the issues, such as identifying the true cost drivers, giving attention to the plight of the underinsured, and focusing on social determinants of health.

Beyer asked about the trend of employers to self-insurance, particularly small employers choosing to offer level-funded plans as a means to self-insure. Brooks-Woods said the NABIP believes the next issue to keep them awake at night is risk, particularly with respect to level-funded plans because of its concern that small employers do not understand their risk exposure and the low level of education they have about the risk associated with such plans when making the decision to offer them to their employees as an alternative to a fully insured plan.

Duhamel said New Mexico also is seeing small employers gravitate toward level-funded plans. She said the New Mexico DOI tries to educate these employers about the loss of state law consumer protections for their employees

## **Draft Pending Adoption**

when offering these plans. She said it is critical that agents and brokers also be educated on the loss of such protections in order for them to educate their clients.

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

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## **Agenda Item #2**

### **Consider Adoption of its Subgroup and Working Group Reports —Commissioner Glen Mulready (OK)**

- *Accident and Sickness Insurance Minimum Standards (B) Subgroup*  
—Andy Schallhorn (OK) and Rachel Bowden (TX)
- *Employee Retirement Income Security Act (ERISA) (B) Working Group—Robert Wake (ME)*
- *Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group*  
—Erica Weyhenmeyer (IL)



*Virtual Meetings*

**ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS (B) SUBGROUP**

February 26, 2024 / February 12, 2024 / January 29, 2024

**Summary Report**

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Feb. 26, Feb. 12, and Jan. 29, 2024. During these meetings, the Subgroup:

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



Draft: 3/7/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup  
Virtual Meeting  
February 26, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Feb. 26, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Christina Jackson (FL); Frank Opelka (LA); Sherry Worth (ME); Camille Anderson-Weddle (MO); Maggie Reinert (NE); Shari Miles (SC); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet, Mary Block, and Jamie Gile (VT); and Ned Gaines (WA).

1. Continued Discussion of the Dec. 1, 2023, Comments Received on Draft Revisions to Model #171

The Subgroup continued its discussion of the Dec. 1, 2023, comments submitted on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)* beginning with the definition of “preexisting condition” in Section 6J. Jolie Matthews (NAIC) reiterated that during its previous discussions of this definition, the Subgroup discussed, but did not make a definitive decision on whether to develop a separate definition of this term for short-term, limited-duration (STLD) plans. Instead, the Subgroup requested that NAIC staff make a note of the issue and have the Subgroup return to it after it completes its review of the entire model. Matthews said that the Oct. 12, 2023, comments include comments from stakeholders on whether to maintain the current definition and apply it to all products regulated under Model #171, including STLD plans or to develop a separate definition for STLD plans. The Subgroup reviewed the comments. After discussion, the Subgroup decided to maintain the current definition and apply it to all products regulated under Model #171, including STLD plans.

The Subgroup next discussed the Schiffbauer Law Office’s suggestion to add the word “illness” to the definition of “sickness” in Section 6L. William Schiffbauer (Schiffbauer Law Office) said he suggests adding the word “illness” for consistency with other language in the draft revisions. After discussion, the Subgroup accepted his suggested revision.

The Subgroup next discussed the NAIC consumer representatives’ suggestion to add “including goods and services” to Section 6M(1), the definition of “total disability.” The Subgroup did not accept the suggested revision for the same reasons it did not accept an identical suggested revision to the definition of “partial disability” in Section 6H(2). The Subgroup discussed the NAIC consumer representatives’ suggestion for Section 6M(2) to delete “may” and substitute “shall.” The Subgroup discussed the impact of the suggested revision, including that it could be detrimental to consumers because it might reduce insurer flexibility in determining a consumer’s ability to perform certain duties in determining whether the consumer is totally disabled. After additional discussion, the Subgroup did not accept the suggested revision.

The Subgroup next discussed the Schiffbauer Law Office’s suggestion to add the word “only” to Section 7A(2) and Section 7A(3) for consistency in referring to an “accident only” policy. The Subgroup accepted the suggested revision.

The Subgroup next discussed the comments received on Section 7D. Matthews explained that some of the comments concerned the note to the Subgroup about clarifying the term “malformed” in Section 7D(5). The Subgroup discussed the comments. After additional discussion, the Subgroup determined that the term needed no clarification and left the provision unchanged. The Subgroup next discussed the NAIC consumer representatives’ comments concerning the permissible exclusion from coverage for “mental or emotional

disorders, alcoholism, and drug addiction” in Section 7D(2). In addition, the NAIC consumer representatives expressed concern with the permissible exclusion from coverage for “suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury” in Section 7D(4)(b).

Lucy Culp (The Leukemia & Lymphoma Society—LLS) said the NAIC consumer representatives strongly object to the inclusion of “mental or emotional disorders, alcoholism, and drug addiction” and “suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury” as allowable exceptions for any type of supplemental or short-term policies. She said that continuing to include this language in Model #171 is not only out of step with advances in the mental health field, but it is also at odds with the NAIC’s commitment to mental health parity and meaningful response to the opioid crisis. The Subgroup discussed the NAIC consumer representatives’ comments, but they did not finish the discussion. The Subgroup plans to continue the discussion during its next scheduled meeting on March 25.

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

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Draft: 3/4/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup  
Virtual Meeting  
February 12, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Feb. 12, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers and Stephen Flick (DC); Christina Jackson (FL); Sherry Worth (ME); Maggie Reinert (NE); Heidi Clausen (UT); Anna Van Fleet and Jamie Gile (VT); and Ned Gaines (WA).

1. Continued Discussion of Dec. 1, 2023, Comments Received on Draft Revisions to Model #171

Before continuing its discussion of the Dec. 1, 2023, comments submitted on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), the Subgroup discussed alternative suggested language for Section 6B(1)(d) to address the issue discussed during its Jan. 29 meeting that assisted living facilities and continued care retirement facilities do not provide continuous 24-hour nursing services. During its Jan. 29 meeting, the Subgroup decided to develop a new definition for these facilities without including the continuous 24-hour nursing provision. Following that meeting, NAIC staff developed and distributed alternative language to address the issue for the Subgroup's consideration. The alternative suggested language carves out assisted living facilities and continued care retirement facilities from the 24-hour nursing requirement in Section 6B(1)(d). After discussion, the Subgroup accepted the NAIC staff's alternative suggested language. Lucy Culp (The Leukemia & Lymphoma Society—LLS) expressed concern with the word "primarily" in Section 6B(1)(c) because not all the facilities listed in Section 6B would "primarily" provide skilled nursing care. After discussion, the Subgroup agreed to delete the word "primarily" from Section 6B(1)(c).

The Subgroup continued its discussion of the Dec. 1, 2023, comments beginning with the NAIC consumer representatives' suggested revision to Section 6C regarding the definition of "hospital." The NAIC consumer representatives suggest removing the provision that allows insurers to exclude a military or veterans' hospital from the definition of "hospital." The NAIC consumer representatives suggest this deletion because it allows for a coverage exclusion for members of the military or veterans. The Subgroup discussed the rationale for retaining the provision. After additional discussion, the Subgroup decided to retain the provision but delete the words "rendered on an emergency basis."

The Subgroup next discussed the NAIC consumer representatives' suggestion to add "including goods and services" to the definition of "partial disability" in Section 6H(2). NAIC staff explained that the Subgroup considered and decided not to accept a similar suggested revision during a meeting on Nov. 19, 2019. Culp said the NAIC consumer representatives are raising this suggested revision again because when the Subgroup discussed it previously, she recalls that the NAIC consumer representative with knowledge of this issue was unavailable to participate. She explained that adding this language would address when an individual providing certain services, such as home health care services, is paid using an alternative payment method like housing or rent. The Subgroup discussed the suggested revision, noting the difficulty insurers would have in putting a value on this type of payment and the potential for fraud. After additional discussion, the Subgroup decided not to accept the suggested revision.

The Subgroup next discussed the NAIC consumer representatives' comments on Section 6I(2), the definition of "physician." The NAIC consumer representatives questioned whether the Subgroup intended to create such a broad exclusion as to the ability of a physician who may be a family member of the insured or have a significant

business interest with the insured to approve and/or certify care for the insured. The Subgroup discussed the rationale for the provision, such as preventing fraud, and why the language might be considered broad. After discussion, the Subgroup decided to leave the provision unchanged.

The Subgroup next discussed Section 6J, the definition of “preexisting condition.” Jolie Matthews (NAIC) explained that during its previous discussions of this definition, the Subgroup discussed but did not make a definitive decision on whether it should develop a separate definition of this term for short-term, limited-duration (STLD) plans. Instead, the Subgroup requested that NAIC staff make a note of the issue and have the Subgroup return to it after it completes its review of the entire model. Matthews said that in requesting comments on the Oct. 12, 2023, draft, the Subgroup received comments from stakeholders on whether to maintain the existing definition should remain unchanged and apply it to all products regulated under Model #171 or to develop a separate definition for STLD plans. The Subgroup deferred additional discussion of Section 6J until its next meeting scheduled for Feb. 26.

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

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Draft: 2/13/24

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

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Jan. 29, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Stephen Flick (DC); Christina Jackson (FL); Frank Opelka (LA); Camille Anderson-Weddle (MO); Martin Swanson (NE); Shari Miles (SC); Shelley Wiseman and Heidi Clausen (UT); Anna Van Fleet, Mary Block, and Jamie Gile (VT); and Ned Gaines (WA).

1. Began Discussion of Dec. 1, 2023, Comments Received on Draft Revisions to Model #171

Before beginning discussion of the Dec. 1, 2023, comments submitted on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), the Subgroup heard an overview of the comments from stakeholders submitting comments—the American Council of Life Insurers (ACLI), America’s Health Insurance Plans (AHIP), the NAIC consumer representatives, the Health Benefits Institute (HBI), and the Schiffbauer Law Office.

Cindy Goff (ACLI) said that as the Subgroup requested, the ACLI’s comments did not revisit previous Subgroup policy decisions. The ACLI’s comments focused on outstanding questions and issues outlined in the draft. She provided an overview of the comments. Chris Petersen (Arbor Strategies LLC), speaking on behalf of AHIP, discussed AHIP’s comments. He said that, like the ACLI, AHIP’s comments focused on the outstanding questions and issues outlined in the draft. J.P. Wieske (HBI) said the HBI’s comments also focused on the outstanding questions and issues outlined in the draft. He said the HBI’s comments also expressed strong support for the Subgroup’s efforts and its express statements not wanting comments from stakeholders on questions and issues the Subgroup already decided.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) said the NAIC consumer representatives also focused on the outstanding issues and questions outlined in the draft. She said, however, that the NAIC consumer representatives have concerns with certain language in the draft, particularly provisions that include “mental or emotional disorders, alcoholism, and drug addiction” and “suicide (sane or insane), attempted suicide or intentionally self-inflicted injury” as allowable exceptions for any type of supplemental or short-term policy. Culp said that continuing to include this language in the model is not only out of step with advances in the mental health field, but it is also at odds with the NAIC’s commitment to mental health parity and meaningful response to the opioid crisis. She urged the Subgroup to revisit this provision and adopt a minimum standard that will protect consumers and align with the values that the states and the NAIC share as it relates to mental health parity. William Schiffbauer (Schiffbauer Law Office) said his comments focused on technical drafting issues.

The Subgroup began its review of the Dec. 1, 2023, comments with comments submitted by the Schiffbauer Law Office on Section 5—Definitions. The comments suggest adding a definition of “excepted benefits” to this section because the term is used in the model. The Subgroup discussed the suggested revision. Some commenters noted that “excepted benefits” are not referenced in the model text, only in drafting notes. After additional discussion, the Subgroup decided to add a definition of “excepted benefits” using the suggested language the first time the term is used in a drafting note.

The Subgroup next discussed the NAIC consumer representatives’ suggested revisions to Section 6B—Policy Definitions. The NAIC consumer representatives suggest removing the word “home” throughout this definition

and replacing it with “facility” to eliminate language no longer used to refer to these types of facilities. The NAIC consumer representatives also suggest revisiting the definition for the terms used in Section 6B(1) or changing the “and” at the end of Section 6B(1)(d) to an “or” because the requirements listed describe a level of care that is inconsistent with the terms they are defining above. Specifically, assisted living facilities and continued care retirement communities do not provide continuous 24-hour nursing. The Subgroup discussed each of the suggested revisions. Some Subgroup members and interested parties expressed concern about removing the word “home” because the term is still being used in in-force policies, and because of that, removing it could cause unintended consequences. The Subgroup also expressed concern with removing the term when there have been no issues with its inclusion to date. After additional discussion, the Subgroup decided not to accept the suggested revision to remove “home.”

The Subgroup discussed the NAIC consumer representatives’ second suggested revision. After discussion, the Subgroup decided not to accept the second suggested revision because of the necessity of needing the “and” to ensure compliance with all the requirements. The Subgroup agreed that the requirements of Section 6B(1)(d) for a facility or home to provide continuous 24-hour nursing would not be consistent with the services provided by an assisted living facility or a continued care retirement facility. The Subgroup noted that these types of facilities were added to the draft and not part of the existing model language. After additional discussion, the Subgroup decided to remove “assisted living facility” and “continued care retirement facility” from Section 6B and develop a new definition for these terms without including the Section 6B(1)(d) continuous 24-hour nursing provision.

The Subgroup next discussed the NAIC consumer representatives’ suggested revision to Section 6C, the definition of “hospital,” to remove a provision that allows insurers to exclude a military or veterans’ hospital from the definition of “hospital.” The NAIC consumer representatives suggest this deletion because it allows for a coverage exclusion for members of the military or veterans. The Subgroup began discussion of the suggested revision, but it deferred taking any action and plans to continue its discussion during the Subgroup’s next meeting scheduled for Feb. 12.

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

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*2024 Spring National Meeting*  
*Phoenix, Arizona*

**MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) (B) WORKING GROUP**

Sunday, March 17, 2024

11:30 a.m. – 12:15 p.m.

**Meeting Summary Report**

The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group will meet March 17, 2024. During this meeting, the Working Group plans to:

1. Head presentations on opioid use disorder and medication for opioid use disorder (MOUD).
2. Adjourn into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues relating to federal legislative and regulatory matters) of the NAIC Policy Statement on Open Meetings, to continue discussion of the opioid use disorder issue.

## Draft Pending Adoption

Attachment **XX**  
Health Insurance and Managed Care (B) Committee  
xx/xx/xx

Draft: 12/11/23

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group  
Orlando, Florida  
December 2, 2023

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Orlando, FL, Dec. 2, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jane Beyer, Vice Chair (WA); Crystal Phelps (AR); Gio Espinosa (AZ); Kate Harris (CO); Kurt Swan (CT); Howard Liebers (DC); Andria Seip (IA); LeAnn Crow and Julie Holmes (KS); Mary Kwei (MD); Paul Hanson (MN); Amy Hoyt (MO); Ted Hamby (NC); Chrystal Bartuska (ND); Sarah Cahn (NH); Paige Duhamel (NM); Kyla Dembowski (OH); Landon Hubbard (OK); Shannon Logue and Lindsy Swartz (PA); Jill Kruger (SD); Ryan Jubber and Shelley Wiseman (UT); Julie Fairbanks (VA); Darcy Paskey and Rebecca Rebholz (WI); Joylynn Fix (WV); and Tana Howard (WY).

### 1. Heard a Panel Discussion on the Tri-Departments' Proposed Rule on Mental Health Parity

Swartz shared news of the death of Sam Muszynski. She recognized the contributions Muszynski made to the passage of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and the compliance tool used to support its implementation. She said he carried the torch of parity for five decades and inspired others to work to improve the lives of those living with mental health and substance use disorders.

Beth Baum (Employee Benefits Security Administration, U.S. Department of Labor—DOL) said the DOL received 9,500 comments on its proposed regulations on mental health parity. She said many comments were very detailed and lengthy and that the DOL would take care in reviewing them.

Weyhenmeyer summarized state regulators' comments on the proposed regulations. She said state regulators focused on the application of the predominant and "substantially all" tests to non-quantitative treatment limits (NQTLs); the exceptions for independent standards and fraud, waste, and abuse; and the collection of outcomes data. She asked the panelists about applying the predominant and substantially all tests to NQTLs.

Meghan Stringer (AHIP) said the organizations' members are committed to making sure their enrollees have access to mental health services. She said AHIP's priority is that patients can access the right care at the right time in the right setting.

Stringer said AHIP believes the predominant and substantially all tests are not appropriate or workable. She said they could prohibit all medical necessity reviews prior to or concurrent with care. She said AHIP agrees with NAIC's comments that the tests could add a substantial burden without proportional benefits in access to care. Kate Berry (AHIP) said health insurers are fully committed to mental health parity. She added that the new terms and tests would shift from processes and standards being the focus of compliance to outcomes. She said much has been done to improve access and quality and more work needs to be done, but AHIP has concerns with the proposed rule's ability to improve access and availability of care.

Tim Clement (American Psychiatric Association—APA) said the predominant test may not be workable in the real world and could be skipped. He said applying the substantially all test would not limit utilization review in the inpatient category. For outpatient benefits, he said the test would increase access and reduce utilization review. He said plans and issuers could meet the substantially all test by designing benefits differently for medical services.



He said some post-payment reviews could be reduced, which would be a benefit. He said the proposed rule is not the end of utilization review.

Lauren Finke (The Kennedy Forum) said the forum is supportive of applying the tests to NQTLs. She said the statute is clear that benefits for mental health should not be more restrictive. She said the rule should stay as close as possible to the statute. She said the tests have been successful for quantitative treatment limits and should be extended to NQTLs.

Weyhenmeyer asked about ways to reduce the burden of applying the tests. Stringer said Fiscal Year 2021 Consolidated Appropriations Act updates to the MHPAEA statute codified tests for NQTLs that were previously in the rules. She said AHIP supports updating those design and application tests. She said those tests would be more workable than the proposed rule. She said the proposal hinders the ability to apply utilization management, requiring a math test rather than clinical evidence. She said building on the current tests could include finding meaningful outcomes data.

Clement said the NQTL language that existed since 2010 is still in place. He said the predominant and substantially all tests have been in the statute since 2008 and apply to treatment limitations. He said it could be argued that those tests should have been in place for 15 years, but he did not endorse this view. He said with creative thinking, the proposed rule would not necessarily transform utilization review. He said there is a way to make it workable and agreed that the work should be built upon the last several years. He said the impacts of the tests would not necessarily be game-changing.

Finke agreed and said state and federal regulators have recently been more successful in holding plans and issuers accountable for compliance. She said a fundamental piece of parity is that NQTLs do limit access. She said the current regulations have been insufficient to hold plans accountable for NQTLs, increasing the burden of mental health. She said the status quo is not acceptable because of inadequate access to care.

Weyhenmeyer asked about exceptions included in the proposed rule. Clement said the exceptions for independent treatment standards or fraud, waste, and abuse are ways to get around the substantially all test. He said these exceptions moderate the test. He said the phrasing of the exceptions could allow almost anything through since almost any limit could be deemed an effort to reduce waste. He urged state insurance departments to narrow the exceptions with more structure on what qualifies as efforts to combat fraud, waste, and abuse.

Finke said independent standards and efforts to combat fraud, waste, and abuse should be embedded into the existing NQTL framework as well as the proposed extensions. She said state insurance departments should establish additional safeguards around the exceptions. She said the exceptions are too open-ended in the proposal and should be incorporated into the existing framework.

Stringer said plans are concerned the exceptions may be too narrow. She said standards of care and combatting fraud, waste, and abuse improve patient care. Because the proposed rule does not fully explain the exceptions, plans remain concerned. AHIP recommends that federal departments adopt Georgia's definition of generally accepted standards of care. Berry supported more emphasis on adding guidelines for standards of care. Stringer said plans are concerned the exceptions may not allow them to address fraud.

Weyhenmeyer asked about the proposal's requirements to collect outcomes data. Finke said the forum supports collecting data to assess the impact of treatment limits. She said standardized data is important and that data on access are rarely collected and analyzed. She said state insurance departments should clarify that mental health and substance use disorder data should be collected and analyzed separately.

Stringer said health plans need to know what data regulators are looking for so they can provide it the first time. She said regulators should develop a definitive list of data to be collected for each NQTL, even if the list is not static. She said plans need to know what to expect and the time to collect needed data. She said not all NQTLs have data that can be easily assessed. She asked for consistency across states, with federal regulators, and across product lines.

Clement agreed that data would not be useful for all NQTLs but said those outlined in the proposed rule do have relevant data. He recommended a fusion between out-of-network utilization data and reimbursement data. He said provider shortages exist for both mental health and physical health providers. He said regulators should compare out-of-network utilization and reimbursement for physical health provider types that have shortages to mental health providers that also have shortages.

Weyhenmeyer asked whether regulators should require plans to submit standardized data. Finke said plans and issuers should be required to submit standardized data. She said regulators should not rely on only process-related measures but instead require outcomes data that directly address disparities.

Stringer outlined AHIP's priorities on outcomes data, including workability, meaningfulness, certainty, and consistency. She said state regulators should use metrics consistent with those in the final federal rule or deem compliance with state standards when federal standards are met.

Clement said regulators should decide how the data are reported. He said organizations are not trying to hide information, but categories, such as denials, can mean different things to different plans. He said more precision is needed in the definition of terms, such as fraud, waste, and abuse.

Finke said the spirit and text of the parity law should be followed. She said medically necessary access to care is the goal, and many aspects of the proposed rule move forward in that direction.

Berry said access and quality in mental health services are important. She said the proposed rules won't move in that direction and instead could erode access to care. She said a collaborative engagement process could improve the proposal.

Having no further business, the Mental Health Parity and Addiction Equity Act (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/MHPAEAWG Min 12.2.docx

### **Agenda Item #3**

**Receive an Update on the Accident and Sickness Insurance Minimum Standards (B) Subgroup's Work—*Andy Schallhorn (OK)***

## **Agenda Item #4**

**Discuss Embedded Insurance Code Provisions Regarding Health Savings Accounts (HSAs)**

**—*J. Kevin McKechnie (Executive Director, American Bankers Association [ABA] HSA Council)*  
*and Jeffrey M. Klein (ABA HSA Council)***



Building Success. Together.

**NAIC Regulatory Framework Task Force**  
**ABA HSA Council Presentation**  
**Spring National Meeting**  
**Phoenix, Arizona**  
**March 16, 2024**

The State Advocacy Team:  
J. Kevin McKechnie  
Jennifer Hatten  
Roy Ramthun  
Jeffrey M. Klein

# State Capitols Update

- **2023 Recap**
  - **Tracked 696 bills**
    - **Mostly benefit mandate/limited cost-sharing bills & copay accumulator bills**
  - **492 died in Committee or failed to advance before adjournment.**
  - **7 bills were vetoed (California, Georgia, Nevada, New Mexico)**
  - **115 bills were enacted**
    - **13 relied on existing carveouts in 8 “vaccine” states**
    - **39 included or were amended with a new carveout**
  - **For bills we monitored, 111 had a carveout of some form noted above**
  - **371 bills carried over to 2024 sessions**

# 2024 State Advocacy Initiatives

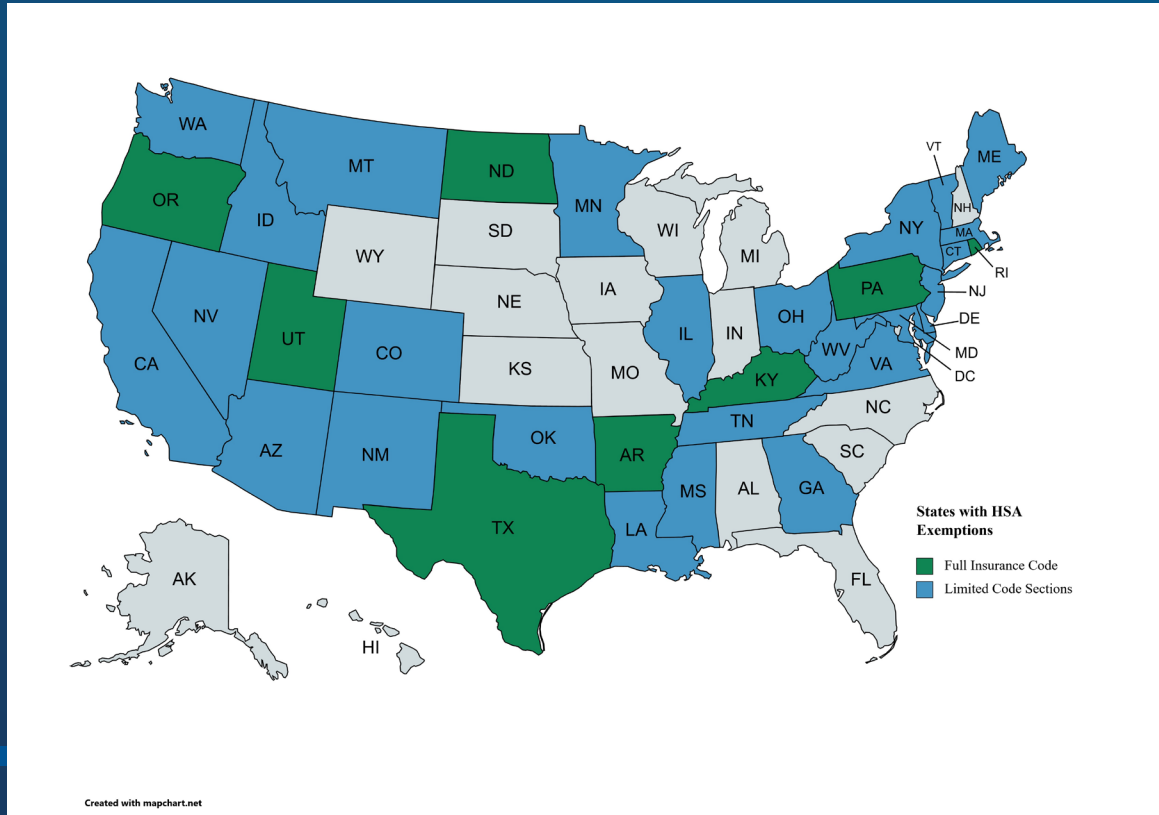
- **Our 2024 Priorities**
  - HIV v. HHS / copay accumulator decision
  - Bankruptcy Reform with assistance from State Bankers Associations
  - Today's topic: Embedded Insurance Code expansion
- **Already tracking over 660 bills for 2024**
- **We have had approximately 35 meetings with DOIs to date.**



# Embedded Insurance Code Provision

- We want to talk to you today about this issue.
- Eight states have one: **Arkansas** (2021-Act 939) , **Kentucky** (KRS Chapter 304, Subtitle 17A. (via Chapter 133/2021), **North Dakota** (Century Code §26.1-36-01.1), **Oregon** (ORS §742.008), **Pennsylvania** (P.S. Title 72, § 3402b.5), **Rhode Island** (Title 27, Chapter 69), **Texas** (Insurance Code § 1653) and **Utah** (Title 31A, Chapter 22, Part 6, §657 (via Chapter 198/2022);
- (See also our Chart distributed and also MAP on next slide)
- Recommending amendments in other states as opportunity arises.
- Outreach to DOIs, legislators, health plans.
- National, “top-down” approach
  - CSG (December 2022)
  - NCOIL Resolution, Columbus, OH, November, 2023

# Embedded Insurance Code Provision



# NCOIL Resolution

- The National Council of Insurance Regulators (NCOIL) Adopted a Resolution in Columbus/November 2024:
- “WHEREAS, NOW, THEREFORE, BE IT RESOLVED, that NCOIL urges states to take action and pass legislation that would protect HSAs and HSA account owners, by providing a ‘carveout’ or exemption, embedded in their insurance code or insurance law, from relevant state benefits mandate and co pay accumulator bills, to ensure consistency with federal law, rules and guidance.”

# CSG Resolution

- The Council of State Governments adopted a Resolution in December, 2022, based at the time on the Arkansas statute:
- HEALTH Arkansas 08-42-10 (SB 664):An Act To Exempt Health Savings Account-Qualified Health Insurance Policies from Certain Insurance Requirements;
- “This bill would ensure that a health insurance plan that is a HSA-qualified plan is exempt from any state law that would cause the plan to be disqualified because the state law requires coverage of and/or cost-sharing for benefits that would cause that plan to fail to meet the definition of a “high deductible health plan” set forth in Section 223(c)(2) of Title 26 of the United States Code.”
- From Sponsor: “This legislation is offered to ensure that health-related legislation does not disqualify a Health Savings Account owner from continuing to make tax-deductible contributions to their HSA.”

# NAIC Regulatory Framework Task Force

- The “Ask”:
- Work with Insurance Departments and other interested parties, to adopt embedded insurance code provisions to protect HSAs.
- This prevents an unintended consequence (and protects HSAs) of well-intended legislation supported by patient advocacy groups and other interested parties, to provide support to enrollees/insureds via state benefit mandate and cost-sharing proposals.
- As we have advocated, this is also for sake of “legislative economy” in view of hundreds of individual state benefit mandate bills considered each year.
- Thank you for your time today and willingness to work with us throughout the year.

## Contact Information:

**J. Kevin A. McKechnie – Executive Director and Founder**

**Jennifer Hatten – Vice President**

**Roy Ramthun – President, HSA Consulting Services, LLC**

**Jeff Klein– McIntyre & Lemon, PLLC**

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## HSA CARVE-OUTS IN

STATE	Citation	Findings/Provisions
<b>ARKANSAS</b>	Arkansas Code Title 23, Chapter 79, Subchapter 1, Section 1 (23-79-164)	<b>23-79-164. Health savings account-qualified health insurance policy — Exemption — Definition.</b> (a) As used in this section, "health savings account-qualified health insurance policy" means a policy of individual or group health insurance coverage that satisfies the criteria for a high deductible health plan under 26 U.S.C. § 223, as it existed on January 1, 2021. (b) A health savings account-qualified health insurance policy is exempt from a prohibition on cost-sharing requirements for a covered benefit that is required under state law to the extent the exemption is necessary to meet the criteria for a health savings account-qualified health insurance policy. (c) This section does not apply to any coverage required by state law that pertains to preventive care as defined by regulation or guidance issued by the United States Department of the Treasury under 26 U.S.C. § 223, as it existed on January 1, 2021, with respect to any health savings account qualified health insurance policy issued, delivered, amended, or renewed while the regulation or guidance issued by the United States Department of the Treasury is effective.
<b>KENTUCKY</b>	2022 HB 317 (Chapter 49); 2021 SB 44 (Chapter 133) and 2021 SB 45 (Chapter 134). Adding KRS 304.17A-255; and KRS 304.17A-164	<b>KRS 304.17A-255 (copay accumulator law)</b> <b>(3)</b> To the extent permitted under federal law, all health benefit plans may accept, and count towards the insured's contributions to any applicable premium or cost-sharing requirement, premium and cost-sharing payments made on behalf of an insured by any person not referenced in subsection (2) of this section. <b>(4)</b> If the application of any requirement of subsection (2) of this section would be the sole cause of a health benefit plan's failure to qualify as a Health Savings Account-qualified High Deductible Health Plan under 26 U.S.C. sec. 223, as amended, then the requirement shall not apply to that health benefit plan until the minimum deductible under 26 U.S.C. sec. 223, as amended, is satisfied.  SB 45 has a weak federal carveout.
<b>NORTH DAKOTA</b>	North Dakota Century Code, Title 26.1	<b>Section. 26.1-36-01.1. Scope - Accident and health insurance policy mandates.</b> Unless expressly provided otherwise, an accident and health insurance policy health coverage mandate under this chapter does not apply to an accident and health insurance policy that is a high-deductible health plan under 26 U.S.C. 223 if the mandate would cause the policy to fail to qualify as a high-deductible health plan under this federal law.
<b>OREGON</b>	ORS Section 742.008	<b>742.008 Health savings account exemption from prohibition on deductible.</b> (1) As used in this section: (a) "Health benefit plan" has the meaning given that term in ORS 743B.005. (b) "Health savings account" means an account established under section 223 of the Internal Revenue Code. (2) This section applies to a health benefit plan that is: (a) Offered by a carrier as a plan that qualifies for a health savings account distribution; and

## HSA CARVE-OUTS IN

STATE	Citation	Findings/Provisions
		<p>(b) Subject to a provision of the Insurance Code that prohibits a health benefit plan from applying a deductible to a specified health care service that is reimbursed by the health benefit plan.</p> <p>(3) The Department of Consumer and Business Services may approve a filing under ORS 742.003 for a health benefit plan described in subsection (2) of this section if:</p> <p>(a) The health benefit plan would be approved but for the failure of the plan to comply with the provision described in subsection (2)(b) of this section;</p> <p>(b) A deductible must be applied to the specified health care service for the plan to qualify for a distribution from a health savings account; and</p> <p>(c) The health benefit plan complies with all other applicable provisions of the Insurance Code.</p> <p>[2018 c.43 §3]</p>
<b>PENNSYLVANIA</b>	P.S. Title 72 Sec. 3402b.5:	<p><b>Section 3402b.5 - Mandated benefits</b></p> <p>(a) General rule.--Except as otherwise provided under subsection (b), a health insurance policy that would qualify as a high deductible health plan under section 223(c)(2) of the Internal Revenue Code of 1986 ( Public Law 99-514, 26 U.S.C. § 223(c)(2) ) shall be subject to any provision of law mandating a minimum health insurance benefit or reimbursement.</p> <p>(b) Exception.--A health insurance policy that would qualify as a high deductible health plan under section 223(c) of the Internal Revenue Code of 1986, when offered in conjunction with a health savings account, shall not be subject to any provision of law which restricts or limits deductibles for mandated minimum health insurance benefits or reimbursements except to the extent such provision mandates benefits for preventive care, as determined by the standards set forth by the Internal Revenue Service.</p>
<b>RHODE ISLAND</b>	R.I. Gen. Laws Title 27 Insurance Chapter 69 Mandated Benefits  § 27-69-3	<p><b>27-69-3. Deductibles and other cost-sharing.</b></p> <p>Notwithstanding anything to the contrary in any mandated benefit law, no mandated benefit law shall be construed to forbid inclusion in any health plan of a provision for any deductible and/or other cost-sharing provisions suitable to qualify a health plan, which may be purchased for use with health savings accounts for a tax preference, as a high deductible health plan or any other similar federal or state tax preference available now or in the future; provided, however, that this section shall not exempt high deductible health plans from any other provision of applicable mandated benefit laws. The commissioner shall retain jurisdiction to approve policies, rates and forms for all high deductible health plans pursuant to the provisions of this title and title 42 of the general laws.</p> <p>History of Section: P.L. 2005, ch. 97, § 5; P.L. 2005, ch. 99, § 5.</p>
<b>TEXAS</b>	Insurance Code Chapter 1653	<p>Sec. 1653.001. DEFINITION. In this chapter, "high deductible health plan" has the meaning assigned by Section 223, Internal Revenue Code of 1986.</p> <p>Sec. 1653.002. APPLICABILITY OF OTHER LAW.</p>



## HSA CARVE-OUTS IN

STATE	Citation	Findings/Provisions
		<p>(a) Subject to Subsection (b), a high deductible health plan is subject to any law mandating a minimum health insurance benefit or reimbursement.</p> <p>(b) Notwithstanding any other law, a provision of this code may not be construed to prevent an insurer, health maintenance organization, or other entity issuing a health insurance policy or certificate of coverage from applying deductible or copayment requirements to benefits, including state-mandated health benefits, in order to qualify the health insurance policy or certificate of coverage as a high deductible health plan.</p> <p>Sec. 1653.003. RULES. The commissioner shall adopt rules necessary to implement this chapter. (Added by Acts 2005, 79th Leg., Ch. 151 (H.B. <a href="#">1602</a>), Sec. 1, eff. May 24, 2005.)</p> <p>2006 adopted rules <a href="#">§§ 21.3901 - 21.3905 in 28 TAC Chapter 21, Subchapter EE</a>, Those rules implement <a href="#">Insurance Code Chapter 1653</a>, which was added by <a href="#">HB 1602 (79R)</a>.</p>
UTAH	2022 HB 31. Chapter laws 198, adopted Title 31A, Chapter 22, Part 6, Section 657)	<p><b>Insurance Code Section 31A-22-657 (2)(a). Insurance benefit mandates carveout. 31A-22-657. Application of health insurance mandates.</b></p> <p>(1) As used in this section:</p> <p>(a) "Cost-sharing requirement" means a copayment, coinsurance, or deductible required by or on behalf of an enrollee in order to receive a benefit under a qualified high-deductible health plan.</p> <p>(b) "Health savings account" means the same as that term is defined in 26 U.S.C. Sec. 223(d)(1).</p> <p>(c) "Qualified high-deductible health plan" means a high-deductible health plan as defined in 26 U.S.C. Sec. 223(c)(2)(A) that is used in conjunction with a health savings account.</p> <p>(d) "Cost-sharing mandate" means a statutory requirement limiting a cost-sharing requirement.</p> <p>(2)(a) Except as provided in Subsection (2)(b), if under federal law, a cost-sharing mandate would result in an enrollee becoming ineligible for a health savings account, the cost-sharing mandate applies only to the enrollee's qualified high-deductible health plan after the enrollee satisfies the enrollee's health plan deductible.</p> <p>(b) Subsection (2)(a) does not apply to an item or service that is preventive care under 26 U.S.C. Sec. 223(c)(2)(C).</p>

08-42-10 An Act To Exempt Health Savings Account-Qualified Health Insurance Policies from Certain Insurance Requirements; [To Clarify The Coverage Of Diagnostic Examination's For Breast Cancer Under Certain Plans; And For Other Purposes].

[SB 664](#)

**Summary:**

This bill would ensure that a health insurance plan that is a HSA-qualified plan is exempt from any state law that would cause the plan to be disqualified because the state law requires coverage of and/or cost-sharing for benefits that would cause that plan to fail to meet the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code.

**Status:** Enacted on April 27th, 2021

**Comments:** From Submitter

This legislation is offered to ensure that health-related legislation does not disqualify a Health Savings Account owner from continuing to make tax-deductible contributions to their HSA. A Health Savings Account ("HSA") is a trust or custodial account offered with a high-deductible health insurance plan that meets specific requirements in the U.S. Internal Revenue Code, as interpreted and administered by the federal Internal Revenue Service. An eligible individual can deduct contributions from income taxes and use contributed funds tax-free for qualified medical expenses. But consumers cannot benefit from an HSA unless they are enrolled in an "HSA-qualified" plan. A plan will fail to qualify if a state law (however well intended) requires coverage without (or with limited) cost sharing for benefits that are not "preventive care" services as defined by federal HSA law. The federal HSA statute requires that HSA-qualified plans apply a minimum deductible to all covered benefits that are not "preventive care."

The Arkansas law (Act 939) was enacted in response to several bills enacted in the 2021 legislative session that were problematic including SB 290, SB 309 & HB 1569.

Other states with similar provisions embedded in their Insurance Codes:

- Kentucky: KRS Chapter 304, Subtitle 17A. (via Chapter 133/2021).
- Oregon: ORS §742.008.
- Rhode Island: Title 27, Chapter 69.
- Utah: Title 31A, Chapter 22, Part 6, §657 (via Chapter 198/2022).

**Staff Note**

**Disposition of Entry:**

SSL Committee Meeting: 2022

- Include in Volume
- Include as a Note
- Defer consideration:
  - next SSL meeting
  - next SSL cycle
- Reject

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VICE PRESIDENT: Rep. Tom Oliverson, TX  
TREASURER: Asw. Pamela Hunter, NY  
SECRETARY: Sen. Paul Utke, MN

IMMEDIATE PAST PRESIDENTS:  
Rep. Matt Lehman, IN  
Sen. Travis Holdman, IN

## National Council of Insurance Legislators (NCOIL)

### Resolution in Support of Embedded Provisions in State Insurance Code to Protect Health Savings Accounts-Qualified Health Insurance Policies from Certain State Benefit Mandates

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*\*Sponsored by Sen. Jerry Klein (ND); \*Co-sponsored by Rep. Tom Oliverson, M.D. (TX); Sen. Beverly Gossage (KS); Rep. Rachel Roberts (KY)*

*\*Adopted by the Health Insurance & Long Term Care Issues Committee on November 16, 2023 and the Executive Committee on November 18, 2023.*

**WHEREAS**, the National Council of Insurance Legislators fully supports the state-based system of regulation for health insurance, consistent with federal statutes, rules, regulations and guidance; and NCOIL supports states continuing serving their role as sources of healthcare innovation in the most meaningful way; and

**WHEREAS**, individual insureds and/or enrollees and those in the group market require all the resources they need, to effectively manage the ever-increasing cost of health insurance; and

**WHEREAS**, qualified Health Savings Accounts, coupled with high deductible health plans, are one such tool that helps individuals or those in the employer group market manage those costs; and

**WHEREAS**, A Health Savings Account (“HSA”) is a trust or custodial account offered with a high-deductible health insurance plan that meets specific requirements in the U.S. Internal Revenue Code, as interpreted and administered by the federal Internal Revenue Service. An eligible individual can deduct contributions from income taxes and use contributed funds tax-free for qualified medical expenses; however, consumers cannot benefit from an HSA unless they are enrolled in an “HSA-qualified” plan; and

**WHEREAS**, many states have recently introduced or enacted sweeping benefit mandate bills and co-pay accumulator bills, to help insureds and enrollees with the cost of health insurance and medical services, by providing for so-called “first dollar or zero dollar coverage” or coverage that otherwise restricts the amount of the applicable deductible, co pay or coinsurance; and

**WHEREAS**, NCOIL recognizes that certain of these state benefit mandate bills, while well-intended, may have the effect of disqualifying an HSA in a given state because the federal HSA statute requires that HSA-qualified plans apply a minimum deductible (single and family) to all covered benefits that are not defined as “preventive care”; and that a plan will fail to so qualify if a state law requires coverage without (or with limited) cost-sharing for benefits that are not “preventive care”; and that such disqualification may prevent account owners from continuing to make tax-deductible contributions to their HSAs and also cause an insured or enrollee to have to possibly re-file their federal taxes and where relevant, their state taxes, and pay penalties; and these consequences were unseen and cause unintended harm to the individual; and

**WHEREAS**, it would serve and further legislative economy, to have each state adopt a provision embedded in its insurance code, as eight states have done, to protect the efficacy of HSAs, via a legislative “carve-out”, as opposed to the necessity of amending each and every state benefit mandate bill, such as those involving diabetes, breast cancer, prostate cancer and other diseases; that this would ensure that a health insurance plan that is an HSA-qualified plan is exempt from any state law that would cause the plan to be disqualified because the state law requires coverage of and/or cost-sharing for, benefits that would cause the plan to fail to meet the definition of a “high deductible health plan”, as that term is set forth in Section 223(c.) (2) of Title 26 of the United States Code.; and

**WHEREAS**, a number of states have enacted to date such a “carveout “ provision<sup>1</sup> and the following provision would serve as a model:

“A health savings account-qualified health insurance policy is exempt from a cost-sharing requirement for a covered benefit that is required under state law to the extent the exemption is necessary to meet the criteria for a health savings account-qualified health insurance policy.

This section does not apply after the enrollee has satisfied the minimum deductible under section 223 of the federal Internal Revenue Code or to any coverage required by state law that pertains to preventive care as defined by regulation or guidance issued by the United States Department of the Treasury under 26 U.S.C. § 223 with respect to any health savings account qualified health insurance policy issued, delivered, amended, or renewed while the regulation or guidance issued by the United States Department of the Treasury is effective.”

**WHEREAS, NOW, THEREFORE, BE IT RESOLVED**, that NCOIL urges states to take action and pass legislation that would protect HSAs and HSA account owners, by providing a ‘carveout’ or exemption, embedded in their insurance code or insurance law, from relevant state benefits mandate and co pay accumulator bills, to ensure consistency with federal law, rules and guidance.

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<sup>1</sup> Arkansas (2021-Act 939) , Kentucky (KRS Chapter 304, Subtitle 17A. (via Chapter 133/2021), North Dakota (Century Code §26.1-36-01.1), Oregon (ORS §742.008), Pennsylvania (P.S. Title 72, § 3402b.5), Rhode Island (Title 27, Chapter 69), Texas (Insurance Code § 1653) and Utah (Title 31A, Chapter 22, Part 6, §657 (via Chapter 198/2022));

**WHEREAS, BE IT FINALLY RESOLVED THAT,** a copy of this Resolution shall be sent to the Chairs of the Committees of insurance jurisdiction in each Legislative Chamber in each state; and each State's Insurance Commissioner.

**Agenda Item #5**

**Discuss Draft Revised 2024 Charges for the Pharmacy Benefit Manager Regulatory Issues (B)  
Subgroup's Successor Group—*Commissioner Glen Mulready (OK)***

## 2024 Revised 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 2024.
  - 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. Develop and provide resources to the states to support a greater understanding of laws, policies, and market conditions related 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~~**Pharmaceutical Benefit Management Regulatory Issues (B) Working Group** 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.~~
  - A. Serve as a forum to educate state insurance regulators on issues related to pharmacy benefit manager (PBM) regulation and other stakeholders in the prescription drug ecosystem.
  - B. Gather and share information, best practices, experience, and data to inform and support dialogue and information-sharing among state insurance regulators on issues related to PBM regulation, such as examinations and contracting, and pharmaceutical drug pricing and transparency.
  - C. Review and consider any necessary updates to the *Health Carrier Prescription Drug Benefit Management Model Act (#22)* out of the emergence of greater regulation in the prescription drug ecosystem.
  - D. Maintain a current listing of PBM laws and regulations and case law for reference by state insurance regulators.
  - E. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
  - F. Monitor, facilitate and coordinate with the states and federal agencies regarding compliance and enforcement efforts regarding PBMs.

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

March 10, 2024

Commissioner Glen Mulready  
Chair, Regulatory Framework (B) Task Force  
National Association of Insurance Commissioners  
444 North Capitol Street, NW, Suite 700,  
Washington, DC 20001  
EMAIL: [JMatthews@naic.org](mailto:JMatthews@naic.org)

**SENT VIA EMAIL**

**Re: 2024 Adopted Charges and Future of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup**

Dear Chair Mulready:

I write on behalf of the Pharmaceutical Care Management Association ("PCMA") to provide our comments regarding both the 2024 Adopted Charges related to, as well as the future of, the Pharmacy Benefit Manager ("PBM") Regulatory Issues (B) Subgroup ("Subgroup"). We appreciate the willingness of the Regulatory Framework (B) Task Force's ("Task Force") to revisit the future purpose of the Subgroup and its adopted 2024 Charges. As indicated during 2023 meetings of both the Task Force and the Subgroup, the adopted 2024 Charges do not reflect the current landscape of the pharmaceutical supply chain, nor the relevant state and federal laws already enacted.

PCMA is a national trade association representing pharmacy benefit managers ("PBMs"). PCMA member companies administer drug benefits for more than 275 million Americans who have health coverage through employer-sponsored health plans, commercial health insurance plans, union plans, Medicare Part D plans, managed Medicaid plans, state employee health plans, and others. PBMs use a variety of benefit management tools to help these plans provide high-quality, cost-effective prescription drug coverage to plan beneficiaries.

As PCMA has previously stated to both the Task Force and the Subgroup, it is important to remember the relationships between **all of the parties** in the pharmaceutical supply chain. Payors, such as health plan sponsors that include employers and labor unions, as well as government entities, often contract with PBMs to manage the pharmacy benefit for a health plan enrollee – the covered individual. Payors dictate the terms of the contracts with the PBMs. The PBMs then fulfil the contracted terms.

In building a network of pharmacies for their payor clients, PBMs enter into contracts with pharmacies on the payer's behalf. As part of the contract, the parties agree to reimbursement terms, which include ingredient costs (for the actual pharmaceutical dispensed) and dispensing fees (for the costs of dispensing the drug).

Many pharmacies contract into buying groups called pharmacy services administrative organizations ("PSAOs") that negotiate with PBMs on a pharmacy's behalf. From a pharmacy's perspective, this is done to secure favorable contract terms with PBMs on the reimbursement side and favorable price terms on the purchase of drugs from wholesale distributors (i.e., the wholesalers who own the largest PSAOs in the country). In fact, the largest three wholesale distributors in the country, who in turn own the largest PSAOs sell most of the pharmaceuticals in the country. These sales and their subsequent distribution are not limited to specific states or

regions. The terms of the contracts between payors and PBMs, just like those between PSAOs/wholesale distributors and pharmacies, are confidential. In other words, the prices that pharmacies pay to wholesale distributors for drugs are not known by the PBMs and payors.

Moreover, PBMs are already regulated extensively by the states. The Subgroup's website even lists many of these laws. However, since the NAIC's lists were last updated in 2021 and 2023, they do not include the many new state laws both enacted since they were last updated. Nor do they include those currently undergoing debate in state legislatures across the country. Here are links to a listing of state laws so far compiled by the Subgroup:

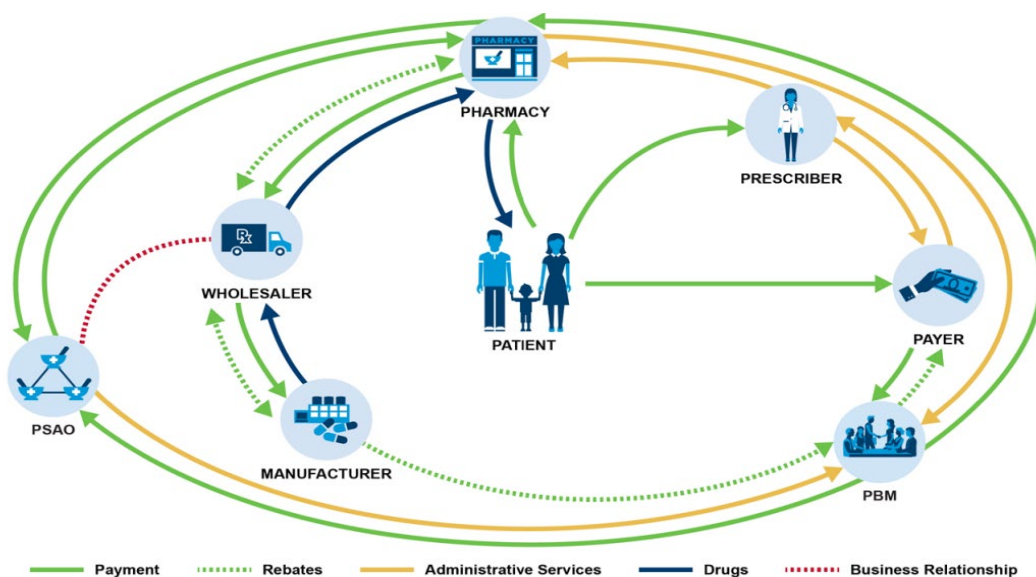
- [State Pharmacy Benefit Manager Registration and Licensing Laws](#) (2021)
- [Compilation of State Pharmacy Benefit Manager Business Practice Laws](#) (2023)

Together, these two documents include **over 200 pages of laws aimed at regulating PBMs.** This shows that states are more than active in their regulation of PBMs. And they are doing so in a manner that they feel best suits their specific state needs.

### **Recommendation for Subgroup**

Adoption of the NAIC's PBM White Paper presents the Task Force with an opportunity to revisit how best to modify the focus of the Subgroup. Further, PCMA recognizes that certain states feel it important to have tools for the oversight of the pharmaceutical supply chain. .

Therefore, we recommend that the PBM Subgroup be disbanded, having completed its charges, and a new **Pharmaceutical Supply Chain Subgroup** be established. The creation of a new Subgroup provides a fresh start while also building on the previous work that the Task Force and the PBM Subgroup have already completed. As outlined in the graphic below, the pharmaceutical supply chain includes many different entities, even before an individual receives a prescription drug as a covered benefit.



By focusing on all aspects of the pharmaceutical supply chain, a re-focus of the Subgroup to this larger ecosystem allows regulators to ensure proper visibility of all of the entities that impact the costs and access associated with prescription drugs in their state.

### **Recommendations for 2024 Charges**

Some proposed charges for this new Pharmaceutical Supply Chain Subgroup could include the following:

- Monitor, report, and analyze developments related to the pharmaceutical supply chain, including such entities as, pharmaceutical manufacturers, wholesale distributors, PSAOs, PBMs, health plans/insurers, and pharmacies – the role each entity plays in the supply chain and make recommendations to the Regulatory Framework (B) Task Force regarding NAIC strategy and policy with respect to those developments.
- Monitor, facilitate, and coordinate best practices with the states and the federal government related to the pharmaceutical supply chain and the role of the different entities within the chain.
- Survey state-enacted laws, including the relevant statutes and administrative rules/regulations, including those pertaining to pharmaceutical supply chain entities, to determine whether there are areas of consensus that could serve as a basis for findings to report to the Regulatory Framework (B) Task Force.

We thank the Task Force for considering our comments on this important matter. PCMA looks forward to the opportunity to provide input to the Task Force as it considers important pharmaceutical supply chain issues and all of the complexities included therein. If you need any additional information, please contact me at [pjelstad@pcmanet.org](mailto:pjelstad@pcmanet.org).

Sincerely,

*Peter Fjelstad*

Peter Fjelstad  
Assistant Vice President, State Legal & Regulatory Affairs

CC: Jolie Matthews  
Senior Health and Life Policy Counsel, NAIC

## FROM THE NAIC CONSUMER REPRESENTATIVES

March 13, 2024

**To: Commissioner Glen Mulready, Chair of the Regulatory Framework (B) Task Force**

**RE: Consumer Representatives' Comments on "Draft Revised 2024 Charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's Successor Group"**

On behalf of the undersigned Consumer Representatives to the National Association of Insurance Commissioners (NAIC), we voice our strong support of the proposed charges for a **Pharmacy Benefit Manager Regulatory Issues (B) Working Group** and urge its immediate adoption without any amendments that would distract from its proposed mission.

Due to the profound impact pharmacy benefit managers (PBMs) have in the drug pricing and delivery system and on consumer access and affordability of prescription medications in the private insurance market, we have long supported the NAIC's interest in PBMs. Over the past several years, we have been involved in helping Commissioners understand the impact of PBMs on consumers, the drafting of a NAIC PBM model law, and the successful drafting and passage of the NAIC White Paper "A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation." Taking each of these actions has helped the NAIC and its Commissioners better understand how PBMs affect formulary design and drug access and how regulators can address PBM actions that are compromising access to affordable drug coverage for consumers.

PBM issues and practices, along with state and federal laws and regulations, continue to evolve. There is a growing need to protect consumers from harmful practices, and we believe it is essential that the NAIC continue to examine the role of PBMs in the insurance market. The proposed Working Group would provide a forum for the NAIC and its members to come together so they can continue to discuss these complex and changing issues. The consumer representatives look forward to participating in such a process to provide the perspective of the patients and beneficiaries we represent.

Since the *Health Carrier Prescription Drug Benefit Management Model Act (#22)* failed to include provisions that directly regulate PBMs or specifically address the significant role that PBMs play in prescription drug benefit plan design and delivery, we strongly support the review and update of the model act to reflect the changing times since it was adopted. While we recognize that states have taken differing steps in the regulation of PBMs, consumers can benefit and need an agreed upon minimum level of protection by regulators.

We realize that any discussion of greater regulation will invite resistance from the potential regulated parties, however, because PBMs have such a significant impact on consumer access to and affordability of prescription drugs we urge you to adopt the Draft PBM Working Group charges without delay and

constitute its membership so that it can begin to execute its work plan. We look forward to providing the consumer perspective as this important work moves forward.

For any questions, please contact Carl Schmid, HIV+Hepatitis Policy Institute at [cschmid@hivhep.org](mailto:cschmid@hivhep.org).

Thank you very much.

Sincerely,

Kellan Baker  
Stephani Becker  
Bonnie Burns  
Laura Colbert  
Deborah Darcy  
Shamus Durac  
Adam Fox  
Stephanie Hengst  
Marguerite Herman  
Kara Nett Hinkley  
Anna Schwamlein Howard  
Anna Hyde  
Amy Killelea  
Carl Schmid  
Deborah Steinberg  
Harry Ting  
Wayne Turner  
Caitlin Westerson  
Silvia Yee

March 14, 2024

Commissioner Glen Mulready  
Chair, Regulatory Framework (B) Task Force  
National Association of Insurance Commissioners  
444 North Capitol Street NW, Suite 700  
Washington, DC 20001

Via email: [JMatthews@naic.org](mailto:JMatthews@naic.org)

RE: 2024 Charge for PBM Subgroup

Dear Commissioner Mulready:

On behalf of the National Community Pharmacists Association (NCPA), I am writing to you in your role as Chair of the Regulatory Framework (B) Task Force at the National Association of Insurance Commissioners (NAIC). NCPA urges you to take up the issue of PBM regulation enforcement as a key focus of the PBM Subgroup's 2024 charge.

We believe a focus on enforcement of existing law is a topic that most stakeholders can appreciate, if not agree upon. We share some context here. Reflecting on NAIC's previous efforts to craft model laws, it was understandable that differing perspectives about how PBMs can or should be regulated might lead to impasse. With the more recent white paper process, addressing verbiage appeared to outweigh discussion of substance, lest the white paper inform or encourage more/less regulation. By contrast, the topic of enforcing existing law would be both less controversial and a practical topic for NAIC members regardless of what laws or regulations are currently enacted in any given state.

NCPA is preparing a document that outlines what we believe are best practices for the enforcement of existing PBM laws, providing state-specific examples for a range of enforcement provisions. We also make recommendations to NAIC for enhancing its support of members to enforce laws. We would be happy to meet with you and work with the PBM Subgroup in due time. In the meantime, we look forward to hearing your thoughts about including enforcement as part of the 2024 charges for the PBM Subgroup.

Thank you very much for receiving our perspective. I can be reached any time at [joel.kurzman@ncpa.org](mailto:joel.kurzman@ncpa.org) or (703) 600-1186.

Regards,



Joel Kurzman  
Director, State Government Affairs

## **Agenda Item #6**

**Hear Information on World Hypertension Day—*J. P. Wieske (Horizon Government Affairs, representing Jazz Pharmaceuticals)***



# HYPERTENSION

## WHAT IS HYPERTENSION?

Hypertension, or high blood pressure (HBP), happens when the pressure of the circulating blood is consistently too high, and when left uncontrolled, can lead to heart disease and stroke.<sup>1</sup>

## WHO IS AT RISK?



Nearly half of all American adults have HBP<sup>1</sup>



About 3 out of 4 Americans don't have their HBP under control<sup>1</sup>



One out of every 2 males are at risk for HBP<sup>1</sup>



Non-Hispanic Black adults and those suffering from obesity or sleep disorders are at the greatest risk for HBP<sup>1,2</sup>

## WHAT YOU CAN DO TO HELP PREVENT OR MANAGE HYPERTENSION

**1. Reduce your salt/sodium intake**  
According to the American Heart Association, the average American consumes 3,400 mg of sodium in their daily diet, which is significantly higher than the 2,300 mg daily recommended limit.<sup>3</sup>

**2. Stop smoking<sup>2</sup>**

**3. Exercise and eat healthy<sup>2</sup>**

**4. Proper medication adherence**  
If you have a prescription drug to reduce hypertension, take your medicine as directed by your doctor.

## DID YOU KNOW?

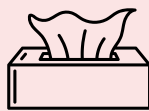
Your medication may be adding to your daily sodium intake. Both over-the-counter and prescription medications can be unrecognized sources of sodium.<sup>4</sup>



## KNOW WHICH MEDICINES CAN AFFECT YOUR BLOOD PRESSURE<sup>4,5</sup>



Some pain medications may cause the body to hold onto water and increase BP



Some decongestants make blood vessels smaller and can raise BP



Some antidepressants and hormonal birth control can raise BP



Some medicines have high sodium content and can raise BP



Getting your blood pressure checked often and monitoring for things that can cause HBP can help fight this "silent killer."<sup>6</sup>

1. Facts about hypertension. Centers for Disease Control and Prevention website. Updated July 6, 2023. Accessed October 20, 2023. <https://www.cdc.gov/bloodpressure/facts.htm>

2. Prevent high blood pressure. Centers for Disease Control and Prevention website. Published March 17, 2023. Accessed October 20, 2023. <https://www.cdc.gov/bloodpressure/prevent.htm>

3. How much sodium should I eat per day? American Heart Association website. Updated November 1, 2021. Accessed October 20, 2023. <https://www.heart.org/en/healthy-living/healthy-eating/eat-smart/sodium/how-much-sodium-should-i-eat-per-day>

4. Sodium sources: where does all that sodium come from? American Heart Association website. Updated January 5, 2023. Accessed October 20, 2023. <https://www.heart.org/en/healthy-living/healthy-eating/eat-smart/sodium/sodium-sources>

5. Mayo Clinic Staff. Medications and supplements that can raise your blood pressure. Mayo Clinic website. Published April 15, 2023. Accessed October 20, 2023. <https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/in-depth/blood-pressure/art-20045245>

6. High blood pressure - understanding the silent killer. Food and Drug Administration. Published August 1, 2023. Accessed October 20, 2023. <https://www.fda.gov/drugs/special-features/high-blood-pressure-understanding-silent-killer>

## SAMPLE DRAFT

### Commissioner [NAME] Urges Sodium Action During World Hypertension Day on May 17

*When it comes to hypertension awareness and control, it is important to take sodium into account*

Commissioner [NAME] is urging [State] residents to take action to help lower their cardiovascular risks during World Hypertension Day. Hypertension, or high blood pressure (HBP), is a leading cause of premature death and, when left uncontrolled, it can lead to heart disease and stroke.<sup>1</sup>

More than 119 million American adults are estimated to have hypertension.<sup>1</sup> Fortunately, there are steps you can take to help reduce your risk of catastrophic heart events, including quitting smoking, watching your diet, exercising, and reducing your sodium intake.<sup>2</sup>

“A leading dietary risk factor for hypertension is sodium intake,” stated Commissioner [NAME]. “Consumers should be working with their healthcare providers to find ways to reduce their risk of hypertension. Foods, drinks and even some sources of medication may all be sources of sodium. Men, black adults and those suffering from obesity or sleep disorders are at heightened risk for hypertension and have an even greater need to watch their sodium intake.”

Nearly half of all American adults have HBP, and many don’t know they have HBP.<sup>3</sup> Three in 4 Americans don’t have their HBP under control.<sup>4</sup> “Talking to your doctor about reducing your sodium intake, stopping smoking, exercising and eating healthy, and adhering to your medications could take you off of the hypertension path that can lead to heart disease and stroke,” said Commissioner [NAME].

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<sup>1</sup>Facts about hypertension. Centers for Disease Control and Prevention website. Published July 6, 2023. Accessed October 20, 2023. <https://www.cdc.gov/bloodpressure/facts.htm>

<sup>2</sup>Prevent high blood pressure. Centers for Disease Control and Prevention website. Updated March 17, 2023. Accessed October 20, 2023. <https://www.cdc.gov/bloodpressure/prevent.htm>

<sup>3</sup>The facts about high blood pressure. American Heart Association website. Updated May 25, 2023. Accessed October 20, 2023. <https://www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure>

<sup>4</sup>Estimated hypertension prevalence, treatment, and control among U.S. adults. Million Hearts website. Updated May 12, 2023. Accessed October 20, 2023. <https://millionhearts.hhs.gov/data-reports/hypertension-prevalence.html>

**Agenda Item #7**

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