

Revised: 7/26/23

*2023 Summer National Meeting
Seattle, Washington*

REGULATORY FRAMEWORK (B) TASK FORCE

Sunday, August 13, 2023

12:15 – 1:00 p.m.

Seattle Convention Center—Signature Room—Level 5

ROLL CALL

Sharon P. Clark, Chair	Kentucky	D.J. Bettencourt	New Hampshire
Glen Mulready, Vice Chair	Oklahoma	Justin Zimmerman	New Jersey
Mark Fowler	Alabama	Mike Causey	North Carolina
Lori K. Wing-Heier	Alaska	Jon Godfread	North Dakota
Peni Itula Sapini Teo	American Samoa	Francisco D. Cabrera	Northern Mariana Islands
Ricardo Lara	California	Judith L. French	Ohio
Michael Conway	Colorado	Andrew R. Stolfi	Oregon
Andrew N. Mais	Connecticut	Michael Humphreys	Pennsylvania
Karima M. Woods	District of Columbia	Alexander S. Adams Vega	Puerto Rico
Dean L. Cameron	Idaho	Larry D. Deiter	South Dakota
Amy L. Beard	Indiana	Cassie Brown	Texas
Doug Ommen	Iowa	Jon Pike	Utah
Vicki Schmidt	Kansas	Scott A. White	Virginia
Timothy N. Schott	Maine	Mike Kreidler	Washington
Gary D. Anderson	Massachusetts	Allan L. McVey	West Virginia
Grace Arnold	Minnesota	Nathan Houdek	Wisconsin
Eric Dunning	Nebraska		

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

AGENDA

1. Consider Adoption of its Spring National Meeting Minutes Attachment One
—*Commissioner Sharon P. Clark (KY)*
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)*
 - D. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup—*TK Keen (OR)*



3. Hear a Panel Discussion on Prior Authorization—*Lucy Culp (Leukemia & Lymphoma Society—LLS), Emily Carroll (American Medical Association—AMA), and Jane Beyer (WA)*
4. Discuss Any Other Matters Brought Before the Task Force—*Commissioner Sharon P. Clark (KY)*
5. Adjournment

Agenda Item #1

Consider Adoption of its Spring National Meeting Minutes
—*Commissioner Sharon P. Clark (KY)*

Draft Pending Adoption

Draft: 3/29/23

Regulatory Framework (B) Task Force
Louisville, Kentucky
March 22, 2023

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

1. Adopted its 2022 Fall National Meeting Minutes

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

2. Adopted its Subgroup and Working Group Reports

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

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

B. ERISA (B) Working Group

Wake said the Employee Retirement Income Security Act (ERISA) (B) Working Group will not be meeting during the Spring National Meeting, but he anticipates the Working Group meeting in person at the Summer National

Draft Pending Adoption

Meeting. Wake said the Working Group will most likely meet virtually prior to the Summer National Meeting to complete its work updating the NAIC chart on multiple employer welfare arrangements (MEWAs)/multiple employer trust (MET) and association plans. He said the Working Group continues to serve as a forum and facilitate discussions among state insurance regulators and federal regulators on issues involving ERISA plans and MEWAs. He said the Working Group also stands ready to assist the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup on any issues it encounters related to ERISA preemption issues as the Subgroup works on its white paper concerning pharmacy benefit managers (PBMs) and their business practices, including the implications of the *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* decision and any subsequent decisions on such business practices.

C. MHPAEA (B) Working Group

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

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

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

D. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

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

Keen said that during its March 22 meeting, the Subgroup adopted its 2022 Fall National Meeting minutes. He said the Subgroup heard an update on federal PBM-related legislative and regulatory activities. The Subgroup also heard a legal update on PBM-related litigation.

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Keen made a motion, seconded by Nollette, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its March 13 (Attachment One), Feb. 27 (Attachment Two), and Feb. 13 (Attachment Three) minutes; the ERISA (B) Working Group; the MHPAEA (B) Working Group, including its Feb. 24 (Attachment Four) minutes; and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its March 22 (Attachment Five) minutes. The motion passed unanimously.

3. Heard an Update on the CHIR's Work

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

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

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

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

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

Commissioner Mulready explained that Oklahoma has seen access issues concerning consumers being able to obtain appointments with behavioral health providers in a timely fashion. He asked Kona if the CHIR has looked at this issue and, if so, whether she could recommend any best practices that other states may be doing to address the issue. Kona said the CHIR has studied the wait time issue with mental health parity as part of comparative analyses of non-quantitative treatment limitations (NQTLs). She said, however, that in examining this issue, it does not seem that any particular state has emerged as a leader in resolving this issue. She noted that California does have certain plan reporting requirements related to wait times for appointments, but the CHIR has not conducted an analysis of how it is working. She said the CHIR could possibly look at this as part of a future project.

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

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Agenda Item #2

Consider Adoption of its Subgroup and Working Group Reports —Commissioner Sharon P. Clark (KY)

- *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)*
- *Pharmacy Benefit Manager Regulatory Issues (B) Subgroup—TK Keen (OR)*

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

August 7, 2023 / July 24, 2023 / July 10, 2023 / June 29, 2023 / May 15, 2023 / April 24, 2023 / April 17, 2023 / March 27, 2023

Summary Report

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Aug. 7, July 24, July 10, June 29, May 15, April 24, April 17, and March 27, 2023. During these meetings, the Subgroup:

1. Completed its discussions of the comments received on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), specifically, Section 8A—General Rules.
2. Completed its discussions of: a) the remainder of Section 8, including revisiting the proposed new subsection on short-term, limited-duration (STLD) plans and the discussion of the Feb. 24 comments received on that section; and b) Section 7—Prohibited Policy Provisions.
3. Discussed the comments received on Section 9—Required Disclosure Revisions, including how the recently proposed federal rules on consumer disclosures for STLD plans and hospital indemnity and other fixed indemnity plans could impact proposed revisions to the section.
4. Made plans to continue its discussions of the Model #171 revisions and, hopefully, complete those discussions by the end of the year.

Draft: 8/9/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
August 7, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Aug. 7, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Tara Smith (CO); Chris Struk (FL); Robert Wake (ME); Maggie Reinert (NE); Shari Miles (SC); Heidi Clausen (UT); Mary Block and Jamie Gile (VT); and Lichiou Lee (WA).

1. Continued Discussion of Section 9A of Model #171

The Subgroup continued its discussion of the suggested revisions to the product statements in Section 9A—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). The Subgroup returned to its discussion of the NAIC consumer representatives' suggested revisions to Section 9A(12). The suggested revisions recommend deleting the first sentence, which states: "Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder." After discussion, the Subgroup decided to delete the clause beginning with "[e]xcept" and retain the remainder of the sentence. The Subgroup also accepted the non-substantive suggested revisions.

The Subgroup next returned to its discussion of the NAIC consumer representatives' suggested revisions to Section 9A(19) concerning the outline of coverages delivered to consumers for certain products regulated under Model #171 to include language on or attached to the first page of the outline of coverage stating that these products are not Medicare supplement policies. The Subgroup accepted the suggested revisions during its July 24 meeting. In continuing its discussion of this provision, the Subgroup discussed whether additional revisions were needed for consistency with the consumer disclosure language in Appendix C of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651). The Subgroup also discussed whether there should be a distinction between the consumer disclosure notices received under Section 9A(12) for individuals eligible for Medicare by reason of age and individuals eligible for Medicare by reasons other than age. After discussion, the Subgroup decided to add a drafting note alerting the states that permit individuals under the age of 65 with Medicare coverage to purchase a Medicare Supplement (Medigap) policy to review how they should provide the notices required under Section 9A(12) to these individuals.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(20). The NAIC consumer representatives suggest deleting the exception for direct response insurers to provide a specified disease insurance buyer's guide to any person applying for a specified disease insurance policy. For consistency with its other suggested revision to this provision, the NAIC consumer representatives also suggest deleting the language requiring direct response insurers to provide the buyer's guide upon request, but not later than the time the policy or certificate is delivered. The Subgroup accepted the suggested revisions.

The Subgroup next moved to the NAIC consumer representatives' suggested revisions for Section 9A(21) to Section 9A(29). The Subgroup agreed that the suggested revisions for these provisions, which concern consumer disclosure language for the products in Model #171 that must be on the first page of a policy or certificate, is already addressed with the previous revisions the Subgroup discussed and accepted for Section 9A(2).

2. Discussed Section 9B of Model #171

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9B establishing an outline of coverage requirements. Beginning with Section 9B(1), the Subgroup discussed the NAIC consumer representatives' clarifying revisions to this provision. The Subgroup accepted the suggested revisions.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9B(2). Section 9B(2) establishes requirements for providing a substitute outline of coverage when there is a change from when the outline of coverage was provided at the time of application or enrollment. The NAIC consumer representatives' suggested revisions would require insurers to provide a substitute outline of coverage to applicants and enrollees at the time of renewal. After discussion, the Subgroup did not accept the suggested revisions because it felt the suggested revisions would expand the scope and intent of the current language. The Subgroup accepted the NAIC consumer representatives' suggested revisions for the drafting note. However, the Subgroup decided to return to the drafting note during its next meeting on Aug. 21 to consider some additional clarifying language. The Subgroup discussed the NAIC consumer representatives' suggestion to add a clarifying sentence to Section 9B(3) to specifically state that a policy or certificate cannot be sold or renewed until the commissioner approves the alternate outline of coverage. No comments were received on Section 9B(4).

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

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Draft: 8/3/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
July 24, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 24, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Chris Struk (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson (NE); Heidi Clausen (UT); Anna Van Fleet and Jamie Gile (VT); and Lichiou Lee (WA).

1. Continued Discussion of Section 9A of Model #171

The Subgroup continued its discussion of the suggested revisions to the product statements in Section 9A—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). Jolie H. Matthews (NAIC) said that prior to the meeting, she distributed a document reflecting the Subgroup’s discussions on Section 9A to date. She said the document also reflects Bowden’s suggested revisions to streamline language related to the readability and accessibility requirements for the product statement disclosures. Bowden pointed out a proposed new sentence in Section 9A(2) stating: “The disclosures required by this section may be modified only as approved by the commissioner and as needed to approve the accuracy and clarity of the disclosure.” The Subgroup discussed the document and confirmed that it accurately reflected the Subgroup’s discussions to date. The Subgroup also accepted Bowden’s suggested streamlining revisions and her suggested new sentence in Section 9A(2). The Subgroup also discussed whether the proposed federal rule on short-term, limited-duration (STLD) plan and hospital indemnity and other fixed indemnity plan consumer disclosures would affect the Subgroup’s proposed language for the product disclosures in Section 9A. After discussion, because the federal rule is not final and because of other issues related to the proposed federal rule, the Subgroup decided to add a drafting note to Section 9A(2) alerting states that they may have to review the language in Section 9A and consider any changes, as appropriate, for consistency with state and/or federal rules applicable to such coverage that may have changed after the Model #171 revisions are adopted.

The Subgroup discussed the NAIC consumer representatives’ suggested product statement disclosure language for limited-scope dental coverage and limited-scope vision coverage. The Subgroup accepted the suggested language. The Subgroup also asked NAIC staff to review the language for consistency with the other product statement disclosures.

The Subgroup discussed the NAIC consumer representatives’ suggested product statement disclosure language for STLD health insurance coverage. The Subgroup discussed whether it should consider the disclosure language in the proposed federal rules instead of the NAIC consumer representatives’ suggested language. After discussion, the Subgroup decided to use the proposed federal rule’s disclosure language.

The Subgroup next discussed the NAIC consumer representatives’ suggested revisions to Section 9A(12). The suggested revisions recommend deleting the first sentence, which states: “Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder.” The Subgroup discussed whether this sentence should be deleted and why the NAIC consumer representatives suggest its deletion. Anna Howard (American Cancer Society Cancer Action Network—ACS CAN)

suggested the NAIC consumer representatives recommend deleting the language for consistency with other proposed revisions. The Subgroup deferred deciding whether to accept the suggested revisions until it could review any other language in Model #171 on riders that could affect its decision.

The Subgroup discussed and agreed to accept the NAIC consumer representatives' suggested revisions to Section 9A(13) to add the language "and the combined total premium clearly identified as such." The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(16) adding language requiring certain notices to be prominently printed in a specified manner. The Subgroup discussed revising this language for consistency with other similar language used in Section 9A or reorganizing and placing this provision in Section 9A's general language. The Subgroup did not reach a decision. Similarly, the Subgroup discussed whether it should also reorganize and place Section 9A(17) in Section 9A's general language. It did not reach a decision. The Subgroup next discussed the NAIC consumer representatives' clarifying suggested revisions to Section 9A(18). The Subgroup accepted the suggested revisions. The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(19) concerning the outline of coverages delivered to consumers for certain products regulated under Model #171 to include language on or attached to the first page of the outline of coverage stating that these products are not Medicare supplement policies. The Subgroup accepted the suggested revisions. It also requested NAIC staff to revise the suggested language for consistency with similar language in Section 9A.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(20). The NAIC consumer representatives suggest deleting the exception for direct response insurers to provide a specified disease insurance buyer's guide to any person applying for a specified disease insurance policy. For consistency with its other suggested revision to this provision, the NAIC consumer representatives also suggest deleting the language requiring direct response insurers to provide the buyer's guide upon request, but not later than the time the policy or certificate is delivered. The Subgroup did not finish its discussion. The Subgroup plans to continue the discussion during its next meeting on Aug. 7.

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

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Draft: 7/17/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
July 10, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 10, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Stephen F. Flick (DC); Christina Jackson (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Shari Miles (SC); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet and Jamie Gile (VT); and Lichiou Lee (WA).

1. Discussed Small Stakeholder Group Revisions to Section 9A of Model #171

Prior to continuing its discussion of the suggested revisions to the product statements in Section 9A—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), the Subgroup discussed the impact, if any, of the recently issued federal proposed rule on short-term, limited-duration (STLD) plans and hospital indemnity and other fixed indemnity plans. The Subgroup discussed if the rule would require the Subgroup to pause its work revising Model #171 and reopen Model #171’s companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170). After discussion, the Subgroup decided to continue revising Model #171 but remain cognizant of the provisions in the federal proposed rule. The Subgroup also concluded that Model #170 most likely would need to be reviewed and possibly reopened after that review for additional revisions to reflect the provisions of the federal rule if it is finalized as proposed. However, this work would begin after the Subgroup finishes revising Model #171. The Subgroup reached these conclusions because, at this point, the federal rule is a proposed rule, which means that after a review of the comments received on it, the federal rule’s final language could change. In addition, NAIC staff explained the Subgroup’s approach to revising both Model #170 and Model #171 as being focused on state laws and regulations and tying both models’ provisions to such laws and regulations, not federal laws and regulations.

Schallhorn said NAIC staff distributed prior to the meeting a revised document reflecting the Subgroup’s June 29 discussion of the proposed language for the product statements. He asked for comments. The Subgroup agreed that the revised language accurately reflects the Subgroup’s discussion. Bonnie Burns (consultant to consumer groups) expressed concern with the language in some of the product statements stating that the product is “supplementary and not intended to replace major medical insurance.” She said the language is confusing to consumers. After discussion, the Subgroup agreed to revise the language to state: “This [policy] [certificate] is not major medical insurance and does not replace it.”

Schallhorn expressed concern with the use of the word “for” in the proposed statement language for hospital indemnity and other fixed indemnity coverage. He said using this word seems to imply that the coverage will pay the cost of the actual expenses for a covered hospitalization or for a covered event resulting from a sickness or injury, which is not how these coverages function. He suggested deleting “for” and replacing it with “as a result of.” Burns noted the Subgroup’s extensive discussion during its June 29 meeting on the issue and the potential for consumers to not understand what that phrase means. After additional discussion, the Subgroup decided to accept Schallhorn’s suggested revision. To avoid duplicative language, the Subgroup also agreed to revise the statement language for hospital indemnity to delete the words “resulting from” and replace them with “due to.”

The Subgroup agreed to defer discussion of the remaining suggested statement language for STLD plans and dental and vision coverage until its July 24 meeting.

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

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Draft: 7/13/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
June 29, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met June 29, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Shannon Doheny (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson and Maggie Reinert (NE); Shari Miles (SC); Heidi Clausen (UT); Anna Van Fleet and Jamie Gile (VT); and Shari Maier (WA).

1. Discussed Small Stakeholder Group Revisions to Section 9A of Model #171

The Subgroup discussed the small stakeholder group's suggested revisions to Section 9A—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) intended to reflect the Subgroup's discussion of the NAIC consumer representatives' suggested disclosure statement language during its May 15 meeting.

J.P. Wieske (Horizon Government Affairs) said following the Subgroup's May 15 meeting, a small group of stakeholders, including industry and consumer representatives, discussed potential revisions to the NAIC consumer representatives' suggested language for the disclosure statements required to be provided to consumers under Section 9A. This discussion aimed to address the Subgroup's concerns that the suggested language could be misleading to consumers about the type of benefit the product is providing. The Subgroup discussed the revised statement language for hospital indemnity and other fixed indemnity. After discussion, the Subgroup preliminarily agreed to the following revised statement language for hospital indemnity and other fixed indemnity:

Hospital Indemnity

"This [policy] [certificate] pays fixed dollar benefits for covered hospitalization resulting from a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is supplementary and not intended to replace major medical insurance. Read the description of benefits provided along with your [enrollment form /application] carefully."

Other Fixed Indemnity

"This [policy] [certificate] pays fixed dollar benefits for covered events resulting from a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is supplementary and not intended to replace major medical insurance. Read the description of benefits provided along with your [enrollment form /application] carefully."

The Subgroup also agreed to delete the word "review" in the last sentence of each of the revised statements and replace it with the word "read."

The Subgroup next discussed the disability income revised statement language. After discussion, the Subgroup agreed to revise the language to make it more consumer-friendly by deleting the words “set length of time” and substituting them with “specific period of time.” The Subgroup also agreed to delete the words “as a result of” and replace them with the word “from.”

The Subgroup next discussed the accident-only revised statement language. The Subgroup agreed to make the same revisions to the language it made to the disability income statement language.

The Subgroup discussed the revised statement language for specified disease coverage, specified accident coverage, and limited benefit coverage. After discussion, the Subgroup agreed to delete duplicative language in each.

The Subgroup asked NAIC staff to distribute prior to its next meeting on July 10 the revised statement language reflecting the Subgroup’s discussion for the Subgroup’s review during that meeting. The Subgroup also plans to continue its discussion of the NAIC consumer representatives’ comments on Section 9A during its July 10 meeting.

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

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Draft: 5/17/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
May 15, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met May 15, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Stephen F. Flick (DC); Chris Struk (FL); Camille Anderson-Weddle (MO); Martin Swanson (NE); Shari Miles (SC); Tanji J. Northrup and Heidi Clausen (UT); Anna Van Fleet and Jamie Gile (VT); and Lichiou Lee (WA).

1. Continued Discussion of Comments Received on Section 9 of Model #171

The Subgroup continued its discussion of the comments received on Section 9—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), beginning with the NAIC consumer representatives' comments for Section 9A(2)—Hospital Indemnity or Other Fixed Indemnity Coverage.

Jolie H. Matthews (NAIC) said that during its April 24 meeting, the Subgroup discussed, from a regulatory perspective, the appropriateness of including specific readability and accessibility requirements for consumer disclosures when such requirements are most likely already in other state laws and regulations, as well as other NAIC models. The Subgroup discussed this issue. After extensive discussion, the Subgroup decided not to accept the NAIC consumer representatives' suggested language on accessibility. The Subgroup decided to add a drafting note to Section 9A(2), alerting states to refer to their state laws and regulations and applicable NAIC models for provisions related to consumer disclosure readability and accessibility standards.

The Subgroup discussed the NAIC consumer representatives' suggested language for the statement in Section 9A(2) to be provided to consumers before submission of a completed application for coverage on hospital indemnity or other fixed indemnity coverage. The Subgroup raised a concern about the language because it seems to state that this type of coverage provides a benefit when it pays a fixed dollar amount triggered by a hospital stay or other covered health-related event regardless of the actual expense amount. The Subgroup discussed the issue, including other potential language to address it, but deferred deciding on what word to use until its May 22 meeting because of the NAIC consumer representatives' concerns that consumers would not understand the meaning of the word "trigger." The Subgroup did agree to bracket both "hospital stay" and "other covered health-related event."

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(3). This provision outlines the statement to be provided to consumers on disability income protection coverage. The other suggested language on readability and accessibility requirements for the statement is identical to the suggested language for Section 9A(2). Based on the Subgroup's discussion on Section 9A(2), the Subgroup agreed to make the same changes to Section 9A(3). The Subgroup discussed the suggested language for the statement. The Subgroup did not have any initial concerns with the suggested statement language.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(4). This provision outlines the statement to be provided to consumers on accident-only coverage. The other suggested language on readability and accessibility requirements for the statement is identical to the suggested language for Section 9A(2). Based on the Subgroup's discussion on Section 9A(2), the Subgroup agreed to make the same

changes to Section 9A(4). The Subgroup discussed the suggested language for the statement. The Subgroup did not have any initial concerns with the suggested statement language.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(5). This provision outlines the statement to be provided to consumers on specified disease coverage. The other suggested language on readability and accessibility requirements for the statement is identical to the suggested language for Section 9A(2). Based on the Subgroup's discussion on Section 9A(2), the Subgroup agreed to make the same changes to Section 9A(5). The Subgroup discussed the suggested language for the statement. Like its discussion about the potential issues with the statement for hospital indemnity or other fixed indemnity coverage in Section 9A(2), the Subgroup discussed concerns that the statement could be misleading because it seems to imply the coverage to be provided under a specified disease policy is for diagnosing and treating a specified disease. The Subgroup agreed to revisit the issue during its May 22 meeting.

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 5-15-23MtgMin.docx

Draft: 5/16/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
April 24, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met April 24, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson and Maggie Reinert (NE); Shari Miles (SC); Shelley Wiseman and Heidi Clausen (UT); Anna Van Fleet and Jamie Gile (VT); and Ned Gaines (WA).

1. Discussed Comments Received on Section 9 of Model #171

The Subgroup discussed the comments received on Section 9—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), beginning with the NAIC consumer representatives' comments. Before discussing the comments, Lucy Culp (Leukemia & Lymphoma Society—LLS) asked if the Subgroup is planning to return to the short-term, limited-duration (STLD) plan provision considering the potential changes to the federal rules regulating those plans. Jolie H. Matthews (NAIC) said she did not believe this would be necessary because the proposed language for the STLD plan provision in Model #171 links the regulatory requirements for these plans with the state's regulatory requirements. Matthews also noted that the revisions to Model #171's companion model, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), took a similar approach. J.P. Wieske (Horizon Government Affairs), as an employee of the Wisconsin Department of Insurance (DOI) and chair of the NAIC group that revised Model #170, agreed with Matthews.

The Subgroup discussed the NAIC consumer representatives' comments on Section 9A—General Rules. Before explaining the comments, Culp asked if the Subgroup would consider the NAIC consumer representatives' request to have another NAIC group, such as the Consumer Information (B) Subgroup, review this section because of its subject matter expertise in this area of consumer disclosures. The Subgroup discussed Culp's suggestion. After discussion, the Subgroup decided to move forward with its review of the comments received on Section 9.

Culp explained that the NAIC consumer representatives' suggested revisions would provide a specific disclosure provision for each type of product regulated under Model #171. She explained that the rationale for this approach is that the disclosure statement for each type of product would vary depending on the product. As such, it makes sense to allow for that variability and for the Subgroup to discuss the language for each disclosure statement and why it would be different based on the type of product rather than discussing a universal disclosure statement.

Chris Petersen (Arbor Strategies LLC) expressed concern with the NAIC consumer representatives' suggested new language for Section 9A(1), which states: "Any disclosures, and the documents to which they refer, must be delivered in the same written medium as the application to consumers. These documents must be available no later than 24 hours before a completed application is submitted by the consumer to the issuer." He said the language is problematic because it seems to prohibit providing the application and other documents electronically, despite a consumer requesting only electronic communications. He said another problem is that the language appears to suggest the insurer is to gather information about the consumer and deliver a disclosure before the consumer submits an application, which raises potential privacy concerns. The Subgroup discussed the potential new language. After discussion, the Subgroup revised the language to read as follows: "Any disclosures,

and the documents to which they refer, must be delivered in the written medium requested by the consumer. These documents must be available before the consumer submits a completed application.”

The Subgroup next discussed the NAIC consumer representatives’ suggested disclosure language for Section 8B—Hospital Indemnity or Other Fixed Indemnity Coverage. Culp explained that the NAIC consumer representatives suggest revising Section 9A(2)(a) so that it only applies to hospital indemnity or other fixed indemnity coverage. She said other revisions suggest using a sans-serif font for the required statement and the proximity of the statement to the applicant’s signature block. Petersen asked why the NAIC consumer representatives suggest the sans-serif font. Culp said NAIC consumer representatives with expertise in consumer disclosures suggested that font type. Petersen also questioned if any of these provisions related to font type and font size would conflict with other state readability laws and regulations. He asked if the *Uniform Individual Accident and Sickness Policy Provision Law* (#180) would include such requirements and, if so, whether it would be appropriate to include the NAIC consumer representatives’ suggested language in Model #171 instead of relying on Model #180’s provisions. Another stakeholder suggested the Subgroup review the *Life and Health Insurance Policy Language Simplification Model Act* (#575). Culp said she would be concerned with separating these requirements from Model #171 and having to refer to provisions in another model. Wieske raised an issue from a regulatory perspective with the NAIC consumer representatives’ product-by-product approach if an insurer combines products. He said if separate disclosures are required for each product, then it could be confusing to consumers if the insurer combines one or more products.

The Subgroup discussed a possible way to streamline the NAIC consumer representatives’ suggested language. The Subgroup also discussed whether to include a drafting note acknowledging the existence of other state readability and accessibility requirements.

In discussing the NAIC consumer representatives’ proposed statement for hospital indemnity or other fixed indemnity coverage, the Subgroup did not have any concerns with the proposed language. Cindy Goff (American Council of Life Insurers—ACLI) said there could be an issue with the statement’s accuracy if hospital indemnity and other fixed indemnity are sold separately. The Subgroup discussed her concern. Bowden said she would not object to including brackets around both “hospital stays” and “other covered health-related event” to address the concern. She said she could also support adding a drafting note alerting insurers that, subject to the insurance commissioner’s approval, they may modify the statement, as needed, for accuracy for a specific product type. The Subgroup did not reach a decision on whether to accept these suggested revisions.

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

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Draft: 4/26/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
April 17, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met April 17, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Chris Struk (FL); Camille Anderson-Weddle (MO); Maggie Reinert (NE); Shari Miles (SC); and Tanji J. Northrup, Shelley Wiseman, and Heidi Clausen (UT).

1. Continued the Discussion of Section 7F of Model #171

The Subgroup continued its discussion of the comments received on Section 7F—Prohibited Policy Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) beginning with the Texas Department of Insurance’s (DOI’s) comments. Section 7F prohibits a policy from limiting or excluding coverage by type of illness, accident, treatment, or medical condition, except as provided in the subsection.

Bowden said her first comment on whether the exclusions in Section 7F are appropriate for short-term, limited-duration (STLD) plans was addressed during the Subgroup’s March 27 meeting. The Subgroup discussed Bowden’s next comment on Section 7F(4) concerning the exclusion of an illness, treatment, or medical condition arising out of war or an act of war (whether declared or undeclared). The Subgroup discussed how this provision would apply to acts of terrorism. After discussion, the Subgroup decided to leave the provision unchanged because of certain court rulings and other decisions related to acts of terrorism, finding that acts of terrorism are generally not considered acts of war. The Subgroup next discussed Bowden’s comments on Section 7F(8) concerning the exclusion for treatment provided in a government hospital. After discussion, the Subgroup agreed to delete the provision because it is no longer an issue for industry. Bowden said the Subgroup addressed her next comment related to the exclusion for dental care or treatment during its March 27 meeting.

The Subgroup next discussed Bowden’s comment on the territorial limitations exclusion. The Subgroup discussed what this provision means and whether the exclusion is related to territories outside the U.S. or a specific state in the U.S. The Subgroup discussed whether it should clarify the provision to note that it applies to territories outside the U.S. After discussion, which included a discussion of the impact of such a change with respect to the U.S. territories and possible confusion on whether the exclusion applies to U.S. territories, the Subgroup decided to leave the provision unchanged but add a drafting note explaining the intent of the provision.

The Subgroup next discussed the Health Benefit Institute’s (HBI’s) suggestion to add an exclusion to Section 7F for “genetic testing not ordered by a medical provider, and not used to diagnose or treat a disease.” The Subgroup discussed the comments. During the discussion, the Subgroup discussed whether medical necessity requirements would address the situation without adding the suggested language. The Subgroup noted that states generally do not apply their utilization review requirements to excepted benefit plans; as such, there would not be a medical necessity review. Cindy Goff (American Council of Life Insurers—ACLI) said she believes the purpose of adding the suggested language is to ensure that insurers can include a requirement in the contract that a health care provider must order the genetic testing to be covered. If a health care provider does not order it, then coverage is excluded. Goff said without this provision, a covered person could challenge the denial of coverage. After additional discussion, the Subgroup agreed to add the exclusion.

The Subgroup next discussed the NAIC consumer representatives' suggestion to delete Section 7G. Section 7G provides that Model #171 shall not impair or limit the use of waivers to exclude, limit, or reduce coverage or benefits for the specifically named or prescribed preexisting diseases, physical conditions, or extra hazardous activities. The Subgroup discussed the rationale for having such a provision and why it appears to benefit consumers. Goff said she believes this provision benefits consumers because it allows insurers to exclude certain pre-existing conditions without having to exclude coverage for the entire disease. She said this provision gives insurers more flexibility with respect to decisions related to the coverage of pre-existing conditions and other conditions not related to the pre-existing condition. The Subgroup discussed how this provision may or may not relate to Model #171's disclosure provisions. After additional discussion, the Subgroup deferred deciding on whether to accept the NAIC consumer representatives' suggestion to delete Section 7G until it completes its review of all the comments received on Model #171.

The Subgroup next turned to the NAIC consumer representatives' suggestions for adding new provisions to Section 7. The Subgroup deferred discussion of the suggested additional provisions until it completes its review of all the comments received on Model #171.

2. Discussed the Comments Received on Section 8H of Model #171

The Subgroup next discussed the comments received on the proposed Section 8H—Short-Term, Limited-Duration Health Insurance Coverage. The Subgroup only received comments from the NAIC consumer representatives. Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) explained that the NAIC consumer representatives' suggestion to revise Section 8H(1) for consistency with similar language in Model #171's companion model, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*). The Subgroup accepted the suggested revisions.

The Subgroup next discussed the NAIC consumer representatives' suggestion to revise the coinsurance percentage in Section 8H(2)(ii) to no more than "50%" of covered charges to no more than "20%" of covered charges. They also suggest striking "or" and substituting "and." Howard said the NAIC consumer representatives believe that a 50% coinsurance of covered charges in an STLD plan is too high of a percentage for consumers to potentially pay. After discussion, the Subgroup decided not to accept the suggested revision to the coinsurance percentage. The Subgroup accepted the suggested revision to strike "or" and substitute "and." The Subgroup next discussed the NAIC consumer representatives' suggestion to revise the provision's drafting note to delete the sentence suggesting that those states that have severely limited coverage time frames with limited renewals or extensions should apply smaller annual and lifetime limits and out-of-pocket maximums. The Subgroup did not accept the suggested revision, but because of impending changes to the federal rules regulating STLD plans, the Subgroup agreed to delete the last sentence in the drafting note suggesting that those states that allow coverage up to the federal maximum of three years might want to consider different limits.

No comments were received on Section 8H(3). The Subgroup discussed the NAIC consumer representatives' suggestion to delete Section 8H(4)(iii). This provision would require an insurer to include a statement in the STLD plan that the insurer retains the right, at the time of policy renewal, to make changes to the premium rate by class. After discussion, the Subgroup agreed to delete the provision, but it agreed to revisit the decision, if necessary.

No comments were received on Section 8H(5). The Subgroup discussed the NAIC consumer representatives' suggestion to add the word "intentionally" to Section 8H(6) to provide that a carrier may not rescind an STLD plan during the coverage period unless the insured "intentionally" fails to disclose a prior diagnosis of a health condition. After discussion, the Subgroup accepted the suggested revision.

No comments were received on Section 8H(7). The Subgroup discussed the NAIC consumer representatives' suggestion to revise the number of days an insurer must notify an insured of policy cancellation or rescission prior to the cancellation or rescission from 20 days to 30 days in Section 8H(8). After discussion, the Subgroup accepted the suggested revision.

Jolie H. Matthews (NAIC) pointed out a sentence in the drafting note for Section 8H(8) referencing the current federal rules for STLD plans, which limit coverage under such plans to less than 12 months and provide for a maximum duration of coverage of no longer than 36 months. The Subgroup decided to retain the sentence and revisit it after the release of the anticipated federal proposed rules on STLD plans.

The Subgroup next discussed the NAIC consumer representatives' suggestion to add a new provision to Section 8H prohibiting an insurer from issuing an STLD plan during the annual enrollment periods for individual health insurance and individual health insurance marketplace plans. The Subgroup discussed the pros and cons of adding such a provision. The Subgroup decided to defer the discussion until a later date.

Matthews pointed out for the Subgroup's future discussion a note to the Subgroup at the end of Section 8H suggesting that the Subgroup may want to consider adding language on pre-existing conditions to the subsection. The note to the Subgroup also alerts the Subgroup that it will have to craft a definition of "pre-existing condition" for STLD plans because the current definition of "pre-existing condition" in Section 6J applies to all coverages regulated under Model #171 except STLD plans.

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

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Draft: 4/25/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
March 27, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met March 27, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Debra Judy (CO); Howard Liebers (DC); Chris Struk (FL); Camille Anderson-Weddle (MO); Maggie Reinert (NE); Shari Miles (SC); Shelley Wiseman and Heidi Clausen (UT); Anna Van Fleet, Jamie Gile, and Mary Block (VT); and Ned Gaines (WA).

1. Continued Discussion of Section 7F of Model #171

The Subgroup continued its discussion of the comments received on Section 7F—Prohibited Policy Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) beginning with the NAIC consumer representatives' comments on this subsection. Section 7F prohibits a policy from limiting or excluding coverage by type of illness, accident, treatment, or medical condition, except as provided in the subsection.

The Subgroup discussed the NAIC consumer representatives' suggestion to delete Section 7F(2), which provides an exclusion for "mental or emotional disorders, alcoholism and drug addiction." Jackson Williams (Dialysis Patient Citizens—DPC) said the NAIC consumer representatives' suggestion to delete this exclusion relates to the issue of whether the products regulated under Model #171 should include a mental health parity component. He said he has identified someone to speak on this issue, and he requested that the Subgroup defer discussion of this issue until this individual could present during an upcoming Subgroup meeting. The Subgroup discussed the issue, noting that federal mental health parity requirements do not apply to excepted benefit plans. The Subgroup also discussed whether there should be a difference between what short-term, limited-duration (STLD) plans should be required to cover versus what excepted benefit plans should be required to cover. After discussion, the Subgroup decided not to accept the NAIC consumer representatives' suggestion to delete Section 7F(2). In addition, the Subgroup decided not to hold a broad discussion of the mental health parity coverage issue related to excepted benefit plans, noting that based on the discussion, few states would require excepted benefit plans to cover mental health benefits. The Subgroup agreed to add a drafting note to the subsection explaining that states should decide if any of the exclusions allowed in Section 7F should apply to STLD plans.

The Subgroup next discussed the NAIC consumer representatives' suggestion to delete Section 7F(4)(b) concerning an exclusion related to suicide and Section 7F(4)(e) concerning an exclusion for incarceration with respect to disability income protection policies. The Subgroup discussed the rationale for such exclusions. The Subgroup returned to its discussion about how Section 7F should apply to STLD plans and whether there should be a specific carve-out included in this provision for STLD plans. After additional discussion, the Subgroup decided not to accept the NAIC consumer representatives' suggestion to delete Section 7F(3)(b) and Section 7F(3)(e). The Subgroup also agreed to revise the drafting note it had agreed to add earlier concerning STLD plans to add a sentence that some of the exclusions listed in Section 7F may not be appropriate for STLD plans, and each state will have to determine which should apply, if any, to such plans. The Subgroup did not accept the NAIC consumer representatives' suggested drafting note for Section 7F(5) because it seems unnecessary. The Subgroup decided during its March 13 meeting to preliminarily accept the NAIC consumer representatives' suggestion to add the language "to improve the function of a malformed body part," subject to additional clarification on the meaning of "malformed."

The Subgroup accepted the NAIC consumer representatives' suggestion to clarify Section 7F(7) by adding the word "chiropractic."

The Subgroup accepted the NAIC consumer representatives' suggestion to add language to Section 7F(9) modifying the exclusion to have it not apply when the provision of dental services is medically necessary due to the underlying medical condition or clinical status of the covered person. The Subgroup did not accept the NAIC consumer representatives' suggested new drafting note for the provision.

The Subgroup next discussed the NAIC consumer representatives' suggestion to delete "routine physical examinations" in Section 7F(11). The Subgroup did not accept the suggestion.

The Subgroup next discussed the Vermont Department of Insurance's (DOI's) suggestion to add a drafting note to Section 7F(2), noting that the exclusion related to mental or emotional disorders, alcoholism, and drug addiction is optional, and states should review the desirability of its use for certain products regulated under the Model #171.

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

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*2023 Summer National Meeting
Seattle, Washington*

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

Monday, August 14, 2023

8:00 – 8:30 a.m.

Meeting Summary Report

The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group will meet Aug. 14, 2023. During this meeting, the Working Group plans to:

1. Hear presentations on autism treatment standards.
2. Meet in 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.

Draft: 4/10/23

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Louisville, Kentucky
March 23, 2023

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Louisville, KY, March 23, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jane Beyer, Vice Chair (WA); Jimmy Harris (AR); Erin Klug (AZ); Kate Harris (CO); Kurt Swan (CT); Howard Liebers (DC); Andria Seip (IA); Julie Holmes (KS); Mary Kwei (MD); Peter Brickwedde (MN); Carrie Couch and Amy Hoyt (MO); Matthew Eberhardt (MT); Tracy Biehn (NC); Santana Edison (ND); Maureen Belanger (NH); Ralph Boeckman (NJ); Laura Miller (OH); Landon Hubbard and Ashley Scott (OK); David Buono (PA); Glynda Daniels (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Julie Fairbanks (VA); Barbara Belling (WI); and Erin K. Hunter (WV).

1. Heard Presentations on *Wit v. United Behavioral Health*

Weyhenmeyer said speakers would inform the Working Group about the *Wit v. United Behavioral Health* case and its implications for mental health parity enforcement.

Brian Hufford (Zuckerman Spaeder) presented on the *Wit* case. He said the suit does not allege parity violations because the plaintiffs wanted to focus on the delivery of mental health services and not compare them to medical and surgical services. He said parity nonetheless had an impact on why the case was brought. He said plans used medical necessity guidelines to limit treatment even further than the quantitative limitations applied before the MHPAEA was passed. He said United Behavioral Health (UBH) limited its treatment to acute care and reduced the level of care after an acute episode. He said a trial court agreed that guidelines were overly restrictive in a 2019 decision. However, the Ninth Circuit appeals court overturned the decision and then later updated its decision to uphold in part the original ruling. He said four states require claims administrators to use specific guidelines.

Hufford said the newest decision included damaging findings related to the federal Employee Retirement Income Security Act (ERISA). He said plaintiffs had argued the company applied flawed guidelines. Therefore, the claims should be reprocessed. However, the Ninth Circuit ruled that reprocessing was not necessary. It also ruled that all class members had to have exhausted their administrative remedies such as internal and external appeals. He said plaintiffs are seeking further review of the decision, with support from 15 states; Washington, DC; and other organizations.

Hufford said UBH's guidelines were more restrictive than commonly accepted treatment standards. He provided examples, including applied behavioral analysis (ABA) and the treatment criteria established by the American Society for Addiction Medicine (ASAM). He said the court found that UBH lied to state insurance regulators regarding the guidelines they employed.

David Lloyd (The Kennedy Forum) provided comments on the importance of the *Wit* case. He said inappropriate medical necessity denials are a primary barrier to care. He said the Kennedy Forum has been pushing for inclusion of a definition of medical necessity in state and federal law. He said it has also advocated for making utilization review criteria consistent with generally accepted standards of care. He said some states have added a definition to their laws and that recently Georgia added it. Lloyd said professional medical societies have developed tools to show the level of care needed for patients, which provides a common standard for patients, providers, and payers. He said care decisions should be made using these tools and said some states have adopted rules to require them to be used. He said federal agencies have also made progress, including a federal Centers for Medicare & Medicaid

Services (CMS) requirement that Medicare Advantage plans made medical necessity determinations using appropriate guidelines. He said that regardless of the final decision in the Wit case, the issues will not go away.

Klug asked which state law definitions of medical necessity could serve as models for other states. Lloyd said laws in California, Georgia, Illinois, and Oregon are good models. Hufford said states should tie guidelines to generally accepted standards developed by medical societies, not those developed by private companies. He said that plans continue to limit treatment to only some parts of the ASAM guidelines. Klug asked whether the CMS definition of medical necessity used in Medicare is a good model. Lloyd said that it is pretty good.

Hoyt asked about exhaustion of administrative remedies. She said Missouri state law does not require internal review before a patient seeks external review. Hufford said prior decisions under federal law have required only a class representative to exhaust such remedies, but in the Wit case, the ruling requires all class members to do so. He said state laws would not be applicable to ERISA cases.

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, to continue work on its goals.

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Virtual Meeting

PHARMACY BENEFIT MANAGER REGULATORY ISSUES (B) SUBGROUP

July 27, 2023

Summary Report

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup met July 27, 2023. During this meeting, the Subgroup:

1. Adopted its April 17 and Spring National Meeting minutes. During its April 17 meeting, the Subgroup exposed the pharmacy benefit manager (PBM) white paper for a 45-day public comment period ending June 1.
2. Adopted the PBM white paper and forwarded it to the Regulatory Framework (B) Task Force for its consideration.

Draft: 8/3/23

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Virtual Meeting
July 27, 2023

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met July 27, 2023. The following Subgroup members participated: TK Keen, Chair (OR); Ashley Scott and Molly Clinkscales, Co-Vice Chairs (OK); Kayla Erickson and Sarah Bailey (AK); Steve Dozier (AL); Crystal Phelps (AR); Jared Kosky (CT); Howard Liebers (DC); Andria Seip (IA); Vicki Schmidt (KS); Sharon P. Clark and Daniel McIlwain (KY); Nina Hunter (LA); Chad Arnold and Karin Gyger (MI); Amy Hoyt, Cynthia Amann, and Camille Anderson-Weddle (MO); David Dachs (MT); Ted Hamby (NC); Cheryl Wolff (NE); Erin Porter (NJ); Paige Duhamel and Renee Blechner (NM); Eamon G. Rock (NY); Jodi Frantz (PA); Maggie Rosa (SC); Scott McAnally (TN); Ryan Jubber (UT); Don Beatty (VA); Jennifer Kreitler (WA); Jennifer Stegall (WI); and Jill Reinking and Tana Howard (WY).

1. Adopted its April 17 and Spring National Meeting Minutes

The Subgroup met April 17 to expose a draft of the pharmacy benefit manager (PBM) white paper for a 45-day public comment period ending June 1.

Scott made a motion, seconded by Arnold, to adopt the Subgroup's April 17 (Attachment ?-A) and March 22 (*see NAIC Proceedings – Spring 2023, Regulatory Framework (B) Task Force, Attachment Five*) minutes. The motion passed unanimously.

2. Adopted the PBM White Paper

Keen discussed the Subgroup's work to date on the PBM white paper. He noted the Subgroup's thoughtful discussions on extraordinarily complex issues and the collaborative process it followed throughout its work drafting the white paper. He said the current white paper draft the Subgroup is considering for adoption during this meeting includes revisions based on the comments received during the public comment period ending June 1. He asked for comments from Subgroup members.

Stegall expressed support for the white paper given the complexities of the issue. She said she believes it will be a great resource to state insurance regulators. Gyger also expressed support for the Subgroup's work, noting the Subgroup's collaborative process in drafting the white paper. She also noted the extensive stakeholder participation in the drafting process. She acknowledged that some stakeholders think additional edits should be made, but after almost two years of work, she believes the current white paper draft reflects the current state of play in the pharmaceutical drug supply chain and ecosystem and that it is time to move forward to the next step in the adoption process.

Kosky asked about the process moving forward assuming the Subgroup adopts the white paper during today's meeting. Keen said that if the Subgroup adopts the white paper during today's meeting, it will forward it to the Regulatory Framework (B) Task Force for its consideration and adoption. Following the Task Force's adoption, the Health Insurance and Managed Care (B) Committee would consider the white paper for adoption. Kosky said he wanted to make sure that this was the process moving forward because Connecticut still has concerns with the accuracy of some the information in the current white paper draft. He said that in addition, parts of the white paper lack citations for some of the statements. He said, generally, Connecticut is concerned with the overall lack of diversity and sources used for some of the information included in the white paper. He said Connecticut has concerns with the tone of some of the language as well. Kosky said that despite these concerns, Connecticut would

vote to support moving the white paper on to the next step in the process because it is important to move it along after more than two years of work. He said Connecticut will consider raising these concerns to the Regulatory Framework (B) Task Force as it considers the white paper.

Commissioner Clark echoed many of the comments already made about the Subgroup's work developing the white paper. Noting that its language will never be perfect to everyone, she expressed support for the white paper and moving it forward to the Regulatory Framework (B) Task Force for its consideration. Hoyt also expressed support for the white paper. She suggested, however, that because the white paper is intended to reflect a snapshot in time concerning the pharmaceutical drug supply chain and ecosystem, the Subgroup should consider including language in it clearly stating that intention. Keen expressed support for such language and the Regulatory Framework (B) Task Force adding it during its discussions on the white paper. He said there is an introduction section in the white paper that NAIC staff are using to track the white paper's development, which could be used to include the language she suggests. He also said that he considers the white paper to be the initial version, Version 1.0, because he believes that, as appropriate, other NAIC groups may want to revise it in the future to reflect changes, particularly with respect to any court decisions made after its adoption.

Keen asked for comments from interested parties. Carl Schmid (HIV+Hepatitis Policy Institute) noted the NAIC consumer representatives had suggested that the Subgroup develop the white paper. He also highlighted the Subgroup's work of approximately two years to complete the white paper and its inclusive process. He expressed support for moving the white paper forward despite the Subgroup not accepting many of the NAIC consumer representatives' suggested revisions.

Kris Hathaway (America's Health Insurance Plans—AHIP) also noted the Subgroup's deliberative and inclusive process in drafting the white paper. She said AHIP has three major concerns with the white paper as currently written. To address those concerns, AHIP believes the Subgroup should revise the white paper to: 1) fulfill the Subgroup's stated and agreed to charges because its focus is on PBMs and its failure to discuss the role of payors, wholesalers, pharmacy services administrative organizations (PSAOs), and other entities involved in the pharmaceutical supply chain; 2) remove non-objective, biased perspectives because there are sections of the white paper providing only one viewpoint; and 3) synthesize and streamline sections. Keen acknowledged AHIP's concerns. He said, however, that at this point in the process, he does not believe everyone agrees with AHIP's concerns about the white paper's biased language.

Peter Fjelstad (Pharmaceutical Care Management Association—PCMA) said the PCMA does not believe the current white paper version is a consensus document. He said the PCMA opposes its adoption. He suggested that because the PCMA does not consider it to be a consensus document, the Subgroup should include the comment letters it received on the white paper with their differing perspectives as an appendix to the paper. Keen acknowledged Fjelstad's comments. He explained that for him, the white paper is a consensus document because of the way the Subgroup members, given their different viewpoints, worked together and compromised on what the white paper should and should not include.

Joel Kurzman (National Community Pharmacists Association—NCPA) expressed appreciation for the Subgroup's work in developing the white paper. He said the NCPA has concerns about a few provisions in the white paper, particularly the language describing spread pricing. He said recent white paper revisions describing spread pricing as a risk mitigation pricing model legitimizes the practice. He said the real-life experience of NCPA members with spread pricing is vastly different. He also suggested that the white paper be carefully reviewed to ensure it does not include inaccurate and outdated views. Kurzman said that as other interested parties stated, the current white paper version does not reflect the NCPA's comments. He expressed hope that if the white paper is adopted, including its recommendation to consider developing model legislation, the NAIC would develop a robust model giving NAIC members the necessary tools to rigorously enforce PBM regulation. He said that assuming the

Subgroup adopts the white paper, he looks forward to working with the Regulatory Framework (B) Task Force to ensure that it incorporates moving forward some of the NCPA's previous suggestions, such as including language in the white paper recommending the creation of a standardized state-based system form for PBM complaints that will enable the NAIC and its Members to analyze and enforce regulation.

Will Dane (Healthcare Distribution Alliance—HDA) said the HDA submitted a comment letter suggesting the Subgroup revise a provision in the white paper concerning PSAOs for accuracy. Keen acknowledged the HDA's suggested revisions.

Sandra Guckian (National Association of Chain Drug Stores—NACDS) said that as other commenters have said, the NACDS' comments are not reflected in the current white paper draft. She said given this, as other comments have said, the NACDS may offer additional comments as the white paper moves forward to the Regulatory Framework (B) Task Force. She said like the NCPA, the NACDS would particularly like to add more language concerning the PBM complaint process.

Commissioner Clark made a motion, seconded by Scott, to adopt the PBM white paper (Attachment ?-B). The motion passed unanimously with the following Subgroup members present and voting: Alaska, Arkansas, California, Connecticut, District of Columbia, Iowa, Kansas, Kentucky, Michigan, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, Washington, Wisconsin, and Wyoming.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/PBM Regulatory Issues Subgrp/PBM Reg Issues MtgMin 7-27-23.docx

Agenda Item #3

Hear a Panel Discussion on Prior Authorization—*Lucy Culp (Leukemia & Lymphoma Society—LLS), Emily Carroll (American Medical Association—AMA), and Jane Beyer (WA)*

BARRIERS TO CARE: PATIENT AND CONSUMER EXPERIENCES WITH PRIOR AUTHORIZATION

Lucy Culp
NAIC Consumer Representative
VP, State Government Affairs
The Leukemia & Lymphoma Society

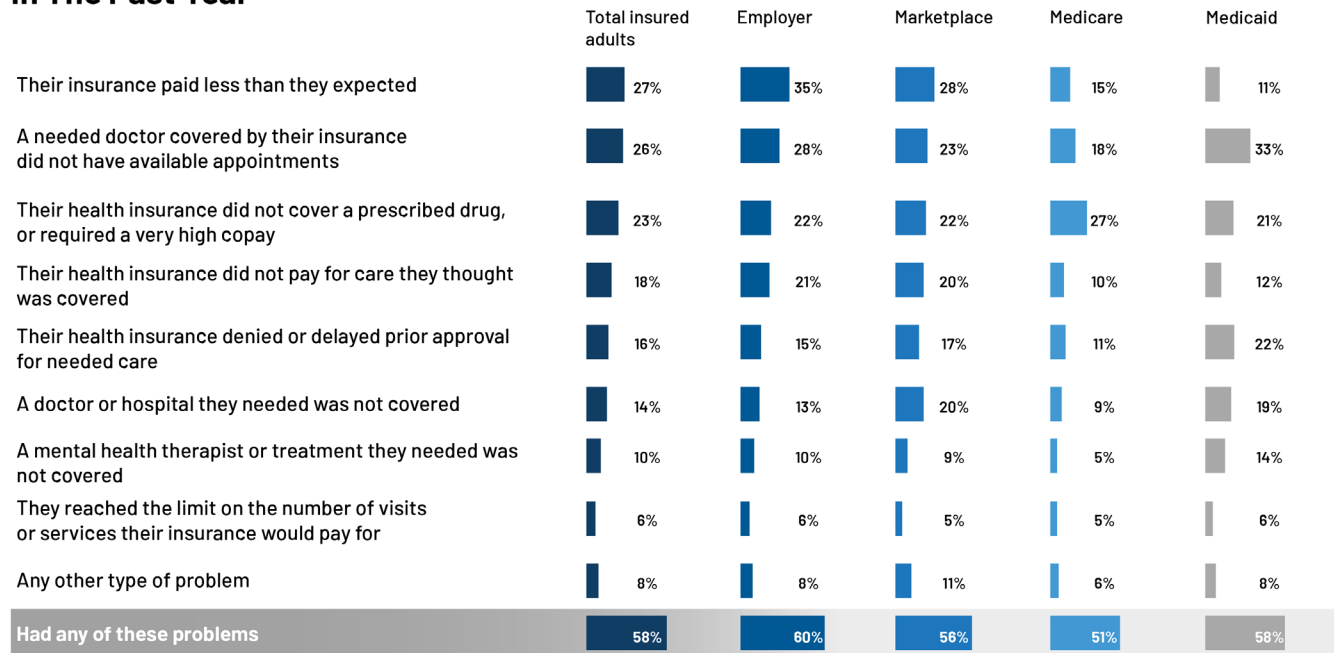
August 13, 2023

Lia,
leukemia survivor



KFF SURVEY OF CONSUMER EXPERIENCES WITH HEALTH INSURANCE

About Six In Ten Insured Adults Say They Have Had A Problem With Their Health Insurance In The Past Year



NOTE: See topline for full question wording.

SOURCE: KFF Survey of Consumer Experiences with Health Insurance (Feb. 21-Mar. 14, 2023)

KFF



CONSUMER REPRESENTATIVES WORK GROUP - PRIOR AUTHORIZATIONS, APPEALS & DENIALS

Areas of Focus

- Current Data & Reporting Requirements
- Prior Authorizations & Medical Necessity
- Appeals & Denials
- Consumer Information
- Use of Artificial Intelligence

FOCUS ON PRIOR AUTHORIZATION

- Extensive reporting, surveys, and consumer stories
- A patient's treatment journey is inextricably linked to their "coverage journey"
- Over-utilization of PA harms consumers
- Leads to delays in care and abandoning treatment
- Increases costs for patients

STAT

INSURANCE

Same patient, same drug, same insurer — coverage denied



By Tara Bannow [Twitter](#) March 2, 2023

Reprints

Intelligencer

MEDICINE | JULY 10, 2023

The Two Words That Can Make Health Care a Nightmare Prior authorization buries doctors in paperwork and delays care, sometimes with disastrous results.

By Chris Stanton

KFF Health News
Feds Move to Rein In Prior Authorization, a System That Harms and Frustrates Patients

By [Lauren Sausser](#)

MARCH 13, 2023

OPPORTUNITIES FOR REGULATORY ACTION

States can address patient and consumer needs through key policy reforms that will:

- Improve access to evidence-based care
- Ensure continuity of care
- Promote transparency and fairness
- Improve timely access to care
- Reduce administrative barriers



THANK YOU

Contact:

Lucy Culp

lucy.culp@lls.org

We have one goal: A world without blood cancers





Opportunities to reform prior authorization

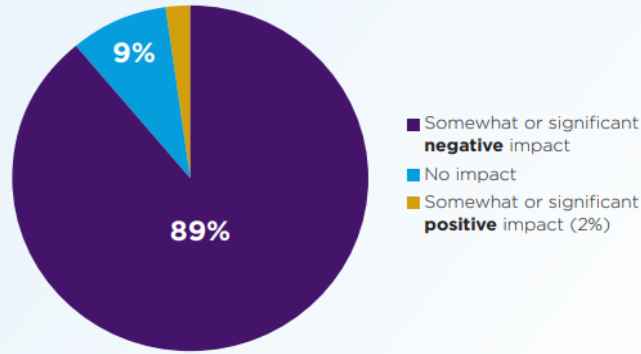
**Regulatory Framework (B) Taskforce
National Association of Insurance Commissioners**

August 13, 2023

Emily Carroll
Senior Attorney
American Medical Association

Impact of PA on clinical outcomes

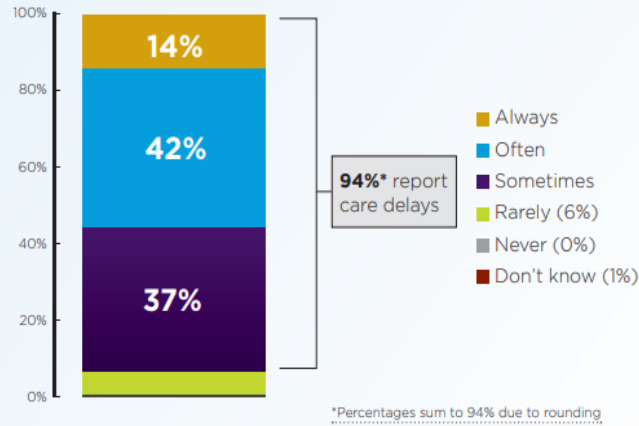
Q: For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?



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Care delays associated with PA

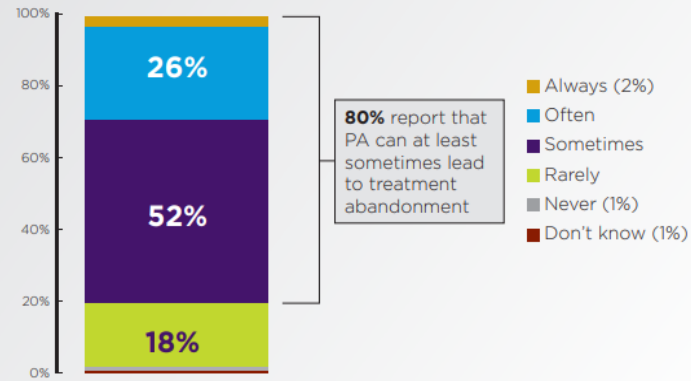
Q: For those patients whose treatment requires PA, how often does this process delay access to necessary care?



Prior authorization harms patients

Abandoned treatment associated with PA

Q: How often do issues related to the PA process lead to patients abandoning their recommended course of treatment?



33% of physicians report that PA has led to a **serious adverse event** for a patient in their care.

Source: 2022 AMA Prior Authorization Physician Survey

Available at: <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>

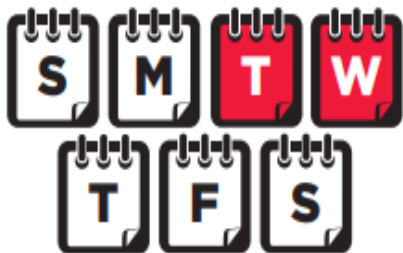
On average,
practices complete

45



**PAs per physician,
per week**

Physicians and their staff
spend an average of



almost two business days (14 hours)
each week completing PAs



Nearly

Two in five or

35%

of physicians have
staff who work
exclusively on PA



88%

of physicians describe
the burden associated
with PA as high or
extremely high

And Burdens Physician Practices . . .

And Wastes Overall Health Care Resources

PA and resource utilization

Q: In your experience, how often does the PA process lead to higher overall utilization of health care resources (e.g., additional office visits, initial use of less effective therapy due to step therapy requirements, emergency room visits, hospitalization)?



■ Sometimes, often, or always ■ Rarely or never ■ Don't know

64%

of physicians report that PA has led to **ineffective initial treatments** (i.e., step therapy)

62%

of physicians report that PA has led to **additional office visits**

46%

of physicians report that PA has led to **immediate care and/or ER visits**

Solutions



Faster response times

24 hours for urgent care and 48 for nonurgent

Use of APIs and ePA (must be paired with other solutions since, by itself, ePA could increase rather than reduce unnecessary use of prior auth)



Ensuring review by clinical peers

Physician of the same specialty, licensed in the state, with experience treating patient's condition.



Reducing prior authorizations

A prior authorization should be good for the course of treatment

Eliminate prior auth for care with high approval rates



Data collection and reporting

Rates of approval, denials, appeals, response times, more

Available to patients, providers, and policymakers
Summary reports by DOI



Continuity of care

90+ day grace period when patient is switching plans



Transparency

Clinical criteria
Prior authorization requirements
Reason for adverse determination
Appeal processes

States are acting on all these solutions and more



Faster response times

WA, AR, KY,
OR, TX, VA



Ensuring review by clinical peers

TX, KY, MO,
PA, TN



Reducing volume of prior authorizations

GA, OR,
IL, IN, TX,
LA, MI,
WV, AR



Data collection and reporting

WA, MI, IL, TX,
NM, OR



Continuity of care

IL, MN



Transparency

CO, MI, IL, KY,
MN, PA, WA

Federal action complementing state progress:

Final CY2024 Medicare Advantage Rule and proposed PA/interoperability rule

Medicare Advantage changes:

- PA only to be used to confirm diagnoses/medical criteria – not as a cost-savings tool only
- Beneficiaries must have access to the same items and services as under traditional Medicare vs. plans using internal proprietary clinical criteria
- Plans' PA approvals must remain valid for the duration of the course of treatment
- 90-day transition period where a PA would remain valid for an ongoing course of treatment when beneficiaries change plans
- After PA approval, MA plans cannot retroactively deny coverage

Interoperability *proposed* rule (MA, MCOs, Medicaid, QHPs in FFEs):

- Plans required to offer application programming interfaces (APIs) that integrate with EHRs to support an electronic PA process
- Plans post metrics (approval/denial rates; overturns on appeal; average processing time)
- Plans to provide specific reason for denial, regardless of processing method

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Opportunities to protect patients and health care resources

- **Legislation**
 - Model language and resources: fixpriorauth.org
 - State examples
- **Enforcement of existing laws and regulations**
 - Prior authorization/UM laws
 - Parity laws
 - Patient education
 - Physician education
- **Monitoring consumer complaints**

Contact information

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Prior authorization in Washington State

NAIC Regulatory Framework Task Force

Jane Beyer, Senior Health Policy Advisor

August 13, 2023



OFFICE of the
**INSURANCE
COMMISSIONER**
WASHINGTON STATE

Prior authorization in Washington state

Prior authorization requirements

- OIC adopted prior authorization rules in 2017, effective 2018. New legislation ([E2SHB 1357](#)) enacted in 2023, effective January 1, 2024
- Components (for current & new law):
 - Address all health services, including prescription drugs
 - Clinical review criteria: must be evidence-based, updated at least annually and accommodate evidence regarding appropriate care for people of color and gender differences

Prior authorization in Washington

- Components (con't):
 - Qualifications of carrier/MCO staff conducting review
 - Must meet national accreditation organization criteria, e.g. NCQA
 - Timeliness standards for review of requests, based upon whether submitted electronically or nonelectronically, including timelines when additional information needed
 - Prior auth denial is an adverse benefit determination that can be appealed by the provider or consumer. Denial must include the specific reason for the decision

Prior Authorization in Washington

- Carrier must have secure online process for provider/facility to:
 - Determine whether prior auth is required
 - Find applicable clinical criteria and required documentation
 - Submit prior auth request with any needed documentation
 - NEW: Submit and obtain response to prior auth requests via an Application Programming Interface (API):
 - Beginning 2025 for health care services (or 2026 if federal NPRM not finalized by Sept. 13, 2023)
 - Beginning 2027 for prescription drugs

Proposed interoperability federal rule (NPRM)

Proposed federal rule

- [Proposed federal rule](#) issued by HHS/Centers for Medicare and Medicaid Services in December 2022. Comments were due March 13, 2023.
- Addresses several issues to increase interoperability in communication between carriers, consumers and providers, including prior authorization processes.
- Use of Application Programming Interface (API) so that different software components can communicate with each other.
- Applies to:
 - Medicare Advantage
 - Medicaid managed care organizations and fee-for-service
 - Children's Health Insurance Program
 - Qualified health plans sold on the federal Health Benefit Exchange

Proposed federal rule

Requires use of Health Level 7[®] (HL7[®]) Fast Healthcare Interoperability Resources[®] (FHIR[®]), Prior Authorization Requirements, Documentation and Decision (PARDD) Application Programming Interface (API):

- Patient access to prior auth requests and decisions
- Allows providers to determine whether a prior auth is required, identify prior auth information requirements, and facilitate exchange of prior auth requests and decisions from providers' EHRs
- Additional non-prior auth components to share patient health data with providers/insurers

How is prior authorization used by carriers?

OIC Prior Authorization Data Reporting

- Reporting required under [RCW 48.43.0161](#), enacted in 2020.
- Requires health carriers with at least 1% of WA market share to report.
- Reporting includes:
 - 10 codes with the highest number of PA requests and the percent of approved requests
 - 10 codes with the highest percentage of approved PA requests and the total number of requests
 - 10 codes with the highest percentage of PA requests that were initially denied and then approved on appeal
- For the following categories of services:
 - Inpatient medical/surgical
 - Outpatient medical/surgical
 - Inpatient mental health and substance use disorder
 - Outpatient mental health and substance use disorder
 - Diabetes supplies and equipment
 - Durable medical equipment

Highlights of reporting

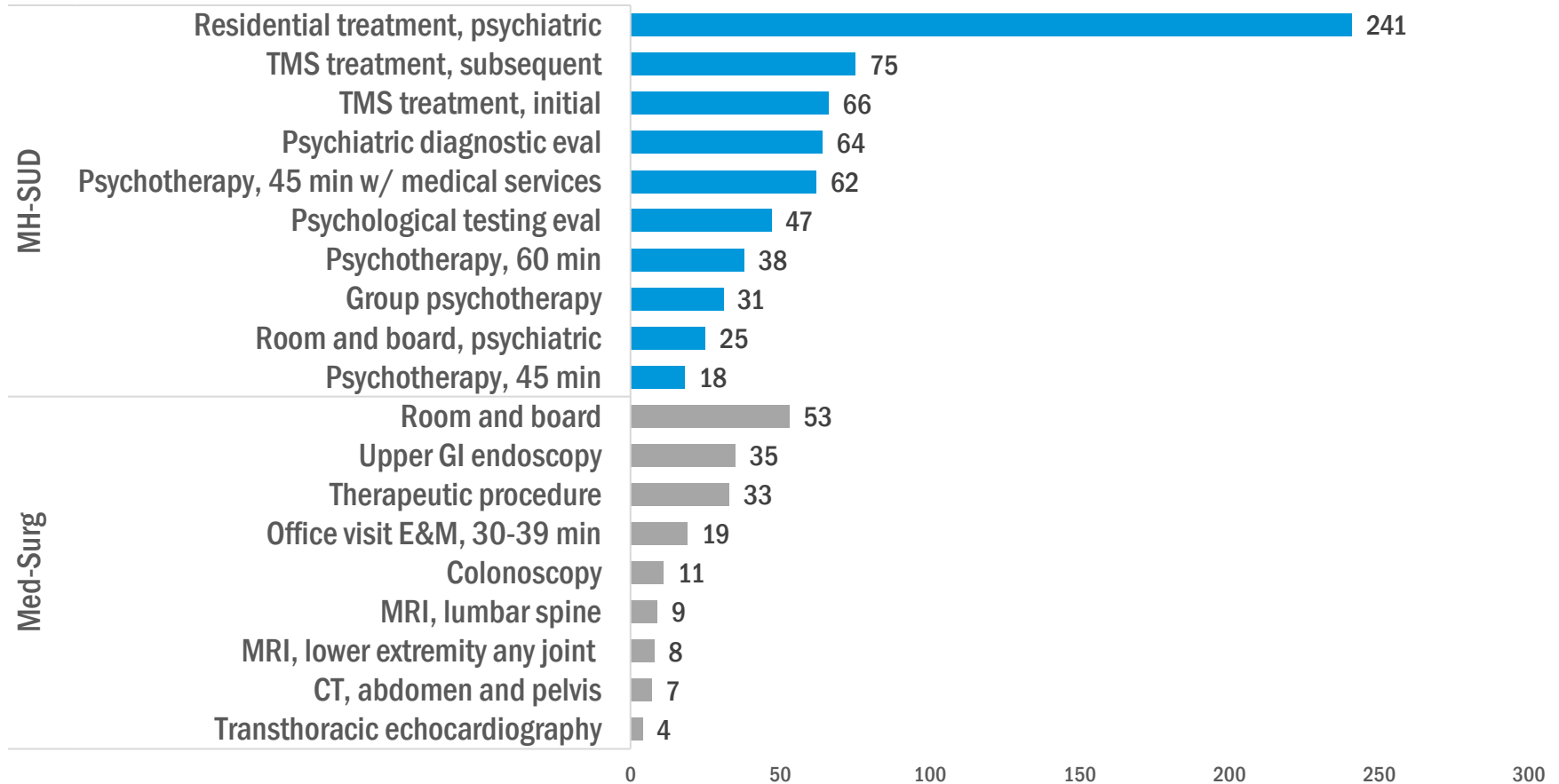
- Services most frequently subject to prior auth:
 - Physical therapy
 - Colonoscopy/endoscopy
 - Continuous airway pressure (CPAP) device
 - Imaging, including CT and MRI
 - Room & board (for both medical and behavioral health)

High rates of approval

- OIC reviewed 2021 data for services with approval rate of 98% or more and at least 50 requests processed
- Approx. 100 codes (CPT/HCPCS) met this threshold
- Examples of services that met threshold:
 - Psychotherapy (53+ minutes)
 - Electric breast pump
 - DME, e.g. crutches, shoulder sling, walking boot
 - CT scan

Prior authorization standard response time 2021

Average Standard Response Time (hrs.) for Codes with the Most PA requests
Medical-Surgical vs. Mental Health/Substance Use Disorder



Appendix

Washington law and NPRM comparison

Prior Authorization- Washington law and Interoperability NPRM

	Current WAC 284-43-2050	E2SHB 1357, Chap. 283, Laws of 2023	Proposed CMS rule (Dec. 6, 2022)
Applicable health plans	Commercial health plans, including fully-insured PEBB/SEBB plans	Commercial health plans, PEBB/SEBB, Medicaid MCOs	Medicaid, CHIP, Medicare Advantage, QHPs sold on federal Exchange (NOTE: WA has state-based Exchange)
Scope of services	Health care services, excluding prescription drugs NOTE: prescription drug exception process - RCW 48.43.400-.420	Health care services, including prescription drugs	Health care services, excluding prescription drugs
Nonelectronic standard PA Request	5 calendar days; timeframes to apply if additional info needed	5 calendar days; additional info must be requested within 5 days	
Nonelectronic Expedited PA Request	2 calendar days; timeframes to apply if additional info needed	2 calendar days; additional information must be requested within 1 day	
Electronic standard PA request	5 calendar days; timeframes to apply if additional info needed	3 calendar days, excluding holidays; additional information must be requested within 1 day	<ul style="list-style-type: none"> • Medicaid/CHIP/Medicare Advantage: 7 calendar days • QHP's on federal Exchange: 15 calendar days

Electronic expedited PA request	2 calendar days; timeframes to apply if additional info needed	1 calendar day; additional information must be requested within 1 day	72 hours
Prior authorization process generally	<ul style="list-style-type: none"> • Must meet national accreditation organization criteria; staff qualifications defined • Clinical review criteria must be evidence-based • Prior auth denial must include reason for denial and clinical criteria used • Consumer or provider can appeal denial 	<ul style="list-style-type: none"> • Detailed prior auth requirements in easily understandable language. • Clinical review criteria available electronically • Clinical review criteria must be evidence-based, updated at least annually and accommodate evidence re appropriateness for people of color & gender 	<ul style="list-style-type: none"> • Prior auth denial must include specific reason for denial • Also see "Electronic Prior Authorization" below
Electronic Prior Authorization process	<p>Effective November 1, 2019, must have a secure online process for a provider to:</p> <ul style="list-style-type: none"> • Determine whether prior auth is required, and find applicable clinical review criteria & required documentation • Complete a prior auth request and upload any documentation 	<p>In addition to electronic portal submissions, Application Programming Interface (PARDD API) system available for prior auth process:</p> <ul style="list-style-type: none"> • Beginning 2025 for health care services (or 2026 if federal rules not adopted by 9/13/23) • Beginning 2027 for prescription drugs. 	<p>Requires use specific prior auth API that:</p> <ul style="list-style-type: none"> • Gives patients access to prior auth requests and decisions; and • Allows providers to determine whether prior auth is required, identify prior auth information requirements, and facilitate exchange of prior auth requests and decisions from provider's EHR
Effective date	Current law	<p>January 1, 2024 for prior auth timelines</p> <p>PARDD API system:</p> <ul style="list-style-type: none"> • 1/1/2025: health care services, with exception request to 2026 or delay to 2026 if federal rules not adopted by 9/13/23 • 1/1/2027: prescription drugs 	January 1, 2026

Prior auth reporting per [RCW 48.43.0161](#)

Total reported codes for each service category

Service Category	Total PA Requests in 2020*	Total PA Requests in 2021*
Outpatient Med-Surg	196,313	293,424
Outpatient MH-SUD	36,190	38,118
DME	23,844	27,934
Inpatient Med-Surg	26,470	22,124
Diabetes Supplies and Equip	3,434	8,287
Inpatient MH-SUD	2,920	3,693
Total	289,171	393,580

*From the top 10 codes submitted by each carrier for the codes with the highest number of prior authorization requests.

* Some of the increase in Oupatient Med-Surg requests likely due to carriers reporting "administrative" prior auth that did not involve review of medical necessity

Top 10 codes with highest number of PA requests in 2021

Code	Short Code Description	Total requests in 2020	Total requests in 2021
99214	Office visit E&M, 30-39 min*	64,197	135,335
90837	Psychotherapy, 60 min*	15,341	24,167
97110	Physical therapy	12,051	23,284
120	Room and board	16,522	19,860
45380	Colonoscopy	8,922	13,377
97124	Physical therapy with compression, etc.	5,073	13,258
E0601	Continuous airway pressure (CPAP) device	9,040	11,006
93306	Transthoracic echocardiography	8,324	10,254
74176	CT, abdomen and pelvis	8,341	10,146
73721	MRI, lower extremity any joint	7,636	8,938

Medical-Surgical codes 2021

Med-Surg (Inpatient and Outpatient)

Code	Description	Total requests	Approval rate
99214	Office visit E&M, 30-39 min	132,586	95.7%
97110	Physical therapy	23,284	87.1%
120	Room and board	19,698	97.4%
45380	Colonoscopy	13,377	97.7%
97124	Physical therapy, with compression, etc.	13,258	96.2%
93306	Transthoracic echocardiography	10,254	94.6%
74176	CT, abdomen and pelvis	10,146	93.9%
73721	MRI, lower extremity any joint	8,938	88.7%
43235	Upper GI endoscopy	6,697	93.7%
72148	MRI, lumbar spine	6,420	85.3%

Mental Health-Substance Use Disorder – 2021

MH-SUD (Inpatient and Outpatient)

Code	Description	Total requests	Approval rate
90837	Psychotherapy, 60 min	24,167	98.2%
90836	Psychotherapy, 45 min w/ medical services	4,829	99.1%
90791	Psychiatric diagnostic eval	2,090	93.4%
90834	Psychotherapy, 45 min	1,520	99.0%
124	Room and board, psychiatric	1,414	97.2%
90853	Group psychotherapy	1,224	98.8%
128	Room and board, rehab	767	96.5%
90868	TMS treatment, subsequent	676	76.8%
900	Other therapy service	605	97.7%
96130	Psychological testing eval	465	97.9%

Questions?

Jane Beyer

Senior Health Policy Advisor

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Agenda Item #4

Discuss Any Other Matters Brought Before the Task Force
—*Commissioner Sharon P. Clark (KY)*