Draft date: 7/23/24

2024 Summer National Meeting
Chicago, Illinois

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
Thursday, August 15, 2024
9:30 – 10:45 a.m.
McCormick Place Convention Center—S103—Level 1

ROLL CALL

Anita G. Fox, Chair	Michigan	Alice T. Kane	New Mexico
Grace Arnold, Co-Vice Chair	Minnesota	Andrew R. Stolfi	Oregon
Glen Mulready, Co-Vice Chair	Oklahoma	Michael Humphreys	Pennsylvania
Trinidad Navarro	Delaware	Alexander S. Adams Vega	Puerto Rico
John F. King	Georgia	Jon Pike	Utah
Dean L. Cameron	Idaho	Mike Kreidler	Washington
Joy Y. Hatchette	Maryland	Allan L. McVey	West Virginia
D.J. Bettencourt	New Hampshire		

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

AGENDA

1. Hear Opening Remarks—*Director Anita G. Fox (MI)*

2. Consider Adoption of its July 26, June 13, and Spring National Meeting Minutes —*Director Anita G. Fox (MI)* — Attachment One, Attachment Two

3. Consider Adoption of its Subgroup, Working Group, and Task Force Reports —*Director Anita G. Fox (MI)*
   A. Consumer Information (B) Subgroup—*David Buono (PA)*
   B. Health Innovations (B) Working Group—*Commissioner Nathan Houdek (WI)*
   C. Health Actuarial (B) Task Force—*Director Anita G. Fox (MI) and Kevin Dyke (MI)*
   D. Long-Term Care Insurance (B) Task Force—*Commissioner Andrew N. Mais (CT) and Paul Lombardo (CT)*
   E. Regulatory Framework (B) Task Force—*Commissioner Glen Mulready (OK)*
   F. Senior Issues (B) Task Force—*Commissioner Scott Kipper (NV)*

4. Hear a Federal Update—*Brian R. Webb (NAIC)*

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5. Hear an Update from the Consumer Perspective on Recent State Activity Related to the Prior Authorization Process—*Carl Schmid (HIV+Hepatitis Policy Institute), Stephani Becker (Shriver Center on Poverty Law), and Lucy Culp (The Leukemia & Lymphoma Society [LLS])*

6. Hear Presentations on Health Cost Transparency—*Sabrina Corlette (Center on Health Insurance Reforms [CHIR] at Georgetown University's McCourt School of Public Policy) and Kelley Schultz (America's Health Insurance Plans [AHIP])*

7. Hear an Update from the Federal Centers for Medicare & Medicaid Services' (CMS') Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities—*Dr. Ellen Montz (CCIIO) and Jeff Wu (CCIIO)*

8. Review Addressed Priorities and Discuss Priorities for the Upcoming Committee Meeting —*Anita G. Fox (MI)*

9. Discuss Any Other Matters Brought Before the Committee—*Director Anita G. Fox (MI)*

10. Adjournment

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Agenda Item #1

Hear Opening Remarks—*Director Anita G. Fox (MI)*

Agenda Item #2

Consider Adoption of its July 26, June 13, and Spring National Meeting Minutes
—Director Anita G. Fox (MI)

Draft: 7/29/24

Health Insurance and Managed Care (B) Committee
E-Vote
July 26, 2024

The Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded July 26, 2024. The following Committee members participated: Anita G. Fox, Chair (MI); Glen Mulready, Co-Vice Chair (OK); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron represented by Shannon Hohl (ID); Joy Y. Hatchette represented by David Cooney (MD); D.J. Bettencourt (NH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Alexander S. Adams Vega (PR); Jon Pike (UT); Mike Kreidler (WA); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted the Regulatory Framework (B) Task Force's 2024 Revised Charges

The Committee conducted an e-vote to consider adoption of the Regulatory Framework (B) Task Force's 2024 revised charges, which amend the 2024 charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup (*see NAIC Proceedings – Summer 2024, Regulatory Framework (B) Task Force, Attachment One-A*). The motion passed unanimously.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Draft: 7/10/24

Health Insurance and Managed Care (B) Committee
Virtual Meeting
June 13, 2024

The Health Insurance and Managed Care (B) Committee met June 13, 2024. The following Committee members participated: Anita G. Fox, Chair, Kevin Dyke, and Tina Nacy (MI); Grace Arnold, Co-Vice Chair (MN); Glen Mulready, Co-Vice Chair (OK); Trinidad Navarro represented by Susan Jennette (DE); John F. King represented by Teresa Winer (GA); Dean L. Cameron represented by Weston Trexler and Shannon Hohl (ID); Kathleen A. Birrane represented by Jamie Sexton and David Cooney (MD); D.J. Bettencourt represented by Michelle Heaton (NH); Alice T. Kane represented by Viara Ianakieva (NM); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Sandra L. Ykema (PA); Alexander S. Adams Vega represented by Carlos Valles (PR); Jon Pike represented by Tanji J. Northrup (UT); Mike Kreidler represented by Ned Gaines (WA); and Allan L. McVey represented by Joylynn Fix (WV).

1. Received an Update on Health Actuarial (B) Task Force Activities

Dyke said the Health Actuarial (B) Task Force has three items it is presenting for the Committee's adoption: 1) proposed revisions to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51); 2) proposed revisions to Valuation Manual (VM)-26, Section 3B—Contract Reserves for Credit Disability Insurance; and 3) proposed revisions to the Task Force's 2024 revised charges. He said two documents related to the AG 51 proposed revisions were included in the meeting materials: a memorandum to the Committee from the Long-Term Care Insurance (B) Task Force describing the proposed revisions and a document including the proposed revisions. Dyke explained that the AG 51 proposed revisions result from the work of the Health Test Ad Hoc Group of the Health Risk-Based Capital (E) Working Group, which reviewed the health test language within the *Annual Statement Instructions* due to inconsistencies in reporting of health business across the different blanks, as well as a significant amount of health business reported on the life and fraternal blank. Through its evaluation and discussion of changes to the health test, a question was raised regarding whether an entity would still be required to comply with the AG 51 requirements for long-term care insurance (LTCI) business if it moved from the life blank to the health blank. To address the issue, the Long-Term Care Actuarial (B) Working Group revised AG 51 to clarify that regardless of the blank the entity files, AG 51 filing is required by the entity if the criteria stated in the guideline are met. Dyke said the Health Actuarial (B) Task Force adopted the amendment Feb. 20. The Long-Term Care Insurance (B) Task Force adopted the amendment March 16.

Dyke said the next items for the Committee's consideration are the proposed revisions to VM-26, Section 3B—Contract Reserves for Credit Disability Insurance. He outlined the process of adopting *Valuation Manual* amendments and the Committee's role in the adoption before the package of *Valuation Manual* amendments is presented to the full NAIC Membership for adoption at each Summer National Meeting. He said the Health Actuarial (B) Task Force adopted this revision to VM-26, Section 3B, and is requesting Committee adoption because credit disability experience has gradually improved since the original 1997 credit disability study. The 2022 study indicates that the current valuation standard contains claim costs from 190%–276% of actual claim cost experience, based on the Society of Actuary's (SOA's) "2023 Credit Disability Study Report." The variations in the range shown above occur by elimination period and occupation class distributions observed over the period studied, 2014 through 2022. Dyke said the proposed changes to VM-26, Section 6B remove the 12% addition to the 1985 Commissioners Individual Disability Table A (85CIDA) incidence rates for newly issued contracts since the addition of the 12% constitutes a margin that is no longer needed or justified by experience. He said the Health

Actuarial (B) Task Force exposed the proposed versions for a 45-day public comment period ending March 22. No comments were received. The Health Actuarial (B) Task Force adopted the revisions May 13.

Dyke said the last items for the Committee's consideration are proposed amendments to the Task Force's 2024 charges (*see NAIC Proceedings – Spring 2024, Health Actuarial (B) Task Force, Attachment Two*). He said the amendments reflect that the Long-Term Care Actuarial (B) Working Group now reports to the Long-Term Care Insurance (B) Task Force instead of the Health Actuarial (B) Task Force.

Gaines made a motion, seconded by Heaton, to adopt the: 1) revisions to AG 51; 2) revisions to VM-26, Section 3B; and 3) Task Force's revised 2024 charges. The motion passed unanimously.

2. Discussed the Effects of Changes to CSRs

Director Fox said the next item was to hear the Health Actuarial (B) Task Force's findings from its review and discussion of an issue the Committee referred to the Task Force late last year on how possible changes to the cost-sharing reduction (CSR) subsidy, like changes to silver loading, could impact plan options and costs to consumers. In making that referral, it was the Committee's understanding that the Task Force had already heard from the American Academy of Actuaries (Academy) and other actuarial groups that silver loading has created odd incentives in the market. Because of this, the Committee felt it would be beneficial to know more about how changes in state silver loading policies or other changes, like the elimination of the enhanced subsidies in 2026, could impact consumer choices and the affordability of coverage.

Dyke said that included in the meeting materials is a memorandum from the Task Force to the Committee outlining its findings (Attachment ?-A). He explained that under the federal Affordable Care Act (ACA), CSRs are available for individuals and families purchasing health coverage in the health insurance marketplace with annual incomes below 250% of the federal poverty level (FPL). The federal government funded the cost of offering CSRs until 2017, when the U.S. Attorney General determined that funding was not appropriated by the U.S. Congress. Dyke said that when the funding was stopped, beginning in 2018, the federal Center for Consumer Information and Insurer Oversight (CCIIO) permitted states to allow insurers to increase plan premium rates to address the CSR shortfall. He said a variety of methods emerged to address the funding shortfall.

Dyke explained that the effect on consumer choices and affordability can vary based on the CSR funding methodology due to its resulting impact on premium subsidies or advanced premium tax credits (APTCs). He said that given the various methodologies that may be used to address the funding shortfall, the Task Force sought guidance and heard from the Academy, the CCIIO, and other stakeholders on the matter. He said the Task Force also updated its state survey of CSR loading approaches. Dyke summarized some of those discussions and the state survey results. He noted that the Task Force has never advocated for any particular approach states should take to address the funding shortfall.

Director Fox noted that enrollment in the ACA health insurance marketplace has increased because of the enhanced subsidies. She asked Dyke whether the next step to be considered if the enhanced subsidies end is whether there would be a corresponding decline in enrollment and whether state insurance regulators need to be vigilant and think about ways to get people enrolled in other coverage. Dyke said the Task Force did consider the impact of the enhanced subsidies ending as part of the referral. He noted that this is not a new issue for the Task Force, and there are many studies on it. He also noted that the NAIC is once again in the process of drafting a letter to Congress urging an extension of the enhanced subsidies or making them permanent. Dyke noted that all the things already discussed related to the enhanced subsidies' impact on enrollment in the ACA health insurance marketplace—increased enrollment and greater affordability—could potentially be reversed if they end. As a possible example, he pointed out the results of the Florida Office of Insurance Regulation's study on the

impact of the enhanced subsidies, which showed that enrollment increased by 51.4% overall from 2021 to 2023. The increase was 67.3% for those with incomes between 100% and 150% of the FPL and 86.9% for those over 400% of the FPL during the same period. He said these results would indicate the probability of a reversal in enrollment numbers if the enhanced subsidies end.

Director Fox said that despite asking for guidance from the CCIIO, the CCIIO has not dictated what methodology a state must use to address the CSR shortfall. As noted in the Task Force's memorandum to the Committee, there are many approaches the states can consider moving forward.

3. Heard a Presentation from the CIPR on Network Adequacy

Director Fox said the Committee would next hear a presentation from Kelly Edmiston (Center for Insurance Policy and Research—CIPR) on a case study the CIPR completed as part of its Network Adequacy Project: Compensation of Travel Costs for In-Network Care in Mississippi. Director Fox explained that she conducted a survey at the beginning of the year, asking Committee members which issues they were interested in learning more about. She said that network adequacy and its maximum time and distance requirements ranked as one of the issues. She said that before the CIPR presentation, Nacy would provide an overview of the network adequacy issue.

Nacy explained what a provider network is and how insurers establish provider networks, including defining and adjusting the number, quality, and type of providers in the network. She discussed the ACA's network adequacy goals and requirements, including maximum time and distance standards and maximum wait-time standards. Nacy explained that the federal Centers for Medicare & Medicaid Services (CMS) will conduct reviews to determine if an insurer satisfies the network adequacy requirements unless a state receives approval from the CMS to conduct its own reviews. To receive such approval, a state's criteria must be as stringent as CMS's network adequacy requirements.

Nacy noted that although her presentation seems to imply that network adequacy is simple and straightforward, state insurance regulators know that it is a challenging and complex issue. She said Edmiston will present a case study reflecting the CIPR's research on network distance issues, which would, hopefully, provide some insight and spark discussions on the issue.

Edmiston said the CIPR has been studying the issue of network adequacy for the past few years. During this meeting, he discussed the findings of a case study the CIPR conducted related to a new regulation in Mississippi requiring insurers to reimburse travel costs for patients who must travel 100 miles or more to access an in-network provider. The new regulations require an economic impact statement (EIS) that provides an estimate of the economic costs of the new regulation. He said the Mississippi Insurance Department requested the CIPR prepare an estimate of the costs to insurers of the regulation (or benefits to policyholders) to be used in the regulations' EIS. Edmiston discussed how the study was conducted. He provided results for one insurer for two provider specialties—allergy and immunology and reproductive endocrinology—from the 75 provider specialties surveyed as part of the study. He explained that the reimbursement costs to an insurer will vary based on whether the insurer has a broad or narrow provider network.

Director Fox asked Edmiston if requiring an insurer to reimburse consumers for travel costs could address an issue for states having insurer network adequacy compliance issues in rural areas. Edmiston said he does not know the impetus for Mississippi's new regulation requiring reimbursement for travel costs, but potentially such a requirement could address that issue for some states.

Nacy asked Edmiston how long it took the CIPR to complete the study, including the required analysis. Edmiston said excluding the time it took for the CIPR to obtain the necessary data, it took a couple of months to complete.

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Nacy said that based on his discussion, it appears the CIPR is looking to obtain software to enable it to conduct more of these types of studies and analyses. She asked Edmiston if the CIPR had thought of other ways to assist the states with this issue. Edmiston said the CIPR is always happy to assist but noted that it seeks to obtain the software primarily to reduce the cost of conducting such studies and analyses to eliminate the need to rely on outside entities, such as Google, to perform the necessary millions of calculations. Commissioner Mulready asked if the CIPR conducted this analysis prior to or after the regulation's adoption. Edmiston answered that the CIPR conducted the analysis prior to its adoption because Mississippi law requires an EIS to be completed as part of the regulation adoption process.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Draft: 3/27/24

Health Insurance and Managed Care (B) Committee
Phoenix, Arizona
March 18, 2024

The Health Insurance and Managed Care (B) Committee met in Phoenix, AZ, March 18, 2024. The following Committee members participated: Anita G. Fox (MI), Chair; Grace Arnold, Co-Vice Chair (MN); Glen Mulready, Co-Vice Chair (OK); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron (ID); D.J. Bettencourt (NH); Alice T. Kane (NM); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Alexander S. Adams Vega (PR); Jon Pike (UT); Mike Kreidler represented by Ned Gaines (WA); and Allan L. McVey represented by Joylynn Fix (WV). Also participating were: Paul Lombardo (CT); Andria Seip (IA); Patrick Smock (RI); and Jennifer Stegall (WI).

1. Heard Opening Remarks

Director Fox said she believes the Committee was able to accomplish many things in 2023. She hopes to continue the collaboration with each other and senior staff and connections this year by continuing to hold virtual and in-person regulator-to-regulator meetings to allow time for more in-depth discussion on its 2024 priority issues. She said the Committee also was able to be more connected with other stakeholders across the NAIC on issues of mutual interest, such as the NAIC consumer representatives, the Center for Insurance Policy and Research (CIPR), and other NAIC committees, including the Market Regulation and Consumer Affairs (D) Committee and the Special (EX) Committee on Race and Insurance's Health Workstream, which she also hopes to continue in 2024.

She said that, like last year, she surveyed Committee members on the priorities and issues they would like to focus on and discuss this year. She explained that the survey results identified many of the same priorities as last year—mental health, ground ambulances, network adequacy, pharmacy benefit managers (PBMs), long-term care insurance (LTCI), prior authorization, and cost transparency. She said that during this meeting, the Committee will discuss two of these priorities—ground ambulances and LTCI.

Director Fox said that, like last year, the Committee is dealing with an unexpected issue. Last year, it was issues related to the low number of consumer appeals of claim denials. She said this year, it concerns the Change Healthcare cybersecurity attack, which is greatly affecting health care operations across the nation given the scope of Change Healthcare's involvement in claims processing and other services it provides to payers and providers.

2. Adopted its 2023 Fall National Meeting Minutes

Commissioner Arnold made a motion, seconded by Commissioner King, to adopt the Committee's Dec. 2, 2023, minutes (*see NAIC Proceedings – Fall 2023, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

3. Adopted its Subgroup, Working Group, and Task Force Reports

Commissioner Stolfi made a motion, seconded by Commissioner Pike, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its Feb. 27 (Attachment One) minutes; 2) the Health Innovations (B) Working Group, including its March 17 minutes (Attachment Two); 3) the Health Actuarial (B) Task Force; 4) the Long-Term Care Insurance (B) Task Force; 5) the Regulatory Framework (B) Task Force; and 6) the Senior Issues (B) Task Force. The motion passed unanimously.

4. Received an Update on the Long-Term Care Insurance (B) Task Force's and the Long-Term Care Actuarial (B) Working Group's Work

Lombardo provided an update on the work of the Long-Term Care Insurance (B) Task Force and the Long-Term Care Actuarial (B) Working Group. He said both the Task Force and the Working Group are focusing their work on developing a single LTCI multistate actuarial (MSA) rate review approach. He said that during its March 15 meeting, the Working Group exposed the Minnesota approach, with modifications to align with agreed-upon concepts, for a 45-day public comment period ending April 3. He encouraged state insurance regulators and interested parties to engage in these discussions and provide feedback to the Working Group on the exposure draft. The goal is to finalize the development of a single approach by the end of 2024.

Lombardo said the Task Force supports the Working Group's work in developing a single LTCI MSA rate review approach and the Working Group's continued consideration of addressing issues related to 80+ attained age considerations, long duration, and cumulative increases, as it develops the single LTCI MSA approach. He said the Task Force also discussed the timeliness of LTCI rate reviews. During that discussion, the Task Force encouraged state insurance regulators to: 1) consider the impact of the timeliness of LTCI rate reviews on future loss ratios and future rate increases that may be requested by insurers; 2) coordinate between rate review and form review staff; communicate to the industry on the best time frames to submit rate filings; and 3) engage with internal staff at all levels about rate filings. He said the Task Force also suggested to industry that when submitting LTCI rate filings, they consider the timing of such filings with other filing deadlines, such as federal Affordable Care Act (ACA)-plan filing deadlines, because if these filings are made at the same time, there could be a delay in reviewing them.

Lombardo said the Task Force also received an overview of a consumer notices and reduced benefit options (RBOs) research project that the CIPR) is conducting. He said the survey will begin next week, and preliminary results are anticipated later in April.

Director Fox asked about the purpose of having a single LTCI MSA rate review approach. Lombardo described the MSA rate review process, noting that it is not going to be a model that NAIC members would be required to adopt. He said the company will continue to file its LTCI rate request with each state either after the MSA process is complete or concurrent with that process. He said the Task Force and Working Group are looking to create a single methodology that the states can use to conduct and incorporate into their LTCI rate reviews. The process is not a mandate. Director Fox asked if the materials the LTCI MSA rate reviewers use in their rate review will be available to the states. Lombardo confirmed that those materials are already available to the states through the Interstate Insurance Product Regulation Commission (Compact) to help reduce redundancy in the rate review process.

5. Heard a Presentation on Understanding the Basics of How Ground Ambulance Services Work in the U.S.

Jack Hoadley (Georgetown University's Health Policy Institute at the McCourt School of Public Policy) provided an overview of how ground ambulance services work in the U.S. He highlighted the lack of protections for consumers in the federal No Surprises Act (NSA) from receiving surprise bills for ground ambulance services. Hoadley said it is important to fill this gap in protections because: 1) patients rarely have a choice of ground ambulance provider; 2) emergency situations limit opportunities for patient disclosure; and 3) many public-sector providers lack resources to contract with ground ambulance service providers. He discussed the level and types of ground ambulance services, explaining that only 10% of patients arrive at the emergency room using a ground ambulance. Hoadley discussed what commercial insurers typically cover for ground ambulance service claims using Washington state as an example. He also discussed the share of ground ambulance rides by ownership type—private equity or publicly traded, facility, nonprofit, public sector, and independent.

Hoadley provided information on the share of out-of-network use for ground ambulance services and potential surprise bills from 2014–2017 versus the share of ambulance rides with an out-of-network charge in 2018. He discussed state consumer protections and state models—California, Colorado, New York, and Texas—for rate reimbursement guidance.

Hoadley suggested certain factors for policymakers to consider when seeking to protect consumers from out-of-network ground ambulance services: 1) the applicability to public/private ground ambulance providers or both; 2) the applicability to non-emergency services (e.g., interfacility transfers); 3) the applicability to circumstances where the patient refuses medical attention or is treated but not transported; and 4) the applicability of negotiation/arbitration process.

Commissioner Mulready said he anticipates legislation being introduced in the Oklahoma legislature modeled after the Texas law, which requires reimbursement of ground ambulance services based on the rate set by a local subdivision or the lesser of 325% of Medicare or the provider's billed charge. He asked Hoadley if that is the trend he is seeing in those states trying to address reimbursement issues. Hoadley said that seems to be the trend since last year. He also noted that the federal Advisory Committee on Ground Ambulance and Patient Billing (GAPB) also appears to support such a reimbursement structure. Hoadley said that some policymakers have raised concerns about the potential inflationary effects of such a reimbursement model.

Director Fox asked if concerns have been raised that setting and possibly locking in local reimbursement rates, particularly if they are low reimbursement rates, could adversely affect consumer access to ground ambulance services, particularly in underserved areas. Hoadley said that, to date, he has not heard of any such concerns, but he could envision it if the local reimbursement rates are locked in at such a level that they do not cover the provider's cost of providing the service.

Gaines said Washington recently passed a ground ambulance billing bill, which will be effective in 2025. He said he forwarded a link to a study Washington completed on the reimbursement issue that he believes will be useful to states considering such legislation to NAIC staff for distribution to Committee members.

6. <u>Heard a Presentation from the Consumer Perspective on the ACA's Section 1557 Nondiscrimination Proposed Rule</u>

Amy Killelea (NAIC consumer representative), Carl Schmid (HIV+Hepatitis Policy Institute), and Kellan Baker (Whitman-Walker Institute) discussed the ACA's Section 1557 nondiscrimination proposed rule from a consumer perspective. They provided a timeline for Section 1557 and the prior federal rules promulgated for this section. The current notice of proposed rulemaking (NPRM) was issued in 2022. It is anticipated that the final rule will be issued in the next few months. The panelists discussed the proposed changes in the rule related to Section 1557's applicability, discriminatory benefit design, and prescription drug access.

The panelists highlighted the importance of enforcement by state departments of insurance (DOIs), the federal Centers for Medicare & Medicaid Services (CMS), and the federal Office of Civil Rights to ensure compliance with Section 1557's requirements. They suggested that compliance can be attained through health plan reviews, approvals, and complaints. The panelists also highlighted, consistent with the 2020 U.S. Supreme Court decision in *Bostock v. Clayton County*, the restoration of the full scope of sex nondiscrimination protections in the 2022 rule.

The panelists included recommendations for what state insurance regulators can do to ensure compliance with Section 1557's nondiscrimination requirements and, when issued, the final rule, including: 1) ensuring that insurers are aware of the new protections; 2) reviewing plans for discriminatory benefit design as part of the ACA

plan certification process; and 3) monitoring and enforcing compliance through the complaint process, data calls, and market conduct examinations.

7. Heard an Update from CMS' CCIIO on its Recent Activities

Jeff Wu (CCIIO) updated the Committee on the CCIIO's recent activities of interest. He said he did not have any updates on the proposed Notice of Benefit and Payment Parameters (NBPP) proposed rule for 2025. The CMS hopes to finalize the rule by the end of March or early February. Wu focused the remainder of his comments on CMS' response to the Change Healthcare cybersecurity attack and its impact on operations.

Wu said that when the Change Healthcare cyberattack was revealed a few weeks ago, CMS' immediate concern was patients' access to prescriptions. He said the cyberattack exposed the vulnerabilities, underpinnings, and infrastructure that underlie a lot of the health care system, and the extent to which players like Change Healthcare are such a huge part of it. Wu said CMS has been able to get a sense of the scope of Change Healthcare's involvement in the health care system as a very large clearinghouse for claims processing on both the provider side and the payer side. As such, CMS has been in discussions with providers and vendors to think of alternative ways to provide those services.

Wu noted the financial impact for providers, who are providing services and not receiving reimbursement for those services. He said some providers have been able to manage this situation, but others, particularly rural providers and smaller providers that provide services to some of the most vulnerable populations, who do not have the capital resources to weather such a disruption, are at risk. He said CMS has been taking steps to try to loosen up cash flow to assist such providers. One such step is providing Medicare Part A and Medicare Part B advance payments to those providers. Wu said CMS has also recently issued guidance providing flexibility to state Medicaid agencies to take similar actions. He said CMS has also reached out to insurers pushing them to provide similar flexibilities to assist providers with their cash flow issues. He also said CMS wants to work with state insurance regulators to identify and assist any providers they might have in their state experiencing cash flow issues.

Director Fox asked what pressures CMS is putting on UnitedHealthcare (UHC) and Change Healthcare to assist providers with their cash-flow problems and what efforts they are taking to resolve the problem. She said the money that would have been paid to providers for services provided is in the system somewhere, and that money should be flowing to providers. Wu agreed with Director Fox's comments and noted that CMS acknowledges this is an issue, but decided to move forward with what it could do to address the problem. He said CMS would be happy to work with state insurance regulators to address these issues.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Agenda Item #3

Consider Adoption of its Subgroup, Working Group and Task Force Reports
—Director Anita G. Fox (MI)

Virtual Meetings

CONSUMER INFORMATION (B) SUBGROUP
July 29, 2024 / June 18, 2024

Summary Report

The Consumer Information (B) Subgroup met July 29 and June 18, 2024. During these meetings, the Subgroup:

1. Adopted its June 18 minutes.

2. Discussed developing guides on prior authorization—a consumer guide and a state insurance regulator guide.

3. Decided to proceed with developing a consumer guide on prior authorization and deferred deciding on developing a state insurance regulator guide on prior authorization.

4. Discussed and adopted a consumer guide on prior authorization.

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Draft: 8/5/24

Consumer Information (B) Subgroup
Virtual Meeting
July 29, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met July 29, 2024. The following Subgroup members participated: David Buono, Chair (PA); T.J. Patton, Vice Chair, (MN); Michelle Baldock (IL); Alex Peck (IN); Terri Smith (MD); Jeana Thomas (MO); Hadiya Swann (NC); Jill Kruger (SD); Jennifer Ramcharan and Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keeley (WI).

1. <u>Discussed a Consumer Guide on Prior Authorization</u>

Buono discussed the work of a drafting group that developed a consumer guide on prior authorization (Attachment 1). He thanked the drafting group for its work and said it intended the guide to cover important points while keeping the language clear and simple. He said the guide, once approved, may be modified by states to fit their needs.

The Subgroup reviewed the draft and discussed a number of changes. It added clarifying language about step therapy and a drafting note that points out where states can add additional information about their state laws. The Subgroup also discussed the document's reading level and was satisfied that it measured just below the ninthgrade level.

Patton made a motion, seconded by Keeley, to approve the guide with the changes added (Attachment ?-A). The motion passed unanimously. Joe Touschner (NAIC) said the guide would be shared with the Health Insurance and Managed Care (B) Committee for awareness, and the final version would be sent to Subgroup members and interested parties.

2. <u>Discussed Other Matters</u>

Buono said the Subgroup should expect to work on updates to the *Frequently Asked Questions About Health Care Reform* (FAQ) starting in September, so the document is ready for the beginning of open enrollment. He said the Subgroup has a list of potential projects to take up after that one, including guides on preventive services, limited benefit plans, mental health parity, and the balance billing protections of the No Surprises Act (NSA). He said the Subgroup could decide at a future meeting which topic to take up after the FAQ.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Prior Authorization: What It Is, When It's Used, and Your Options

What Is Prior Authorization?

Prior authorization means your health plan requires your doctor or other healthcare provider to get approval *before* they provide health care services or prescribe prescription drugs. Without prior authorization, your health plan may not pay for your treatment or medication.

NOTE: Emergency services don't require prior authorization.

Why Do Health Plans Require Prior Authorization?

Prior authorization serves two purposes. First, it's a check that your plan covers the proposed care. It's also a way the health plan can decide if the care is medically necessary, safe, and cost effective.

What Is Medically Necessary?

A medically necessary service or prescription drug is one that's needed to diagnose or treat an illness, injury, condition, disease, or its symptoms. It must meet accepted standards of medicine. To decide what's medically necessary, your health plan must follow any state and federal laws that apply.

How Do Health Plans Decide What's Safe?

To be safe, procedures, treatments, and prescription drugs must meet the latest clinical standards and guidelines. They must avoid negative interactions between drugs you're already taking or treatments you're receiving.

What If My Health Plan Has Concerns with a Proposed Treatment or Medication?

The health plan may deny the request, ask for more information, recommend another approach, or talk with your provider to agree on the most appropriate care plan. Your health plan might suggest other tests based on clinical guidelines before it makes a decision.

Could My Health Plan Deny Prior Authorization Because of Cost?

Yes. Health plans may deny prior authorization when similar drugs or services are equally safe and effective but cost less. For example, a health plan may approve a drug only if you try a less expensive drug first and that drug isn't effective or causes side effects. This may be called step therapy.

Do I Need Prior Authorization to Continue a Treatment I'm Currently Receiving?

You may. Your health plan may require your provider to confirm that ongoing services or medications would continue to help you.

What Medications and Services Require Prior Authorization?

Your health plan has a list of medications and services that typically require prior authorization. You can find the list in printed plan documents and/or online.

Does Medicare Require Prior Authorization?

Original Medicare (Medicare Part A and Part B) generally does not require prior authorization.

Medicare Advantage and Medicare prescription drug plans (Part D) may require prior authorization.

How Long Do Prior Authorization Decisions Take?

How long it takes to get a prior authorization decision depends on how urgently you need the care. If your need is urgent, you or your provider can ask for an expedited (or quick) review. State or federal rules may limit the time a health plan can take to make decisions.

What Rules Must Plans Follow About Prior Authorization?

Health plans' prior authorization policies must follow federal and state laws. Depending on your state, these laws may address:

- How quickly health plans must respond to requests for prior authorization and appeals,
- What types of professionals may review and approve or deny a prior authorization request,
- What information a health plan must share with you and your provider when it denies a prior authorization request, and
- How long a prior authorization approval may last before you must ask for a new authorization.

How Do I Ask for Prior Authorization?

Your health care provider can make the prior authorization request. In some cases, your provider will request that you start the prior authorization process.

If your provider submits the request, they will send the required information to the health plan. You may need to fill out forms for your provider's office to use. A prior authorization form will include information about you, your medical conditions, and your health care needs. It's important to fill out the form completely and accurately. Missing or wrong information could delay your request or result in a denial.

If you submit the prior authorization request, ask your health plan how to do that. Make sure you meet the deadlines your health plan gives you. Keep copies of all documents and communications sent and received. Note dates and the names and titles of people you speak with. You may need this information if the request is denied. Keep a record of approved prior authorizations in case you need to ask for another one in the future.

Can I Appeal If I Think My Prior Authorization Was Incorrectly Denied?

You may appeal a health plan's prior authorization decision. Before starting the appeal process, call your health plan to learn why the prior authorization was denied. Check that all the requested information was received and was correct. If a simple error was the problem, such as missing information, correcting the error might be a quick fix.

If all information is correct and nothing is missing, you'll need to partner with your provider's office to start an appeal. Give the office the reason for the denial. Ask if there's other information that could support the prior authorization request. If so, you or your provider can follow your health plan's instructions to submit an appeal.

For more information about how to appeal a prior authorization decision, contact [your state Insurance Department] to help guide you through the process or help you file a complaint if appropriate.

Drafting Note: State laws or rules are referenced in three answers (What is Medically Necessary?, How Long Do Prior Authorization Decisions Take?, and What Rules Must Plans Follow About Prior Authorization?). States may wish to provide specific information on state laws or link to additional information. The final answer on appeals includes a reference to the state department of insurance, where it may be helpful to add contact information.

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Draft: 6/26/24

Consumer Information (B) Subgroup
Virtual Meeting
June 18, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met June 18, 2024. The following Subgroup members participated: David Buono, Chair (PA); T.J. Patton, Vice Chair (MN); Michelle Baldock (IL); Terri Smith (MD); Jeana Thomas (MO); Hadiya Swann (NC); Jill Kruger (SD); Shelley Wiseman (UT); and Christina Keeley and Jody Ullman (WI). Also participating was: Susan Jeanette (DE).

1. Heard Introductory Remarks

Buono and Patton introduced themselves as the Subgroup's new chair and vice chair. Buono described his background with the Pennsylvania Insurance Department and his work on consumer issues. Patton shared his history with the Minnesota Department of Commerce and his work managing consumer assistance. Both said they are eager to develop materials for use by state insurance regulators with the Subgroup.

2. Discussed Guides on Prior Authorization

Buono discussed the work of a drafting group working on a consumer guide on prior authorization. He said the drafting group has made progress, and he hopes the drafting group will have a draft to share with the Subgroup after one or two additional meetings. He invited state insurance regulators and interested parties to join the drafting group's upcoming meetings.

Buono said that the drafting group had discussed developing two guides: one for consumers and one for state insurance regulators. He asked Subgroup members whether a guide for state insurance regulators would be useful. The Subgroup decided to defer to the drafting group on this question.

3. Discussed Other Matters

Buono said that in addition to the prior authorization guide and updates to the *Frequently Asked Questions about Health Care Reform*, the Subgroup should consider additional projects for the remainder of 2024 or 2025. He said two potential projects would produce consumer guides on the federal No Surprises Act (NSA) or mental health parity protections. He asked the Subgroup what additional topics should be considered.

Subgroup members and interested parties suggested a variety of potential topics for consumer materials, including coverage of preventive services, education on self-funded versus fully-insured plans, alternative payment models, making updates to the Subgroup's existing health insurance shopping tools, and limited benefit plans like short-term, limited duration (STLD), discount plans, and health care sharing ministries (HCSMs). Subgroup members also supported the idea of producing guides on the NSA and mental health parity. Buono said that he and Patton would discuss the suggestions and come back to the Subgroup with a proposal for its next project.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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2024 Summer National Meeting
Chicago, Illinois

HEALTH ACTUARIAL (B) TASK FORCE
Monday, August 12, 2024
2:30 – 4:00 p.m.

Meeting Summary Report

The Health Actuarial (B) Task Force met Aug. 12, 2024. During this meeting, the Task Force:

1. Adopted its May 13 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its Spring National Meeting Minutes.
   B. Adopted an amendment proposal form (APF) to revise Valuation Manual (VM)-26, Credit Life and Disability Reserve Requirements, Section 3.B. Contract Reserves for Credit Disability Insurance.

2. Heard a presentation from the American Academy of Actuaries (Academy) on drivers of 2025 federal Affordable Care Act (ACA) health insurance premium changes.

3. Heard an update on Society of Actuaries (SOA) Research Institute activities and on SOA education redesign.

4. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on Bright HealthCare and Friday Health Plans risk adjustment payments, risk adjustment and risk adjustment data validation (RADV) topics, the proposed 2026 Notice of Benefit and Payment Parameters (NBPP), and plan year 2025 federal ACA rate filings.

5. Heard an update from the Academy's Health Practice Council on recent Academy health-related webinars and Academy engagement with various NAIC groups.

6. Heard a presentation from the Academy on health knowledge statements.

7. Heard an Academy professionalism update.

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2024 Summer National Meeting
Chicago, Illinois

LONG-TERM CARE INSURANCE (B) TASK FORCE
Tuesday, August 13, 2024
10:30 – 11:15 a.m.

Meeting Summary Report

The Long-Term Care Insurance (B) Task Force met Aug. 13, 2024. During this meeting, the Task Force:

1. Adopted its Spring National Meeting minutes.

2. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met Aug. 12. During this meeting, the Working Group took the following action:
   A. Adopted its Spring National Meeting minutes.
   B. Adopted its July 2 minutes. During this meeting, the Working Group took the following action:
      i. Discussed comments received on the exposure of the Minnesota approach with any suggested adjustments as a candidate for a single long-term care insurance (LTCI) multistate rate review approach methodology for use in multistate actuarial (MSA) filing reviews.
      ii. Exposed the Minnesota approach with any suggested adjustments to the cost-sharing formula to address large rate increases for policyholders at roughly age 85 with a policy duration of 25 years (85/25 issue) as a candidate for a single LTCI multistate rate review approach for a 30-day public comment period ending Aug. 1.
   C. Discussed and received comments on a proposed single multistate long-term care insurance (LTCI) rate review approach.
   D. Exposed proposed single multistate rate review approaches for a 45-day comment period.

3. Heard a report on industry trends that could have an impact on the solvency of LTCI companies and reserves.

4. Heard an update from Delaware regarding consumer education on reduced benefit options (RBOs). The updated included Delaware Department of Insurance's (DOI's) Office of Long-Term Care Insurance website, staff who are trained to provide customer assistance, and links to additional LTCI and RBO information.

5. Heard a presentation from the Center for Insurance Policy and Research (CIPR) on a study of RBO letters to consumers and consumer choices. The CIPR plans to continue to model the data, as well as consider ways to improve RBO checklists and better ways to educate consumers.

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2024 Summer National Meeting
Chicago, Illinois

REGULATORY FRAMEWORK (B) TASK FORCE
Tuesday, August 13, 2024
11:30 a.m. – 12:30 p.m.

Meeting Summary Report

The Regulatory Framework (B) Task Force met Aug. 13, 2024. During this meeting, the Task Force:

1. Adopted its Spring National Meeting minutes.

2. Adopted its July 1 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its 2024 revised charges, which revised the 2024 charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup.

3. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its July 29, July 15, June 24, April 22, April 8, and March 25 minutes. During these meetings, the Subgroup took the following action:
   A. Completed its discussion of the Dec. 1, 2023, comments received on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).
   B. Distributed for final review a May 3 draft of proposed revisions to Model #171 reflecting the Subgroup's discussions.
   C. Discussed comments received on the May 3 draft of proposed revisions to Model #171.

4. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group.

5. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Spring National Meeting minutes. The Working Group will meet Aug. 14. During this meeting, the Working Group plans to take the following action:
   A. Hear presentations on clinical guidelines for behavioral health care.
   B. Meet in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue discussion of the opioid use disorder issue.

6. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its June 7 and May 2 minutes. During these meetings, the Subgroup took the following action:
   A. Discussed and adopted its revised 2024 charges, which included renaming the Subgroup as the "Pharmaceutical Benefit Management Regulatory Issues (B) Working Group."
   B. Forwarded the proposed revised 2024 charges to the Task Force for its consideration and adoption.

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7. Heard a presentation from the Center on Health Insurance Reforms (CHIR) on outpatient facility fee reforms focusing on options for the states.

8. Discussed the *Loper Bright Enterprises v. Raimondo* and *Relentless v. Department of Commerce* (Loper Bright) ruling, which overturned the so-called "Chevron Doctrine" and its potential implications on health insurance-related regulations. Schiffbauer Law Office provided an overview of the case and highlighted several health insurance-related regulations, including the federal Affordable Care Act's (ACA) Section 1557 federal regulations, the ACA's cost-sharing and deductible regulations, and Medicare hospital payment rules that could be affected by its overturning of the Chevron Doctrine, which provided deference to federal agencies in rulemaking in interpreting statutes they administer.

9. Heard a presentation from America's Health Insurance Plans (AHIP) and the Bipartisan Policy Center on a new collaborative multi-stakeholder initiative "Promoting Health Through Prevention (PHtP)."

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2024 Summer National Meeting
Chicago, Illinois

SENIOR ISSUES (B) TASK FORCE
Tuesday, August 13, 2024
9:00 – 10:15 a.m.

Meeting Summary Report

The Senior Issues (B) Task Force met Aug. 13, 2024. During this meeting, the Task Force:

1. Adopted its Spring National Meeting minutes.

2. Adopted its July 18 minutes. During this meeting, the Task Force took the following action:
   A. Discussed Medicare Supplement Insurance (Medigap) Guaranteed Issue and provider withdrawals from Medicare Advantage plans.
   B. Discussed the impacts of Section 1557 of the federal Affordable Care Act (ACA) and the application of nondiscrimination rules to Medigap.

3. Heard a presentation on State Health Insurance Assistance Programs (SHIPs).

4. Discussed Medigap guaranteed issue and provider withdrawals from Medicare Advantage plans. The Task Force agreed to send a letter to the federal Centers for Medicare & Medicaid Services (CMS).

5. Discussed the impacts of Section 1557 of the ACA and the application of nondiscrimination rules to Medigap. The Task Force agreed to send a letter to the U.S. Office of Civil Rights (OCR).

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Agenda Item #4

Hear a Federal Update—*Brian R. Webb (NAIC)*

Agenda Item #5

Hear an Update from the Consumer Perspective on Recent State Activity Related to the Prior Authorization Process—*Carl Schmid (HIV+Hepatitis Policy Institute), Stephani Becker (Shriver Center on Poverty Law), and Lucy Culp (The Leukemia & Lymphoma Society [LLS])*

Recent Activity on Improving Prior Authorization (PA)

Stephani Becker, Shriver Center on Poverty Law
Lucy Culp, The Leukemia & Lymphoma Society
Carl Schmid, HIV+Hepatitis Policy Institute

NAIC Health Insurance and Managed Care (B) Committee
Chicago, Illinois
August 15, 2024

Impacts Patients & Providers (AMA Survey)

- 78% of physicians reported PA often or sometimes results in patients abandoning recommended treatment
- 19% say resulted in a serious adverse event leading to a patient being hospitalized
- Spend 12 hours completing PA each week
- Leads to burnout & increased healthcare costs

94%

Of providers say PA delays patients' accessing necessary care.

https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

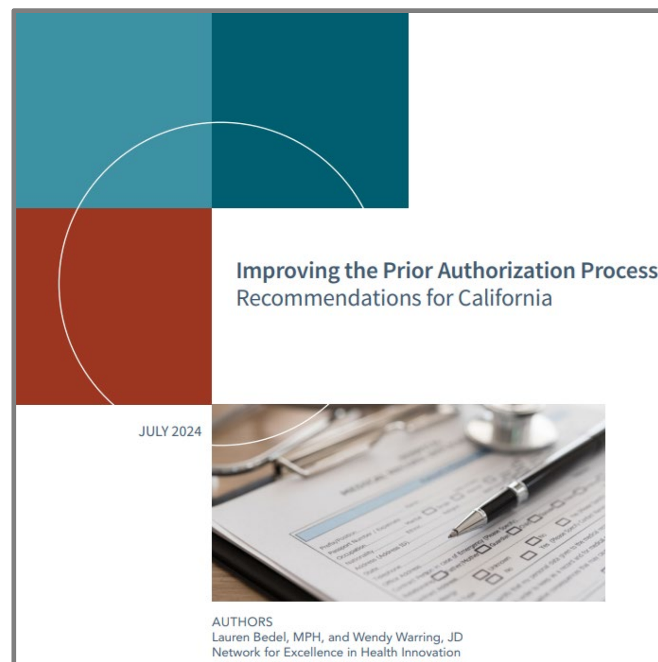
New Report: The Good, The Bad, The Costly

- **Researchers at Georgetown Center on Health Insurance Reforms examined PA state laws in AR, IL, TX, WA**
- **Recommendations:**
  - Requiring greater transparency of services subject to PA, clinical review standards, & reasons for denying PA authorization requests;
  - Setting maximum time periods for insurers to respond to PA requests;
  - Standardizing the form & method for exchanging PA requests, decisions, and related information;
  - Establishing expectations for peer-to-peer review of PA requests & use of accepted & transparent clinical review standards.

https://georgetown.us11.list-manage.com/track/click?u=9fbf2a80844d7b5a6854a365c&id=d9d7c2411e&e=d51b511857

NEHI report for California Health Care Foundation

- **Recommendations:**
  - Mandate technical requirements to advance adoption of automation.
  - Refine public reporting requirements to promote trust and enable dialogue about additional reforms.
  - Extend the duration and scope of prior authorization approval for ongoing care.
  - Develop transparent principles for the annual review of PA requirements



https://24315998.fs1.hubspotusercontent-na1.net/hubfs/24315998/CHCF%20Prior%20Auth%20Report.pdf

New York-HIV (S.1001A/A.1619A)

- **Prevents Insurers from Implementing PA on HIV treatment & prevention drugs**
  - Overcomes barriers to access in effort to end HIV
  - Will promote racial and ethnic equity
  - Insurers oppose, PA is needed to protect patients
  - Signed by Gov. Hochul June 28, 2024
- **Other States, including CA, already prohibit PA for PrEP.**

https://www.nysenate.gov/legislation/bills/2023/S1001/amendment/A

Vermont (H. 766)

- No PA for treatments & services ordered by primary care providers, but allows for Rx and out-of-network services
- Helps ensure that patients with chronic conditions don't have to continuously seek repeat PAs.
- Require urgent PA requests are responded to within 24 hours.
- Requires plans, physicians and providers to report to the legislature on impact of the law

https://legislature.vermont.gov/Documents/2024/Docs/ACTS/ACT111/ACT111%20As%20Enacted.pdf

California: PA & AI (SB 1120)

- Require AI tools be fair & equitably applied, can't discriminate based on present or predicted disability, expected length of life, quality of life or other health conditions.
- AI tools must be based upon an enrollee's medical history & individual circumstances & not supplant healthcare provider decision-making.
- Health plans file written policies & procedures w/ state agencies
- Requirement that licensed physician supervise the use of AI removed from bill
- **Status:** Passed Senate 37-0; Passed 2 Assembly Cmtes. Unanimously; Pending in Approps. Cmte.

https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202320240SB1120

Illinois (Public Act 103-0650)

- **Healthcare Protection Act (signed July 10, 2024).**

Builds on prior Illinois PA laws and includes negotiated language between the Governor's Office, DOI, insurers and provider groups.

- Requires insurers to maintain and publish a complete list of services for which PA is required on their public-facing website (i.e., not requiring credentials or membership to access it).
- Bans "step therapy" - ending the practice of requiring patients to try cheaper, less effective medications before accessing their prescribed treatment.
- Prohibits PA for in-patient mental health hospitalizations for both children and adults.

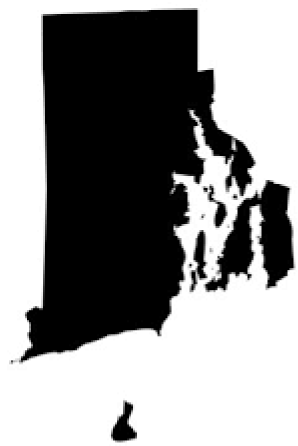
https://www.ilga.gov/legislation/publicacts/103/PDF/103-0650.pdf

Minnesota (HF 5247)

- **A Healthcare Omnibus bill passed this year builds on prior PA laws and includes the following:**
  - Requires that a prior authorization received for a chronic condition does not expire unless the standard of treatment changes.
  - Prohibits all prior authorizations for preventive services, pediatric hospice care and pediatric neonatal abstinence programs.
  - Prohibits prior authorization for non-medication treatments for cancer, outpatient mental health and substance use disorder.
    - While the law continues to allow prior authorization for medications to treat these conditions, it now requires a decision from the insurer within 48 hours, instead of five days.
  - Requires health plans to submit an annual report to the Minnesota Department of Health on how often they use prior authorization and approve or deny services

https://www.revisor.mn.gov/bills/text.php?number=HF5247&type=bill&version=4&session=ls93&session_year=2024&session_number=0

Rhode Island (SB 290Aaa)



- **Law signed on June 22, 2023, required the Office of the Health Insurance Commissioner (OHIC) to convene the Administrative Simplification Task Force to make PA recommendations.**
  - In its Final Report (June 28, 2024), OHIC committed to ensuring uniform implementation of a reduction in the volume of PA; collecting data in new ways to measure volume reductions; and creating a new public body convened to serve as a forum for ongoing dialogue between payers and providers to inform process improvements.
  - OHIC also noted in the report that "facts concerning prior authorization burden and the strategies proposed to address them warrant regulatory action."

https://webserver.rilegislature.gov/BillText/BillText23/SenateText23/S0290Aaa.pdf

Many More States Taking Action

- **New Hampshire (SB 561)**
  - Establishes clear criteria for prior authorization in managed care health plan
  - Streamlining access to necessary medical treatments.
- **Plus new or strengthened laws in Colorado, Maine, Maryland, Minnesota, Mississippi, Oklahoma, Virginia, Vermont, and Wyoming**

Federal Changes that Impact State Efforts

- **Prior Authorization and Interoperability final rule**
  - Impacts MA, Medicaid, CHIP, and QHPs on the federal marketplace
  - Requirements include: specific reason for denial, shortened response times, public reporting, and automation
  - No changes for prescription drugs, but a proposed rule is anticipated (fall)
- **2024 Medicare Advantage final rule**
  - Numerous meaningful changes that states can borrow from
  - New limits on use of PA, bans retroactive denials, PA approvals as long as medically necessary, grace period with new plans, expert reviewers, and more!
  - Also includes limits on AI for PA determinations

Federal Activities Continued

- **FTC Interim Staff Report on PBMs**
  - Found PBMs use PA not for medical reasons & "put payers' financial interests before patients' best interests"
  - Use PA to steer to higher priced drugs & away from generics

Suggested Next Steps

- **Align state requirements with federal regulations**
  - Adopt continuity of care provisions, prohibit retroactive denials, and increase automation
- **Take further actions beyond federal floors**
  - Include Rx, shorten response times, increase transparency, public reporting, ensure clinical criteria is part of the determination and includes review by a qualified expert
  - Reduce the volume of PA through data collection and analysis by regulators, or gold-carding programs

Suggested Next Steps

- **Partner in your state to reform prior authorization**
- **Consumer Information Subgroup**
  - Modify and utilize the new consumer guide on prior authorization to help educate consumers
- **Form new B Committee Working Group**
  - Share information
  - Work on implementation, best practices & enforcement
- **Partner with H Committee on the use of AI in the prior authorization process**
  - Consumer Representative research coming this fall!
- **Additional B Committee meetings to discuss this topic**

Thank you!

Stephani Becker
stephanibecker@povertylaw.org

Lucy Culp
lucy.culp@lls.org

Carl Schmid
cschmid@hivhep.org

Agenda Item #6

Hear Presentations on Health Cost Transparency—*Sabrina Corlette (Center on Health Insurance Reforms [CHIR] at Georgetown University's McCourt School of Public Policy) and Kelley Schultz (America's Health Insurance Plans [AHIP])*

National Association of Insurance Commissioners

Health Insurance Committee

August 15, 2024

Health Plan Price Transparency Files Are a Mess: States Can Help Make Them Better

Georgetown University
Center on Health Insurance Reforms (CHIR)
Sabrina Corlette, J.D.

GEORGETOWN UNIVERSITY
McCourt School of Public Policy

CENTER ON HEALTH INSURANCE REFORMS

Georgetown University Center on Health Insurance Reforms (CHIR)

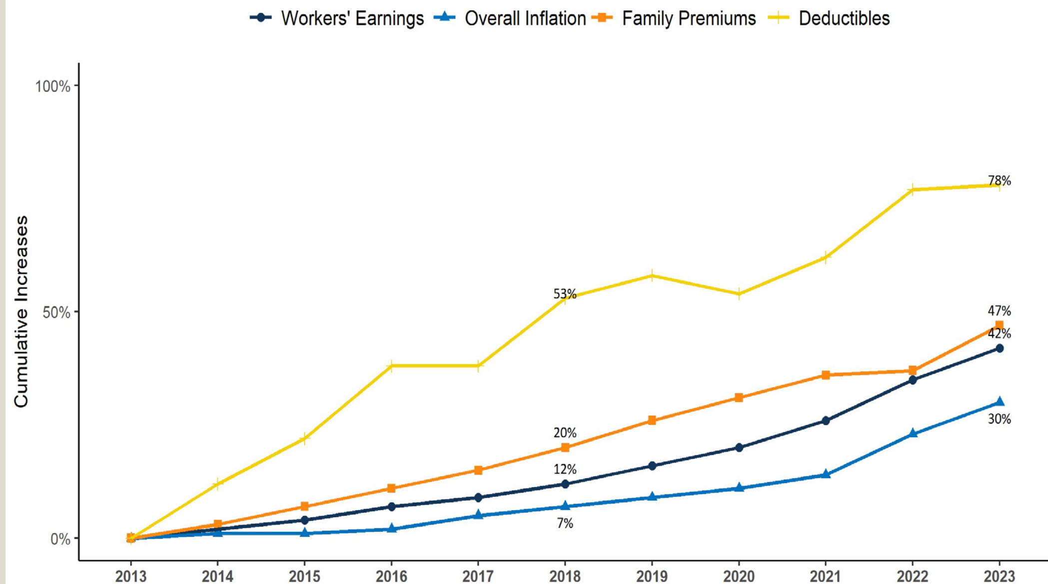
Nationally recognized team of private insurance experts

- Part of McCourt School of Public Policy
- Legal & policy analysis
  - Federal and state regulation
  - Market trends
- Published reports, studies, blog posts
- Technical assistance

Why Price Transparency?

Identifying Costs, Targeting Solutions

- Health insurance premiums are rising faster than inflation and earnings
- Average family premiums nearly **$24,000** in 2023
  - An increase of **7%** over last year
- Average annual deductible has grown from $303 in 2006 to $1735 in 2023
- What's driving this cost growth?



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@GtownCHIR

Prices—Not Consumption—Drive Up Costs

Health Affairs & RAND Studies (2003, 2019, 2022)

RESEARCH ARTICLE

HEALTH AFFAIRS > VOL. 22, NO. 3

It's The Prices, Stupid: Why The United States Is So Different From Other Countries

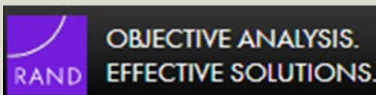
Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

RESEARCH ARTICLE COSTS & SPENDING

HEALTH AFFAIRS > VOL. 38, NO. 1: SUBSTANCE USE, PAYMENT & MORE

It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt

Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan



Private Health Plans Paid Hospitals 254 Percent of What Medicare Would Pay

Continuum of Policy Options to Promote Affordability

Price Regulation	Anti-trust Oversight/Enforcement	Transparency
Moderate to large price reductions	Small price reductions	Very small price reductions

Congressional Budget Office
Nonpartisan Analysis for the U.S. Congress

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McCourt School of Public Policy

CENTER ON HEALTH INSURANCE REFORMS

Price Transparency: Federal Rules

- **Hospital Price Transparency**
  - Hospitals must publish gross charges, discounted cash prices, negotiated charges, and minimum/maximum negotiated amounts via machine-readable digital files
  - In effect January 2021
- **Transparency in Coverage (TiC)**
  - Group plans/issuers must publish in-network rates, OON allowed amounts available via machine-readable files, for all covered items & services
  - In effect July 2022

TiC requirements apply to self-funded, fully insured, and non-federal government health plans

Potential State-level Uses of TiC Data

- **Market scans**
  - Identify price outliers, cost drivers
- **Anti-trust enforcement**
  - Monitor compliance with anti-trust actions, settlements
- **Cost containment initiatives**
  - Implementation/oversight of cost-growth benchmarks, public option, reference pricing
- **Purchasing alliances**
  - Support employer purchasing efforts
- **Surprise billing**
  - Independent source of data on median in-network rates
- **Rate review**

Multiple Problems With Current TiC Data

- **Difficult to find**
  - No single repository or standard way to post
- **Duplicative/irrelevant data**
- **MRF files too large**
  - Requires massive computing capacity
- **Lack of standardization**
- **No summary or guideposts**
  - ”Like trying to find a single word in a very large dictionary that isn’t in alphabetical order”
- **Questionable data quality**

Health plans and issuers spent an estimated *$3 billion* to implement TiC requirements

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TiC Enforcement: A Federal-State Partnership

Oversight/Enforcement

Issuers		Self-funded ESI
State DOI	CMS	Department of Labor

45 states responded to this question in 2020
48 states responded to this question in 2022

State-level Options to Improve TiC Data

- **Require issuers to**
  - Attest to completeness/accuracy of TiC files
  - Provide a data directory or library index to enable users to identify TiC file contents
  - Submit extracts to enable an assessment of data quality
  - Publicly share data summaries, such as negotiated prices for the top-10 most utilized services
- **Prohibit redacting information that could be acquired from TiC data**
- **Host a centralized website with links to all issuer TiC files**
- **Require greater standardization**
- **Use TiC data to inform public-facing reports about health system cost drivers**
- **Hold issuers accountable for poor data quality**

Questions?

CHIR Publications

www.chir.georgetown.edu

CHIRBlog

www.chirblog.org

SEHP Report and Maps

https://sehpcostcontainment.chir.georgetown.edu/

Sabrina Corlette sc732@georgetown.edu

AHIP
Guiding Greater Health

Transparency in Coverage

Kelley Schultz, Vice President, Commercial Policy
AHIP

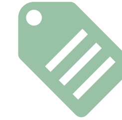
Overview of Transparency in Coverage Requirements

Machine-Readable Files (MRFs)

- In-network negotiated rates
- Out-of-network allowed amounts
- Prescription drug negotiated rates and historic net prices

Cost Estimator Tool

Internet-based self-service tool that provides personalized, real-time estimate of cost-sharing for a covered item or service for a specific in-network provider. Based on a descriptive term or billing code searched by the enrollee.



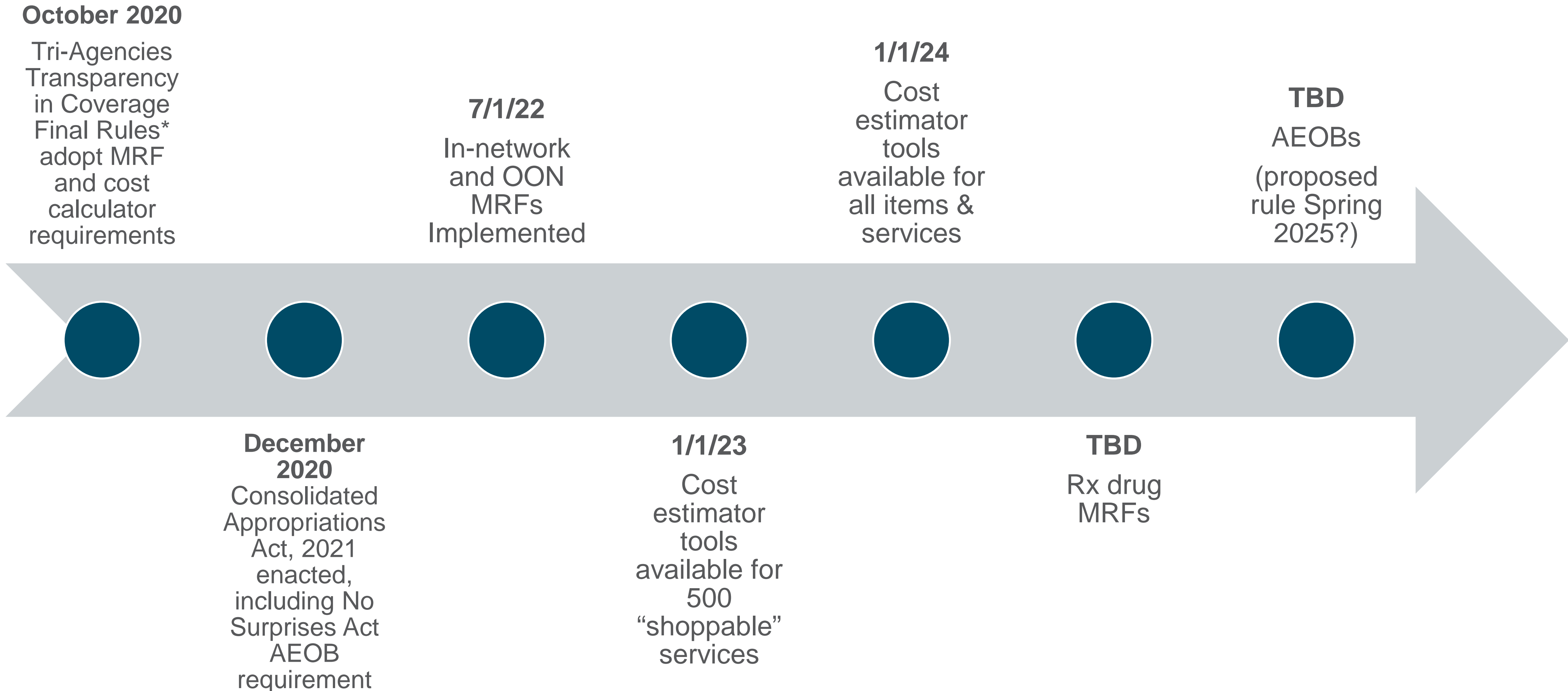
Advanced Explanation of Benefits (AEOB)

Personalized, real-time estimate of cost-sharing for a scheduled service for a specific in-network provider based on billing code(s) submitted by the provider to the issuer via a Good Faith Estimate (GFE).

Apply to most non-grandfathered group health plans and issuers in the individual & group markets

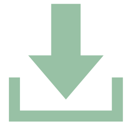
States are the primary enforcers

Reminder: Implementation Status



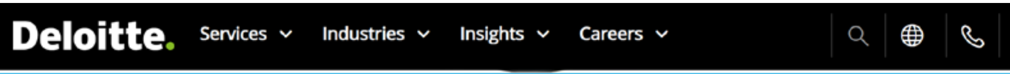
* Implemented under section 1311(e)(3) of the ACA

Overlapping Requirements, Different Consumer Value

 **MRFs**	**Cost Estimator Tool**	**AEOB**
X Real time	✓ Real time	✓ Real time
X Personalized	✓ Personalized	✓ Personalized
X Accumulated amounts	✓ Accumulated amount	✓ Accumulated amounts
X Provider's expected charges	X Provider's expected charges	✓ Provider's expected charges

Consumer-facing tools

Machine-Readable Files



Services

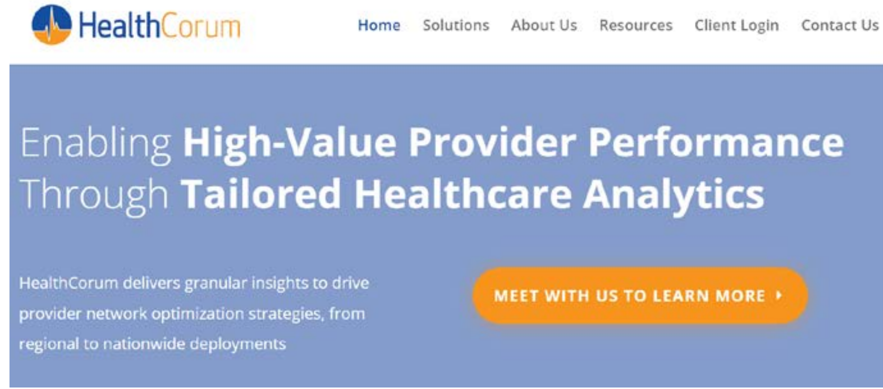
Health care price transparency solutions

Transparency in health care can be a catalyst for growth

Our health care price transparency solutions

Through the combination of our proprietary tools and modeling methodologies, and our deep industry and technical experience, we can help your business leverage pricing and contracting strategies as a sustained source of market advantage. Together, we can help you outperform your peers and improve your overall market and brand value.

Our health care price transparency solutions help your organization for the future of consumer-centric health care by addressing key considerations and challenges in three priority areas:



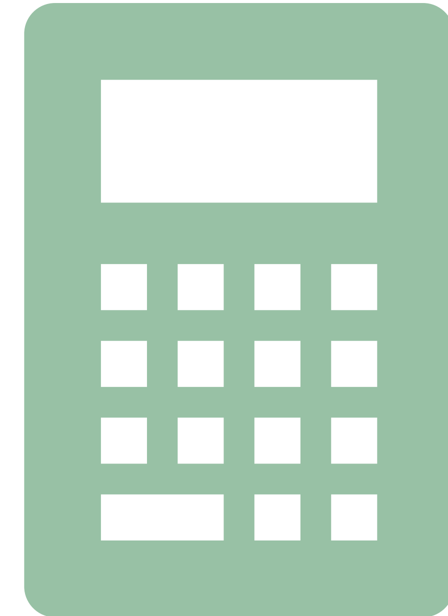
Machine-Readable Files

- Not consumer-friendly
- Not personalized, specific, or real-time
- Large & complex
- State Activity
- **Next up:**
  - Rx MRF implementation
  - Potential future updates

Cost Estimator Tools

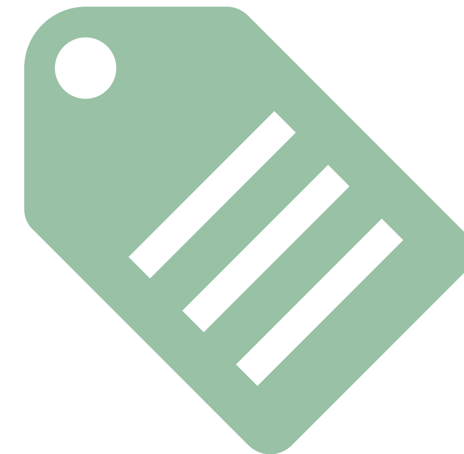
2023 AHIP Member Survey Findings

- <10% enrollees accessed cost estimator tool
- Most frequently searched services:
  - Colonoscopy
  - Vaginal delivery
  - Mammogram
  - Physical therapy
  - Vasectomy
  - Behavioral health
  - Eye exam
  - Dentist
  - Mental health
  - Office visit
  - C-section
  - Urgent care
- **Next up:** Consumer education
  - Availability of tool
  - How to search for costs
  - How to use cost information to make health care decisions



AEOBs

- Holds potential to provide the most accurate estimate
- Implementation will be extremely complex
- **Next up**: Standards designation and proposed rulemaking



What’s Next for States?

- Prioritize solutions that provide direct consumer value
- Consider approaches to expand consumer awareness & education of tools
- Avoid single-state solutions
- Engage on next iteration of review/updates to Federal MRF requirements

AHIP
Guiding Greater Health

Thank You

Kelley Schultz, Vice President, Commercial Policy
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Agenda Item #7

Hear an Update from the Federal Centers for Medicare & Medicaid Services' (CMS') Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities
—Dr. Ellen Montz (CCIIO) and Jeff Wu (CCIIO)

Agenda Item #8

Review Addressed Priorities and Discuss Priorities for the Upcoming Committee Meeting
—Director Anita G. Fox (MI)

Agenda Item #9

Discuss Any Other Matters Brought Before the Committee
—Director Anita G. Fox (MI)