

Draft date: 2/28/24

2024 Spring National Meeting
Phoenix, Arizona

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Monday, March 18, 2024

9:30 – 10:45 a.m.

Phoenix Convention Center—101 West—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
Kathleen A. Birrane	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. Consider Adoption of its 2023 Fall National Meeting Minutes Attachment One
—*Director Anita G. Fox (MI)*
2. Opening Remarks—*Director Anita G. Fox (MI)*
3. Consider Adoption of its Subgroup, Working Group, and Task Force Reports
—*Director Anita G. Fox (MI)*
 - A. Consumer Information (B) Subgroup—*LeAnn Crow (KS)*
 - 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. Receive an Update on the Long-Term Care Insurance (B) Task Force’s and the Long-Term Care Actuarial (B) Working Group’s 2023 Work and Planned Work for 2024—*Paul Lombardo (CT)*



5. Hear 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)*
6. Hear a Presentation from the Consumer Perspective on the Affordable Care Act (ACA) Section 1557 Nondiscrimination Proposed Rule—*Amy Killelea (NAIC Consumer Representative), Carl Schmid (HIV+Hepatitis Policy Institute), and Kellan Baker (Whitman-Walker Institute)*
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, including the Final Notice of Payment and Benefit Parameters for 2025 and the Prior Authorization Rule—*Jeff Wu (CCIIO)*
8. Discuss Any Other Matters Brought Before the Committee—*Director Anita G. Fox (MI)*
9. Adjournment

Agenda Item #1

Consider Adoption of its 2023 Fall National Meeting Minutes
—*Director Anita G. Fox (MI)*

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Draft: 12/14/23

Health Insurance and Managed Care (B) Committee
Orlando, Florida
December 2, 2023

The Health Insurance and Managed Care (B) Committee met in Orlando, FL, Dec. 2, 2023. The following Committee members participated: Anita G. Fox (MI), Chair; Jon Pike, Co-Vice Chair (UT); Mike Kreidler, Co-Vice Chair (WA); John F. King and Gregg Conley (GA); Dean L. Cameron represented by Shannon Hohl (ID); Kathleen A. Birrane (MD); Grace Arnold (MN); Mike Chaney represented by Bob Williams (MS); D.J. Bettencourt (NH); Glen Mulready (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); Alexander S. Adams Vega (PR); and Allan L. McVey represented by Joylynn Fix (WV). Also participating were: Michael Conway (CO); Paul Lombardo (CT); Andria Seip (IA); LeAnn Crow (KS); Timothy N. Schott (ME); Justin Zimmerman (NJ); Diane Cooper (SC); and Scott A. White and Keven Patchett (VA).

1. Adopted its Nov. 2 and Summer National Meeting Minutes

The Committee met Nov. 2 and Aug. 14. During its Nov. 2 meeting, the Committee took the following action: 1) adopted its task forces' 2024 proposed charges; 2) adopted its 2024 proposed charges; and 3) adopted the white paper *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation*.

Commissioner Stolfi made a motion, seconded by Commissioner Mulready, to adopt the Committee's Nov. 2 (Attachment One) and Aug. 14 (*see NAIC Proceedings – Summer 2023, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

2. 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 Nov. 21 (Attachment Two), Oct. 25 (Attachment Three), Oct. 17 (Attachment Four), and Sept. 18 (Attachment Five) minutes; 2) the Health Innovations (B) Working Group, including its Dec. 1 minutes (Attachment Six); 3) the Health Actuarial (B) Task Force; 4) the Regulatory Framework (B) Task Force; and 5) the Senior Issues (B) Task Force. The motion passed unanimously.

3. Received an Update on the Consumer Information (B) Subgroup's Work Related to Educating Consumers on Claim Denial Appeal Rights

Crow provided an update on the work of the Consumer Information (B) Subgroup to educate consumers on their claim denial appeal rights. She said that since the Committee's discussion of claim denials and appeals at the Spring National Meeting, the Consumer Information (B) Subgroup has been working on these topics.

Crow said that since her last update to the Committee at the Summer National Meeting, the Subgroup has continued to meet and recently completed its work to revise and update a series of consumer guides: 1) "Filing Health Insurance Claims"; 2) "Explanation of Benefits"; 3) "Understanding Medical Necessity"; and 4) "How to Appeal a Denied Claim." She said the guides are intended to help consumers understand the claims process and the steps they must follow to appeal denied claims. She explained that these guides build on a previous series of consumer guides the Subgroup worked on in 2021.

Crow said state departments of insurance (DOIs) are free to use the guides as-is or amend them to suit their needs, including adding their own branding or pulling out pieces of the guides to use on social media or elsewhere. She

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encouraged state DOIs to review the guides and use them if they do not already have something similar. Crow said the guides are currently available in Word format. She said the Subgroup, however, plans to work with the NAIC's Communications Department to produce versions that are designed with more consumer appeal and compatibility for mobile users.

Crow said the Subgroup also plans to add to its series of consumer guides. She explained that the current guides focus on appealing claims submitted after the consumer receives a health care service. The Subgroup recognizes that different issues arise when an insurer denies a prior authorization request before the service is provided. She said a new consumer guide focused on pre-service denials will help consumers understand these issues.

4. Heard a Discussion on SBM Activities

Conley and Patchett discussed the rationale behind the creation of the Georgia and Virginia, respectively, state-based marketplaces (SBMs), including reducing the number of uninsured by designing an SBM that is more consumer-friendly with respect to shopping for a plan and plan enrollment and enhancing the ability, through an SBM, to coordinate more closely with other state agencies.

Conley discussed the challenges in setting up the Georgia Access Exchange, including: 1) that as of 2021, Georgia's uninsured rate of 12.7%; and 2) that only three in 10 Georgians responsible for purchasing their own health insurance did so, as of 2021, through the federally facilitated marketplace (FFM). He explained that these challenges, particularly the decreased enrollment in the FFM led to fewer insurance companies on the FFM and higher premiums.

Conley discussed the SBM's goals to address these issues and how it was designed to serve the needs of Georgians and facilitate a more competitive marketplace with greater consumer choice by engaging Georgia's private-sector entities to provide innovative solutions for plan shopping, enrollment, and support. He explained the process for consumers to access the Georgia Access Exchange, apply, shop, and enroll in a qualified health plan (QHP). He also explained how its eligibility system works with other Georgia state agencies, particularly with its Medicaid agency, in accessing eligibility for either the SBM or Medicaid to make it seem seamless to the consumer.

Conley said that moving to an SBM builds upon the Georgia DOI's efforts to understand and improve the market for consumers. He explained how two Georgia DOI studies—network adequacy analysis and health market scan—helped direct those efforts with the Georgia Access Exchange. He highlighted Georgia's success in increasing enrollment for the 2023 plan year using its SBM in 2023 versus the 2022 plan year when enrollment was through the FFM. He attributed this increase in enrollment to Georgia Access' open enrollment 2023 campaign. Conley said that coupling an SBM with a state-based reinsurance program, which can control and stabilize premium costs, can also increase access, and bring more people to the marketplace to consider purchasing coverage and, therefore, increasing enrollment.

Patchett discussed Virginia's insurance marketplace. He said that, like Georgia, the goals of Virginia's Insurance Marketplace were to 1) more closely coordinate with Virginia state agencies; 2) improve coverage transitions from Medicaid to the insurance marketplace; 3) reduce the number of uninsured Virginians; and 4) support the continuity of coverage. He said Virginia just became operational on Nov. 1 for its first plan open enrollment period as a fully operational SBM. He noted that Virginia is a determination state, which means that when accessing the SBM for coverage, if a consumer is determined eligible for Medicaid coverage based on the financial information the consumer provides, instead of transferring the consumer to the state Medicaid agency to make a final determination of Medicaid eligibility, the Virginia SBM makes that final determination. If a consumer is not determined eligible for Medicaid coverage, then the consumer continues to the next step in the SBM to shop and enroll for coverage in a QHP.

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Patchett discussed Virginia's coverage landscape. He explained that Healthcare.gov is the insurance marketplace for about 31 states, which means the federal Center for Consumer Information and Insurance Oversight (CCIIO), which operates Healthcare.gov, cannot tailor the FFM to specifically meet the needs of Virginians, but by having an SBM, Virginia can. He discussed how Virginia's Insurance Marketplace works with other state agencies, including the Virginia DOI, health plans, insurance producers, navigators, and assistors, to better serve and understand the needs of Virginians and why there may be coverage gaps and address them. He explained that like Georgia, Virginia obtained a federal Affordable Care Act (ACA) section 1332 waiver to establish a state-based reinsurance program to help stabilize its marketplace. Patchett highlighted the increased enrollment over the past few years of individuals aged 55–64. He also noted Virginia's robust stand-alone dental plan program. Patchett said that to date, Virginia has not experienced the decrease in enrollment in its SBM that other SBMs traditionally have seen. He said Virginia is encouraged by the high numbers of enrollment in the first two weeks of open enrollment and anticipates that trend continuing until its end.

Commissioner Mulready asked about the process Georgia and Virginia took to establish their SBM, including legislation, vendors, costs, and funding. Commissioner King said that for Georgia, he had early conversations with the governor's office and legislative leaders. He said he also used the messaging throughout these conversations to establish the SBM as "Georgians Helping Georgians." Conley agreed. He said that because the Georgia DOI started conversations early in the process and the messaging, the legislation establishing the SBM passed through the legislature with little resistance. He explained that Georgia used vendors that had an established record of working with the states. Patchett agreed. He explained how Virginia funds its SBM through assessments, which means it does not have to rely on state general fund funding. He said this funding mechanism also allows the SBM to fund other programs important to the SBM, such as its navigator programs.

Commissioner Kreidler asked if Georgia or Virginia has been able to track the percentage of uninsured and whether the percentage has changed since moving to an SBM. Patchett said Virginia will be tracking this because moving to an SBM gives it better access to such data. Conley said if marketplace enrollment continues at the pace it has during the first few weeks of open enrollment, Georgia anticipates a lower percentage of uninsured. Commissioner Kreidler asked how, if at all, enrollment in the SBM has been affected by the Medicaid redetermination process. Patchett said Virginia is assessing this now. He explained how the Virginia SBM has been working with other state agencies to make it easy for consumers to seamlessly transition, such as through passive enrollment, from Medicaid to the SBM. He said he believes this process will make a difference in reducing the number of uninsured.

5. Heard a Federal Update

Brian R. Webb (NAIC) provided a federal update on pharmacy benefit managers (PBMs), Medicare Advantage marketing, recently issued federal regulations, and ongoing federal court cases. He said H.R. 5378, The Lower Costs, More Transparency Act, a single health transparency (and PBM) bill, was recently introduced in the U.S. House of Representatives. He said the House Education and Workforce, Energy and Commerce, and Ways and Means committees jointly introduced the bill, which combines the bills that were passed by the three committees. Webb said the bill requires health care providers and insurers to disclose certain information about health care costs. He said that of interest to the Committee, the bill also requires: 1) PBMs to semiannually report to health plan sponsors on the number and types of claims for covered drugs, including whether the drugs were brand-name or generic drugs and associated costs; 2) contracts with PBMs for employer-sponsored health plans to allow health plan fiduciaries to audit certain claims and cost information without undue restrictions; and 3) pass-through pricing models. H.R. 5378 also prohibits spread pricing for payment arrangements with PBMs under Medicaid. Webb said from all the bills being considered this Congressional session related to PBMs, this bill is the one with the best chance of passing the House. He said the NAIC Government Relations staff will continue to monitor the bill and others for any conflicts with state insurance laws regulating PBMs or provisions that could pre-empt state insurance regulation in any of these areas.

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Webb next discussed Medicare Advantage marketing. He noted that this is an issue that state insurance regulators brought to the attention of the U.S. Congress. He discussed the work that several NAIC groups were doing to raise more awareness with Congress about the concerns and marketing issues, including the Improper Marketing of Health Insurance (D) Working Group and the Senior Issues (B) Task Force. Webb also discussed a report issued by the Senate Committee on Finance on Medicare Advantage marketing. He said that since the report and additional discussions among state and federal regulators, the federal Centers for Medicare & Medicaid Services (CMS) has updated its regulations on Medicare Advantage marketing to add additional requirements, particularly to third-party marketing organizations, and has increased its monitoring and enforcement actions in this area. He said CMS recently issued a proposed rule on the topic with comments due Jan. 5, 2024. Webb said that there is still the remaining question of state authority to regulate MA marketing. He said the NAIC Government Relations staff is still talking to appropriate Congressional staff about giving such authority back to state insurance regulators.

Webb discussed other congressional legislation, including funding for the mental health parity grants to the states to assist them in enforcing the mental health parity requirements under the federal Mental Health Parity and Addiction Equity Act (MHPAEA). He explained that the grant money, which is \$10 million dollars per year for five years, has been authorized but not appropriated. He noted that the Senate Committee on Appropriations put in its year-end report that it believes the CMS has sufficient funds in its budget to start the grant program without an additional appropriation of funds. He said that because of this information, the NAIC has sent letters to the CMS urging them to start the grant program.

Webb also mentioned the NAIC's opposition to H.R. 3799, the federal Custom Health Option and Individual Care Expense (CHOICE) Arrangement Act, which was recently passed by the House, because it preempts state insurance laws related to association health plans (AHPs) and some stop-loss insurance laws in several states. He said the NAIC Government Relations staff have had conversations with Senate congressional staff about the NAIC's concerns with the legislation. He said that because of these conversations, he is hopeful the legislation will not pass the Senate in its current form.

Webb next discussed the proposed rule on Notice and Benefit Payment Parameters (NBPP) for 2025. He highlighted a provision in the proposed rule that potentially could change how states establish SBMs. He said the NAIC is awaiting the final rules on short-term, limited-duration (STLD) plans and fixed indemnity plans. It is anticipated that the final rules will be issued sometime in the spring of 2024. Webb said the NAIC is also awaiting a possible proposed rule on AHPs. He explained that during the Trump administration, a federal rule on AHPs was issued. The rule was challenged and overturned. He said the Biden administration decided not to appeal the ruling choosing instead to potentially issue its own rule on the subject. Webb said that based on conversations with Biden administration officials, it is possible the proposed rule could be issued before the end of the year or sometime in the spring of 2024. He said that whenever the proposed rule is issued, he anticipates the NAIC would want to submit comments on it.

Webb next discussed federal court action. He said the NAIC Government Relations staff is still tracking several court cases, including the *Braidwood v. Becerra* case, which challenged the ACA's preventive service requirements, and *Pharmaceutical Care Management Association (PCMA) v. Mulready*, which challenges state insurance regulators' right to regulate PBMs. He said both cases are making their way through the federal courts and depending on the appeals court ruling, which could have major implications for state insurance regulators. Webb also discussed the pending appeal in the *Data Marketing Partnership v. the U.S. Department of Labor (DOL)* case. He reminded everyone that this case ruled against the DOL in defining who is considered an "employer" for purposes of the federal Employee Retirement Income Security Act (ERISA), which affects the ability of the states to regulate such arrangements and the application of certain ACA consumer protections.

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

Ellen Montz (CCIIO) updated the Committee on the CCIIO's recent activities of interest. She discussed one of the CCIIO's top priorities—the Medicaid redetermination process and ensuring consumers can maintain coverage by seamlessly transitioning to Medicaid, the federal Children's Health Insurance Program (CHIP), employer-based coverage, or marketplace coverage. She expressed appreciation for the work of state insurance regulators and the willingness of state insurance regulators to partner with the CCIIO in its work.

Montz provided a status update from the marketplace side of the Medicaid redetermination process due to the end of the public health emergency (PHE) and the transition back to the regular Medicaid redetermination process. She said she is also interested in hearing how the process is proceeding from the state perspective. Montz noted that at this point, it has been about eight months since the Medicaid redetermination process began nationwide, but depending on a particular state, probably about 50% of individuals subject to Medicaid redetermination have completed the process, which means there is still a lot of work to be done and time to make improvements in the process. She discussed how CMS is working with the states as the Medicaid redetermination process continues. She also highlighted the work the CCIIO is doing to provide a more seamless transition to marketplace coverage for consumers determined no longer eligible for Medicaid or CHIP, including its outreach efforts to educate consumers about the Medicaid redetermination process and their options. Montz highlighted CMS data indicating a high number of successful transitions from Medicaid or CHIP to the marketplaces, both FFM and SBMs. Montz also touched on the CCIIO's desire to work with the states and other entities to assist consumers no longer eligible for Medicaid or CHIP to transition to employer-based coverage.

Montz also provided a high-level summary of the recently released proposed NBPP for 2025. This annual regulation governs core provisions of the ACA, including the operation of the health insurance marketplaces, standards for health plans, agents, and brokers, and the risk adjustment program. She highlighted provisions in the proposed 2025 NBPP of particular interest to state insurance regulators, including: 1) several provisions requiring SBMs to align with the standards and requirements of the FFM, proposals to clarify and improve the process for states to determine and update essential health benefits, and initiatives to ease the eligibility and enrollment process for consumers. Montz said that with this proposal, the CMS is continuing its trend of raising the bar regarding consumer protections and raising the bar on value regarding QHPs. She said CMS is looking forward to receiving comments on these proposals, particularly comments from the SBMs and the states that are interested in becoming an SBM.

7. Discussed Committee Activities and Accomplishments for the Year Related to its Priorities

Director Fox highlighted the Committee's accomplishments for the year related to the priorities Committee members identified at the beginning of the year. She said she believed her main goal in expanding connections with each other and senior staff was accomplished particularly by holding virtual and in-person regulator-to-regulator meetings to allow time for more in-depth discussion. Director Fox said she felt 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.

Director Fox said that as described in her memorandum to the Committee (Attachment Seven), with the support of the Committee members and the NAIC, the Committee was able to move forward, hear discussions, and take action on many of the priority issues identified and some not identified at the beginning of the year, including: 1) network adequacy; 2) Medicaid unwinding; 3) essential health benefits (EHBs); 4) PBM regulation; 5) SBMs; and 6) claim denial appeals.

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Carl Schmid (HIV+Hepatitis Policy Institute), an NAIC consumer representative, thanked the Committee for its work this year on issues of particular importance to consumers. He said the NAIC consumer representatives particularly appreciated the work of the Consumer Information (B) Subgroup on its work updating documents that educate consumers on the rights to appeal claim denials. He said that now the job is to get that information out to consumers. Schmid said that he is hoping that additional work in this area will include an examination of why consumers are receiving these denials and a better understanding of the data related to these denials. He said prior authorization is another issue of importance to the NAIC consumer representatives, particularly with respect to the use of artificial intelligence (AI) in making prior authorization determinations. Schmid urged the Committee to work with other NAIC groups as those groups examine related AI issues.

Schmid also said the NAIC consumer representatives' continuing concern with insurers requiring cost-sharing for preventive services as evidenced in the NAIC consumer representatives' preventive services report, *Preventive Services and Coverage and Cost-Sharing Protections Are Inconsistently and Inequitably Implemented: Considerations for Regulators*, shared with the Committee at the Summer National Meeting. He urged the Committee to continue looking at this issue.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2023 Fall National Meeting/12-Bmin.docx

Agenda Item #2

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

Agenda Item #3

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



Virtual Meeting

CONSUMER INFORMATION (B) SUBGROUP

February 27, 2024

Summary Report

The Consumer Information (B) Subgroup met Feb. 27, 2024. During this meeting, the Subgroup:

1. Discussed its activities for 2024.

Draft: 3/1/24

Consumer Information (B) Subgroup
Virtual Meeting
February 27, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Feb. 27, 2024. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony Williams (AL); Terri Smith (MD); Carrie Couch (MO); Nichole Faulkner (NC); Donna Dorr (OK); Jill Kruger (SD); Vickie Trice and Jennifer Ramcharan (TN); Ryan Jubber (UT); and Christina Keeley (WI). Also participating were: Susan Jennette (DE) and Susan Brown (MT).

1. Discussed Subgroup Activities for the Year

Crow reviewed the documents the Subgroup completed in 2023, including a guide for state insurance regulators on Medicaid redeterminations, an updated version of Frequently Asked Questions (FAQ) about Health Care Reform, and revisions to a series of consumer guides on health insurance claims and appeals.

Crow said that during the work on the appeals guides, the Subgroup discussed the need for an additional guide on prior authorization. She said the Subgroup decided in 2023 that a prior authorization guide should be a goal of the Subgroup in 2024. She asked the Subgroup whether should consider any other topics to work on in 2024.

Harry Ting (Individual Health Care Consumer Advocate) asked whether the Subgroup should return to the focus groups and surveys it conducted in 2022 and share feedback received. Joe Tuschner (NAIC) noted that Brenda Cude had written up themes from the focus groups and her compilation was shared with Subgroup interested parties and posted on the Subgroup's website.

Wayne Turner (National Health Law Program) said that, during its revisions to the FAQ, the Subgroup considered whether to develop a guide on preventive services. He also noted that NAIC Consumer Representatives authored an analysis of preventive services that showed low consumer understanding of coverage for preventive services. Joe Tuschner added that state and federal regulators have been discussing problems with coverage of colonoscopies as preventive services. He said the Subgroup could consider a guide for different audiences, including consumers, state insurance regulators, insurers, or providers. Wayne added that CMS guidance has covered a number of issues related to colonoscopies.

Crow asked the group which guide should be the first to be taken up during the year. She said her preference would be to start with a prior authorization piece since the group agreed on the need for it last year. Bonnie Burns (California Health Advocates) asked whether the prior authorization guide would be oriented toward consumers or to state insurance regulators. Crow said she understood the consensus of the group to be that a consumer-facing guide is needed.

Crow said it may be helpful to start with a guide on what prior authorization is and provide a definition. Joe Feldman (Individual Consumer Advocate) said the document should tell consumers what is reasonable to expect during a prior authorization request and what to do about it if the expectation is not met. Crow said states may have different laws that set different timelines. Feldman said a document could reference the maximum timeline or provide a range of time limits across state laws, as long as it establishes the idea that there is a limit.

Couch suggested that the document outline the types of services that are commonly subject to prior authorization. Ting said his research has shown that states do have different timelines for different services, particularly for prescription drugs.

Crow said that covering the topic may require a series of guides that break down different pieces, including what prior authorization is, when it applies, who submits requests, and options for responding to denials.

Katie Dzurec (Examination Resources) said that providers' roles and responsibilities should be covered. Jennette said Delaware has specific laws that differ based on whether the services are pharmaceutical, mental health, emergency or other factors. She said any document on colonoscopies should clarify the distinction between routine and follow-up services. She said consumers also have difficulty when a provider recommends a treatment, but the insurer finds that the treatment is experimental. Crow said the Subgroup will aim to create a document that is useful for all states, even if they have differing laws.

Crow said a prior authorization guide will be more challenging than the appeals guides because the Subgroup may have to start from scratch rather than revising existing documents. Brown said consumers can get trapped if they receive emergency treatment, but an insurer later decides treatment or further treatment is not medically necessary. She said the document is needed because regulators have heard many examples of issues consumers have run into and consumer representatives have raised them, as well.

Kristen Hathaway (AHIP) said her organization has many existing resources that help explain prior authorization concepts.

Crow asked Subgroup members and interested parties to join a drafting group to develop a first draft of a guide or series of guides on prior authorization. She said the drafting group would aim to meet soon after the Spring National Meeting, pending any further direction from the B Committee on priorities for the Subgroup for the year. She asked members and interested parties to send any template of existing documents that could help in drafting a guide.

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

NAIC Support Staff Hub/B CMTE/National Meetings/2024 Spring National Meeting/Final Minutes/Cons Info 2.27.pdf

2024 Spring National Meeting
Phoenix, Arizona

HEALTH ACTUARIAL (B) TASK FORCE

Friday, March 15, 2024
2:30 – 4:00 p.m.

Meeting Summary Report

The Health Actuarial (B) Task Force met March 15, 2024. During this meeting, the Task Force:

1. Adopted its Feb. 20 minutes. During this meeting, the Task Force took the following action:
 - A. Adopted its 2023 Fall National Meeting Minutes
 - B. Adopted a proposal from the Long-Term Care Actuarial (B) Working Group to add language to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51)* that clarifies that regardless of which annual statement blank an insurer files, it must make an AG 51 filing if the AG 51 filing requirement criteria are met.
 - C. Discussed an American Academy of Actuaries (Academy)/Society of Actuaries (SOA) 2013 Individual Disability Income Valuation Tables update proposal.
 - D. Exposed an SOA proposal to revise VM-26, Credit Life and Disability Reserve Requirements, Section 3.B. Contract Reserves for Credit Disability Insurance for a 45-day public comment period ending May 3.
2. Adopted its amended 2024 charges.
3. Heard an update on SOA Research Institute activities.
4. Heard a presentation on SOA education redesign.
5. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO).
6. Heard an update from the Academy Health Practice Council.
7. Heard an Academy professionalism update.
8. Discussed Medicare Supplement underwriting and rating issues.

2024 Spring National Meeting
Phoenix, Arizona

LONG-TERM CARE INSURANCE (B) TASK FORCE

Saturday, March 16, 2024
10:30 – 11:15 a.m.

Meeting Summary Report

The Long-Term Care Insurance (B) Task Force met March 16, 2024. During this meeting, the Task Force:

1. Adopted its 2023 Fall National Meeting minutes.
2. Heard a report on industry trends that could have an impact on the solvency of long-term care insurance (LTCI) companies and reserves. Topics that will continue to be monitored include the impacts of cost-of-care inflation, morbidity and incidence improvements, rate increase approvals, and performance of the assets supporting the LTCI block of business.
3. Received an overview of a consumer notices and reduced benefit options (RBOs) research project that the NAIC Center for Insurance Policy and Research (CIPR) is conducting. A survey will begin next week, and preliminary results are anticipated later in April.
4. Adopted an amendment to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51).
5. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met March 15. During this meeting, the Working Group took the following actions:
 - A. Adopted its 2023 Fall National Meeting minutes.
 - B. Adopted its Feb. 20 minutes. During this meeting, the Working Group took the following action:
 - i. Discussed a single long-term care insurance (LTCI) multistate rate review approach.
 - C. Discussed developing a single LTCI multistate actuarial (MSA) rate review approach.
 - D. Exposed the Minnesota approach, with modifications to align with agreed-upon concepts, for a 45-day public comment period ending April 3.
6. Discussed LTCI MSA matters. The Task Force indicated support for the Long-Term Care Actuarial (B) Working Group's development of a single LTCI MSA 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 MSO approach. State insurance regulators and interested parties are encouraged to be engaged in these discussions and provide feedback on the exposure draft at the Long-Term Care Actuarial (B) Working Group. The goal is to finalize the development of a single approach by the end of 2024.
7. Discussed the timeliness of LTCI rate reviews. State insurance regulators are encouraged to: consider the impact of the timeliness of LTCI rate reviews on future loss ratios and future rate increases that



may be requested by insurers; coordinate between rate review and form review staff; communicate to the industry on the best time frames to submit rate filings; and engage with internal staff at all levels about rate filings.

2024 Spring National Meeting
Phoenix, Arizona

REGULATORY FRAMEWORK (B) TASK FORCE

Saturday, March 16, 2024
11:30 a.m. – 12:30 p.m.

Meeting Summary Report

The Regulatory Framework (B) Task Force met March 16, 2024. During this meeting, the Task Force:

1. Adopted its 2023 Fall National Meeting minutes.
2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Feb. 26, Feb. 12, and Jan. 29 minutes. During these meetings, the Subgroup took the following action:
 - A. Discussed the Dec. 1, 2023, comments received on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).
3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group.
4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Dec. 2, 2023, minutes. The Working Group will meet March 17. During this meeting, the Working Group plans to take the following action:
 - A. Hear presentations on opioid use disorder and medication for opioid use disorder (MOUD).
 - 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.
5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup.
6. Received an update on the work of the Accident and Sickness Insurance Minimum Standards (B) Subgroup. The Subgroup is currently reviewing and discussing the comments received on the Oct. 12, 2023, draft of proposed revisions to Model #171. The Subgroup hopes to complete its review of the comments prior to the Summer National Meeting and forward the revised draft to the Task Force for its consideration.
7. Heard a presentation from the American Bankers Association (ABA) Health Savings Account (HSA) Council on embedded insurance code provisions protecting HSAs. The presentation highlighted 2023 state legislative activity using embedded insurance code provisions to carve out or exempt HSAs from certain benefit mandate/limited cost-sharing bills and copayment accumulator bills to protect the ability of HSA account holders to continue to use their HSA. The presentation also discussed the ABA HSA Council's 2024 state advocacy initiatives and priorities, which include working with states to expand the number of states that have enacted embedded insurance code provisions. Currently, eight



states have such provisions. The presentation included an “ask” that the Task Force work with state Departments of Insurance (DOIs) and other stakeholders to adopt embedded insurance code provisions to protect HSAs.

8. Discussed draft proposed revised 2024 charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. The proposed revised charges would expand the scope of the current Subgroup’s work to include other entities in the prescription drug ecosystem. The Task Force set a 30-day public comment period to receive comments on the draft proposed revised 2024 charges. Following the end of the public comment period, the Task Force will meet to discuss the comments received and consider adoption of the revised charges.
9. Heard information on World Hypertension Day, which is May 17.

2024 Spring National Meeting
Phoenix, Arizona

SENIOR ISSUES (B) TASK FORCE

Saturday, March 16, 2024
9:00 – 10:15 a.m.

Meeting Summary Report

The Senior Issues (B) Task Force met March 16, 2024. During this meeting, the Task Force:

1. Adopted its Feb. 29 minutes. During this meeting, the Task Force took the following action:
 - A. Discussed access to Medigap coverage and challenges for those under and over the age of 65.
2. Heard an update from the federal Centers for Medicare & Medicaid Services (CMS) on the status of the provisions of the new prescription drug law in the federal Inflation Reduction Act (IRA).
3. Heard an update on the status of California’s Long-Term Care Insurance Task Force.
4. Heard an update on the status of Washington state’s WA Cares Fund.
5. Heard a request from NAIC consumer representatives, who asked the NAIC to explore proposals to create state programs to finance long-term care (LTC).

Agenda Item #4

Receive an Update on the Long-Term Care Insurance (B) Task Force's and the Long-Term Care Actuarial (B) Working Group's 2023 Work—*Paul Lombardo (CT)*

Agenda Item #5

Hear 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)*

Adding Protections for Ground Ambulance Services to the No Surprises Act

Jack Hoadley, PhD

Research Professor Emeritus

Center on Health Insurance Reforms

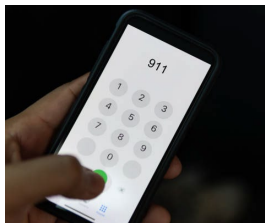
McCourt School of Public Policy

Georgetown University

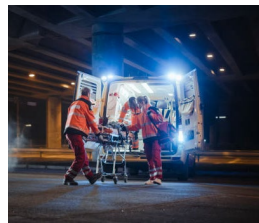
Status of the No Surprises Act (NSA)

- Effective date of the law: January 2022
- Georgetown/Urban qualitative study
 - Consumers are being protected
 - Insurers, providers took steps to comply
 - Too early to consider broader impacts
- New data on dispute resolution
 - High volume of cases with backlogs
 - Providers winning often with big payoffs
- Gap for ground ambulance services

Why is it Important to Fill the Ground Ambulance Billing Protection Gap?



Patients rarely have choice of ground ambulance provider



Emergency limits opportunities for patient disclosure



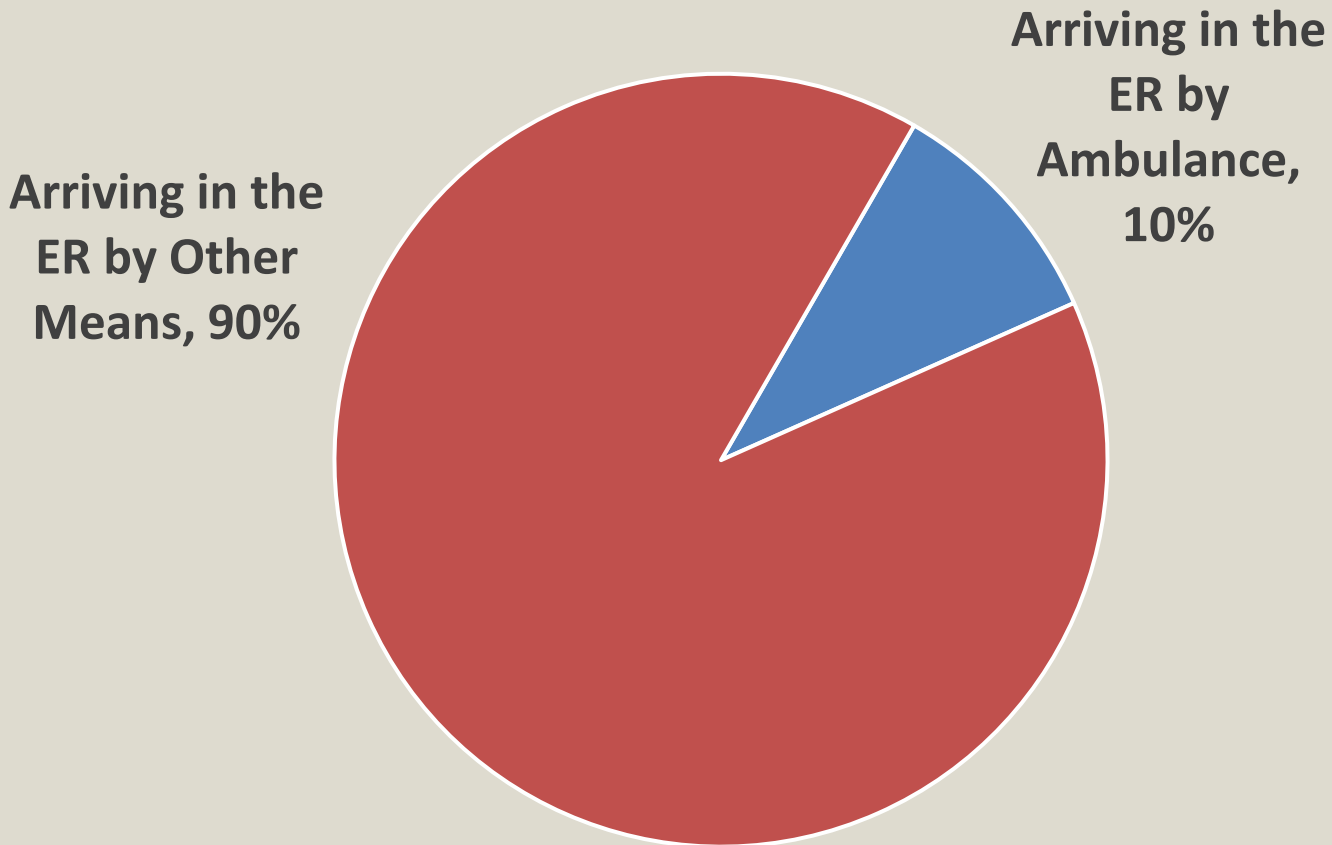
Many public-sector providers lack resources to contract with providers

Ground Ambulance Services

- Levels of Services
 - Basic life support
 - Intermediate life support
 - Advanced life support
- Types of Services
 - Dispatch
 - Assess
 - Treat and refer to services
 - Transport to emergency department
 - Transport to alternative sites

SOURCE: Washington Office of the Insurance Commissioner, Ground ambulance balance billing study, Legislative study report, October 2023.

Source of ER Visits



SOURCE: Krutika Amin et al, Ground ambulance rides and potential for surprise billing, Peterson-KFF Health System Tracker, June 2021.

What Do Insurers Cover?

Washington State

Type of Service	Coverage by Commercial Payors
Emergency transport to higher care	Yes
Non-emergency transport, interfacility	Only if covered, often not in full
Treat but no transport	Conditional, generally no
Specialty care transport	Yes
Transport to alternate destination	Conditional, generally no

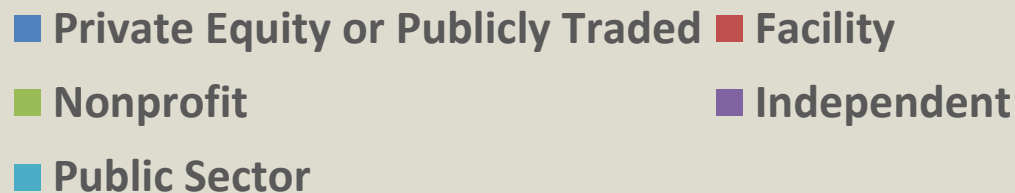
SOURCE: Washington Office of the Insurance Commissioner, Ground ambulance balance billing study, Legislative study report, October 2023.

Share of Ambulance Rides, by Ownership Type, 2014-17

Emergency Transports



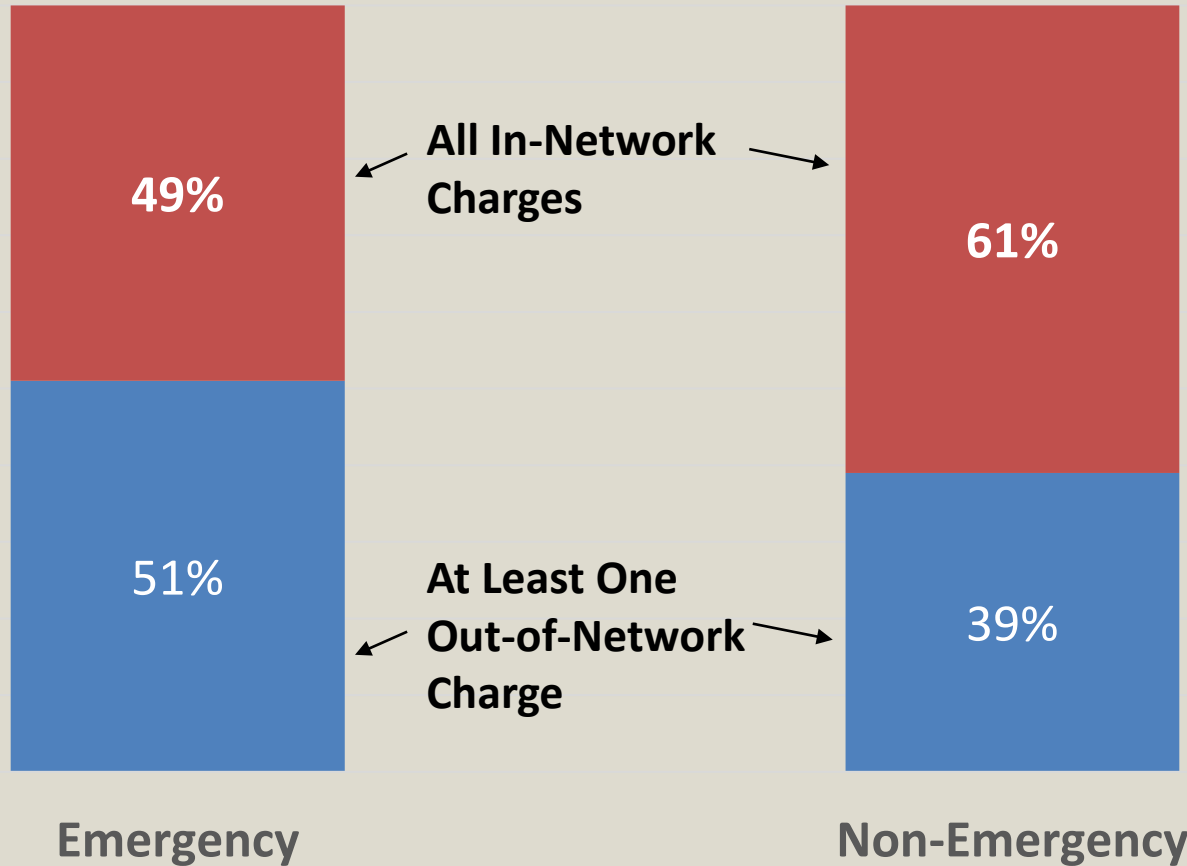
Non-Emergency Transports



SOURCE: Loren Adler et al, Ground Ambulance Billing And Prices Differ By Ownership Structure, Health Affairs, January 2023.

Share of Ambulance Rides with an Out-of-Network Charge, 2018

Among People with Large Employer Coverage



Out-of-Network Use and Potential Surprise Bills, 2014-17

	Emergency Transports	Non-Emergency Transports
Services Delivered Out of Network	85%	57%
Potential Surprise Out-of-Network Bill	28%	26%

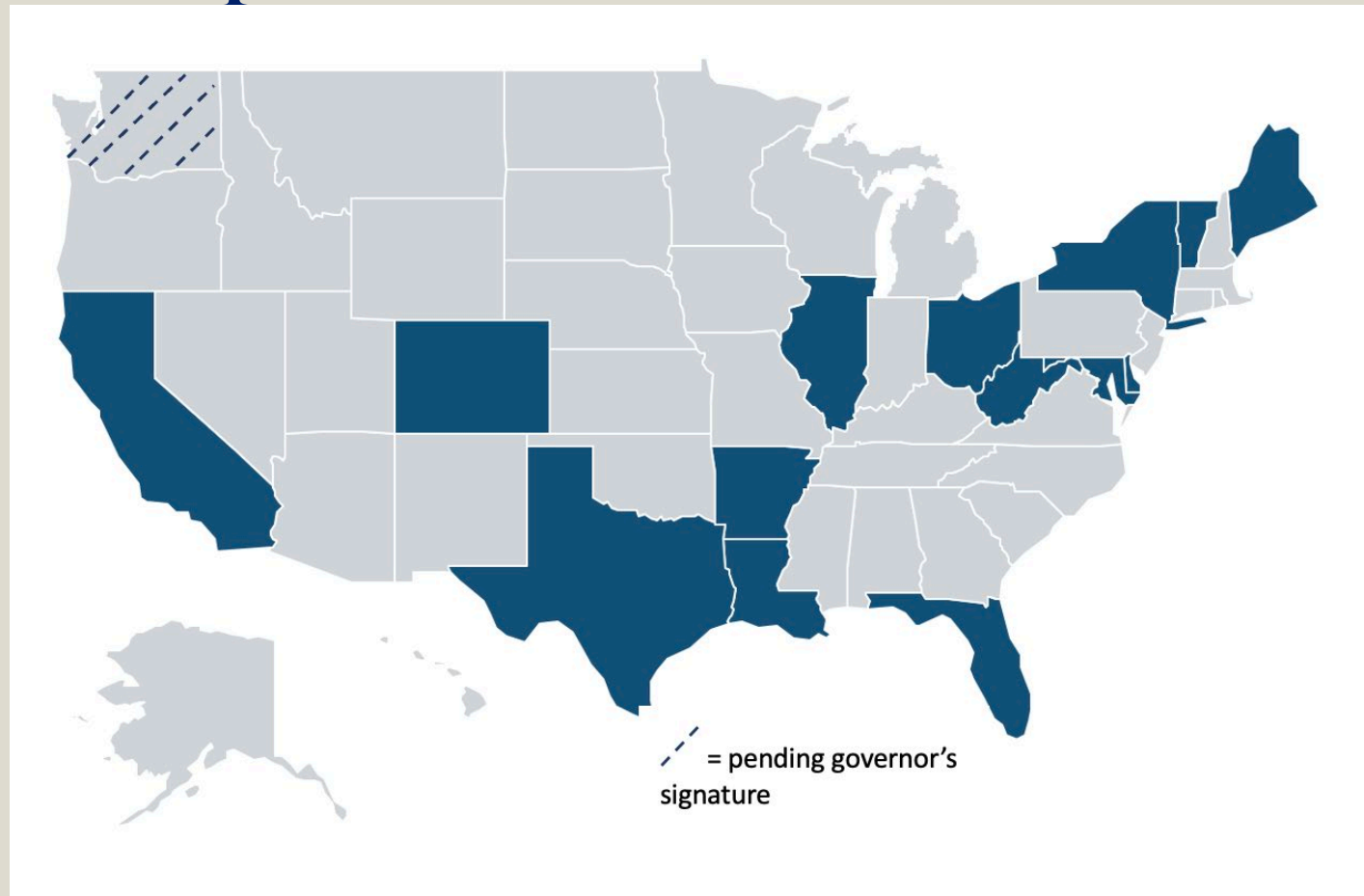
- For some claims, the insurer paid the provider's full charge, eliminating the possibility of a balance bill

Various Payment Amounts, 2017

Average-distance emergency transport with advanced life support level 1 (CPT code A0427)

	Private-Sector Ownership	Public-Sector Ownership
Billed Charges	\$1413	\$1024
Allowed Amounts	\$1027	\$761
Medicare Payment	\$494	\$494
Potential Surprise Bill	\$734	\$483
Cost Sharing	\$260	\$207

15 States Protect Patients from Surprise Ambulance Bills



State Variations: Consumer Protection and Rate Reimbursement

States that Hold Consumers Harmless for Surprise Bills

Arkansas (Emergency only)	Maryland (Public only)
California (Emergency only)	New York
Colorado (Private only)	Ohio (Emergency only)
Delaware	Texas (Emergency only)
Illinois	Vermont (Emergency only)
Florida	Washington
Louisiana (Emergency only)	West Virginia
Maine	

States that Offer Rate Reimbursement Guidance

Arkansas
California
Colorado
Florida
Louisiana
Maine
New York
Ohio
Washington
West Virginia

State Models for Rate Reimbursement Guidance

- California. Based on (a) local government rate or (b) state-set rate as reasonable and customary value, considering various factors
- Colorado. (a) 325% of Medicare or (b) negotiated independent rate
- New York. Usual and customary rate, but not excessive or unreasonable
- Texas. Based on (a) rate set by a local subdivision or (b) lesser of 325% of Medicare or provider's billed charge

Factors for Policymakers to Consider

- Applicability to public/private ground ambulance providers or both
- Applicability to non-emergency services, e.g., interfacility transfers
- Applicability to circumstances where patient refuses medical attention or is treated but not transported
- Applicability of negotiation/arbitration process

Advisory Committee on Ground Ambulance and Patient Billing (GAPB)

- Created by the NSA
- Membership
 - Insurance providers
 - Ambulance providers and medical personnel
 - State and federal officials
 - Consumer advocates
- Met from May to November 2023
- Adopted recommendations to Congress
- Report to be published soon

SOURCE: GAPB Committee.

GAPB Recommendations (I)

- Settings: ground ambulance transports
 - Responses to 911 calls
 - Interfacility transports
- Providers defined: entities authorized and licensed to respond to request for ground ambulance services
- Improve coverage for emergency medical services (“no transport”)

SOURCE: GAPB Committee.

GAPB Recommendations (II)

- Consumer protections
 - Limit on cost sharing = lesser of \$100 or 10% of established rate
 - Ban on balance billing for all ground ambulance providers or suppliers
- Include ground ambulance emergency services under Essential Health Benefit requirements under the ACA

SOURCE: GAPB Committee.

GAPB Recommendations (III)

- Payment standard
 - Payment required to provider within 30 days
 - Amounts specified in order as follows:
 1. Amount specified in a state law
 2. State or local regulated rate
 3. Mutually agreed rate by stakeholders
 4. Congressionally set % of Medicare or congressionally set amount (if not Medicare)
- No use of independent dispute resolution

Prospects for Expanding Protections to Ground Ambulance

- Broad support likely for adding protections
 - White House endorsement
- Valuable lessons from state laws, but federal protections are needed
- Breadth of services covered
- Potential for inflationary impact of approaches to payment determination

Georgetown CHIR Resources

- Blog posts for Commonwealth with our analysis of state laws
 - <https://www.commonwealthfund.org/blog/2021/protecting-consumers-surprise-ambulance-bills>
 - <https://www.commonwealthfund.org/blog/2024/expanding-no-surprises-act-protect-consumers-surprise-ambulance-bills>
- Blog post for CHIRBlog, with an enhanced table that includes some additional details on the state laws
 - <https://chirblog.org/filling-gap-no-surprises-act-states-protect-consumers-network-ground-ambulance-bills/>
- Interactive map
 - <https://www.commonwealthfund.org/publications/maps-and-interactives/expanding-no-surprises-act-protect-consumers-surprise-ambulance>

Agenda Item #6

Hear a Presentation from the Consumer Perspective on the Affordable Care Act (ACA) Section 1557 Nondiscrimination Proposed Rule—*Amy Killelea (NAIC Consumer Representative), Carl Schmid (HIV+Hepatitis Policy Institute), and Kellan Baker (Whitman-Walker Institute)*

Section 1557 Proposed Changes: What New Non-Discrimination Protections Mean for Consumers and Regulators

NAIC Spring Meeting 2024, B Committee

Presented by:

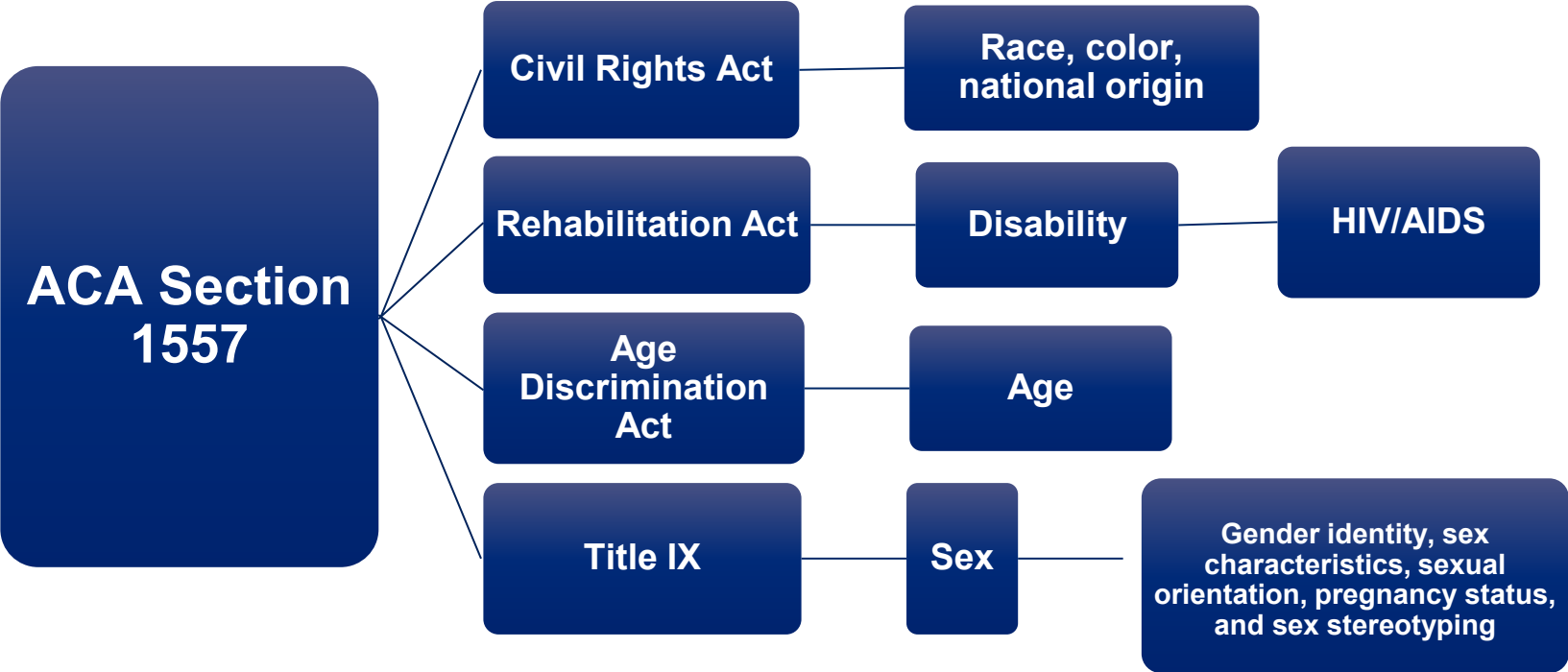
- Amy Killelea
- Carl Schmid, HIV+Hep Policy Institute
- Kellan Baker, Whitman-Walker Institute

Roadmap

- Section 1557 background, scope and applicability
- Discriminatory benefit design
- Prescription drug access
- Nondiscrimination on the basis of sex
- Reproductive and sexual health
- Health care refusals and exemptions
- Key issues for regulators

Section 1557: Overview and Regulatory History

Section 1557: Nondiscrimination in Coverage and Care



Section 1557 Timeline

- ACA enacted – March 23, 2010
- Request for Information (RFI) – August 2013
- Notice of Proposed Rulemaking (NPRM) – September 2015
- Final 2016 Rule published – May 2016
- Trump administration NPRM – May 2019
- Final 2020 Rule published – June 2020
- [HHS notice](#) of interpretation and enforcement in *Bostock* – May 2021
- NPRM – August-October 2022
- Final Rule expected – Spring 2024

2022 Proposed Changes - Applicability

- Clarifies that §1557 applies to all federal health programs and activities (not just ACA)
- Providing or administering health insurance is a health program/activity
- Applies § 1557 to short term limited duration plans and limited benefit plans
- Applies to third party administrators and PBMs

Section 1557: Discriminatory benefit design

2022 Proposed Rule: Discriminatory Benefit Design

Builds upon NBPP examples of presumptive discriminatory design

- Cost sharing
- Medical necessity definitions
- Narrow networks
- Drug formularies
- Adverse tiering
- Benefit substitution
- Utilization management
- Exclusions
- Visit limits
- Waiting periods
- Service areas
- Coercive wellness programs

Section 1557: Prescription drug access

2022 Proposed Changes - Rx's

- Applies to PBMs
- Benefit Design includes coverage, exclusions, and limitations of benefits; prescription drug formularies;
 - cost sharing (including copays, coinsurance, and deductibles)
 - Placing all or almost all drugs to treat a condition on the highest tier
 - utilization management techniques (such as step therapy, prior authorization, durational or quantity limits)

2022 Proposed Changes - Rx's

- Acknowledges UM is “standard industry practice.. but must be applied in a neutral, nondiscriminatory manner”
- Potential Discrimination
 - Excessive use or administration of utilization management tools that target a particular condition
 - Rx formularies that place utilization management on most or all drugs that treat a particular condition regardless of their costs that don't do this for other conditions.
- Where there is alleged discrimination, must be a legitimate, nondiscriminatory reason, based on clinical evidence

Need for Enforcement - Rx's

- State Insurance Regulators, CMS & OCR must ensure compliance w/laws & regulations (1557 & EHB)
 - Plan reviews, approvals, & complaints
- **North Carolina Blue Cross/Blue Shield**
 - Place almost all HIV Rx's, including generics, on highest tiers, all w/ quantity limits
 - Complaint filed
 - No action by state insurance commissioners
 - OCR initiated review after plan corrected drug tiering, bought issuer reasoning that plan was based on clinical practices

Need for Enforcement - Rx's

- **Community Health Choice Texas**
 - Doesn't meet treatment guidelines
 - Excludes many antiretrovirals
 - Breaks up single tablet regimens
 - Covers old & discontinued drugs
 - Places drugs on highest tier
 - Complaint filed w/CMS, inadequate response & actions
- **Without enforcement, race to the bottom & jeopardize treatment nationwide**

Section 1557: Scope of Sex Nondiscrimination Protections

Restoration of the Full Scope of Sex Nondiscrimination Protections

- **2016 rule:**
 - Gender identity, sex stereotypes, and pregnancy status included under the definition of sex
 - Specific examples of gender identity nondiscrimination in coverage and care
 - Followed previous action by ~20 state regulators to prohibit discrimination against transgender people, particularly in benefit design
- **2020 rule:**
 - Eliminated gender identity, sex stereotyping, and pregnancy nondiscrimination protections
 - Also eliminated sexual orientation and gender identity (SOGI) protections from various CMS rules

Restoration of the Full Scope of Sex Nondiscrimination Protections

- **2022 Rule:**

- Based on the 2020 Supreme Court decision in *Bostock v. Clayton County*, re-establishes gender identity nondiscrimination protections under the basis of sex and adds sexual orientation
- Re-establishes protections on the basis of sex stereotypes and pregnancy status
- Clarifies that sex-based distinctions are allowed, but only if they cause *de minimis* harm to beneficiaries or patients
- Clarifies that religious/conscience exemptions will be considered on a case-by-case basis by OCR under existing federal laws
- Does not require providers to perform services outside of their scope of practice or area of specialty
- Re-establishes CMS regulations that were eliminated by the 2020 rule

Regulator and Industry Support for 2022 NPRM

- **In 2022, 21 state insurance regulators sent a letter to HHS in support of the changes in the 2022 NPRM related to sex discrimination:**
 - “The proposed changes to the 2020 rule will promote the goal of robust civil rights protections and nondiscrimination in coverage while providing additional clarity for the consumers we serve and the companies we regulate”
 - “We are also aware that the proposed changes to the rule are consistent with several federal court rulings that have explicitly found that the sex nondiscrimination protections in Section 1557 prohibit discrimination against LGBTQ people.”
- **AHIP’s 2022 comments state:** “We strongly support ensuring that appropriate gender-affirming care is available and accessible to enrollees. We [are committed] to ensuring benefit designs and coverage decisions reflect evidence-based guidelines and recommendations and do not restrict coverage related to gender identity.”

Section 1557: Reproductive and Sexual Health

Section 1557: Exceptions Process and Health Care Refusals

Proposals for Health Care Refusals

- No blanket exemptions from § 1557 for religious or other covered entities
- Establishes procedures for submitting requests for exemptions to Office for Civil Rights
 - “Fact-sensitive, case-by-case analysis”
- Rescinds 45 C.F.R. § 92.6(b), where 2020 Final Rule incorporated the Danforth Amendment, Title IX’s exemption for abortion-related services

Section 1557: What State Regulators Can Do

What State Regulators Can Do

- Ensure that insurers are aware of the new protections (for instance via release of bulletins and guidance)
- Review plans for discriminatory benefit design as part of certification process
 - This could include more in-depth review for particular service categories or conditions more likely to be subject to discriminatory plan design
- Review and revise the state's EHB benchmark plan selection to ensure it does not have exclusions or other benefit design features that contravene Section 1557's requirements
- Monitor and enforce compliance through complaint process, data calls, and market conduct exams
- Make data and reports from market conduct and other investigations public

Questions?

Contact:

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Carl Schmid - cschmid@hivhep.org

Kellan Baker - KBaker@whitman-walker.org

Wayne Turner - turner@healthlaw.org

Dorianne Mason - dmason@nwlc.org

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

—*Jeff Wu (CCIIO)*

Agenda Item #8

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