HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Aug. 15, 2024, Minutes

Health Insurance and Managed Care (B) Committee July 26, 2024, Minutes (Attachment One)

Health Insurance and Managed Care (B) Committee June 13, 2024, Minutes (Attachment Two)

J Health Actuarial (B) Task Force Memorandum to the Committee ,

Draft: 8/21/24

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

The Health Insurance and Managed Care (B) Committee met in Chicago, IL, Aug. 15, 2024. The following Committee members participated: Anita G. Fox, Chair ,,an07 001[(rs)9M.01[,(,).an07Tw 1.228 0 Td[(C)-0.6 (h)2.2 (ic)-2 (ag)13.5 (

again, the Senate Committee on Appropriations put in its year-end report that it believes the federal Centers for Medicare & Medicaid Services (CMS) has sufficient funds in its budget to start the grant program without an additional appropriation of funds. He said NAIC Government Relations staff will continue to work to get CMS to fund and start the grant program. Webb said that this year, both the U.S. House of Representatives (House) and the U.S. Senate have maintained the same level of State Health Insurance Assistance Program (SHIP) funding in their respective budget bills. He said that, typically, one chamber zeros out the funding, and the other one funds it. This year, both have included full funding for SHIP in their committee appropriation bills.

Webb said the NAIC recently sent a letter to Congress regarding the enhanced advance premium tax credits (APTCs) under the federal Affordable Care Act (ACA). He explained that the APTCs are currently scheduled to end in 2025. The NAIC letter urges that they be extended past 2025 for many good reasons, the principal reason being that the increased size and availability of the premium tax credits that have been available since the passage of the American Rescue Plan Act of 2021 have resulted in greater enrollment in marketplace plans in state individual health insurance markets. The greater subsidies have enhanced the affordability of coverage for families of modest means as well as those who were previously denied help with coverage costs due to income limits, those above 400% of the federal poverty level. Webb also noted the APTCs on reinsurance programs in states with an ACA Section 1332 waiver.

Webb said Medicare Advantage plan marketing continues to be a big issue and the subject of much discussion. He said NAIC Government Relations staff are continuing to work with the relevant Senate and House committees to add language to year-end Congressional budget legislation to make it clear that CMS can work with states through a cooperative enforcement agreement to enforce the federal rules related to Medicare Advantage marketing. He said some states have requested such an arrangement to address consumer complaints directly.

Webb said that in July, the Federal Trade Commission (FTC) released an interim staff report, "Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies." The report is highly critical of pharmacy benefit managers (PBMs), their funding, and their effect on consumers. He said the NAIC Government Relations staff will continue to follow this issue and see if it triggers any additional Congressional legislative activity on PBMs.

Regarding federal rules, Webb said it is anticipated that the new federal rule revamping provisions implementing the MHPAEA and establishing new requirements regarding non-quantitative treatment limitation (NQTL) requirements will be finalized soon. He said the NAIC also continues to look for clarity on the co-payment accumulator issue since the U.S. District Court for the District of Columbia's Sept. 29, 2023, decision vacating the 2021 U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters (NBPP) rule to the extent it permitted health plans to use a co-payment accumulator policy and HHS' decision not to enforce the 2020 NBPP rule, which prohibited copay accumulators except where a medically appropriate generic alternative is available. He said it has been rumored that such clarity could be included in the 2026 NBPP rule. He said he is aware of two states enforcing the 2020 NBPP rule, but other states need guidance on the issue.

Webb said the last federal rule he wanted to discuss was the ACA's Section 1557 final rule. He said there continue to be issues related to the final rule's language prohibiting discrimination based on a disability or age and Medicare supplement insurance (Medigap) plans. He said NAIC Government Relations staff have been seeking clarity on this issue from the HHS Office for Civil Rights (OCR) since May, right after the rule was finalized in April. To date, the OCR has not been responsive. He said NAIC Government Relations staff will continue to reach out to the OCR for a meeting to discuss the issue.

Webb next discussed recent court rulings, beginning with and (collectively referred to as) rulings, which overturned the so-called "Chevron Doctrine." He said it is too early to tell what impact the ruling will have on federal health rules and

federal rulemaking, but he has already seen the ruling mentioned in some court cases related to the ACA Section 1557 rule. Webb said NAIC Government Relations staff continue to track both the case, which challenged the ACA's preventive service requirements, and the case, which challenges state insurance regulators' right to regulate PBMs. He said both cases are continuing to make their way through the federal courts, which could have major implications for state insurance regulators.

5. Heard an Update from a Consumer Perspective on Recent State Activity on the Prior Authorization Process

Carl Schmid (HIV+Hepatitis Policy Institute), Stephani Becker (Shriver Center on Poverty Law), and Lucy Culp (Leukemia & Lymphoma Society—LLS) provided an update from a consumer perspective on recent state activity improving the prior authorization process.

Schmid discussed how the prior authorization process impacts patients and providers. He said that according to a 2023 American Medical Association (AMA) survey on prior authorization, 94% of providers said the prior authorization process delays patients' accessing necessary care. He provided additional statistics highlighting the effect of the prior authorization process on providers. He discussed the recommendations from two reports—the Center on Health Insurance Reforms (CHIR) report, "The Good, The Bad, The Costly," and the Network for Excellence in Health Innovation (NEHI) report, "Improving the Prior Authorization Process Recommendations for California," prepared for the California Health Care Foundation (CHCF)—suggesting potential reforms to improve the prior authorization process.

Schmid and Becker discussed prior authorization reform legislation in several states, including California, Illinois, Minnesota, New York, Vermont, and Rhode Island. Becker explained that the Rhode Island law signed in 2023 required the Office of the Health Insurance Commissioner (OHIC) to convene the Administrative Simplification Task Force to make prior authorization recommendations. She said that in its June 28 final report, the OHIC committed to: 1) ensuring uniform interpretation of a reduction in the volume of prior authorization; 2) collecting data in new ways to measure volume reductions; and 3) creating a new public body to serve as a forum for ongoing dialogue between payers and providers to inform prior authorization process improvements. Becker also noted new or strengthened prior authorization laws in Colorado, Maine, Maryland, Minnesota, Mississippi, Oklahoma, Vermont, Virginia, and Wyoming.

Culp discussed CMS's Interoperability and Prior Authorization Final Rule. She explained that the federal rule applies to Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP), and qualified health plans (QHPs) on the federal marketplaces. The final rule's requirements include: 1) a specific reason for denial; 2) shortened prior authorization response times; 3) public reporting; and 4) automation. Culp noted that the federal final rule does not include prior authorization changes for prescription drugs, but she anticipates CMS issuing a proposed rule for prescription drugs later this year.

Culp also discussed CMS's 2024 Medicare Advantage and Part D Final Rule. She explained that although it applies only to Medicare Advantage plans, she believes its provisions include meaningful changes to the prior authorization process that states can borrow from. She said those changes include: 1) new limits on the use of prior authorization; 2) banning retroactive denials; and 3) continuing prior authorization approvals as long as they remain medically necessary. The final rule also includes limits on the use of artificial intelligence (AI) for prior authorization determinations.

Culp suggested the following next steps for the Committee to consider: 1) charging the Consumer Information (B) Subgroup to modify and use the Subgroup's new consumer prior authorization guide to educate consumers; 2) forming a new Committee working group to share information and work on implementation, best practices, and

enforcement; and 3) partnering with the

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

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 (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 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 insuranceContract Reserves for Credit Disability Insurance. He outlined the process of adopting amendments and the Committee's role in the adoption before the package of 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%–

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 (

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.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2024 Summer National Meeting/B Cmte 6-13-24 MtgMin.docx

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states in the survey, we will provide under separate cover the complete results of the survey in a regulator-only format.

Impact of Elimination of Enhanced Subsidies

Under the Affordable Care Act (ACA), premium tax credits are available to people purchasing health coverage on

morbidity between members expected to enroll in each plan, and each Benefit Factor should be developed assuming that the same standard population of members is enrolled on every Plan design.

- CMS has delegated to each state's effective rate review function the responsibility for determining how the Cost Sharing Reduction (CSR) benefit costs should be applied in ACA Individual rate settineci4 (ec)11.3 .4-44-4 (i 11.3)-82h sts efadef-127.6l ecidl rcl ra .d92e

occur. Utilizing Nebraska PUF enrollment data from the recent plan year's enrollment among the standard Silver Plan, and the 73%, 87% and 94% variants, may provide a realistic distribution of membership to assume, given that the environment has not changed from the current year to the projected year (ARPA subsidies remain in place, etc.).

Additional Requirement for What Needs to Be Provided as Rate Filing S5xw23.6 (.1 ( )10.9 (S5xw23

(e) For On-Exchange Silver Plans the complete development of the CSR Load should be provided, and should include at least the following:

- Membership distribution assumptions used for enrollment in Base Silver, 73%, 87% and 94% Silver plan variants
- Data source used to determine the distribution (i.e. NE PUF Enrollment Data, Issuer's own experience, or other source)
- Membership adjustments made to the source data
- Utilization adjustments, including a description of any adjustments

(f) Issuers utilizing predictive models, such as GLMs, GAMs or other such predictive models, must provide the required support contained on the NDOI L&H webpage. Any other simulation models, or other models used in the process of setting benefit factors, need to be fully documented.

(2)Texas

Texas Association of Health Plans (axioshq.com)

(3) Washington

https://content.naic.org/sites/default/files/inline-files/cmte_b_ha_tf_related_state_cost_sharing_washington.pdf

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2024 Summer National Meeting/HATF CSR Memo B Committee Final.docx

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Frequently Asked Questions About Health Care Reform

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