HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee April 7, 2019, Minutes
- Amended 2019 Charges (Attachment One)
- Health Insurance and Managed Care (B) Committee Feb. 14, 2019, Minutes (Attachment Two)
- Consumer Information (B) Subgroup March 29, 2019, Minutes (Attachment Three)
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- Health Innovations (B) Working Group April 6, 2019, Minutes (Attachment Six)

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Draft: 4/16/19

Health Insurance and Managed Care (B) Committee
Orlando, Florida
April 7, 2019

The Health Insurance and Managed Care (B) Committee met in Orlando, FL, April 7, 2019. The following Committee members participated: Jessica Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); Dean L. Cameron (ID); Vicki Schmidt (KS); Nancy G. Atkins (KY); Steve Kelley represented by Kristi Bohn and Grace Arnold (MN); Jon Godfread (ND); Linda A. Lacewell (NY); Andrew Stolfi and TK Keen (OR); Julie Mix McPeak represented by Michael Humphries and Lorrie Brouse (TN); Scott A. White (VA); and Mike Kreidler (WA). Also participating were: Kenneth Ryan James (AR); Perry Kupferman (CA); Fleur McKendell (DE); Craig Wright (FL); Andria Seip (IA); Angela Nelson (MO); Kevin Dyke (MI); Bruce R. Ramge and Martin Swanson (NE); Paige Duhamel (NM); and Marie Ganim (RI).

1. Adopted Via E-Vote Amended 2019 Charges

The Committee adopted via e-vote ending March 29 amended 2019 charges (Attachment One), which deleted the charges for the Health Care Reform Regulatory Alternatives (B) Working and the CO-OP Solvency and Receivership (B) Subgroup and adopted the charges for the Health Innovations (B) Working Group. The revised charges reflect the Committee's action taken during its Feb. 14 conference call.

2. Adopted its Feb. 14, 2019, and 2018 Fall National Meeting Minutes

The Committee met Feb.14, 2019, and Nov. 16, 2018. During its Feb. 14 meeting, the Committee: 1) adopted revisions to the *NAIC Medicare Supplement Insurance Model Regulation Compliance Manual* related to the federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); 2) adopted revisions to the *Health and Welfare Plans Under the Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook); 3) adopted revisions to the *Accident and Sickness Insurance Minimum Standards Model Act* (#170); 4) adopted revisions to the *Shopper's Guide to Long-Term Care Insurance* (Shopper's Guide); 5) adopted the Regulatory Framework (B) Task Force's recommendation to open the *Health Maintenance Organization Model Act* (#430) to address identified conflicts and redundancies between Model #430 and the *Life and Health Insurance Guaranty Association Model Act* (#520); 6) disbanded the Health Care Reform Regulatory Alternatives (B) Working Group and appointed the Health Innovations (B) Working Group; and 7) disbanded the CO-OP Solvency and Receivership (B) Subgroup.

Commissioner Atkins made a motion, seconded by Commissioner Conway, to adopt the Committee's Feb. 14, 2019 (Attachment Two) and Nov. 16, 2018 (*see NAIC Proceedings – Fall 2018, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

3. Adopted the Report of the Regulatory Framework (B) Task Force and its Request for NAIC Model Law Development

Commissioner Conway said the Regulatory Framework Task Force met April 6. During the meeting, Marilyn Bartlett (MT) discussed how Montana has used transparent pricing/contracting to address costs in the State of Montana Benefit Plan. The Task Force also heard presentations related to the opioid epidemic and mental health parity.

Commissioner Conway said the Task Force also adopted the reports of its subgroups and working group, including the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup and its Request for NAIC Model Law Development to develop a new NAIC model establishing a registration or licensing process for pharmacy benefit managers.

Mr. Keen said he anticipates the Subgroup having a robust discussion of what provisions to include in the new NAIC model before it begins the drafting process. He said the Subgroup quickly moved forward with the Request for NAIC Model Law Development at this meeting given the timing.

Commissioner Godfread asked whether the Request for NAIC Model Law Development would limit the Subgroup's work to only establishing a PBM licensing or registration process. Mr. Keen said the Subgroup's charge permits it to consider other related issues.

Commissioner Conway made a motion, seconded by Commissioner Stolfi, to adopt report of the Regulatory Framework (B) Task Force and its Request for NAIC Model Law Development (*see NAIC Proceedings – Spring 2019, Regulatory Framework (B) Task Force, Attachment Two*). The motion passed unanimously.

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

Director Wing-Heier made a motion, seconded by Director Cameron, to adopt the following reports: the Consumer Information (B) Subgroup, including its March 29 (Attachment Three), March 15 (Attachment Four) and Feb. 11 (Attachment Five) minutes; the Health Innovations (B) Working Group (Attachment Six); the Health Actuarial (B) Task Force; and the Senior Issues (B) Task Force. The motion passed unanimously.

5. Heard a Panel Presentation on Health Care Cost Drivers

Kim Holland (Blue Cross and Blue Shield Association—BCBSA) discussed what the BCBSA's health care cost data show with respect to health care costs, health care cost drivers and potential solutions to address rising health care costs. She noted that, nationally, health care expenditures are consuming greater portions of family and public budgets. Private insurance per capita cost growth has outpaced public programs, which has become a strain on individuals and families.

Ms. Holland detailed the costs of certain health care services in the commercial market. She said the BCBSA believes the main drivers of cost increases are due to provider consolidation, costly chronic health conditions and prescription drug costs. She offered some policy proposals to control health care costs, including: 1) reducing the prevalence of chronic disease; and 2) reducing prescription drug costs. She said the BCBSA believes value-based insurance design (VBID) could be the key to improving the quality of health care provided and reducing health care costs. A few Blue Cross and Blue Shield plans are testing out this design model and have partnered with physicians to provide resources and data and to identify care gaps.

Kevin Kennedy (Health Care Cost Institute—HCCI) discussed the health care cost data the HCCI compiled from 2013 to 2017, which are found in its *2017 Health Care Cost and Utilization Report* (Report), and what the data showed with respect to health care cost spending, health care costs and health care cost drivers. He said that if the Committee remembers anything from his presentation it would be: 1) health care spending is continuing to grow; 2) rising prices are driving growth overall; and 3) variation across service categories and subgroups are providing insight into areas to focus reform efforts.

Mr. Kennedy provided an overview of the Report's findings. He highlighted the fact that per person spending on health care services reached an all-time high of $5,641 in 2017. Utilization of services, however, remained flat over the 2013 to 2017 period. He explained that health care service utilization and price trends varied across service categories, and spending levels and growth varied by population subgroups. He summarized the Report's findings with the following question for the Committee to consider: "People are spending more because prices are rising, but what are those higher costs buying us?"

Maureen Mustard (NH) discussed New Hampshire's all-payer claims database and how the database has helped New Hampshire provide price transparency to consumers. She explained how New Hampshire established the database, noting that New Hampshire is unique in using its insurance authority to collect claims data. She also explained the action New Hampshire took to protect its ability to continue to collect data from self-insured health benefit plans after the U.S. Supreme Court's decision in *Gobeille v. Liberty Mutual Insurance Company*. She pointed out that New Hampshire de-identifies all claims submitted to the database.

Ms. Mustard said New Hampshire uses the claims data in its database to: 1) produce a quarterly statewide rate report, which shows charge and paid amounts for thousands of health care procedures; 2) support increased transparency and market competition with respect to network adequacy; and 3) most likely in the future, help determine the reasonable market rate for provider payment in balance billing disputes. She discussed the impact of its *NHHealthCost.org* website in improving the price transparency of health care services for consumers, not only in New Hampshire but across the U.S., as well.

Commissioner Altman asked the panelists if they had any policy recommendations for possibly reducing health care costs. Mr. Kennedy said the HCCI tries to use its findings to point policymakers to certain areas where they should focus to address health care costs. Ms. Holland said the BCBSA believes one main area policymakers could focus on to reduce health care costs is education and early intervention with young people to prevent high-cost chronic diseases, which it has found to be a high cost driver.

Director Wing-Heier asked about the impact of probable cost-shifting between Medicare/Medicaid and the commercial, private market on increased utilization of health care services. Mr. Kennedy said the HCCI has not specifically examined cost-shifting, but knows it occurs to some degree.

Commissioner Conway said Colorado has looked at cost-shifting. He asked how state insurance regulators could help health carriers better negotiate in order to reduce prices. Ms. Holland said provider consolidation has challenged health carriers in

their negotiations with providers. She also noted the challenge of state network adequacy laws and regulations. She said health carriers have become more and more known as "price takers."

6. Heard an Update on Legal Action Surrounding the ACA

William Schiffbauer (Law Office of William G. Schiffbauer) gave an update from his presentation at the 2018 Fall National Meeting on the three major cases involving the federal Affordable Care Act (ACA): 1) *Texas v. United States of America et al*, which challenges the constitutionality of the ACA's individual mandate and its potential impact on other key ACA provisions; 2) *State of New York v. U.S. Department of Labor*, which challenges the legality of the federal association health plan (AHP) regulation; and 3) *Association of Community Affiliated Plans, et al v. U.S. Department of Treasury et al*, which challenges the legality of the federal short-term, limited-duration (STLD) plan regulation.

Mr. Schiffbauer provided an overview of the timeline for the *Texas v. USA* case since November 2018. He explained that oral arguments in the *Texas v. USA* case have not yet been scheduled but could be scheduled for June or July. He explained that after oral arguments, the U.S. Court of Appeals for the 5th Circuit will issue a decision and, no matter what that decision is, the parties will file for a petition of certiorari to the U.S. Supreme Court for the 2019 term, with a decision issued in 2020.

Mr. Schiffbauer walked through the timeline for the *State of New York v. U.S. Department of Labor* case. He explained that the district court ruled in favor of New York March 28, vacating key provisions in the DOL's AHP final rule. He said the DOL has not yet filed an appeal with the U.S. Court of Appeals for the District of Columbia Circuit. However, the DOL did post on its website April 2 a set of frequently asked questions (FAQs) about the district court's ruling and its impact. Mr. Schiffbauer also walked through the key arguments and timeline for *Association of Community Affiliated Plans, et al v. U.S. Department of Treasury et al*.

Commissioner Altman asked what, if any, could be the possible impact of the Trump administration's shift in its position to not defend the constitutionality of other key provisions in the ACA in the *Texas v. USA* case, on the case's outcome. Mr. Schiffbauer said it is unknown until the government files its brief in the case. He theorized that the Trump administration in shifting its position wanted to align itself with the "red" states and possibly, ultimately, check the pulse of the U.S. Supreme Court, given the recent addition of two new conservative-leaning justices.

Ms. Bohn asked if there have been any arguments that the individual mandate requirement already was effectively eliminated, given the high percentage of individuals who qualified for the hardship exemption. Mr. Schiffbauer said that possibly an amicus brief includes such an argument, but the main parties to the case have not included such an argument in their briefs.

7. Heard Results of Consumer Testing Related to STLD Plans

Katie Keith (Out2Enroll) said that in light of recent developments related to STLD plans and the ongoing concerns with such plans from a consumer perspective, a group of NAIC consumer representatives commissioned the Kleimann Communications Group (Kleimann Group) to test whether consumers shown the marketing brochure for a popular, six-month short-term plan could understand the plan's benefits, limits and out-of-pocket costs. She said they also wanted to test the sufficiency of the federally mandated disclosure and whether consumers believed it adequately conveyed the limitations of the policy.

Susan Kleimann (Kleimann Communication Group—Kleimann Group) provided an overview of the Kleimann Group's findings when it conducted consumer testing of a STLD plan. She described how the Kleimann Group conducted the testing and the questions asked. She then provided an overview of the findings. Ms. Kleimann said, generally, consumers did not understand the coverage or the potential limitations of the coverage. She concluded that current marketing materials do not sufficiently help consumers in their understanding and fail to emphasize these types of plans differences with ACA plans. She also noted that consumers have a lack of health literacy, which compounds their inability to understand plan coverage and to calculate their potential out-of-pocket costs in addition to premium before enrolling in the plan.

Director Wing-Heier asked if the Kleimann Group's finding might have been different if it had conducted the testing in consultation with an insurance producer or enrollment assister. Ms. Kleimann said she did not know.

Ms. Keith said the NAIC consumer representatives specifically wanted to conduct testing on STLD plans, not other types of plans.

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8. Heard a Federal Legislative Update

Joseph Touschner (NAIC) provided a federal update on congressional legislative and administrative actions of interest to the Committee. He focused his update on individual market and general ACA reform legislation and similar administrative activity.

Mr. Touschner said the U.S. House of Representatives' Energy and Commerce Committee's Subcommittee on Health has passed legislation, including bills to: 1) overturn the recently finalized DOL short-term, limited duration regulation; 2) make void the latest ACA Section 1332 waiver guidance; 3) provide $10 billion per year for reinsurance and other subsidies; 4) create a $200 million grant for the states to set up state-based exchanges; 5) require $100 million in spending for exchange outreach; and 6) provide funding for navigators. He said, in addition, the House Democratic leadership has unveiled a package of reforms that include many of the above bills, plus providing additional subsidies and undoing many Trump administration actions.

Mr. Touschner said the Republican-led U.S. Senate committees have focused on bipartisan efforts to address high prescription drug costs and surprise bills. He said that with respect to market stabilization legislation, after last year's bitter defeat of the bipartisan market stabilization effort in the Senate, U.S. Sen. Lamar Alexander (R-TN) and U.S. Sen. Patty Murray (D-WA) are not in a hurry to reignite that effort.

Mr. Touschner noted that the health insurance tax (HIT) is not in effect in 2019. He said there is strong bipartisan support for further delaying the HIT. The only difficulty is how to pay for it, as the HIT brings in more than $16 billion a year.

Mr. Touschner discussed several pending administrative rules, including: 1) the proposed program integrity rule, which would, among other things, require carriers to collect a separate premium for coverage of abortion services. Currently, as required by the ACA, this coverage may not be subsidized and the premium for abortion services coverage must be segregated. The proposed rule is expected to be finalized within the next few months; 2) the proposed health reimbursement arrangements (HRAs) rule, which would expand the use of HRAs. The proposed rule should be finalized within the next few months; and 3) the package of rules related to the 2020 open enrollment period into qualified health plans (QHPs), which is currently open for public comment.

Mr. Touschner also noted that the federal Centers for Medicare & Medicaid Services (CMS) issued a bulletin March 25 allowing transition plans to continue through Dec. 31, 2020. He said NAIC Government Relations Division staff are tracking activity related to the advisory committee established under the federal FAA Reauthorization Act of 2018 (H.R. 4) to study network participation and balance billing in the air ambulance industry, and then make recommendations for enhanced regulation and consumer disclosures. He said the NAIC has recommended that Commissioner Godfread be appointed to the state insurance regulator seat on the advisory committee. However, the U.S. Department of Transportation has not yet announced the members of the advisory committee. He said, meanwhile, the NAIC continues to seek other opportunities to address this issue through federal legislation.

9. Discussed MHPAEA and Next Steps for Future Discussions

Commissioner Altman said she added this item to the Committee's agenda to discuss the federal Mental Health Parity and Addition Equity Act of 2008 (MHPAEA), because she has been approached by Committee members and other NAIC members on the issue of mental health parity and possible future Committee discussions of the issue. She said she would like to receive feedback from the Committee on what types of discussions the Committee should hold to be of assistance to the states in dealing with this issue.

Commissioner Godfread suggested the Committee hear a legal update on mental health parity-related lawsuits. He said such an update was helpful to North Dakota.

Ms. Bohn said Minnesota is developing an online mental health parity course in conjunction with the NAIC Education and Training Department. She said she anticipates the course being ready sometime in the fall.

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

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Draft: 3/25/19
Adopted by the Health Insurance and Managed Care (B) Committee – March 29, 2019

2019 AMENDED CHARGES

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

The mission of the Health Insurance and Managed Care (B) Committee is to consider issues relating to all aspects of health insurance.

Ongoing Support of NAIC Programs, Products or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
   A. Respond to inquiries from the U.S. Congress, the White House and federal agencies; analyze policy implications and effect on states of proposed and enacted federal legislation and regulations; and communicate the NAIC's position through letters and testimony when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   C. Monitor the activities of the Regulatory Framework (B) Task Force.
   D. Monitor the activities of the Senior Issues (B) Task Force.
   E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee on Quality Assurance (NCQA) and URAC.
   F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
   G. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).
   H. Coordinate with the Producer Licensing (D) Task Force, as necessary, regarding the regulation and activities of navigators and non-navigator assistance personnel as provided under the ACA and regulations implementing the ACA.
   I. Coordinate with the Antifraud (D) Task Force, as necessary, regarding state and federal antifraud activities related to the implementation of the ACA.
   J. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the Affordable Care Act, including short-term, limited-duration insurance, association health plans, and packaged indemnity health products.

2. The **Consumer Information (B) Subgroup** will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.

3. The **Health Innovations (B) Working Group** will:
   A. Gather and share information, best practices, experience and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
   B. Discuss state innovations related to health care—including access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision-making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.
   C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
   D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to utilize the information gathered by the Working Group.
   E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

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

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Draft: 3/11/19

Health Insurance and Managed Care (B) Committee
Conference Call
February 14, 2019

The Health Insurance and Managed Care (B) Committee met via conference call Feb. 14, 2019. The following Committee members participated: Jessica Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); Dean L. Cameron (ID); Vicki Schmidt (KS); Nancy G. Atkins (KY); Steve Kelley represented by Kristi Bohn and Fred Andersen (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); John Elias represented by Jennifer Patterson (NH); Linda Lacewell represented by Troy Oechsner (NY); Andrew Stolfi (OR); Julie Mix McPeak (TN); Scott A. White (VA); and Mike Kreidler represented by Jane Beyer and Molly Nollette (WA). Also participating were: Robert Wake (ME); Kevin Dyke (MI); and Martin Swanson (NE).

1. Adopted Revisions to the Compliance Manual

Mr. Dyke said the Health Actuarial (B) Task Force received a referral in 2017 from the Senior Issues (B) Task Force to consider revisions to the *NAIC Medicare Supplement Insurance Model Regulation Compliance Manual* (Compliance Manual) related to the federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). He said the Health Actuarial (B) Task Force began discussion of the revisions at the 2017 Summer National Meeting. He described the Task Force's drafting process ending with its adoption of the revisions during a Jan. 10 conference call.

Director Wing-Heier made a motion, seconded by Director Cameron, to adopt the revisions to the Compliance Manual (*see NAIC Proceedings – Spring 2019, Executive (EX) Committee and Plenary, Attachment Eight*). The motion passed unanimously.

2. Adopted Revisions to the ERISA Handbook

Mr. Wake said the ERISA (B) Working Group discussed the revisions to the *Health and Welfare Plans Under the Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) during several conference calls throughout 2018. He said the proposed revisions to the ERISA Handbook include several important updates since its last revision in 2004. Mr. Wake said those revisions include updates to case law, as well as new sections related to the federal Affordable Care Act (ACA) and the recently finalized federal regulations on association health plans (AHPs). He said the Working Group adopted the revisions via an e-vote that concluded Nov. 1, 2018, and the Regulatory Framework (B) Task Force adopted the revisions at the 2018 Fall National Meeting.

Ms. Patterson made a motion, seconded by Director Cameron, to adopt the revisions to the ERISA Handbook (*see NAIC Proceedings – Spring 2019, Executive (EX) Committee and Plenary, Attachment Seven*). The motion passed unanimously.

3. Adopted Revisions to Model #170

Commissioner Conway said the Regulatory Framework (B) Task Force adopted revisions to the *Accident and Sickness Insurance Minimum Standards Model Act* (#170), including changing the title to the Supplementary and Short-Term Health Insurance Minimum Standards Model Act, at the 2018 Fall National Meeting. He said the revisions remove provisions in the model concerning the types of health benefit plans subject to the ACA's requirements, and they leave remaining in the model those types of plans that are not subject to the ACA's requirements.

Commissioner Conway said the revisions reflect the Accident and Sickness Insurance Minimum Standards (B) Subgroup's almost year-long, extensive discussion and debate of myriad issues, such as the model's title, scope and purpose. The main issues the Subgroup discussed were providing flexibility to the states with respect to the regulation of short-term, limited-duration (STLD) plans and what information to include in consumer disclosures for these types of plans, such that consumers are aware of what type of plan they are purchasing prior to purchase. Commissioner Conway said that because this is a model act, at least two-thirds of the Committee members must vote in favor of the revisions for them to be adopted.

Commissioner Conway made a motion, seconded by Ms. Bohn, to adopt the revisions to Model #170 (*see NAIC Proceedings – Spring 2019, Executive (EX) Committee and Plenary, Attachment Six*).

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Director Cameron asked why the Subgroup included STLD plans in the revised model, because such plans are not excepted benefits as the other coverages in the revised model. Jolie Matthews (NAIC) explained that the Subgroup decided to include STLD plans in the revised model because there were no other NAIC models in which to include the coverage. In addition, she explained that the Subgroup wanted to provide guidance to the states for such plans as expeditiously as possible, because if the Subgroup had decided to develop a new NAIC model, then it would have taken at least a year to complete the work. Mr. Swanson agreed with Ms. Matthews. Mr. Wake also explained the Subgroup's reasoning for including STLD plans in the revised model, supporting Ms. Matthews' comments.

Director Cameron asked if the states are required to adopt Model #170 to satisfy the NAIC's accreditation standards. Ms. Matthews said Model #170 is not an accreditation standard.

The motion passed unanimously, with Alaska, Colorado, Idaho, Kansas, Kentucky, Minnesota, Mississippi, New Hampshire, New York, North Dakota, Oregon, Pennsylvania, Tennessee, Virginia and Washington voting in favor of the motion (i.e., more than the requisite number of Committee members needed for adoption).

4. Adopted Revisions to the Shopper's Guide

Director Wing-Heier said the Senior Issues (B) Task Force adopted revisions to the *Shopper's Guide to Long-Term Care Insurance* (Shopper's Guide) during its Oct. 29, 2018, conference call. She noted that the Long-Term Care Shopper's Guide (B) Working Group adopted the revisions during its Oct. 15, 2018, conference call, after working on the revisions throughout 2018. She said the revisions delete obsolete language and update out-of-date language. The revisions also streamline language, shortening the Shopper's Guide's length.

Commissioner Conway made a motion, seconded by Commissioner Godfread, to adopt the revisions to the Shopper's Guide (*see NAIC Proceedings – see NAIC Proceedings – Spring 2019, Executive (EX) Committee and Plenary, Attachment Nine*). The motion passed unanimously.

5. Adopted the Regulatory Framework (B) Task Force's Recommendation to Open Model #430 for Revision in Response to the Receivership and Insolvency (E) Task Force's Referral to the Committee

Commissioner Conway said the Committee received a referral in May 2018 from the Receivership and Insolvency (E) Task Force to perform a review of relevant health maintenance organization (HMO) model laws to determine if conforming changes are needed to provide options for the states that have enacted or are enacting the recently revised *Life and Health Insurance Guaranty Association Model Act* (#520). He explained that the revisions to Model #520 added HMOs as members of the life and health insurance guaranty association.

Commissioner Conway said the Committee accepted the referral and charged the Regulatory Framework (B) Task Force with conducting the requested review and reporting back to Committee with its recommendation. The Task Force established the HMO Issues (B) Subgroup to carry out the review and report back to the Task Force with its recommendation. He said the Subgroup met via conference call two times. During these conference calls, the Subgroup identified conflicts and redundancies between Model #520 and the *Health Maintenance Organization Model Act* (#430).

Commissioner Conway said the Subgroup submitted its report to the Task Force at the 2018 Fall National Meeting, noting that it recommended opening Model #430 for revisions to resolve the identified conflicts. He said the Task Force adopted the Subgroup's recommendation. However, in adopting the recommendation, the Task Force chose not to provide guidance on whether Model #430 should be opened for revision in its entirety or only for those areas of specific conflict. Commissioner Conway said the Task Force sent this recommendation to the Committee for its consideration.

Commissioner Altman requested comments. Ms. Nollette said Washington does not oppose opening Model #430 for revision, but the revisions should provide flexibility for those states not planning to adopt the Model #520 revisions.

Bob Ridgeway (America's Health Insurance Plans—AHIP) reiterated AHIP's position that opening Model #430 is not necessary, and it is premature at best. He noted that the revisions to Model #520 have been adopted by some states, but not all states. He also noted that HMOs do not fully operate like insurers. He said AHIP recommends waiting until the NAIC knows what the states plan to do with respect to the Model #520 revisions before opening Model #430.

Chris Petersen (Arbor Strategies) expressed concern with opening Model #430 if the scope of the revisions is going to include consideration of revisions not related to those provisions in conflict with Model #520.

David Link (Kaiser Permanente—Kaiser) reiterated Kaiser's comments from previous discussions related to opening Model #430. He said if Model #430 is opened, the Task Force should only consider revisions to provisions in Model #430 that conflict with Model #520.

Commissioner Conway made a motion, seconded by Director Wing-Heier, to adopt the Task Force's recommendation to open Model #430. The motion passed unanimously.

6. Disbanded the Health Care Reform Regulatory Alternatives (B) Working Group and Appointed the Health Innovations (B) Working Group

Brian Webb (NAIC) said the Health Care Reform Regulatory Alternatives (B) Working Group was appointed soon after the enactment of the ACA. He said the Working Group was appointed to act as a forum for state insurance regulators to consider and discuss the states' alternative approaches to implementing certain ACA provisions, such as through the ACA's Section 1332 waiver process. He said that since the Working Group's appointment, things have changed such that the Committee should consider appointing a new group with a broader scope to allow it to consider other state alternatives and innovations in addition to the ACA Section 1332 innovative waiver option, such as different state innovations to address increasing health care costs. The Committee expressed support for disbanding the Working Group and appointing the Health Innovations (B) Working Group.

Ms. Patterson made a motion, seconded by Director Cameron, to disband the Health Care Reform Regulatory Alternatives (B) Working Group and appoint the Health Innovations (B) Working Group. The motion passed unanimously.

7. Disbanded the CO-OP Solvency and Receivership (B) Subgroup

Mr. Webb said the CO-OP Solvency and Receivership (B) Subgroup was appointed in 2016 to provide a forum for state insurance regulators to discuss and share information through conference calls and meetings on the status of the Consumer Operated and Oriented Plans (CO-OPs) created under the ACA. He said when the Subgroup was first appointed, the Subgroup met almost monthly via conference call in regulator-to-regulator session to discuss the status of the existing CO-OPs. The Subgroup also met at the national meetings. Mr. Webb explained that as the number of operational CO-OPs has decreased, the Subgroup has been meeting quarterly via conference call in regulator-to-regulator sessions. Mr. Webb said, currently, because there are few existing operational CO-OPs, he suggests the Committee consider disbanding the Subgroup and carrying out the Subgroup's work through the Committee on a less formal basis. The Committee expressed support for Mr. Webb's suggestion.

Commissioner Atkins made a motion, seconded by Commissioner Stolfi, to disband the CO-OP Solvency and Receivership (B) Subgroup. The motion passed unanimously.

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

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Draft: 4/3/19

Consumer Information (B) Subgroup
Conference Call
March 29, 2019

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call March 29, 2019. The following Subgroup members participated: Angela Nelson, Chair, Amy Hoyt, Carrie Couch and Mary Mealer (MO); William Rodgers (AL); Alexandria Peck (IN); Mary Kwei (MD); Andrew Kleinendorst (MN); Kathy Shortt (NC); Martin Swanson (NE); Cuc Nguyen, Lydia Shirley and Rebecca Ross (OK); Katie Dzurec (PA); Candy Holbrook, Gretchen Brodkorb and Mallori Barnett (SD); Jaakob Sundberg and Tanji Northrup (UT); and Eric Cormany, Susan Ezalarab, Barbara Belling, Rebecca Rebholz and Jennifer Stegall (WI). Also participating were: Jacob Lauten (AK); Dayle Axman (CO); Debra Pierce (GA); Nicholas Lee (HI); Sonya Sellmeyer and Cynthia Banks-Radke (IA); Michelle Baldock (IL); Emily DeLaGarza (MI); Bob Williams (MS); Vickie Trice (TN); Scott Helmcamp (TX); Yolanda Tennyson (VA); Anna Van Fleet (VT); Dena Wildman, Greg Elam, Joylynn Fix and Theresa Miller (WV); and Denise Burke (WY).

1. Discussed the Draft Question List

Ms. Nelson provided an overview of the Subgroup's work plan as decided on the previous call. The Subgroup plans to develop four products: 1) a consumer alert titled, "What to Ask When Shopping for Health Coverage"; 2) a consumer guide on choosing a plan; 3) a consumer guide on using coverage; and 4) a consumer guide on how to get claims paid when there is an issue.

Ms. Nelson stated that the draft question list sent via email to the Subgroup was truly a rough draft, and participants should suggest any changes, big or small. She asked whether the overall structure of the document is what the group had in mind.

Harry Ting (Chester County Department of Aging Services, Apprise Program) said he especially likes the "Questions to ask yourself" and "Questions to ask about a plan you're considering" sections. He suggested adding a glossary, noting that consumers want advice from someone on which plan to choose.

Ms. Nelson responded that the document should refer to the glossary on *Healthcare.gov*. She said she believes the document should not get into providing advice on which plan to choose, because that gets into the realm of licensed agents.

Mr. Swanson suggested several questions for the list: What is your license number?; Do I have to pay to join a group to get coverage?; What is the direct number to call you back?; and Can you send me this information in writing?

Ms. Nelson asked whether an introduction to the "Questions to ask if you receive a phone call about health insurance" section would be good. Mr. Swanson said it would be, and perhaps a warning that consumers may be contacted after they search online for health insurance options.

Ms. Mealer suggested adding that it is a red flag if a consumer must login to an account to get needed information.

Mr. Swanson asked whether there should be a section dedicated to shopping online.

Ms. Stegall mentioned that Wisconsin produced a consumer alert in 2018 that cautioned against providing personal information such as a Social Security numbers or bank information.

Ms. Dzurec said it is easy to get into the "weeds" on plan types, given that some short-term plans are sold through associations. She added that sometimes providing personal information is necessary, so the warning should be not to provide it until a consumer has verified the person or entity they are dealing with, and not simply to withhold personal information at all times.

Mr. Ting suggested adding that a consumer does not need to make a decision during a call.

The Subgroup also suggested not including information about tiers in formularies, and suggested consumers ask, "Will I be able to use my doctor?" rather than ask about access to a provider directory.

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Ms. Nelson asked how fine-tuned the document should be; i.e., if it should be ready to use or customizable by states. Mr. Swanson said it could be both: a product ready for distribution, but one the states can feel free to adapt.

The Subgroup requested that any other comments and suggestions be submitted by April 8. Another conference call will be scheduled for the second half of April.

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

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Draft: 3/26/19

Consumer Information (B) Subgroup
Conference Call
March 15, 2019

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call March 15, 2019. The following Subgroup members participated: Angela Nelson, Chair, and Mary Mealer (MO); Yada Horace (AL); Donna Daniel, Kathy McGill and Elaine Mellon (ID); Alexandria Peck, Claire Szpara, Karl Knable, and Jenifer Groth (IN); Mary Kwei (MD); Judith Watters (ME); Martin Swanson and Laura Arp (NE); Cuc Nguyen and Rebecca Ross (OK); Alison Beam and Katie Dzurec (PA); Gretchen Brodkorb and Jill Kruger (SD); Jaakob Sundberg (UT); Melanie Anderson (WA); and Eric Cormany, Jody Ullman, Susan Ezalarab, Barbara Belling and Jennifer Stegall (WI). Also participating were: Jacob Lauten and Chelsy Maller (AK); Howard Liebers (DC); Andria Seip and Cynthia Banks-Radke (IA); Mike Chrysler (IL); Josh Rayborn (KY); Renee Campbell (MI); Bob Williams (MS); Pam Koenig (MT); Maureen Belanger (NH); Jana Jarrett (OH); Victor Woods (RI); Teresa Luna (TX); Yolanda Tennyson (VA); Dena Wildman and Theresa Miller (WV); and Denise Burke (WY).

1. Discussed its Work for 2019

Ms. Nelson recapped the Subgroup's prior conference call. She mentioned that the Subgroup discussed posting materials developed in 2018 to the NAIC website and developing new materials this year. She explained that a smaller group had met separately to consider work products for the Subgroup.

Ms. Nelson reviewed the smaller group's recommendations, which consisted of four products. The first product would be a consumer alert that would list questions for consumers to ask when shopping for coverage. It would help consumers navigate the information they get while shopping and ask for additional information they need.

Ms. Nelson described the other three products as a series of consumer guides. One would cover shopping for coverage and could borrow from the Health Insurance Shopping Tool the Subgroup developed in 2018. The next would cover how consumers can best use coverage, explaining cost-sharing and deductibles, networks, formularies, and how to seek care in the most appropriate and/or least expensive setting. The final guide would offer help in getting claims paid. It would describe how to read an explanation of benefits, consumers' appeal rights and how to contact the state insurance department or other regulators to get help.

Ms. Nelson asked whether this plan sounded good to the Subgroup. Ms. Watters and Ms. Kruger expressed support for developing the materials as described.

Ms. Watters said two issues coming up in Maine are the differences between the different types of non-Affordable Care Act (ACA) coverage, as well as accessing catastrophic plans using the affordability exception. Ms. Dzurec agreed that a lot of things are becoming confusing, given the way producers bundle different products. She said state insurance regulators should stay on top of things, as marketing shifts every year.

Chris Petersen (Arbor Strategies) mentioned that the Accident and Sickness Insurance Minimum Standards (B) Subgroup is making changes to the *Accident and Sickness Minimum Standards Model Act* (#170). He said the Subgroup may want to wait and see what that Subgroup is doing.

Candy M. Gallaher (America's Health Insurance Plans—AHIP) suggested making sure that consumers find the content of the guides actionable. Rather than questions to ask, she suggested a framing of "know what you are buying." A list should encourage consumers to ask themselves what they are looking for and then provide considerations for each answer.

Katie Keith (Out2Enroll) said the NAIC consumer representatives had commissioned a consumer test of short-term plan documentation to better understand consumer comprehension of their terms. The results will be rolled out at the Spring National Meeting.

Ms. Stegall suggested that the consumer alert have two pieces: one for consumers going into open enrollment and another focused on how to respond to telemarketers.

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Eric Ellsworth (Consumers Checkbook) pointed out that *www.healthcare.gov* has "From Coverage to Care" materials, noting that these might be useful for the guide about using insurance.

Joe Touschner (NAIC) suggested that there are many types of coverage, and the Subgroup should consider which ones the guides will be applicable to and how to convey that. Ms. Nelson said she was thinking they would apply only to major medical coverage. The Subgroup discussed how to treat other types of plans, including health care sharing ministries. Ms. Arp suggested including a phone number or website for information on other plan types and possibly a statement that health care sharing ministries are not insurance and, therefore, are not subject to state-based insurance regulation.

Ms. Nelson suggested working on the consumer alert first, followed by using coverage and getting bills paid, and finally back to the shopping tool in time for open enrollment.

Ms. Dzurec said it would be good to have a document to work from when considering the consumer alert. The Subgroup decided that participants would send suggested questions to Mr. Touschner, who would then circulate a draft to the Subgroup. The Subgroup decided that suggested questions would be due March 22 and its next conference call would occur March 29.

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

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Draft: 3/1/19

Consumer Information (B) Subgroup
Conference Call
February 11, 2019

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Feb. 11, 2019. The following Subgroup members participated: Angela Nelson, Chair, Jessica Schrimpf, Carrie Couch and Amy Hoyt (MO); Yada Horace (AL); Donna Daniel and Elaine Mellon (ID); Claire Szpara (IN); Tate Flott (KS); Mary Kwei (MD); Candace Gergen and Maybeth Moses (MN); Kathy Shortt and Rosemary Gillespie (NC); Laura Arp (NE); Cuc Nguyen (OK); Elizabeth Hart (PA); Gretchen Brodkorb and Candy Holbrook (SD); Heidi Clausen and Jaakob Sundberg (UT); Melanie Anderson (WA); and Christina Keeley, Darcy Paskey, Julie Walsh, Lisa Brandt, Mary Kay Rodriguez, Sue Ezalarab, Barbara Belling and Jennifer Stegall (WI). Also participating were: Jacob Lauten and Chelsey Maller (AK); Jackie Smith and Donna Lambert (AR); Gloria Barnes-Jackson (AZ); Julia Heath (CA); Laura McCandle (DE); Matthew Guy and Pam White (FL); Debra Peirce (GA); Mark Ono (HI); Andria Seip, Angela Burke Boston and Cynthia Banks-Radke (IA); Michelle Baldock (IL); Frank Opelka (LA); Emily DeLaGarza (MI); Josh Ammerman and Bob Williams (MS); Jeannie Keller, Ashley Perez and Pam Koenig (MT); Gary Weiss (NJ); Mark Garratt (NV); Tynesia Dorsey (OH); Brian Hoffmeister and Vickie Trice (TN); Scott Helmcamp (TX); Yolanda Tennyson (VA); Christina Rouleau (VT); Barbara Hudson and Dena Wildman (WV); and Denise Burke (WY).

1. <u>Discussed its Work Plan for 2019</u>

Ms. Nelson explained that she wanted to open the floor for suggestions on the Subgroup's work plan, but said she first wanted to review the Subgroup's charges.

Ms. Nelson reminded the Subgroup of its work to develop the Health Insurance Shopping Tool and asked whether any states had made use of it. Ms. Arp reported that Nebraska has used the shopping tool in presentations around the state, given it to consumer support staff and shared it with academic researchers. Ms. Nelson said the Missouri Department of Insurance had placed the tool on its website and promoted it on social media.

Ms. Nelson briefly discussed the *Frequently Asked Questions About Health Care Reform* (FAQ) document. Ms. Shortt asked how the FAQ document had been distributed. Joseph Touschner (NAIC) said it had been emailed to the contact list for the Subgroup and included in Brian R. Webb's (NAIC) Health Reform Update email.

Ms. Nelson asked whether the FAQ document was available on the NAIC website. Mr. Touschner said working versions were posted, but not the final version. The Subgroup discussed whether the FAQ should be posted on its web page. Some noted that the FAQ document requires state-specific material that state insurance regulators must add before it is complete. Others observed that the 2015 version of the FAQ document is available on the web page, but not the 2018 update. Ms. Stegall suggested that it should be posted on the website, with disclaimer language to describe its intended use. Others agreed.

Eric Ellsworth (Consumers Checkbook) suggested that disclaimer language include a statement that the document does not apply to short-term health plans. Ms. Nelson and Mr. Touschner said individual questions already include information on whether they apply to short-term health plans.

The Subgroup next discussed whether the Health Insurance Shopping Tool should be posted on the NAIC website. Some said it should have greater functionality or be in a checklist format. Others said it just needs a more attractive layout, noting that the Subgroup should not wait for the perfect document but instead use what is available. Ms. Nelson suggested that the existing tool be submitted to the NAIC Communications Division to see if it can be developed into something more useful and engaging, perhaps a web page, app or video.

Ms. Nelson asked the Subgroup to think through its next steps now that open enrollment is over. She suggested providing answers for the basic things that trip up consumers when they are using insurance. She asked what information the Subgroup would like to communicate.

Ms. Mealer said the biggest issue is certification, then grievances and appeals. Ms. Shortt said a comparison chart would be helpful to allow consumers to understand the differences between qualified health plans (QHPs), association health plans (AHPs), short-term plans and health care sharing ministries.

Ms. Mealer said there are concerns with AHPs, noting that a one-page that describes what they are would be helpful. Chris Petersen (Arbor Strategies) pointed out that the updated *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) has related information.

Ms. Arp noted that a document with questions to ask when a consumer gets a call offering cheap health insurance would be useful. Ms. Mealer suggested something geared toward young adults and something that describes how a bill goes through the claims process. Others suggested infographics, differences with student health insurance and appeals.

The group also discussed explanation of benefits (EOB) forms. Candy Gallaher (America's Health Insurance Plans—AHIP) said it would be helpful to report state requirements for EOBs. She said real estate on the EOB form is scarce and there is a lot of mandated language.

Ms. Nelson outlined three general areas the group had suggested: 1) claims; 2) a comparison between different kinds of coverage; and 3) questions to ask when shopping. She asked for volunteers to flesh out these ideas and report back to the Subgroup. Ms. Anderson, Ms. Kwei and Ms. Mellon volunteered.

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

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Draft: 4/15/19

Health Innovations (B) Working Group
Orlando, Florida
April 6, 2019

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Orlando, FL, April 6, 2019. The following Working Group members participated: Marie Ganim, Chair (RI); Martin Swanson, Vice Chair, and Laura Arp (NE); Andrew Stolfi, Vice Chair (OR); Sarah Bailey (AK); Steven Ostlund (AL); Howard Liebers (DC); Andria Seip (IA); Alex Peck and Karl Knable (IN); Julie Holmes (KS); Carrie Couch (MO); Jon Godfread and Chrystal Bartuska (ND); Philip Gennace (NJ); Paige Duhamel (NM); Alison Beam (PA); Raja Malkani (TX); Jaakob Sundberg (UT); Molly Nollette (WA); and Olivia Hwang, Nathan Houdek and Jennifer Stegall (WI). Also participating were: Lucy Jabourian and Perry Kupferman (CA); Michael Conway and Peg Brown (CO); Paul Lombardo (CT); Jennifer Reif (IL); Kevin Dyke (MI); Grace Arnold (MN); Troy Oechsner (NY); Jill Kruger (SD); and Mike Humphreys (TN).

1. Reviewed its Charges

Health Insurance Commissioner Ganim welcomed members and attendees and provided an overview of the Working Group's charges, which the Working Group approved March 21 by e-vote.

2. Heard a Presentation on Governors' Initiatives on Health Innovations

Caroline Picher (National Governors Association—NGA) discussed governors' efforts on federal Affordable Care Act (ACA) Section 1332 waivers, value-based purchasing, prescription drug pricing and surprise billing.

Mr. Swanson asked what governors believe to be the greatest hinderance to the states adopting Section 1332 waivers. Ms. Picher replied that the 2015 guidance released by the federal Centers for Medicare & Medicaid Services (CMS) was strict in its interpretation of the waiver guardrails. Mr. Swanson inquired whether the NGA is working to address this, and Ms. Picher explained that the NGA issued a statement when the guidance was first released, and it continues to work with the states on the issue.

Health Insurance Commissioner Ganim asked what reactions governors have had to the pass-through amounts under Section 1332 waivers. Ms. Picher said governors have had concerns with some of them when they came in below projections. She said, in general, governors want to get as much pass-through funds for their state as they can.

Mr. Oechsner asked whether the states that have taken steps to address prescription drug prices have been able to measure the impact of their efforts. Ms. Picher replied that a different team at the NGA works on prescription drug pricing, and she would have to get back to the Working Group.

3. Reviewed State Activity on Section 1332 Waivers

Joe Touschner (NAIC) provided context around state activity on Section 1332 waivers. He relayed that a majority states have taken legislative or executive action to consider a Section 1332 waiver, even if only eight states had made it through to approval of a waiver. He shared statistics on the seven approved reinsurance waivers, showing the percentage by which they are estimated to reduce individual market premiums, as well as the share of total program funding provided by the states.

4. Discussed a Reinsurance Proposal from Colorado

Mike Brown (Lewis & Ellis) shared the results of actuarial modeling of Colorado's original plan to reprice high claims based on Medicare rates and use the savings as the state funding for a reinsurance program. He briefly reviewed the methodology for the modeling, then he gave a pricing example for a high annual claim amount. He summarized the model results and provided potential reinsurance payment parameters.

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Commissioner Conway explained that repricing will be removed from the plan due to concerns about federal approval of the waiver, but he said he expects to move ahead with state funding coming from an assessment on hospitals. He also explained that repricing would have required insurers to write new provisions into their contracts with providers, although some existing contracts had provisions that would make it work.

5. Discussed State Approaches to Section 1332 Waivers

Health Insurance Commissioner Ganim asked Working Group members to describe their states' experience with Section 1332 waivers, whether approved or in development.

Commissioner Stolfi described Oregon's waiver as more of a traditional reinsurance program. He noted the payment parameters. He cited as difficult the length of time between when a funding commitment is needed for the waiver application and when the money is actually paid. He had to tell carriers in the second quarter of 2017 how much they would receive for plan year 2018, but they would not be paid until 2019. This makes cash flow a mess and goes across state budgeting cycles.

Ms. Bohn said Minnesota got a lot of help from CMS in writing its application, but because much of the state's application was not approved, the state is revisiting its approach. She corrected an earlier reference to the state share of funding, saying the state will put up around $10 million. She said the states that do not have a Basic Health Program (BHP) would not have the same problems in establishing reinsurance.

Ms. Seip asked whether the states with reinsurance had seen an increase in enrollment. Ms. Bohn said Minnesota had not seen a significant increase, and Commissioner Stolfi said Oregon had difficulty in measuring, but reinsurance may have slowed the state's decline in enrollment.

Ms. Bailey described Alaska's reinsurance program and cited the detailed reporting and auditing requirements related to the receipt of federal funds as a difficulty.

Mr. Gennace explained New Jersey's reinsurance waiver. He said the CMS has been active in the implementation, and he pointed out that, unlike other states, the law allows the state to appropriate funds the year after the plan year.

Commissioner Stolfi asked whether the law established a limit on what the state would pay. Mr. Gennace said there is no limit, but the law has a target for the amount of premium reduction.

Ms. Bohn pointed out that Minnesota gets funds from the federal government the year before the plan year, noting that it may be because of the guarantees in the state's appropriations law. She said the state was surprised when the federal government-based payments on her initial projections for the state's waiver application. She recommended clarifying expectations on this point.

Mr. Dyke said Michigan is in the midst of an actuarial study on reinsurance, and it is looking at options.

Commissioner Godfread said North Dakota's waiver bill is waiting for the governor's signature, and the state has begun accepting public comments.

The Working Group discussed whether the states prefer state reinsurance programs or the federal reinsurance program that existed from 2014 to 2016. Due to the workload and state funding requirements, several members agreed that the federal program was preferable.

6. Reviewed the Process for Updating EHBs

Ms. Reif explained the steps Illinois took to meet the short timeline for submitting a request to the CMS to update essential health benefits (EHBs) by the deadline. She described engaging contractors and the need for many staff hours to complete the required actuarial certifications and other documents. The updated EHBs will go into effect for plan year 2020.

Ms. Bohn asked whether the issue of defraying the cost of newly mandated benefits came up. Ms. Reif said Illinois demonstrated that the changes were cost-neutral because they were merely clarifying the scope of the benefit. Ms. Bohn asked whether a state law gave the Illinois Department of Insurance the authority for the update. Ms. Reif said authority was not an issue, because preexisting state law gave the department broad authority.

Ms. Kruger said South Dakota is looking at this now, but state insurance regulators are concerned with the deadlines. She asked whether all documents need to be in a final state at the deadline. Ms. Reif said Illinois made changes after the deadline, and CMS was open to considering the updated information. She stressed the importance of using evidence-based resources, which make the process smoother.

Health Insurance Commissioner Ganim and Ms. Duhamel said Rhode Island and New Mexico are also considering updates to their EHBs.

The Working Group discussed how to achieve cost-neutrality. Ms. Bohn warned that it is hard to measure cost savings from enhancing a particular benefit. She suggested that it is easier to reduce another benefit, and she said most benefits only make a small contribution to costs, so the needed reductions are also small.

7. Discussed Innovative Initiatives from Working Group Member States and Future Directions for the Working Group

Health Insurance Commissioner Ganim asked the Working Group to report on health innovation efforts in their states and mention which ideas they would like the Working Group to devote time to in future meetings.

Working Group members mentioned state individual mandates, including Maryland’s down payment proposal; Medicaid buy-ins; other public options; regulation of pharmacy benefits managers (PBMs); health care cost growth targets; and fees for employers who do not provide a threshold level of funds for health coverage.

Having no further business, the Health Innovations (B) Working Group adjourned.

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