



Date: 7/26/21

*Virtual Meeting
(in lieu of meeting at the 2021 Summer National Meeting)*

HEALTH INNOVATIONS (B) WORKING GROUP

Tuesday, July 27, 2021

3:00 – 4:30 p.m. ET / 2:00 – 3:30 p.m. CT / 1:00 – 2:30 p.m. MT / 12:00 – 1:30 p.m. PT

ROLL CALL

Andrew Stolfi, Chair	Oregon	Maureen Belanger	New Hampshire
Laura Arp, Vice Chair	Nebraska	Philip Gennace	New Jersey
Nathan Houdek/ Jennifer Stegall, Vice Chairs	Wisconsin	Paige Duhamel/ Viara Ianakieva/Margaret Pena	New Mexico
Howard Liebers	Dist. of Columbia	Chrystal Bartuska	North Dakota
Alex Peck	Indiana	Katie Dzurec	Pennsylvania
Andria Seip	Iowa	Barbara Snyder/	Texas
Julie Holmes	Kansas	Rachel Bowden/R Michael Markham	
Bob Wake	Maine	Tanji Northrup	Utah
Galen Benshoof	Minnesota	Molly Nollette	Washington
Anita Fox	Michigan	Joylynn Fix	West Virginia
Amy Hoyt	Missouri		
Mark Garratt	Nevada		

NAIC Support Staff: Joe Tuschner

AGENDA

1. Consider Adoption of its March 26 Meeting Minutes—*Commissioner Andrew Stolfi (OR)* Attachment One
2. Review Charges Adopted by the Special (EX) Committee on Race and Insurance—*Commissioner Andrew Stolfi (OR)* Attachment Two
3. Hear Presentations on Federal Price Transparency Requirements—*Commissioner Andrew Stolfi (OR)*
 - Hospital Price Transparency: Dr. Terri Postma, Center for Medicare, Centers for Medicare and Medicaid Services
 - Insurer Price Transparency: Matthew Lynch, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services
4. Hear a Presentation on Price Transparency Trends—*Commissioner Andrew Stolfi (OR)*
 - Robin Gelburd, Fair Health
5. Hear a Presentation on Consumer-Friendly Approaches to Price Transparency—*Commissioner Andrew Stolfi (OR)*
 - Eric Ellsworth, Consumer Checkbook



**NATIONAL MEETING
SUMMER 2021**

6. Discuss Any Other Matters Brought Before the Task Force
—*Commissioner Andrew Stolfi (OR)*
7. Adjournment

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Attachment 1

Draft: 4/5/21

Health Innovations (B) Working Group
Virtual Meeting (*in lieu of meeting at the 2021 Spring National Meeting*)
March 26, 2021

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met March 26, 2021. The following Working Group members participated: Andrew R. Stolfi, Chair (OR); Laura Arp, Co-Vice Chair (NE); Nathan Houdek, Co-Vice Chair, Barbara Belling, Diane Dambach, Darcy Paskey, Mark Prodoehl, Rebecca Rebholz and Richard Wicka (WI); Philip Barlow and Howard Liebers (DC); Angela Burke Boston, Andria Seip and Cynthia Banks Radke (IA); Claire Szpara (IN); Craig Van Aalst, Julie Holmes and Tate Flott (KS); Robert Wake and Marti Hooper (ME); Renee Campbell and Karen Dennis (MI); Grace Arnold, Helen Bassett, Galen Benshoof and Peter Brickwedde (MN); Camille Anderson-Weddle, Carrie Couch, Chlora Lindley-Myers, Jo LeDuc and Amy Hoyt (MO); Chrystal Bartuska, Angie Voegelé and Karri Volk (ND); Michelle Heaton and Maureen Belanger (NH); Christine Machnowsky (NJ); Paige Duhamel (NM); Mark Garratt (NV); Jessica K. Altman and Katie Dzurec (PA); Doug Danzeiser, Essi Eargle, R. Michael Markham, Ryan Jaffe, Debra Diaz-Lara and Angelica Garza (TX); Shelly Wiseman, Tanji Northrup and Jaakob Sundberg (UT); Jane Beyer, Jennifer Kreidler and Molly Nollette (WA); and Joylynn Fix (WV).

I. Heard Presentations on Regulations Regarding Coverage for Telehealth Services

Mei Wa Kwong (Center for Connected Health Policy—CCHP) gave a presentation on recent activity by the federal government and states to regulate coverage for telehealth services. She described changes made to allow and encourage greater use of telehealth in Medicare, Medicaid and by private payers. She identified state trends in 2021, including activity related to mental health and substance use disorder services, allowing telephone-only connections, requirements on regulatory boards to consider telehealth, and discussions on what to make permanent. She shared resources available from CCHP that continue to track changes in telehealth policy. Commissioner Stolfi asked about lists of state legislative activity. Ms. Kwong said the CCHP website has a section devoted to state COVID-19 responses, as well an annual legislative roundup. Commissioner Stolfi asked what states might see from the federal level going forward. Ms. Kwong said federal programs have significant influence, but they are in the same position of a lot of states, deciding which changes to make permanent. She said her expectation is that some but not all of the federal telehealth changes will be extended.

Tim Clement (American Psychiatric Association—APA) provided a presentation on the use of telehealth by psychiatrists. He noted the sharp increase in telehealth services provided during the pandemic and shared study results that he said indicate the quality of telehealth services matches that of in-person services. He said the APA has supported state insurance regulators' efforts to expand access to telehealth. He said even though APA members strongly prefer in-person services, they recognize some patients prefer or need telehealth services, both during the pandemic and after. He cited the APA's model legislation on telehealth, which requires payment parity, allows telephone-only connections in limited circumstances, and prohibits insurers from employing utilization review that is not used for in-person services. He noted that physicians' overhead costs are not lower because of telehealth unless they completely shut down their offices and only offer telehealth. He said the APA is open to payment parity requirements that might require a provider to maintain an office location.

Dr. Drew Oliveira (Regence BlueShield) presented on his plan's experience with telehealth, as well as virtual and digital care. He said telehealth had previously been focused on urgent care visits and provider-to-provider consultations in rural areas. He said the majority of patients who used telehealth during the pandemic would do so again, and about 20% prefer virtual over in-person services. He said up to half of primary care and 85% of behavioral health care could potentially be delivered virtually. He described digital and in-home care as

treatment methods in addition to synchronous telecommunication. He gave examples of physical therapy visits and orthopedic exams as new types of care that are starting to be delivered by telehealth. He said telehealth can support better access to care in rural and underserved areas, but it may require audio-only services until gaps in broadband access can be closed. He said he worries about fragmentation in care due to telehealth and said information sharing is important. He said there is also some worry about high-frequency, low-value care—like texting back and forth—that may not be beneficial. He said payment parity can perpetuate fee for service payments, and it would be helpful to put telehealth into a prospective payment system. He said a federal Health Insurance Portability and Accessibility Act (HIPAA)-compliant system would be preferable to audio-only, but it may take a while to get there.

Commissioner Stolfi asked whether there is any difference in effectiveness in telehealth for first visits and also about health equity. Mr. Clement said studies he is aware of did not break out first versus subsequent visits. He said research shows telehealth can increase access to underserved communities and that more research is ongoing. Dr. Oliveira said behavioral health services have been underused in the past and that telehealth can encourage more appropriate use. Ms. Kwong said there has been a lack of studies on the impact of telehealth on communities of color. She said impacts are likely to vary from place to place.

Mr. Houdek asked how the payment parity issue has worked in other states and what state insurance regulators should think about. Mr. Clement said alternative payment models should be developed specifically for telehealth and that providers are willing to compromise on pure payment parity. Ms. Kwong said quality levels are comparable and questioned whether lower payments for telehealth would discourage its use after the pandemic. She said telehealth utilization dropped as states opened up. Dr. Oliveira said Medicare's relative value calculation took overhead costs into account, and they should be considered with telehealth going forward, but closer to 80% of in-person costs than one-third. He said some telehealth visits are replacements for in-person, and others are in addition.

Commissioner Stolfi asked how health plan thinking about telehealth has shifted due to the pandemic. Dr. Oliveira said access to trained practitioners needs to be expanded. He said there can be cost savings if a practitioner can monitor someone who gets better faster because they complete physical therapy at home rather than waiting for an office visit. He said the biggest concern is connecting back to the practitioners who are providing care in person.

2. Discussed State Responses to the COVID-19 Pandemic

Commissioner Stolfi asked state insurance regulators how they have innovated and changed how they do business in the last 13 months due to the pandemic. Ms. Nolette and Ms. Kreitler responded for Washington. They described how the provider network access program responded to a proposal from an issuer to offer a product with a telemedicine-only network tier. Ms. Kreitler described the questions state insurance regulators asked the carrier and said the network was approved when the carrier agreed to the same cost-sharing for the telemedicine-only tier and the second tier of in-person providers. Commissioner Stolfi asked about the scope of Washington's provider contract reviews and the staff resources devoted to it. Ms. Kreitler said four staff members work on the reviews for about 8,000 contracts per year, and it takes approximately two hours per contract. Contracts are reviewed for the protection of the enrollee, including hold harmless, clean claim and grievance provisions.

Ms. Arp said Nebraska received many complaints from the behavioral health community regarding telehealth near the beginning of the pandemic. The state surveyed carriers on their policies and posted the answers on its website.

The Working Group discussed payment parity laws in their states.

3. Discussed Other Matters

Commissioner Arnold raised the impacts of increased premium tax credits on state reinsurance programs run with Section 1332 waivers. She said Minnesota and other states with reinsurance programs sent a letter to the federal Centers for Medicare & Medicaid Services (CMS) asking it to revise the pass through amounts it will pay states for 2021. She said insurers' rates have already been set, but tax credits are changing, so the federal government will save more and should recalculate to share savings with states. She said there are other complex issues for 2022, but the letter was focused on 2021. Commissioner Stolfi asked how much movement there could be and whether states might adjust their reinsurance parameters. Commissioner Arnold said Minnesota is likely at the high end of how much additional funds it would receive because it has a lower percentage of subsidized enrollees compared to other states. She said states will likely have to provide additional information to CMS to justify revised amounts.

Wayne Turner (National Health Law Program—NHeLP) pointed out two resources for the Working Group. One was an article in *Health Affairs* on disproportionately low use of telehealth by patients with limited English proficiency. The second was a set of principles from a consortium of citizens with disabilities on how best to serve persons with disabilities with telehealth.

Kris Hathaway (America's Health Insurance Plans—AHIP) noted that AHIP and the Blue Cross and Blue Shield Association (BCBSA) have initiated a vaccine community connector program to enhance vaccinations among vulnerable groups. She said state insurance regulators with questions could reach out to her or to the BCBSA through Randi Chapman or Clay McClure.

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

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Excerpt from
2021/2022 Charges

SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

The **Health Innovations (B) Working Group** will evaluate mechanisms to resolve disparities through improving access to care, including the efficacy of telehealth as a mechanism for addressing access issues; the use of alternative payment models and value-based payments and their impact on exacerbating or ameliorating disparities and social determinants of health; and programs to improve access to historically underserved communities.