AGENDA

1. Consider Adoption of its April 28 and Feb. 26, 2020, and 2019 Fall National Meeting Minutes
   —Commissioner Jessica K. Altman (PA)

2. Consider Adoption of its Subgroup, Working Group and Task Force Reports
   —Commissioner Jessica K. Altman (PA)
   • Consumer Information (B) Subgroup—Mary Kwei (MD)
   • Health Innovations (B) Working Group—Health Insurance Commissioner Marie Ganim (RI)
   • Health Actuarial (B) Task Force—Commissioner Todd E. Kiser (UT) and Jaakob Sundberg (UT)
   • Regulatory Framework (B) Task Force—Commissioner Michael Conway (CO)
   • Senior Issues (B) Task Force—Commissioner Marlene Caride (NJ)

3. Hear a Presentation on Health Equity and Disparities in Health Care and Coverage
   —Samantha Artiga (Kaiser Family Foundation—KFF)

4. Hear a Presentation on COVID-19: Lessons Learned—Daniel J. Meuse (State Health and Value
   Strategies [SHVS], Princeton School of Public and International Affairs, Princeton University)

5. Hear a Presentation on COVID-19 Testing and Costs
   —Matt Eyles (America’s Health Insurance Plans—AHIP)

6. Hear an Update on Federal Affordable Care Act (ACA) Court Cases—Katie Keith (Out2Enroll)

7. Receive an Update on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s Work—TK
   Keen (OR)

8. Hear a Federal Legislative Update—Brian Webb (NAIC)

9. Discuss Any Other Matters Brought Before the Committee—Commissioner Jessica K. Altman (PA)
10. Adjournment

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Agenda Item #1

Consider Adoption of its April 28 and Feb. 26, 2020, and 2019 Fall National Meeting Minutes
—Commissioner Jessica K. Altman (PA)
The Health Insurance and Managed Care (B) Committee met via conference call April 28, 2020. The following Committee members participated: Jessica Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); John F. King represented by Teresa Winer (GA); Vicki Schmidt (KS); Al Redmer Jr. (MD); Steve Kelley represented by Grace Arnold and Sherri Mortensen Brown (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); Linda A. Lacewell represented by John Powell and Frank Horn (NY); Glen Mulready (OK); Andrew R. Stolfi represented by TK Keen (OR); Hodgen Maimda (TN); Todd E. Kiser represented by Jaakob Sundberg (UT); and Mike Kreidler represented by Molly Nollette and Jane Beyer (WA). Also participating were: David Altmaier (FL); Chlora Lindley-Myers (MO); Russell Toal (NM); Barbara D. Richardson (NV); and Marie Ganim (RI).

1. Received a Report from the Health Actuarial (B) Task Force

Mr. Sundberg provided a brief overview of the Health Actuarial (B) Task Force’s April 23 meeting. He said the Task Force heard presentations from the American Academy of Actuaries (Academy), America’s Health Insurance Plans (AHIP), Blue Cross and Blue Shield Association (BCBSA), and the Society of Actuaries (SOA) on COVID-19’s potential effects on health care spending and the health insurance system, particularly with respect to the federal Affordable Care Act (ACA) 2021 premium rate assumptions. He said each presenter emphasized the uncertainty in 2021 pricing assumptions due to COVID-19 because of several factors, including 1) the rate of COVID-19 testing; 2) treatment rate, including treatment setting and treatment services provided; 3) treatment cost; 4) rate of services deferred from 2020; and 5) cost of services deferred from 2020. Mr. Sundberg said some presenters also suggested that the states target July 22 to give issuers time to incorporate the most recent data on the impact of COVID-19 when finalizing 2021 rates and strongly encouraged the states to allow issuers to revise their rate filings using the latest information available prior to states finalizing rates. He said presenters also stressed the importance of state insurance regulators working collaboratively with the industry to address these issues.

Mr. Sundberg said that among its next steps, the Task Force is meeting May 1 via conference call in regulator-to-regulator session to begin development of an outline and eventual 2021 rate pricing resource and guidance document for the states to consider when reviewing initial 2021 rates. He said the Task Force also will be discussing potential impact on risk corridors, particularly in light of the recent U.S. Supreme Court decision in Maine Community Health Options v. United States, which ruled that, in accordance with the ACA, the federal government illegally withheld full risk corridor payment amounts to insurers for significant losses to their health plans incurred during the first three years of the ACA’s health marketplaces and that the insurers could sue for nonpayment of approximately $12 billion in the U.S. Court of Federal Claims.

Commissioner Altman asked Mr. Sundberg about the Task Force’s timeline for completing the resource and guidance document. Mr. Sundberg said he anticipates the Task Force completing this work and sending out a draft of the document within the next few weeks for comment given that some states have initial filing deadlines in May.

2. Discussed and Heard Comments from Stakeholders on Regulatory Flexibility Requests Due to COVID-19

Brian R. Webb (NAIC) said the NAIC has received letters from various stakeholders requesting state insurance regulatory relief due to COVID-19 in a number of categories, including: 1) telehealth and telebehavioral health access expansion and flexibility, including parity in payment and not limited to COVID-19; 2) administrative flexibility related to grace periods and continuity of coverage policies and requirements; 3) filing requirement flexibility; and 4) reducing administrative barriers, particularly related to prior authorization, provider credentialing, timely claim and payment requirements. He said many of these requests have already been addressed by the states, the federal government and industry itself. He noted that AHIP and the BCBSA recently submitted a letter to the Committee recommending that the states assess their current rate filing deadlines and delay them if possible to July 22 to give carriers time to incorporate the most recent data on the impact of COVID-19 when finalizing 2021 rates. Specifically, AHIP and the BCBSA are encouraging the states to allow issuers to revise their rate filings using the latest information available prior to states finalizing rates in the Health Insurance and Oversight System (HIOS).

Mr. Webb said another outstanding issue some stakeholders have raised is the creation of a new special enrollment period (SEP) for individuals who obtained their health insurance coverage through the individual market, but lose income and become...
eligible for subsidized individual market coverage through the health insurance marketplaces. He said there is no existing SEP that addresses this situation. Mr. Webb said the federal Center for Consumer Information and Insurance Oversight (CCIIO) is relying on its existing SEPs to address loss of health insurance coverage issues due to COVID-19.

Commissioner Altman said NAIC staff prepared a summary compilation chart of the stakeholder letters submitted to the NAIC (Attachment 8), which she will go through section-by-section to provide each stakeholder the opportunity to provide any additional comments. Allison Ivie (Eating Disorders Coalition for Research, Policy & Action—EDC), on behalf of the Mental Health Liaison Group (MHLG), said that, as stated in its letter to the NAIC, the MHLG’s most pressing concern is ensuring the continuity of care for its stakeholders via telehealth due to COVID-19. She said it is important that the states provide access to this benefit regardless of the type of insurance and ensure that consumers can receive this benefit from out-of-network providers, including providers across state lines, if the consumer’s health benefit plan does not have an in-network specialty provider to treat the covered person.

Kate Gilliard (American Physical Therapy Association—APTA) said the APTA realizes that most states have already expanded telehealth to provide physical therapy-related services. She said, however, that this benefit has been provided with respect to established patients, not for new patients requiring an initial evaluation. She said that unless this issue is addressed, it could be problematic moving forward.

Emily Carroll (American Medical Association—AMA) said that as state insurance regulators continue to debate how best and responsibly to address the myriad of health insurance issues that have arisen due to COVID-19, the AMA urges the states to examine current policies that establish or fail to remove roadblocks between patients and their physicians that could threaten continuity of care or access to care, such as policies involving prior authorization and step therapy. She suggested that the states consider suspending such policies during the COVID-19 emergency because physicians are: 1) caring for COVID-19 patients; and 2) physician support staff are not in the office to process these requirements. Kim Horvath (AMA) stressed the need for plan flexibility for telehealth benefits, particularly for consumers with chronic health conditions. She noted the new requirements the U.S. Department of Health and Human Services (HHS) issued expanding telehealth services for Medicare enrollees. She said the AMA encourages all states to adopt telehealth policies that reflect those now being required under Medicare.

Justine Handelman (BCBSA) stressed the importance of extending the final rate filing deadline for plan 2021 rates, at least until August, because of the uncertainty insurers have in determining rates due to COVID-19. She urged state insurance regulators to use their influence with the CCIIO to move the date. Kristin Hathaway (AHIP) discussed the work the health insurance industry has done to date related to COVID-19, such as COVID-19 testing and fast-tracking providing credentialing and audits. She said AHIP appreciates the NAIC’s and state insurance regulators’ work providing flexibility in financial filing requirements and collaboration among the states in data requests.

Jessica Adams (American Society for Radiation Oncology—ASTRO) said the ASTRO has similar issues and concerns as those discussed by the AMA, particularly with respect to prior authorization requirements. She urged state insurance regulators to direct insurers to suspend prior authorization requirements for radiation therapy services for the duration of the COVID-19 health emergency because non-treating provider staff members, who would be processing these requests, are working remotely and treating provider staff members are being diverted to COVID-19 response activities, reducing staff manpower to process prior authorization requests. Molly Collins Offner (American Hospital Association—AHA) said the AHA’s comments are similar to those already expressed. She said the AHA is working with its members to discuss additional operational challenges and areas where state insurance regulatory flexibility would be helpful. Robert Still (Radiology Business Management Association—RBMA) said the RBMA’s comments are similar to the ASTRO’s, the AMA’s and the AHA’s comments.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) said that as state insurance regulators encounter challenges in their states and continue to advocate for policy changes to federal law due to the COVID-19 emergency, the NAIC consumer representatives urge state insurance regulators to: 1) maximize access to comprehensive health coverage so people can access the care they need. More limited coverage or coverage that triggers only if a person becomes ill will be less successful at achieving the goals of getting people to proactively seek testing and treatment; 2) find ways to ease financial strain and support people’s ability to comply with social distancing measures, such as ensuring easier access to prescription drug refills, telehealth services and mental health services—especially as the crisis continues; 3) ensure coverage of important health benefits, as well as cost protections, related to treatment and detection of the virus, including protection from surprise medical bills; and 4) continue to protect consumers from fraud and scams.
Katie Morgan (National Infusion Center Association—NICA) said the NICA supports patients’ access to non-hospital non-oncology infusion centers, where they can receive provider-administered medical benefit drugs for the treatment of autoimmune diseases, immunodeficiency disorders, rare and genetic disorders, and other chronic, complex conditions. She said these patient populations are at high risk of severe COVID-19 disease should they be exposed. She said the NICA urges state insurance regulators to provide needed insurance flexibility and consider policy options that proactively facilitate continuity of care for these patients, such as: 1) allowing patients to use an out-of-network site of care at the in-network benefit level in the event they are unable to get treatment in their usual care setting due to a drug shortage or closure related to COVID-19; 2) waiving prior authorization requirements for established patients currently on therapy that are switching site of care; and 3) waiving step therapy policies and formulary restrictions in the event of drug shortages.

Rodney Peele (American Optometric Association—AOA) said the AOA urges state insurance regulators to provide the same regulatory flexibility for vision plans that is being provided for health benefit plans. He said the AOA suggestions for regulatory flexibility include: 1) extending contract renewal deadlines; 2) delaying claims audits and recoupments; 3) extending deadlines for filing claims and appeals; and 4) expanding access to telehealth services. He said state insurance regulators also should promote and respect the role of optometrists in the COVID-19 health emergency, including acknowledging that optometrists: 1) may order or perform COVID-19 testing; 2) provide essential eye health and vision care; and 3) have the autonomy to follow the advice of local, state and public health authorities, and best meet the needs of patients. Mr. Peele said optometrists take a leading role in patient care with respect to eye health and vision care, as well as general health and well-being. As primary health care providers, optometrists have extensive, ongoing training to examine, diagnose, treat and manage ocular disorders, diseases and injuries, and many of these treatments are essential. He said studies show that the same groups burdened by COVID-19 complications, such as those with hypertension and respiratory conditions, also suffer more vision problems. He said ensuring patient access to urgent and emergency eye care provided by optometrists is critical to ensuring that patients, particularly from at-risk populations, do not needlessly end up in an emergency room and potentially exposed to COVID-19 during this current public health emergency.

Commissioner Altman requested comments from Committee members. Director Lindley-Myers said she could support the NAIC requesting the federal Centers for Medicare & Medicaid Services (CMS) to push the final 2021 rate filing back to sometime in September to provide additional time for insurers to factor in any changes related to COVID-19. Superintendent Toal expressed support for Director Lindley-Myers’ comments. The Committee members discussed whether to make such a request to the CMS. Some Committee members explained that they are maintaining their initial rate filing deadlines, but typically they permit carriers to revise their rate assumptions many times during the rate review process before the rates are final. After additional discussion, Commissioner Altman said the next step is for this issue to be discussed by the Government Relations (EX) Leadership Council. The Committee agreed.

Commissioner Godfrey said the states have addressed on an individual basis the issues stakeholders raised in their letters to the NAIC. He said he thinks the next issue the state insurance regulators will have to address concerns payment for COVID-19 antibody testing. He said it would be nice if there could be some uniformity on how this issue is addressed across the states. Commissioner Mulready said he also is concerned and has reach out to Oklahoma’s U.S. Senate delegation to obtain guidance on this issue and others. Commissioner Conway said it would be helpful to receive clarification from the CMS on the issue. Mr. Webb said the CMS anticipates providing additional guidance on the issue, but it has not set a time frame on when such guidance will be released.

3. **Heard an Update from the CCIIO**

Randy Pate (CCIIO) updated the Committee on the CCIIO’s recent activities, particularly its activities related to the COVID-19 health emergency. He said the CCIIO recently released guidance related to the expansion of telehealth services in response to COVID-19. He said that as part of the Trump administration’s efforts to combat the COVID-19, the CMS has postponed the 2019 benefit year HHS Risk Adjustment Data Validation (HHS-RADV) process in order for issuers and providers to focus on the health and safety threats currently faced by enrollees, participants and other impacted individuals due to the COVID-19 pandemic.

Mr. Pate said the CCIIO is working on establishing a new SEP for consumers enrolled in individual health insurance plans off the health insurance marketplace, but due to reduction of income because of job loss or some other event become eligible for subsidized individual health insurance coverage on the health insurance marketplace. He said the CCIIO is working quickly to operationalize this new SEP, but, currently, it does not have a specific date when it will be operational. Mr. Pate said the CCIIO also is considering providing additional time for submission of final 2021 rates consistent with the Committee’s discussion.
The CCIIO is helping to disseminate information to individuals and employees to assist them in taking advantage of SEPs they might be eligible for due to COVID-19 through the HealthCare.gov website.

Mr. Pate said the HHS, through the Health Resources and Services Administration (HRSA), has launched a new COVID-19 Uninsured Program Portal, allowing health care providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 individuals on or after Feb. 4 to submit claims for reimbursement. Providers can access the portal at https://COVIDUninsuredClaim.HRSA.gov.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
Health Insurance and Managed Care (B) Committee
E-Vote
February 26, 2020

The Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Feb. 26, 2020. The following Committee members participated: Jessica K. Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); John F. King (GA); Vicki Schmidt (KS); Steve Kelley represented by Grace Arnold (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); Glen Mulready (OK); Andrew R. Stolfi (OR); Hodgen Mainda represented by Rachel Jrade-Rice (TN); and Mike Kreidler represented by Molly Nollette (WA).

1. Adopted the Regulatory Framework (B) Task Force’s 2020 Revised Charges

The Committee conducted an e-vote to consider adoption of the Regulatory Framework (B) Task Force’s 2020 revised charges, which add 2020 charges for the newly appointed MHPAEA (B) Working Group (see NAIC Proceedings – Spring 2020, Regulatory Framework (B) Task Force, Attachment One-A). A majority of the Committee members voted in favor of adopting the Task Force’s 2020 revised charges. The motion passed unanimously.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
The Health Insurance and Managed Care (B) Committee met in Austin, TX, Dec. 8, 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 represented by John Melvin (KY); Steve Kelley (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); John Elias represented by Maureen Belanger (NH); Linda A. Lacewell represented by Tom Dudek (NY); Andrew Stolfi (OR); Hodgen Mainda (TN); Scott A. White represented by Julie Blauvelt (VA); and Mike Kreidler and Jane Beyer (WA). Also participating were: Steve Ostlund (AL); Ryan James (AR); Fleur McKendell and Leslie Ledogar (DE); Doug Ommen and Andria Seip (IA); Alex Peck (IN); Frank Opelka (LA); Kevin Dyke (MI); Paige Duhamel (NM); Glen Mulaedy (OK); Marie Ganim (RI); Nancy Clark (TX); Todd E. Kiser and Tanji Northrup (UT); and Nathan Houdek and Jennifer Stegall (WI).

1. Adopted its Oct. 24 and Summer National Meeting Minutes

The Committee met Oct. 24 and Aug. 4. During its Oct. 24 meeting, the Committee took the following action: 1) adopted the Health Actuarial (B) Task Force’s 2020 proposed charges, the Regulatory Framework (B) Task Force’s 2020 proposed charges, and the Senior Issues (B) Task Force’s 2020 proposed charges; and 2) adopted its 2020 proposed charges.

Director Wing-Heier made a motion, seconded by Commissioner Godfread, to adopt the Committee’s Oct. 24 (Attachment One) and Aug. 4 (see NAIC Proceedings – Summer 2019, Health Insurance and Managed Care (B) Committee) minutes. The motion passed unanimously.

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

Commissioner Conway made a motion, seconded by Commissioner Kreidler, to adopt the following reports: the Consumer Information (B) Subgroup, including its Nov. 18 (Attachment Two), Oct. 21 (Attachment Three) and Oct. 7 (Attachment Four) minutes; the Health Innovations (B) Working Group (Attachment Five); the Health Actuarial (B) Task Force; the Long-Term Care Insurance (E/B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force. The motion passed unanimously.

3. Heard an Update from the CCIIO

Randy Pate (federal Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO’s regulatory activities related to the federal Affordable Care Act (ACA) and other activities of interest to the Committee. He provided a snapshot of the current open enrollment period to date, including application and enrollment numbers. He highlighted the effect of the ACA Section 1332 waivers in reducing premium costs. He said that to date, the CCIIO has approved 13 waivers. Most of the approved waivers were for establishing a reinsurance program. He also highlighted the steps the Trump Administration has taken to improve price transparency in healthcare, which is one of the Trump Administration’s key priorities, including the publication of a proposed rule on Nov. 15 to require issuers to provide information to consumers on projected out-of-pocket (OOP) costs and make price information available to third-party vendors. Mr. Pate also discussed the CCIIO’s recently released Risk Adjustment Data Verification (RAD-V) white paper. The RAD-V white paper lays out options for potential modifications to several aspects of the U.S Department of Health and Human Services (HHS)-RADV methodology. Mr. Pate urged state insurance regulators to submit comments on the RAD-V white paper.

4. Heard a Presentation on “Overcharged: Why Americans Pay Too Much for Health Care”

Charles Silver (University of Texas at Austin & CATO Institute), co-author of the book “Overcharged: Why Americans Pay Too Much for Health Care,” discussed the problems in the U.S. healthcare system, which have contributed to high health care costs. He said these problems include: 1) fraud, waste and abuse; 2) uncontrollable spending; 3) opaque prices; 4) surprise bills; 5) quality that is highly variable and often mediocre; and 6) absurd prices for prescription drugs. He suggested several potential solutions to address these problems, such as: 1) eliminating tax exemptions and coverage for mandates; 2) promoting competition and encouraging medical tourism; 3) letting the insurance-driven spending cycle burn itself out; and 4) turning Medicare, Medicaid and other programs into cash-transfer programs along the lines of social security and the earned income tax credit.
Draft Pending Adoption

Professor Silver described the problems in the U.S. health care system and its high and increasing health care costs as a vicious cycle with its excessive reliance on third-party payment. He said coverage of health care costs stimulates demand for more and more expensive medical treatments. This heightened demand drives up prices and encourages the proliferation of services. He said with these rising prices and expanded health care needs, consumers become scared and demand more protection. Insurers and government agencies respond to this panic by offering more comprehensive coverage, circling back to the beginning of the problem.

Professor Silver said the solution to ending this vicious cycle is to let it burn out. He said that as spending increases, insurance becomes more expensive, which leads to more uninsured. As people go without insurance or carry higher deductible and copays, the army of self-paying consumers grows. He said the retail sector responds to this increase in demand by offering options for obtaining medical care that is cheaper and more convenient. He discussed a current example of this retail revolution, the Surgery Center of Oklahoma.

Commissioner Stolfi asked Professor Silver about the consequences of letting the system burn itself out, particularly with respect to the poor. Professor Silver said he believes consumers should use health insurance to insure against catastrophic events like other types of insurances. He said his idea for creating cash-transfer programs would address the needs of the poor. Commissioner Conway questioned one aspect of Professor Silver’s theory of letting the system burn itself out with respect to consumers paying more in deductibles and copays leading to lower health care prices in light of the growth of high deductible health plans (HDHPs). Professor Silver said it takes time for the transition. He cited the example of CVS halting the sale of tobacco products and establishing walk-in health care clinics. He acknowledged the difficulty of such a change with respect to catastrophic health care services.

5. Heard a Panel Presentation on State Surprise Billing Laws

Ms. Beyer provided an overview of Washington’s Balance Billing Protection Act (BBPA). She explained that as of Jan. 1, 2020, in Washington, surprise/balance billing is prohibited for: 1) all emergency services at in-network and out-of-network (OON) hospitals; and 2) non-emergency surgical or ancillary services provided by an OON provider at an in-network hospital or ambulatory surgical center. She discussed the scope of the BBPA, including how it applies to emergency services received out-of-state. She discussed the BBPA’s application, including a provision that permits self-funded plans to opt-in to the BBPA’s balance billing prohibition, consumer protections, and arbitration provisions. She said that self-funded plans that want to opt-in can use a simple on-line “opt-in” process to do so. She said the Washington Department of Insurance (DOI) will maintain a list of self-funded plans choosing to opt-in.

Ms. Beyer discussed the BBPA’s OON payment provision. She said the BBPA provides that the OON provider be paid a “commercially reasonable amount based on payment for the same or similar services provided in a similar geographic area.” If the provider and health carrier cannot agree on this amount, after a 30-day informal negotiation period, they can proceed to arbitration. Ms. Beyer explained that to inform negotiations and arbitration, providers, carriers and arbitrators have access to a data set from the state’s all payer claims database (APCD). She also described the BBPA’s transparency and enforcement provisions.

Ms. Taylor said Texas’ surprise billing law is similar in many ways to Washington’s BBPA. She said Texas’ law is also effective Jan. 1, 2020. The Texas law’s application to insured plans and state employee plans is similar to Washington’s law, except Texas’ law does not include provisions permitting self-funded plans to opt-in. Ms. Taylor said Texas’ law is unique in that it includes both an arbitration process and a mediation process. She said Texas’ arbitration process must conclude by day 51. Its mediation process may last up to 120 days. Ms. Taylor said the OON provider payment is based on 80% of billed charges and geographic area.

Commissioner Altman asked what advice Ms. Beyer and Ms. Taylor would provide to the states considering such legislation. Ms. Beyer said she believes that in order to get such legislation enacted, it must strike a balance where stakeholders are not completely happy with the legislation, but they can live with it. Ms. Taylor agreed. Commissioner Godfrey asked what services are not included in the scope of either law. Ms. Beyer said air ambulance and ground ambulance services are not included in the scope of Washington’s law. Ms. Taylor said Texas’ law is similar. Ms. Duhamel discussed New Mexico’s surprise bill law and its challenge with setting the OON payment benchmark. She agreed with Washington and Texas that one key to getting such legislation enacted was involving stakeholders throughout the process. Commissioner Mulready discussed Oklahoma’s struggle with such legislation concerning the lack of authority the DOI has over certain health care providers. Ms. Beyer said Washington worked through this issue and ultimately worked out an agreement to work collaboratively with its Department of Health (DOH) concerning any provider enforcement issues.
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 Spring National Meeting on the four major cases involving the 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; 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; and 4) Maine Community Health Options v. United States, which challenges the legality of the federal government withholding full risk corridor payment amounts to participants.

Mr. Schiffbauer provided an overview of the timeline, current status, and main arguments for each of the cases. The Texas v. United States of America, et al. case is pending in the U.S. Court of Appeals for the Fifth Circuit. The State of New York v. U.S. Department of Labor and Association of Community Affiliated Plans, et al. v. U.S. Department of Treasury, et al., cases are both pending in the U.S. Court of Appeals for the Washington, DC Circuit. The Maine Community Health Options v. United States case is pending before the U.S. Supreme Court. Oral arguments in this case are scheduled before the U.S. Supreme Court Dec. 10.

Mr. Schiffbauer explained that if these cases are not already before the U.S. Supreme Court, no matter the outcome at the U.S. Court of Appeals level, it is anticipated that the parties in these cases will file a Petition for Certiorari to the U.S. Supreme Court. He summarized the cases as follows: 1) the Fifth Circuit Court of Appeals decision in Texas v. United States of America, et al. is expected before the end of the year, most likely following the end of the current open enrollment period ending Dec. 15. A U.S. Supreme Court opinion would be issued on or before July 31, 2020; 2) the District of Columbia Court’s opinion in State of New York v. U.S. Department of Labor is expected in by December 2019 or January 2020. A U.S. Supreme Court opinion would be issued on or before July 31, 2020; 3) The District of Columbia Court will hold oral arguments in the Association of Community Affiliated Plans, et al. v. U.S. Department of Treasury, et al. case in March or April 2020. The court would issue an opinion in May or June 2020. It is unlikely that the U.S. Supreme Court would issue an opinion on or before July 31, 2020; and 4) The U.S. Supreme Court is likely to issue an opinion in the Maine Community Health Options v. United States on or before July 31, 2020.

7. Heard a Federal Legislative Update

Joe Touschner (NAIC) provided a federal legislative update on Congressional activity of interest to the Committee. He discussed the current status of surprise billing legislation, explaining that it appears that a bi-cameral agreement has been reached. He said he would provide more details on this agreement to the Committee and other state insurance regulators after the Fall National Meeting. He said the NAIC received a letter from the federal Centers for Medicare & Medicaid Services (CMS) Administrator seeking recommendations for creating interstate compacts for the sale of health insurance across state lines, as required by ACA section 1333 and in compliance with an Executive Order. He said the Government Relations (EX) Leadership Council considered a letter responding to the request Dec. 4. He also said there is strong bipartisan support for further delaying the health insurance tax (HIT), which was not paid in 2019. He said the difficulty that the U.S. Congress (Congress) is facing is how to pay for it. The HIT brings in over $16 billion a year. Mr. Touschner said delaying the HIT could be part of an end-of-the-year budget deal.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
Agenda Item #2

Consider Adoption of its Subgroup, Working Group and Task Force Reports
   —Commissioner Jessica K. Altman (PA)
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call July 9, Jan. 21 and Jan. 7, 2020. During these calls, the Subgroup:

1. Discussed and adopted the revised consumer guide entitled *Using Your Health Coverage*. The guide helps consumers better understand health coverage they are enrolled in by providing guidance on cost sharing, provider networks, referrals, coordination of benefits, life changes, and other topics.

2. Discussed its work plan for the remainder of the year, including completing its work on a new consumer guide to the claims process, developing materials related to the COVID-19 pandemic and updating its Frequently Asked Questions (FAQ) document on health care reform for the plan year 2021.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call July 9, 2020. The following Subgroup members participated: Mary Kwei, Chair, Ben Chandhok, Paul Meyer, and Joy Hatchette (MD); Debra Judy, Vice Chair and Caitlin Westerson (CO); Alex Peck, Jenifer Groth and Claire Szpara (IN); LeAnn Crow (KS); Judita Watters (ME); Carrie Couch, Marjorie Thompson, Camille Anderson-Weddle, and Amy Hoyt (MO); Laura Arp and Barbara Peterson (NE); Cuc Nguyen (OK); Katie Dzurec and Elizabeth Hart (PA); Gretchen Brodkorb and Jill Kruger (SD); Jennifer Ramcharan (TN); Tanji Northrup, Heidi Clausen, Shelley Wiseman and Jaakob Sundberg, (UT); Jennifer Stegall, Julie Walsh, Mary Kay Rodriguez and Christina Keeley (WI). Also participating were: Chelsy Maller (AK); William Rodgers (AL); Vanessa Darrah (AZ); Stephen Kim (CA); Howard Liebers (DC); Pamela White (FL); Teresa Winer (GA); Arlene Ige and Mavis Okihara (HI); Cynthia Banks-Radke and Angela Boston (IA); Kathy McGill and Kristen Finau (ID); Jill Mitchell and Daniel McIlwain (KY); Allison Buda, Emily DeLaGarza and Nicholeigh Drake (MI); Candace Gergen (MN); Kathy Hall (MS); Robert Kurzylowski and Jennifer Grady (NC); Chanell McDevitt (NJ); Jessica Baker (NM); Tynesia Dorsey (OH); Teresa Luna, Valerie Brown and Scott Helmcamp (TX); Jackie Myers (VA); Barbara Hudson and Joylynn Fix (WV); and Mavis Earnshaw, Denise Burke and Tana Howard (WY).

1. **Discussed the Subgroup’s 2020 Work Plan**

Ms. Judy outlined a number of potential work products the Subgroup could take up next. She mentioned the consumer guide to the claims process, which had been planned by the Subgroup since last year; materials related to the COVID-19 pandemic; and Frequently Asked Questions about Health Care Reform, which the Subgroup has worked on in each of the last several years and should be updated for plan year 2021. Some Subgroup members supported consumer-facing documents related to COVID-19, but were unsure exactly what form they should take. Others suggested a consumer guide related to short-term plans and coverage that is not comprehensive health insurance, like health care sharing ministries.

Harry Ting (Consumer Advocate Volunteer, Chester County Department of Aging Services – Apprise Program) also suggested a guide focused on short-term plans. Bonnie Burns (California Health Advocates—CHA) said that guides developed by the Subgroup should reference Medicare. Kris Hathaway (America’s Health Insurance Plans—AHIP) said that enrollment materials, like the FAQ, should be updated with Covid-19 in mind. Chris Petersen (Arbor Strategies) said that any materials from the Subgroup related to short-term plans should be aligned with the minimum standards for such plans being developed in other NAIC groups.

Ms. Kwei said the group plans to work on the FAQ closer to the beginning of open enrollment and encouraged Subgroup members and interested parties to submit further feedback by e-mail.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Jan. 21, 2020. The following Subgroup members participated: Angela Nelson, Chair, Camille Anderson-Weddle, Carrie Couch and Jessica Schrimpf (MO); Anthony L. Williams (AL); Weston Trexler (ID); Michelle Baldock, Ryan Gillespie and Eryn Krueger (IL); LeAnn Crow (KS); Mary Kwei and Joy Hatchette (MD); Kathy Shortt (NC); Cuc Nguyen and Rebecca Ross (OK); Elizabeth Hart (PA); Gretchen Brodkorb and Jill Kruger (SD); Vickie Trice and Jennifer Ramcharan (TN); and Jennifer Stegall, Julie Walsh and Shannon McNally (WI). Also participating were: Chelsey Maller (AK); Julia Yee (CA); Adam Boggess (CO); Matthew Smith and Justine Sorrentino (DC); Matthew Guy and Bryan Peters (FL); Cynthia Banks Radke and Sonya Sellmeyer (IA); Shawn Boggs (KY); Sherri Montana Brown (MN); Bob Williams (MS); Jeannie Keller (MT); Jason Dexter (NH); Jana Jarrett (OH); Scott Helmcamp and Valarie Brown (TX); Yolanda Tennyson (VA); and Dena Wildman, Joylynn Fix and Ellen Potter (WV).

1. Discussed a Consumer Guide on Using Health Insurance

Ms. Nelson noted that the current guide under review is in very good shape, and she expressed her hope that after a final walkthrough during today’s conference call, the document could be finalized.

The Subgroup then proceeded to go through the draft guide, page by page, and discussed any comments received prior to the call or that participants wanted to raise. On the page entitled “Choose a Primary Care Provider in Your Network,” Ms. Shortt asked whether OB-GYN practitioners should be listed as primary providers. NAIC staff noted that other providers (e.g., pediatricians) could also be added. The Subgroup decided that listing types of providers could be too confusing, and no such references were added. It was also noted that the last paragraph of the page did not seem to belong, so it was deleted.

Additional minor edits were made to the document to make it clearer and more readable.

The Subgroup then approved the amended guide.

Ms. Nelson said that the next module the Subgroup will be working on is “Claims Process.” She asked call participants to send any existing documents on internal/external review that they think would be helpful to the Subgroup. She said the next call will be in mid-February.

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

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Consumer Information (B) Subgroup
Conference Call
January 7, 2020

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Jan. 7, 2020. The following Subgroup members participated: Angela Nelson, Chair (MO); Anthony L. Williams (AL); Weston Trexler (ID); Michelle Baldock and Eryn Crueger (IL); LeAnn Crow (KS); Judith Watters (ME); Mary Kwei (MD); Laura Arp and Martin Swanson (NE); Cuc Nguyen and Rebecca Ross (OK); Elizabeth Hart (PA); Gretchen Brodkorb and Jill Kruger (SD); Jennifer Ramcharan (TN); Tanji Northrup, Shelley Wiseman, Heidi Clausen and Jaakob Sundberg (UT); and Jennifer Stegall (WI). Also participating were: Chelsy Maller and Jacob Lauten (AK); Debra Judy (CO); Matthew Guy, Bryan Peters and Carolyn Diggs (FL); Cynthia Banks-Radke and Sonya Sellmeyer (IA); Sherri Mortensen Brown (MN); Bob Williams (MS); Pam Koenig (MT); Tynesia Dorsey (OH); John Garrett (RI); Scott Helmcamp and Douglas Danzeiser (TX); Michelle McNamee (VA); Todd Dixon (WA); and Dena Wildman and Joylynn Fix (WV).

1. Discussed a Consumer Guide on Using Health Insurance

Ms. Nelson reviewed the plan of the Subgroup to produce a series of modules for consumer assistance. The one currently under development is to help consumer understand their plans, the next would be to help consumers use their plans, including claims and appeals. She said she hopes to release the guide on understanding plans as early as possible in the year. She asked Subgroup members to focus on the edits suggested by consumer representatives who had reviewed the latest draft.

The Subgroup discussed the section on different network types. It considered whether to list network types so that the more commonly used types are listed first. Ms. Watters observed that the most common types in one state may not be the same in other states. Ms. Nelson suggested that preferred provider organizations (PPOs), exclusive provider organizations (EPOs), and health maintenance organizations (HMOs) be listed first. Others agreed.

The Subgroup discussed the section on prescription drugs. Kris Hathaway (America’s Health Insurance Plans—AHIP) suggested that the section reference the Summary of Benefits and Coverage (SBC), since that document describes whether a plan has a formulary. She also said the section should be clear that four formulary tiers is an example; plans could have more or fewer tiers.

The Subgroup discussed the section on coordination of benefits. Members discussed how commonly plans impose a surcharge when covering an enrollee’s spouse who could be covered by his or her own employer insurance plan. Mr. Trexler pointed out that the presence or absence of a surcharge does not relate to coordination of benefits between two plans on enrollee is enrolled it. He suggested removing the reference to the surcharge and others agreed.

The Subgroup discussed the section on leaving a group plan. Ms. Watters said that COBRA should not be the only option mentioned, individual market coverage should also be presented as an option for those leaving a group plan. Mr. Swanson said it would also be worth mentioning the different continuation options available depending on the size of the employer. The Subgroup agreed that a number of options should be referenced.

The Subgroup discussed circulating a revised version of the guide and considering the latest version in its next call.

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

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Meeting Summary Report

The Health Innovations (B) Working Group met July 30, 2020. During this meeting, the Working Group:

1. Adopted its June 23 minutes. During this meeting, the Working Group discussed the regulation of coverage for telehealth services and potential topics for the Working Group’s meeting during the Summer National Meeting.

2. Heard a presentation on privacy requirements for telehealth communications under the Health Insurance Portability and Accountability Act (HIPAA). An attorney with Manatt Health reviewed which HIPAA standards were required versus addressable, the flexibility established under the COVID-19 pandemic, and other considerations for covered entities in complying with privacy requirements.

3. Heard a panel discussion on telemedicine from representatives of stakeholder groups. The National Alliance on Mental Illness (NAMI) shared poll results and concerns from patients and mental health providers. America’s Health Insurance Plans (AHIP) reviewed the growth in telehealth services, ongoing challenges, and what states can do to further promote telehealth. The American Academy of Family Physicians (AAFP) discussed changes to provider workflows, regulatory flexibilities and ongoing challenges, including the lack of alignment across payers.

4. Heard a presentation from the Milbank Memorial Fund on strategies for cost control. It suggested five areas in which state insurance regulators can incentivize and encourage greater health care system affordability.
The Health Actuarial (B) Task Force met Aug. 4, 2020. During this meeting, the Task Force:

1. Adopted the report of the Health Care Reform Actuarial (B) Working Group, which included the following action:
   a. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on 2021 federal Affordable Care Act (ACA) rate filings.

2. Adopted its May 27, April 23, and Feb. 14 minutes, which included the following action:
   b. Discussed the impact of COVID-19 on 2021 ACA rates.
   c. Adopted its 2019 Fall National Meeting minutes.
   d. Adopted revisions to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement and instructions for the revised forms as forwarded to the Task Force by the Long-Term Care Actuarial (B) Working Group.

3. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which included a summary of its Aug. 4 meeting. During its Aug. 4 meeting, the Working Group took the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Adopted the report of the Long-Term Care Valuation (B) Subgroup.
   c. Adopted the report of the Long-Term Care Pricing (B) Subgroup.

4. Adopted the Long-Term Care Pricing (B) Subgroup’s Feb. 6 and Jan. 6 minutes, which included the following action:
   a. Discussed long-term care insurance (LTCI) cash value buyouts.


6. Heard an update from the Society of Actuaries (SOA) on health insurance research.

7. Heard an update from the Academy Health Practice Council.
Meeting Summary Report

The Long-Term Care Actuarial (B) Working Group met Aug. 4, 2020. During this meeting, the Working Group:

1. Adopted its Jan. 23 and 2019 Fall National Meeting minutes, which included the following action:
   a. Adopted revisions to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement and instructions for the revised Forms.
   b. Adopted the report of the Long-Term Care Pricing (B) Subgroup.
   c. Adopted the report of the Long-Term Care Valuation (B) Subgroup.

2. Adopted the report of the Long-Term Care Pricing (B) Subgroup, which included the following action:
   a. Adopted its Feb. 6 and Jan. 6 minutes, which included the following action:
      1. Discussed long-term care insurance (LTCI) cash value buyouts.

3. Adopted the report of the Long-Term Care Valuation (B) Subgroup.

4. Heard an update from the American Academy of Actuaries (Academy) on LTCI Work Group activities.

5. Heard an update from the Society of Actuaries (SOA) on LTCI research.
Meeting Summary Report

The Regulatory Framework (B) Task Force met Aug. 4, 2020. During this meeting, the Task Force:

1. Adopted its Feb. 20 and 2019 Fall National Meeting minutes. During its Feb. 20 meeting, the Task Force:
   a. Appointed the MHPAEA (B) Working Group and adopted its 2020 proposed charges.

2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, which met Dec. 19, 2019, and took the following action:
   a. Continued its discussion of the comments received on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), now known as the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170).
   b. Set a public comment period ending Feb. 7 to receive comments on Sections 6 and 7 of Model #171. The Subgroup had planned to begin meeting via conference call in February to complete its discussion of the comments received on Sections 1–5 and begin discussion of the comments received on Sections 6 and 7, but due to the COVID-19 public health emergency and the loss of one of its co-chairs, the Subgroup has not met since December 2019.

3. Adopted the report of the ERISA (B) Working Group, which met July 31 and July 28 and took the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Discussed what the Working Group should focus on in 2021, including reviewing the Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation (#220) to consider its continuing relevance.
   c. Met in a regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

4. Adopted the report of the HMO Issues (B) Subgroup, which met July 13 and June 24 minutes and did not include adopting the revisions to the Health Maintenance Organization Model Act (#430). During these meetings, the Subgroup:
   a. Discussed the comments received by the public comment period ending March 18 on proposed revisions to Model #430 to address inconsistencies and redundancies in the model with the provisions in the Life and Health Insurance Guaranty Association Model Act (#520), which added health maintenance organizations (HMOs) as members of the guaranty association.
   b. Adopted the revisions to Model #430.

5. Adopted the report of the MHPAEA (B) Working Group, which met July 29 and July 28 and took the following action:
   a. Heard a presentation on activities and work being done to assist self-funded group health plans and private employers to comply with mental health parity requirements under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Additon Equity Act of 2008 (MHPAEA).
   b. Heard a presentation from the American Psychiatric Association (APA) on state activities and legislation related to MHPAEA parity data reporting requirements.
   c. Discussed current parity compliance resources and tools available to the states to determine plan compliance with the MHPAEA parity requirements and potential resources and tools the Working Group developed to supplement, but not supplant, these existing tools and resources.
   d. Discussed next steps in developing supplemental MHPAEA parity compliance resources and tools for the states related to non-quantitative treatment limitations (NQTLs).
   e. Met in regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.
6. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which met July 16 and took the following action:
   a. Discussed the ad hoc drafting group’s draft pharmacy benefit manager (PBM) model act.
   b. Exposed the PBM draft for a public comment period ending Sept. 1. The Subgroup plans to meet via conference call to begin discussion of the comments received sometime in September after the public comment period ends.

7. Heard an update from the Center on Health Insurance Reforms’ (CHIR’s) work related to federal Affordable Care Act (ACA) implementation and other issues of interest to state insurance regulators. The update included a discussion of the CHIR’s efforts to track state activity related to COVID-19’s effect on private coverage of critical services. The CHIR is continuing to track and analyze developments under the ACA’s Section 1332 waiver program and state regulatory approaches to short-term, limited-duration (STLD) plans. The CHIR is also continuing its work to track state reforms affecting the individual market and the affordability of comprehensive coverage. The presentation also highlighted the CHIR’s ongoing technical assistance regarding insurance regulatory matters, including state COVID-19 responses through the State Health and Value Strategies Program (SHVSP) and assistance provided to state and federal policymakers regarding regulatory approaches to balance billing.

8. Heard a panel presentation on health care sharing ministries (HCSMs). The CHIR discussed consumer confusion with HCSMs because of how they are marketed by some HCSMs and their similarity in many aspects to traditional health insurance plans, such as defined benefit packages, cost-sharing, and premium-like payment requirements. A representative from Samaritan Ministries discussed suggestions for best practices for HCSMs to provide transparency and potentially reduce consumer confusion between HCSMs and traditional health insurance plans.

9. Heard a discussion on premium holidays, early medical loss ratio (MLR) rebate payments, and adjustments to cost-sharing benefits due to fewer claim filings in 2020 because of COVID-19. As part of this discussion, the federal Centers for Medicare & Medicaid Services (CMS) announced that it had just released guidance on a new temporary policy that will allow issuers to offer temporary premium reductions for individuals with 2020 coverage in the individual and small group markets. The guidance can be found at this link: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Premium-Credit-Guidance.pdf.

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The Senior Issues (B) Task Force met Aug. 3, 2020. During this meeting, the Task Force:

1. Adopted its March 3, 2020, and 2019 Fall National Meeting minutes, which included the following action:
   a. Established the LTCI Model Update (B) Working Group, with a charge of determining whether the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641) need to be updated.

2. Heard a federal legislative update, including an update on federal funding for the State Health Insurance Assistance Program (SHIP) and the work of the Federal Interagency Task Force on Long-Term Care Insurance and its final report.

3. Heard a discussion about seniors and COVID-19 and what states are experiencing.

4. Heard a discussion regarding misleading advertisements that lead seniors unknowingly off their current plan and into Medicare Advantage plans they did not ask for and, in most cases, do not need.

5. Heard a discussion regarding the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and Medicare. Too many workers do not know that they must enroll in Medicare even if they are continuing to work past the age 65, and there should be an edit of the *Coordination of Benefits Model Regulation* (#120) to help with this issue.
Agenda Item #3

Hear a Presentation on Health Equity and Disparities in Health Care and Coverage
—Samantha Artiga (Kaiser Family Foundation—KFF)
Disparities in Health and Health Care: An Overview

Samantha Artiga
Director, Disparities Policy Project and Associate Director,
Kaiser Program on Medicaid and the Uninsured
Kaiser Family Foundation
KFF (Kaiser Family Foundation)

- Non-profit organization focusing on national health issues, as well as the U.S. role in global health policy
- Develop and run our own policy analysis, journalism, and communications programs
- Provide basic education to increase awareness and understanding of disparities
- Conduct data analysis to provide greater insight into status of disparities
- Analyze implications of emerging policy issues on disparities and efforts to advance equity
- Inform broad range of stakeholders through reports, meetings, briefings, and media
- All materials available through our website at www.kff.org
What are health and health care disparities?

- Differences in health and health care between populations
  - Higher burden of illness, injury, disability, or mortality
  - Differences in insurance coverage, access to and use of care, and quality of care
- Arise from a complex and interrelated set of individual, provider, health system, societal, and economic factors
- Occur across a broad range of dimensions: race/ethnicity; socioeconomic status; gender; age; disability; sexual orientation or gender identity; geographic location, etc.
- Remain a longstanding and persistent issue
Black, American Indian and Alaska Native, and Native Hawaiian and Other Pacific Islander people have higher infant mortality rates compared to other groups.

Infant Mortality per 1,000 Live Births, by Maternal Race/Ethnicity, 2018

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Infant Mortality Rate (per 1,000 Live Births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Races/Ethnicities</td>
<td>5.7</td>
</tr>
<tr>
<td>White</td>
<td>4.6</td>
</tr>
<tr>
<td>Black</td>
<td>10.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4.9</td>
</tr>
<tr>
<td>Asian</td>
<td>3.6</td>
</tr>
<tr>
<td>AIAN</td>
<td>8.2</td>
</tr>
<tr>
<td>NHOPIC</td>
<td>9.4</td>
</tr>
</tbody>
</table>

NOTE: AIAN refers to American Indian and Alaska Native people. NHOPIC refers to Native Hawaiians and Other Pacific Islander people. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

Black and Hispanic people face stark disparities in HIV and AIDS diagnoses and death rates among people with HIV.

HIV or AIDS Diagnosis and Death Rate per 100,000 among Teens and Adults by Race/Ethnicity, 2018

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>HIV Diagnosis Rate</th>
<th>AIDS Diagnosis Rate</th>
<th>Death Rate for Individuals with HIV Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>5.6</td>
<td>23.8</td>
<td>3.0</td>
</tr>
<tr>
<td>Black</td>
<td>20.9</td>
<td>8.4</td>
<td>5.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>47.5</td>
<td>42.1</td>
<td>21.1</td>
</tr>
<tr>
<td>Asian</td>
<td>5.4</td>
<td>3.2</td>
<td>0.5</td>
</tr>
<tr>
<td>AIAN</td>
<td>9.6</td>
<td>2.1</td>
<td>2.0</td>
</tr>
<tr>
<td>NHOPI</td>
<td>14.4</td>
<td>4.2</td>
<td>1.7</td>
</tr>
</tbody>
</table>

NOTE: Data based on surveillance data reported by states to the CDC. AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons categorized by race were not Hispanic or Latino. Individuals in each race category may, however, include persons whose ethnicity was not reported. Includes individuals age 13 and older. Data for HIV and AIDS diagnoses are as of 2018 and death rate data are as of 2017. Death rates for individuals with HIV are deaths due to any cause, not only from HIV-related illness.

Figure 5

People of color have higher rates of death due to certain diseases.

Age-Adjusted Death Rates per 100,000 for Selected Diseases by Race/Ethnicity, 2018

<table>
<thead>
<tr>
<th></th>
<th>Diabetes</th>
<th>Heart Disease</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>18.8</td>
<td>167.5</td>
<td>154.4</td>
</tr>
<tr>
<td>Black</td>
<td>38.7*</td>
<td>209.3*</td>
<td>173.8*</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>24.6*</td>
<td>112.3*</td>
<td>107.4*</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>16.5*</td>
<td>85.2*</td>
<td>93.4*</td>
</tr>
<tr>
<td>AIAN</td>
<td>42.1*</td>
<td>145.8*</td>
<td>128.1*</td>
</tr>
</tbody>
</table>

NOTE: * Indicates statistically significant difference from White people at the p<0.05 level. AIAN refers to American Indian and Alaska Native people. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes individuals of all ages. Data for some groups should be interpreted with caution; see http://wonder.cdc.gov/wonder/help/ucd.html#Racial. SOURCE: CDC, National Center for Health Statistics, WONDER Online Database, Underlying Cause of Death, 2018.
The disparate impacts of COVID-19 mirror and compound underlying health disparities.

Share of Adults Ages 18-64 at Higher Risk of Serious Illness if Infected with Coronavirus by Race/Ethnicity

NOTE: Data includes adults ages 18-64; excludes adults living in nursing homes or other institutional settings. Persons of Hispanic origin may be of any race, but are categorized as Hispanic for this analysis; other groups are non-Hispanic.
Black people account for a disproportionate share of COVID-19 cases and deaths in most states reporting data.

Black People as a Share of Coronavirus Cases, Deaths, and Total Population in Select States, August 3, 2020

Hispanic people account for a disproportionate share of COVID-19 cases in most states reporting data.

Hispanic People as a Share of Coronavirus Cases, Deaths, and Total Population in Select States, August 3, 2020

<table>
<thead>
<tr>
<th>State</th>
<th>Total Population</th>
<th>Cases</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nebraska</td>
<td>11%</td>
<td>23%</td>
<td>40%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>7%</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>6%</td>
<td>19%</td>
<td>12%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>5%</td>
<td>19%</td>
<td>5%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>5%</td>
<td>17%</td>
<td>9%</td>
</tr>
<tr>
<td>South Dakota</td>
<td>4%</td>
<td>13%</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: As of August 3, 2020, South Dakota does not report coronavirus deaths by race/ethnicity.

COVID-19 is having stark impacts for American Indian and Alaska Native (AIAN) and Asian people in some states.

AIAN and Asian People as a Share of Coronavirus Cases, Deaths, and Total Population in Select States, August 3, 2020

<table>
<thead>
<tr>
<th>State</th>
<th>AIAN Percent of Cases</th>
<th>AIAN Percent of Total Population</th>
<th>Asian Percent of Cases</th>
<th>Asian Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico</td>
<td>9%</td>
<td>36%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>South Dakota</td>
<td>9%</td>
<td>16%</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>Arizona</td>
<td>6%</td>
<td>12%</td>
<td>6%</td>
<td>16%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>2%</td>
<td>5%</td>
<td>2%</td>
<td>8%</td>
</tr>
</tbody>
</table>

NOTE: As of August 3, 2020, New Mexico and South Dakota did not report coronavirus deaths by race/ethnicity.

Health disparities are a symptom of social and economic inequities.

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Food security</td>
<td>Social integration</td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Health coverage</td>
<td>Community engagement</td>
<td></td>
</tr>
<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Provider availability</td>
<td>Stress</td>
<td></td>
</tr>
<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Provider linguistic and cultural competency</td>
<td>Exposure to violence/trauma</td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td></td>
<td>Quality of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zip code/ geography</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Health Outcomes:** Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Uninsured rates have declined since implementation of the Affordable Care Act, but disparities persist for some groups.

NOTE: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0-64 years. SOURCE: KFF analysis of 2013-2018 American Community Survey.
Uninsured Black individuals are more likely to fall in the coverage gap than their White counterparts.

Eligibility for ACA Coverage Among Nonelderly Uninsured by Race/Ethnicity, 2018

NOTE: * Indicates statistically significant difference from Whites at the p<0.05 level. Totals may not sum due to rounding. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0-64 years of age. AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders.

SOURCE: KFF analysis based on 2019 Medicaid eligibility levels and 2018 American Community Survey.
Black people make up a higher share of the population in the South, where many states have not expanded Medicaid.

Share of Total Nonelderly Population that is Black by State and Medicaid Expansion Status as of July 2020

NOTE: Includes nonelderly individuals 0-64 years of age and non-Hispanic Blacks.

People of color face increased barriers to accessing care.

Share of Nonelderly Adults Reporting Selected Barriers to Accessing Health Care by Race/Ethnicity, 2018

- Did Not See a Doctor Due to Cost
- Delayed Care Due to Other Reasons
- No Usual Source of Care When Sick Other than Emergency Room

NOTE: AIAN refers to American Indian and Alaska Native people. NHOPI refers to Native Hawaiian and Other Pacific Islander people. N/A: data cannot be separately identified. Persons of Hispanic origin may be of any race, but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly adults 18-64 years of age.

SOURCE: KFF analysis of 2018 Behavioral Risk Factor Surveillance System and National Health Interview Survey data.
People of color are more likely to have income below poverty compared to White people.

Percent of Nonelderly Population with Income Below Poverty by Race/Ethnicity, 2018

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Poverty Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>10%</td>
</tr>
<tr>
<td>Black</td>
<td>19%*</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15%*</td>
</tr>
<tr>
<td>Asian</td>
<td>10%*</td>
</tr>
<tr>
<td>AIAN</td>
<td>23%*</td>
</tr>
<tr>
<td>NHOPI</td>
<td>16%*</td>
</tr>
</tbody>
</table>

NOTE: * Indicates statistically significant difference from the White population at the p<0.05 level. AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. N/A: data cannot be separately identified. Persons of Hispanic origin may be of any race, but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0-64 years of age. SOURCE: KFF analysis of 2018 American Community Survey.
Households of color are more likely to be facing food insecurity than White households.

Food Security among Reporting Households in the Last 7 Days by Race/Ethnicity, July 9 - July 14, 2020

Health and health care disparities are a longstanding and persistent issue.

The COVID-19 pandemic has highlighted and exacerbated underlying disparities.

Health disparities are a symptom of broader social and economic inequities rooted in structural and systemic barriers that disadvantage people of color, including racism and discrimination.

Increased awareness and recognition of disparities provides an opportunity to advance equity.

Progress will require long-term efforts across sectors to prioritize equity and address systemic and structural barriers, including racism and discrimination.
Disparities in Health and Health Care: An Overview

Samantha Artiga
Director, Disparities Policy Project and Associate Director, Kaiser Program on Medicaid and the Uninsured
Kaiser Family Foundation
Agenda Item #4

Hear a Presentation on COVID-19: Lessons Learned
—Daniel J. Meuse (State Health and Value Strategies [SHVS], Princeton School of Public and International Affairs, Princeton University)
About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University’s School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Dan Meuse at dmeuse@Princeton.edu.

Special thanks to Marissa Korn, Princeton School of Public and International Affairs, for research assistance.

Support for this presentation was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.
Topics for Today

• What do we know about how the COVID-19 recession is affecting ESI?

• Where do people go if they lose ESI? What does it mean for consumers and providers?

• What are the larger policy considerations for regulators?
Pre-COVID Coverage Landscape

Source of Coverage for Non-Elderly (0-64)

Date sourced from Kaiser Family Foundation / ACS – https://www.kff.org/other/state-indicator/nonelderly-0-64/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
The Recession’s Effects

Weekly New UI Claims

From data retrieved from https://oui.doleta.gov/unemploy/claims.asp
The Recession’s Effects

Aggregate New UI Claims

From data retrieved from https://oui.doleta.gov/unemploy/claims.asp
The Recession’s Effects

Projected Unemployment Rate

https://www.cbo.gov/publication/56465
The Recession’s Effects

Policy Responses

• Federal Legislation
  – FMAP Increase with Maintenance of Effort
  – Paycheck Protection Program
  – Economic Injury Disaster Loan

• State Reaction
  – Special Enrollment Periods for Marketplace
  – Premium Grace Periods
The Recession’s Effects

- New enrollments have been less than initially modeled
- Possible Causes:
  - Furloughs vs. Layoffs
  - Hierarchy of needs (income, food, ..., coverage)
  - Health care utilization decline
  - Federal program preserving ESI
  - Does job loss result in coverage loss?

**Timeline:**
- Nationwide Shutdowns
- PPP Applications Open
- First PPP Recipients End Program
- March
- April
- May
- June
- July
- August

**Key Dates:**
- SEPs Begin
- SEPs Start to End
The Recession’s Effects

What we don’t know

• Who is actually losing job-based coverage?
• Where they are going to get coverage?
• Is the loss of coverage disproportionately impacting communities of color or patients at-risk for increased morbidity?
The Recession’s Effects

Figure 1. Health Insurance Coverage Prior to Pandemic Among Those with Subsequent Job Loss in Family, 2020

- 48 million nonelderly Americans
- 34% (16.6m) Medicaid and CHIP
- 27% (12.7m) ESI through other family member
- 10% (4.7m) ESI through job lost due to COVID-19
- 5% (2.4m) Medicare and other
- 2% (1.1m) Nongroup
- 1% (0.4m) STLD

Figure 2. Post Job Loss Coverage Among Workers and Family Members Losing ESI Due to COVID-19 Recession, 2020

- 10.1 million nonelderly Americans
- 28% (2.9m) Medicaid and CHIP
- 34% (3.5m) ESI through other family member
- 32% (3.3m) Uninsured
- 6% (0.6m) ESI through job lost due to COVID-19
- 5% (0.6m) Medicare and other
- 2% (0.2m) Nongroup

Source: Urban Institute’s Health Insurance Policy Simulation Model
Notes: Estimates can be interpreted as applying to the average month in the last three quarters of 2020. ESI is employer-sponsored insurance, STLD is short-term limited duration plans, CHIP is Children’s Health Insurance Program

Choices After ESI Loss

- COBRA
- Spouse/Family
- Medicaid/CHIP
- Marketplace/QHP
- Off-Marketplace
- Non-Compliant Plans
- Uninsured
Choices After ESI Loss

Consumer Considerations

- Premium Costs
- Deductibles
- Network of Providers
- Continuity of Care
- Administrative Burden
- Eligibility/Family Glitch

- COBRA
- Spouse/Family
- Medicaid/CHIP
- Uninsured
- Marketplace/QHP
- Off-Marketplace
- Non-Compliant Plans
- Uninsured
Policy Opportunities and Lessons

• First widespread coverage loss since full ACA implementation
  – Impact of Medicaid expansion
  – Timing of enrollment & outreach
  – Outreach challenges
Policy Opportunities and Lessons

• Lack of data hampers decision making
  – Potential to add coverage questions to UI applications
• Cost shifting due to lower ESI numbers
• Public Health directives and self-funded plans
  – Nursing Facility Testing Requirements
Policy Opportunities and Lessons

• Churn
  – Income changes likely to drive enrollment from non-group to Medicaid
  – When Medicaid Maintenance of Effort requirements end, influx of enrollees to Marketplace may require increased enrollment efforts (SEP or extension of OEP)
Policy Opportunities and Lessons

• Impact on non-group market risk pool
• Population health efforts
  – Vaccination rates (non-COVID vaccines)
  – Chronic disease care
  – Preventive services
• Opportunities for Alternative Payment Models (with self-funded participation!)
Discussion
Thank You

Dan Meuse
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State Health and Value Strategies
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609-258-7389
www.shvs.org
Agenda Item #5

Hear a Presentation on COVID-19 Testing and Costs
—Matt Eyles (America’s Health Insurance Plans—AHIP)
Expanding Access to COVID Testing: The Need for Additional Federal Funding

NAIC Health Insurance and Managed Care (B) Committee

Matt Eyles, CEO
America’s Health Insurance Plans

August 11, 2020
Virtual Summer Meeting
COVID-19 Testing: Background

• Unprecedented global and national public health crisis
• Widespread testing that is safe, effective and accurate is necessary
• Essential components:
  1. Quickly diagnose the virus
  2. Proactively screen to prevent/mitigate the spread
• Testing purpose:
  − Guiding care and treatment
  − Public Health surveillance
  − Occupational Health (examples: return to work, school)
• Access to testing should not be dependent on someone’s ability to pay
• As August 4, almost 53 million COVID tests have been reported to the [CDC](https://www.cdc.gov)
• Given the exceptional scale and scope of the testing required, public health testing efforts must be a national priority, federally funded, and locally administered
• Federal agencies have a critical responsibility to ensure quality, to support appropriate use and prioritize affordable solutions
<table>
<thead>
<tr>
<th>Testing Purpose</th>
<th>Health Insurer Role</th>
<th>Gov’t / Public Health Entity Role</th>
<th>Employer Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing for Purposes of Guiding Care and Treatment</td>
<td>Yes</td>
<td>Yes, For covered individuals</td>
<td>Yes, For self-insured</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Testing for Purposes of Public Health Surveillance</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td></td>
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</tr>
<tr>
<td>Testing for Occupational Health</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>CARES 3.5 includes $25 billion for COVID-19 testing, including funding for states, localities, and territories and employer testing</td>
<td>If done at public health site or other government-directed location</td>
<td>If done at employer site or other employer-directed location</td>
</tr>
</tbody>
</table>
## COVID-19 Testing: Current Federal Law

|----------------------------|--------------------|
| Families First Coronavirus Relief Act (*H.R. 6201*) | • Includes $1 B in funding for provider costs associated with COVID-19 related items and testing and provider visits.  
• Requires insurers to cover testing and waive cost sharing or prior authorization for testing in the individual, small group, and large group markets.  
• Provides coverage of testing at no cost sharing in Medicaid, CHIP, Medicare, and MA plans. |
| CARES Act (*H.R. 748*) | • Includes $1.32 B in supplemental funding for FY 2020 to community health centers on the front lines of testing and treating patients for COVID-19.  
• Clarified that individual and group health plans must waive cost sharing and prior authorization for COVID testing and test-related items and services.  
• Requires health insurance providers to reimburse providers for tests at the negotiated rate or, at the cash price of the test listed on a public website. |
| Paycheck Protection Program and Health Care Enhancement Act (*H.R. 266*) | • Includes $25 B for COVID-19 testing, including funding for states, localities, and territories and employer testing. |

|-----------------------|--------------------|
| **Heroes Act (H.R. 6800): House Democrats** | • $75 billion for coronavirus testing, contact tracing and isolation measures.  
• Requires lab developed tests to attest to meeting basic FDA accuracy standards.  
• Establishes standards for collection and posting of testing accuracy and price. |
| **HEALS Act (S. ___): Senate Republicans** | • $16 billion for coronavirus testing (additional $9 billion in CARES funds that would also be used for testing).  
• Requires HHS to issue guidance on development and distribution of diagnostic tests for emerging infectious diseases.  
• Establishes a refundable payroll tax credit equal to 50% of an employer’s “qualified employee protection expenses,” such as testing for COVID-19.  
• Authorizes HHS to establish enhanced diagnostic testing of visitors to, personnel of, and residents of, any facilities in which COVID–19 measures support more frequent testing. |
COVID-19 Testing: Cost Estimate Studies

**Wakely Report**
(June 3, 2020)
- $6 B - $25 B for diagnostic testing
- $5 B - $19 B for antibody testing
- Annually: .2 - .6 per member per year
- $40-$125 per test

**Milliman Report**
(July 2020)
- $600 M - $2.9 B for 3Q & 4Q of 2020 for commercially insured patients in New York
- $59-$82 per test
- 60 - 333 tests per 1000 residents monthly

**LeadingAge Comments**
(June 15, 2020)
- $10 B to augment the $75 B within Heroes Act to test aging services staff.

**Covered California Policy Brief**
(March 22, 2020)
- $34 B - $251 B for testing, treatment, and care in the commercial market
- 20-60 M tested once annually
- $50 - $240 per test

**Rockefeller Action Plan**
(July 16, 2020)
- $75 B funding for testing & tracing
- 4.5 M tests should increase to 30 M weekly tests by Oct
- $5 - $70 for the public cost per test (price billed to payor will be higher)

**Variations in Cost:**
- Cost per test
- Type of test
- Test frequency
- Provider charges
- Market Share
- Pooling assumptions
COVID-19 Testing: Premium Impact

Health Affairs Blog

- Essential workers tested weekly is $5200 (Medicare price), would imply a premium increase of more than 70%
- Leads to dramatic reductions in insurance coverage
- Essential = Agriculture, Home health, Child day care, Residential care facilities, Grocery stores, Skilled nursing facilities, Funeral, Meat plants, Medical offices, Educations, Hospitals
- July 28, 2020
- By Linda Blumberg, Sabrina Corlette, Michael Simpson
COVID-19 Testing: AHIP, Others Call on Congress for Dedicated Funding

AHIP and 48 other organizations representing patients, employers, clinical laboratories, and health insurance providers sent a letter to congressional leadership requesting dedicated federal funding for the critical testing needed to reopen the country.

Highlights from the letter include:

“Testing is one of the most important tools we have to combat this crisis, both for identifying the virus and also for preventing its spread in communities across the country. It’s vital that the federal government designate the resources to support expanded access to testing.”

“Swift action is needed to ensure that every American, especially essential workers, frontline healthcare physicians and other clinicians and those at disproportionate risk for COVID-19 have access to vital COVID-19 testing, whether for diagnostic, occupational, return-to-school, public health or virus monitoring purposes.”
COVID-19 Testing: Recommendations

• Ensure all Americans are able to access COVID-19 testing regardless of coverage status

• Ensure federal funding accounts for:
  − The magnitude of tests required to get the economy back on track
  − Reduces the risk of transmission in different settings
  − The progression of the disease.

• Solidify comprehensive strategies that incorporate testing to achieve occupational and public health goals

• Ensure testing doesn’t lead to premium spikes in 2021

• Protect against fraud of testing
Purpose of Testing: State Examples

COVID-19 Testing

Idaho Bulletin 20-13:
• Cover all medically necessary and at home test prescribed by provider; does not include return to work or public surveillance. (7.10.20)

Iowa Bulletin 20-10:
• Coverage to treat people with symptoms under a providers’ order; does not include broad population or back to work testing. (6.22.20)

Louisiana SB 426:
• Coverage of diagnostic tests, antibody tests and antiviral drugs when ordered by physician for clinical decisions. Not subject to cost sharing until 12.31.21. (Gov signed 5.30.20)

New Mexico Bulletin 2020-16:
• Cover all medically necessary and at home test prescribed by provider; does not include return to work or public surveillance (8.4.20)

Oklahoma LH Bulletin NO. 2020-03:
• Coverage when symptoms are medically necessary and order by a medical professional; return to work programs and public health surveillance testing are not considered medically necessary. (5.22.20).

Wyoming Informational Bulletin:
• Cover all medically necessary testing as prescribed by provider; public surveillance or employee screening are not considered medically necessary. (6.10.20)
Agenda Item #6

Hear an Update on Federal Affordable Care Act (ACA) Court Cases—Katie Keith (Out2Enroll)
Update on Federal ACA Court Cases

Health Insurance and Managed Care (B) Committee

Katie Keith, JD, MPH
Georgetown University Law Center
Supreme Court Cases

Taking Stock of the 2019 Term
- *Maine Community Health Options*: insurers are entitled to more than $12.2 billion in unpaid risk corridors payments from 2014 to 2016
  Next steps: resolution of amounts owed, timing of payments, MLR
- *Little Sisters of the Poor*: government has the authority to create broad exemptions to the ACA’s contraceptive mandate
  Next steps: employers can claim exemption under new rules, more litigation

What to Expect in the 2020 Term
- *California v. Texas* (global challenge to the ACA) → briefing completed in mid-August, oral argument TBD, two severability cases in 2019 term
- *Rutledge v. PCMA* (state regulation of pharmacy benefit managers) → oral argument set for October 6, 2020
- *Gresham v. Azar* (validity of Medicaid work requirements) → *cert* not yet granted
<table>
<thead>
<tr>
<th>Topic</th>
<th>Court</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term plans</td>
<td>D.C. Circuit</td>
<td>Upheld 2018 rule on STLDI (request for <em>en banc</em> review)</td>
</tr>
<tr>
<td>Risk adjustment</td>
<td>Second Circuit</td>
<td>New York risk adjustment rule is preempted by the ACA</td>
</tr>
<tr>
<td>HIT</td>
<td>Fifth Circuit</td>
<td>States not entitled to recoup prior year HIT from MCOs</td>
</tr>
<tr>
<td>Plan design</td>
<td>Ninth Circuit</td>
<td>Sec. 1557 prohibits discrimination in benefit design (exclusion was for all hearing loss treatment except cochlear implants)</td>
</tr>
<tr>
<td>Multiple policy decisions</td>
<td>MD district court</td>
<td>Claims advance under the APA but not the Take Care Clause of the Constitution</td>
</tr>
<tr>
<td>Double billing rule</td>
<td>CA, MD, WA district courts</td>
<td>Vacated the 2019 rule requiring double billing/payment for certain abortion services (on appeal to Fourth, Ninth Circuits)</td>
</tr>
<tr>
<td>AHPs</td>
<td>D.C. Circuit</td>
<td>Decision pending (oral argument in Nov. 2019)</td>
</tr>
<tr>
<td>Unpaid CSRs</td>
<td>Federal Circuit</td>
<td>Decision pending (oral argument in Jan. 2020)</td>
</tr>
<tr>
<td>Sec. 1557</td>
<td>Fifth Circuit; CA, DC, MA, NY district courts</td>
<td>Briefing $\rightarrow$ effective date of Aug. 18th if not blocked</td>
</tr>
<tr>
<td>Forcing a SEP</td>
<td>DC district court</td>
<td>Briefing completed in early August</td>
</tr>
</tbody>
</table>
Other Health Litigation Issues

- Public charge rule (district courts in CA, MD, NY)
- Provider conscience rule (Second, Ninth Circuits)
- Prescription drug transparency rule (D.C. Circuit)
- Hospital transparency rule (D.C. Circuit)
- Site-neutral payments (D.C. Circuit)
- Title X domestic gag rule (Ninth Circuit)
Thank you!

Katie Keith, JD, MPH
Georgetown University Law Center
katie.keith@georgetown.edu
More resources available at: healthaffairs.org/blog
Agenda Item #7

Receive an Update on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s Work
—TK Keen (OR)
Conference Call

PHARMACY BENEFIT MANAGER REGULATORY ISSUES (B) SUBGROUP
July 16, 2020

Summary Report

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call July 16, 2020. During this call, the Subgroup:

1. Discussed the ad hoc drafting group’s draft pharmacy benefit manager (PBM) model act.

2. Exposed the PBM draft for a public comment period ending Sept. 1. The Subgroup plans to meet via conference call to begin discussion of the comments received sometime in September after the public comment period ends.
Agenda Item #8

Hear a Federal Legislative Update—Brian Webb (NAIC)
Agenda Item #9

Discuss Any Other Matters Brought Before the Committee

—Commissioner Jessica K. Altman (PA)