

Revised: 8/2/22

2022 Summer National Meeting
Portland, Oregon

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Thursday, August 11, 2022

3:45 – 5:30 p.m.

Oregon Convention Center—Oregon Ballroom 201–204—Level 2

ROLL CALL

Glen Mulready, Chair	Oklahoma	Grace Arnold	Minnesota
Troy Downing, Co-Vice Chair	Montana	Chris Nicolopoulos	New Hampshire
Russell Toal, Co-Vice Chair	New Mexico	Andrew R. Stolfi	Oregon
Lori K. Wing-Heier	Alaska	Michael Humphreys	Pennsylvania
Michael Conway	Colorado	Jon Pike	Utah
John F. King	Georgia	Mike Kreidler	Washington
Amy L. Beard	Indiana	Allan L. McVey	West Virginia
Anita G. Fox	Michigan		

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

AGENDA

1. Consider Adoption of its Spring National Meeting Minutes
—*Commissioner Glen Mulready (OK)*
2. Consider Adoption of its Subgroup, Working Group, and Task Force Reports
—*Commissioner Glen Mulready (OK)*
 - A. Consumer Information (B) Subgroup—*Mary Kwei (MD)*
 - B. Health Innovations (B) Working Group—*Commissioner Andrew R. Stolfi (OR)*
 - C. Health Actuarial (B) Task Force—*Commissioner Andrew N. Mais (CT) and Paul Lombardo (CT)*
 - D. Regulatory Framework (B) Task Force—*Commissioner Vicki Schmidt (KS)*
 - E. Senior Issues (B) Task Force—*Commissioner Marlene Caride (NJ)*
3. Hear a Discussion on Efforts to Create State-Based Health Insurance Exchanges
—*J.P. Wieske (Horizon Government Affairs), Randy Pate (StatesWork), and Heather Korbolic (GetInsured)*
4. Hear a Discussion on Medicaid Redeterminations Following the End of the COVID-19 Public Health Emergency (PHE)—*Miranda Motter (America’s Health Insurance Plans—AHIP)*
5. Hear an Update from the Federal Centers for Medicare & Medicaid Services’ (CMS’) Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities
—*Dr. Ellen Montz (CCIIO)*

6. Hear an Update on Federal Legislative and Regulatory Issues and on Federal No Surprises Act (NSA) Implementation—*Brian R. Webb (NAIC)*
7. Receive an Update on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s Work—*TK Keen (OR)*
8. Receive an Update on the Special (EX) Committee on Race and Insurance Workstream Five’s Work—*Commissioner Kathleen A. Birrane (MD) and Commissioner Grace Arnold (MN)*
9. Discuss Any Other Matters Brought Before the Committee—*Commissioner Glen Mulready (OK)*

Agenda Item #1

Consider Adoption of its Spring National Meeting Minutes
—Commissioner Glen Mulready (OK)

Draft Pending Adoption

Draft: 4/12/22

Health Insurance and Managed Care (B) Committee
Kansas City, Missouri
April 7, 2022

The Health Insurance and Managed Care (B) Committee met in Kansas City, MO, April 7, 2022. The following Committee members participated: Glen Mulready, Chair (OK); Troy Downing, Co-Vice Chair (MT); Russell Toal Co-Vice Chair (NM); Lori K. Wing-Heier (AK); Michael Conway (CO); John F. King represented by Steve Manders (GA); Amy L. Beard (IN); Anita G. Fox (MI); Grace Arnold (MN); Chris Nicolopoulos (NH); Andrew R. Stolfi (OR); Michael Humphreys (PA); Jon Pike (UT); Mike Kreidler (WA); and Allan L. McVey (WV). Also participating were: Karima M. Woods (DC); Dana Popish Severinghaus (IL); Vicki Schmidt (KS); and Edward M. Deleon Guerrero (NMI).

1. Adopted its 2021 Fall National Meeting Minutes

Commissioner McVey made a motion, seconded by Director Wing-Heier, to adopt the Committee's Dec. 15, 2021, minutes (*see NAIC Proceedings – Fall 2021, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

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

Commissioner Stolfi made a motion, seconded by Commissioner McVey, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its March 22 minutes (Attachment One); 2) the Health Innovations (B) Working Group, including its April 4 minutes (Attachment Two); 3) the Health Actuarial (B) Task Force; 4) the Regulatory Framework (B) Task Force; and 5) the Senior Issues (B) Task Force. The motion passed unanimously.

3. Received an Update on the Special (EX) Committee on Race and Insurance Workstream Five's Work

Commissioner Arnold provided an update to the Committee on Workstream Five's work to date as the new Workstream co-chair for 2022. She said that along with Commissioner Birrane, the other Workstream Five co-chair for 2022, she met with the Workstream's 2021 co-chairs, Commissioner Ricardo Lara (CA) and former Commissioner Jessica K. Altman (PA), to discuss the Workstream's 2021 work and potential 2022 work. She said that following this meeting, the Workstream met in a regulator-to-regulator session to discuss its focus and work plan for 2022.

Commissioner Arnold said the Workstream discussed and agreed its focus should center on: 1) identifying demographic-based barriers to the acquisition and use of health insurance and creating strategies for mitigating or removing such barriers; and 2) understanding the role health insurance can play in addressing inequities in health outcomes and social determinates of health. She said the Workstream also agreed on a framework for executing on those objectives, including the specific topics it will cover this year.

With respect to the first objective, Commissioner Arnold said the Workstream decided that the topics it will focus on this year will be: 1) benefit design, which includes examining provider network design and benefit structures; and 2) consumer empowerment and engagement. She said the first topic is foundational because it is critically important that products are inclusive in design and that carriers consider the actual health needs of certain communities. She provided examples of what the Workstream would be examining: "Are prescription drug formularies designed to assure that medications that treat conditions more prevalent among Black or Brown people are offered with no or minimal co-pays?" and "What do preventative services look like, and how are wellness programs designed and promoted?" She said the use of scales and Fitbits in wellness programs may be a great incentive for some people to focus on their health, but nutritional support and transportation may be far

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more important for people whose health is affected by their environment. Similarly, the Workstream will be considering, with respect to benefit design, what the network looks like, not only in the traditional sense of the availability of appointments, but also looking at the impact of the kinds of providers and the cultural competency of providers on the willingness and ability of people to use services.

Commissioner Arnold said that with respect to the second topic, consumer engagement and empowerment, the Workstream will be looking at successful strategies for enrollments and for facilitating consumer understanding of how to access care through insurance and how to navigate claim issues.

Commissioner Arnold said the Workstream also discussed what its end work product should be. She said the Workstream is considering developing a guide for state insurance regulators that compiles information about barriers and presents potential tools and strategies for state insurance regulators to use to address them. She said the Workstream is mapping out a schedule for completing its work before the end of the year. The Workstream hopes to meet at least monthly to hear from various stakeholders—such as consumer groups, academics, and industry—on the topics it has identified as its focus for this year: benefit design and consumer empowerment.

Commissioner Arnold said that with respect to the second objective, the Workstream also discussed holding listening sessions, potentially in conjunction with Zone member meetings, with community-based individuals and organizations who work with racially disadvantaged and historically underserved and underrepresented populations to facilitate a ground zero understanding of the determinants of health and how insurance can affect that.

4. Heard an Update from the CCIIO on NSA Implementation

Jeff Wu (federal Center for Consumer Information and Insurance Oversight—CCIIO) provided an update on the steps the federal Centers for Medicare & Medicaid Services (CMS) has taken to date in implementing the federal No Surprises Act (NSA) since its launch Jan. 1.

Mr. Wu said the CMS created a No Surprises Help Desk, which consumers and providers can call to ask questions or file complaints. Consumers and providers can also file a complaint online. He said the CMS created a consumer web form and a provider web form to assist in submitting online complaints. He said the CMS also has created a document providing helpful tips on how to complete a complaint form. The CMS also has developed several sets of frequently asked questions (FAQ)—provider FAQ, good faith estimates FAQ, and independent dispute resolution (IDR) updates FAQ.

Mr. Wu discussed the CMS' NSA outreach and education efforts targeted at consumers and providers. He also said the CMS also has specifically conducted lots of outreach to consumers and providers related to the good faith estimates for uninsured or self-pay individuals provision. He said the CMS is leveraging its contacts with organizations such as the Kaiser Family Foundation (KFF), the federal Consumer Financial Protection Bureau (CFPB), and the Commonwealth Fund to assist it in these education efforts.

Mr. Wu discussed NSA enforcement and its interaction with state law. He reiterated that the states are the primary enforcers of the NSA. Under the statute, the CMS will only enforce a provision with respect to the applicable regulated parties if the CMS determines that a state is not substantially enforcing a provision. He said that the CCIIO recognizes that the states are in different positions as far as NSA enforcement is concerned and that it is committed to working with the states to address any implementation and enforcement issues. He explained that the CCIIO has held meetings with the states to discuss NSA enforcement and recently published a series of Consolidated Appropriations Act of 2021 (CAA) enforcement letters that outline the CMS' understanding of the federal Public Health Service Act (PHSA) provisions, as extended or added by the CAA, that each state is enforcing directly or through a collaborative enforcement agreement and the provisions the CMS will enforce. These letters

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also communicate whether the federal IDR process and federal patient-provider dispute resolution process apply in each state and in what circumstances.

Commissioner Mulready asked about the status of, and timeline for resolving, the *Texas Medical Association (TMA) v. United States Department of Health and Human Services (HHS)* case, which challenged the Biden administration's Sept. 30, 2021, interim final rule that directed arbiters under the IDR process to presume that the median in-network rate is the appropriate out-of-network rate and limit when and how other statutory factors come into play. The U.S. District Court for the Eastern District of Texas, Tyler Division, ruled Feb. 23 that the NSA unambiguously establishes the framework for deciding payment disputes and concluded that the interim final rule conflicted with the statutory text and must be set aside under the federal Administrative Procedure Act (APA). The court also ruled that the HHS improperly bypassed the APA's notice and comment requirements, and thus the interim final rule must be set aside for this additional reason. Mr. Wu said the HHS has no idea when there could be a final resolution of the case, but meanwhile, the CMS is moving forward with implementing the NSA provisions, including the IDR process provisions.

Commissioner Mulready asked about the nature of the calls the CMS has received through the No Surprises Help Desk. Mr. Wu said the calls received have changed over time. He said that initially, the calls involved general questions about the NSA. He said that currently the Help Desk is receiving more specific questions about the NSA's provisions and complaints, which are mostly complaints about billing and related issues.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned into regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Statement on Open Meetings.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/HEALTH INS and MANAGED CARE (B) COMMITTEE/04-Bmin

Agenda Item #2

**Consider Adoption of its Subgroup, Working Group and Task Force Reports
—*Commissioner Glen Mulready (OK)***

Meeting Summary

CONSUMER INFORMATION (B) SUBGROUP

Summary Report

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee has not met as a group since March 22, 2022. However, the Subgroup chair and a few Subgroup members:

1. In June, decided to conduct focus groups with a small number of states to gather information on the consumer engagement strategies they have used and which they find most effective. The first focus group was completed June 13. The second focus group was completed July 8.
2. Are working to prepare summaries of the focus groups and expects to identify themes from the focus groups and share them with the full Subgroup and interested parties within the next few months.



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HEALTH INNOVATIONS (B) WORKING GROUP

Wednesday, August 10, 2022

9:00 – 10:30 a.m.

Meeting Summary Report

The Health Innovations (B) Working Group met Aug. 10, 2022. During this meeting, the Working Group:

1. Adopted its Spring National Meeting minutes, which included the following action:
 - A. Heard presentations on coverage changes expected due to the end of the COVID-19 public health emergency (PHE).
 - B. Heard an update on research into health disparities.
2. Heard a presentation from Colorado on the Colorado Option state innovation waiver.
3. Heard presentations from Oregon health plans (e.g., Kaiser Permanente, Moda Health, and PacificSource) on their programs to address health equity and improve access.
4. Heard a presentation from the federal Centers for Medicare & Medicaid Services (CMS) on its programs to address health equity and improve access.

Virtual Meeting

(in lieu of meeting at the 2022 Summer National Meeting)

HEALTH ACTUARIAL (B) TASK FORCE

August 1, 2022

10:00 a.m. – 12:00 p.m. ET / 9:00 – 11:00 a.m. CT / 8:00 – 10:00 a.m. MT / 7:00 – 9:00 a.m. PT

Meeting Summary Report

The Health Actuarial (B) Task Force met Aug. 1, 2022. During this meeting, the Task Force:

1. Adopted its June 30 and May 16 minutes, which included the following action:
 - A. Heard a Society of Actuaries (SOA) Research Institute 2022 Individual Life Waiver of Premium (ILWOP) Experience Study presentation.
 - B. Heard an update on the American Academy of Actuaries (Academy) and SOA Research Institute Group Life Waiver of Premium Valuation Table (GLWPVT) Work Group efforts towards developing valuation tables to replace the 2005 Group Term Life Waiver Mortality and Recovery Tables in *Actuarial Guideline XLIV—Group Term Life Waiver of Premium Disabled Life Reserves (AG 44)*.
2. Adopted the report of the Long-Term Care Actuarial (B) Working Group, including its June 24 minutes. During this meeting, the Working Group took the following action:
 - A. Discussed the Academy and SOA Research Institute’s final Long-Term Care Insurance Mortality and Lapse Study.
3. Heard an update on the SOA Research Institute/Life Insurance Marketing and Research Association (LIMRA) Experience Studies Partnership.
4. Heard an update from the Academy Health Practice Council.
5. Heard an Academy update on professionalism.
6. Discussed an Academy and SOA Research Institute GLWPVT Work Group Valuation Tables proposal that is exposed for a public comment period ending Aug. 11.

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REGULATORY FRAMEWORK (B) TASK FORCE

Wednesday, August 10, 2022

11:30 a.m. – 1:00 p.m.

Meeting Summary Report

The Regulatory Framework (B) Task Force met Aug. 10, 2022. During this meeting, the Task Force:

1. Adopted its Spring National Meeting minutes.
2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its July 11, June 13, June 6, May 9, and April 18 minutes. During these meetings, the Subgroup took the following action:
 - A. Discussed the comments received on Section 8B—Hospital Indemnity or Other Fixed Indemnity Coverage of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) and its drafting note to clarify what is and is not “fixed indemnity coverage.”
 - B. Developed a chair draft of proposed revisions to Section 8B based on the comments received and discussion.
 - C. Discussed the chair draft of proposed revisions to Section 8B and agreed on preliminary revisions to Section 8B for inclusion in the draft of revisions to Model #171.
 - D. Discussed the comments received on the NAIC consumer representatives’ initial comments on Section 8C—Disability Income Protection Coverage and agreed on preliminary revisions to Section 8C for inclusion in the draft of revisions to Model #171.
3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group, which met Aug. 10 and took the following action:
 - A. Adopted its May 24 minutes, which included the following action:
 - i. Adopted a summary of the *Rutledge v. Pharmaceutical Care Management Association (PCMA)* case for inclusion in the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook).
 - B. Heard an update from the U.S. Department of Labor (DOL).
 - C. Discussed updating the NAIC Chart on Multiple Employer Welfare Arrangement (MEWA)/Multiple Employer Trust (MET) and Association Plans.
 - D. Discussed whether the ERISA Handbook needs to be reviewed for outdated information.
 - E. Adjourned into regulator-to-regulator session, pursuant to paragraph 2 (pending investigations), paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group. The Working Group will meet Aug. 11. During this meeting, the Working Group plans to take the following action:
 - A. Adopt its Spring National Meeting minutes.
 - B. Hear an expert presentation on parity issues.
 - C. Hear presentations from providers on parity issues.
 - D. Meet in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which met Aug. 9 and took the following action:
 - A. Adopted its July 29, June 15, April 25, and Spring National Meeting minutes, which included the following action:
 - i. Heard presentations from various stakeholders on issues from their perspective on the Subgroup's 2022 charge to develop a white paper to: 1) analyze and assess the role pharmacy benefit managers (PBMs), pharmacy services administrative organizations (PSAOs), and other supply chain entities play in the provision of prescription drug benefits; 2) identify, examine, and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements; rebating; and spread pricing, including the implications of the *Rutledge vs. PCMA* decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.
 - B. Heard a presentation from the Pharmaceutical Care Management Association (PCMA).
 - C. Heard a presentation from the Pharmaceutical Research and Manufacturers of America (PhRMA).
 - D. Heard a presentation from the Oregon Primary Care Association (OPCA).

6. Heard an update from the Center on Health Insurance Reforms (CHIR) on its work on various projects of interest to the Task Force. The CHIR is researching public option plans and recently published an in-depth analysis of Colorado's federal Affordable Care Act (ACA) Section 1332 waiver for a public option-style plan. The CHIR recently published a brief on the efforts California's state-based insurance marketplace is trying to reduce the number of uninsured and underinsured. The CHIR also recently published a brief on actions state insurance regulators can take to prepare for the post-public health emergency (PHE) Medicaid unwinding. Another issue the CHIR is analyzing is abortion and contraceptive coverage after the recent U.S. Supreme Court ruling in *Dobbs v. Jackson Women's Health Organization*. The CHIR is continuing to monitor and analyze state action related to health equity. It recently published a report entitled, "Improving Race and Ethnicity Data Collection: A First Step to Furthering Health Equity Through SBMs." The CHIR is also continuing its work related to the implementation of the federal No Surprises Act (NSA). The CHIR plans to release a study on state laws related to surprise billing enacted since the enactment of the NSA. The CHIR recently completed a study comparing the federal and state network adequacy standards governing Medicaid and ACA marketplace plans in six states. The CHIR's future work includes: 1) publishing an issue brief on state efforts to enforce the MHPAEA; and 2) a 50-state research project on medical debt consumer protections.

7. Heard a presentation from the Association for Accessible Medicines (AAM) on the usage of the term “interchangeable biosimilar product” in the *Health Carrier Prescription Drug Benefit Management Model Act (#22)* and its effect on prescription drug substitutions. The Task Force decided to form an ad hoc group consisting of a few Task Force members to study this issue and report back to the Task Force at or prior to the Fall National Meeting regarding next steps.
8. Heard an update on the implementation of the federal network adequacy standards for qualified health plans (QHPs) in the federally facilitated health insurance exchanges.

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SENIOR ISSUES (B) TASK FORCE

Wednesday, August 10, 2022

2:30 – 3:30 p.m.

Meeting Summary Report

The Senior Issues (B) Task Force met Aug. 10, 2022. During this meeting, the Task Force:

1. Adopted its June 7, May 11, and Spring National Meeting minutes, which included the following action:
 - A. Adopted a letter asking the federal Centers for Medicare & Medicaid Services (CMS) to: 1) ensure there will be coordination between the CMS and the U.S. Social Security Administration (SSA) should the proposed rule to simplify Medicare enrollment and expand access be made final and implemented; and 2) work with state insurance regulators to minimize any possible gaps in coverage for beneficiaries.
 - B. Discussed the CMS's Proposed Rule on Medicare Enrollment.
2. Heard a discussion about Medicare Part D beneficiaries being crosswalked from one Medicare Prescription Drug Plan (PDP) to another. The Task Force agreed to reach out to the CMS.
3. Heard a discussion on a conflict between Medicare and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) rules that has led to some confusion about which system, which set of rules governs eligibility for coverage, and how the responsibility for payment of health care benefits for eligible individuals is determined. The Task Force agreed to hold a meeting solely on this issue with invited stakeholders.
4. Heard a discussion on the status and future of the Long-Term Care Insurance Model Update (B) Subgroup, and the Task Force agreed to disband the Subgroup.
5. The chair informed the Task Force that she received a response the previous night from the CMS to the Task Force regarding a letter sent on March 17 regarding durable medical equipment (DME) suppliers, and she informed the Task Force that the CMS response has been posted on the Task Force web page and sent to Task Force members, interested state insurance regulators, and interested parties.

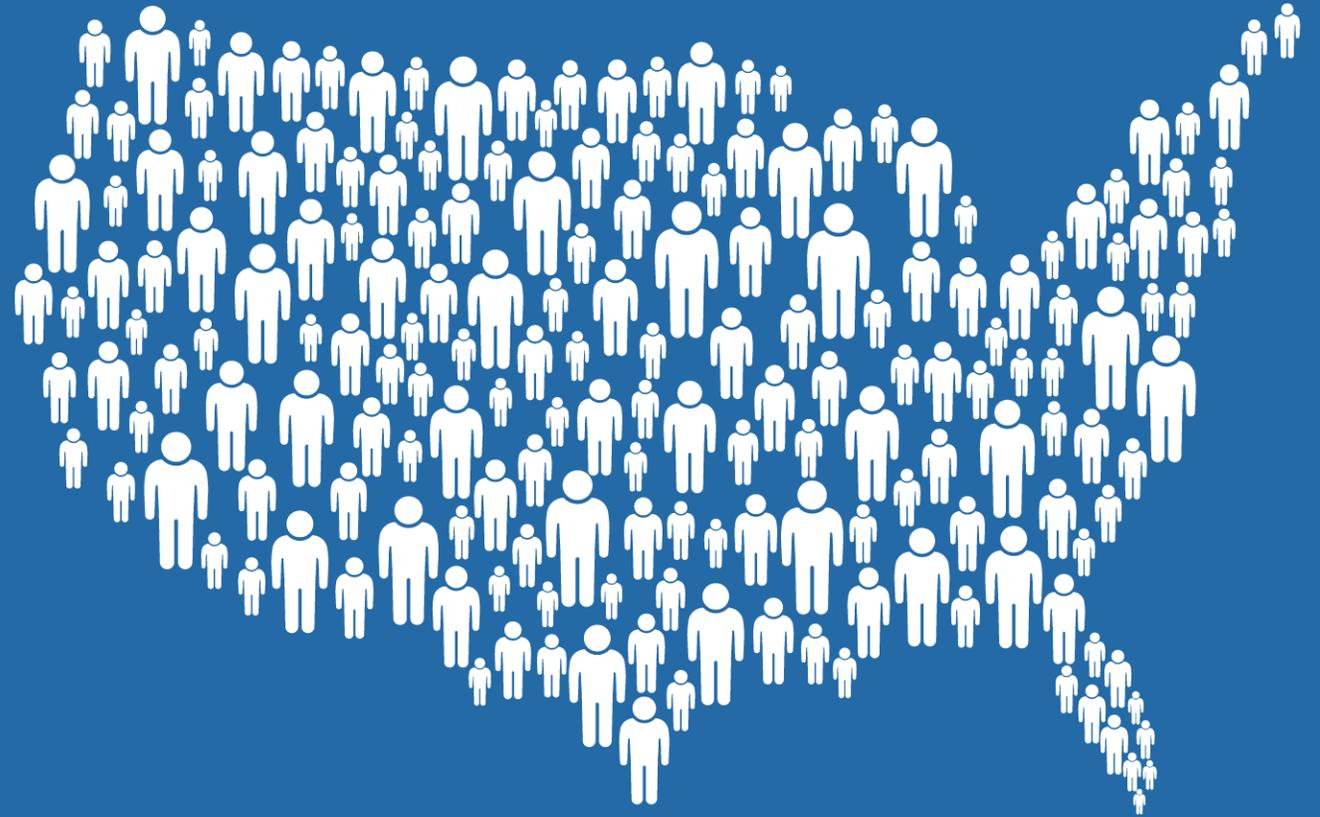
Agenda Item #3

Hear a Discussion on Efforts to Create State-Based Health Insurance Exchanges

—*J.P. Wieske (Horizon Government Affairs), Randy Pate (StatesWork), and Heather Korbulic (GetInsured)*

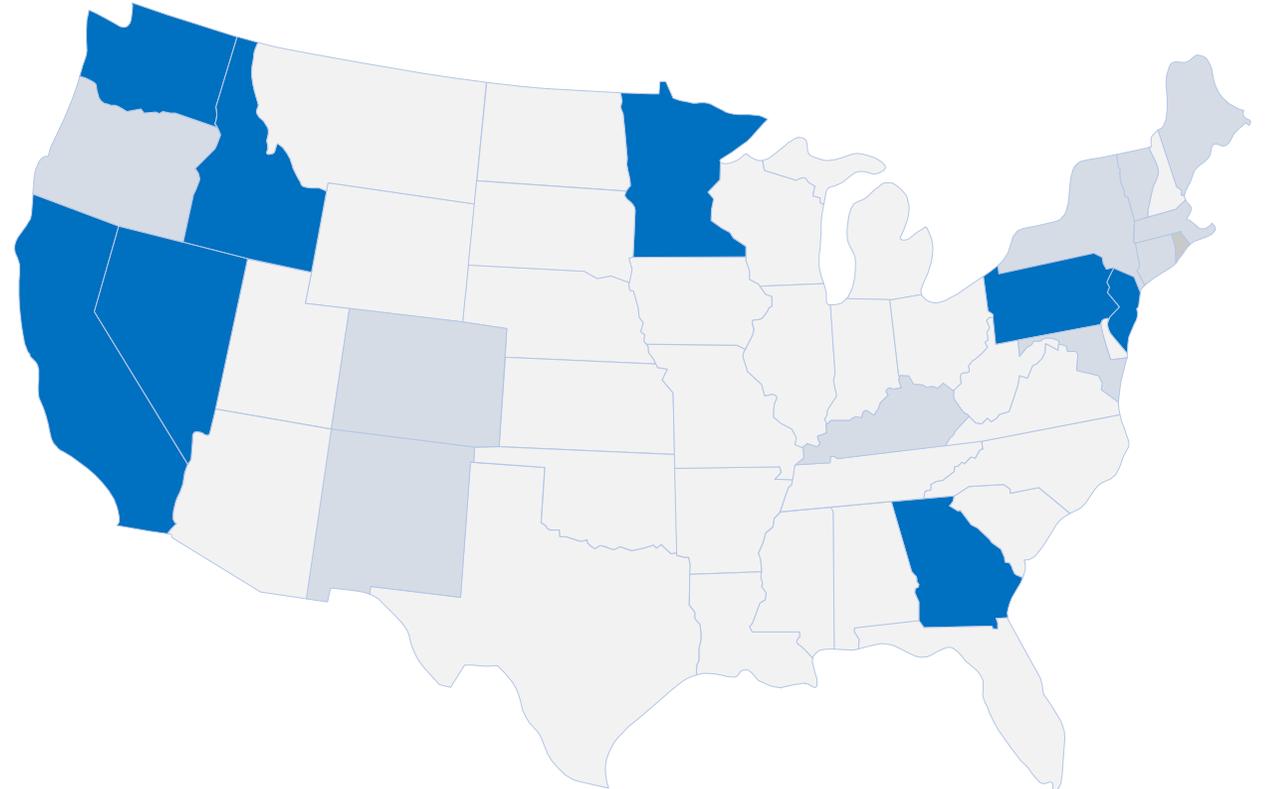
NAIC Discussion on State-Based Exchanges

August 11, 2022



What is a state-based exchange?

A state-based health insurance exchange is an **insurance marketplace** where the state provides the **technological infrastructure, the website, and the customer support** for individuals to access financial assistance to purchase state-based plans.



State-Based Exchange Operation Models

State-Based Exchange	Organization	Eligibility System	Plan Mgmt, Carrier EDI & Enrollment	Call Center Operations
Covered California (CCA)	CCA Exchange operations; IT - CalHEERS	Common system, shared with Medicaid	Exchange-owned, external vendor managed	Exchange-owned
Minnesota (MNSure)	MNSure Exchange operations; IT - MN.IT	Common system, shared with Medicaid	Exchange-owned, external vendor managed	Exchange-owned, supplemented by external vendor
Your Health Idaho (YHI)	Exchange and IT operations owned by YHI (internal)	Common system, shared with Medicaid	Exchange-owned, external vendor managed	Exchange-owned and operated
Silver State Health Insurance Exchange (SSHIX- Nevada)	Exchange and IT operations owned by SSHIX(internal)	Exchange-owned MAGI eligibility	Exchange-owned, external vendor managed	External vendor
Pennsylvania Health Insurance Exchange Authority (PHIEA)	Exchange and IT operations owner internally	Exchange-owned MAGI eligibility	Exchange-owned, external vendor managed	External vendor

Why should states establish a state-based exchange?

The move from HealthCare.gov to a state-based exchange is risk-free now that end-to-end (call center, technology, and operations) solutions are readily available from private vendors with a proven track record. The exchange operates as a public-private partnership or quasi-government entity.

Healthcare.gov is built to support many states with an inflexible infrastructure that will not easily support policy flexibility. High-level benefits of building an SBE include:

- Cost savings, which can be repurposed for reinsurance
- Independence from Federal Government - Local control, transparency
- Lower premium growth rates, ability to innovate with state policy
- Better collaboration with carriers, easier reconciliation
- Better control and access to the state data for planning purposes
- Better consumer experience
- Increased enrollments
- Better churn management between Medicaid and commercial insurers
- 150-300 local call-center jobs

Model Legislation

- Purpose and Intent
- General Provisions
- Creation; purpose
- Powers and duties of Exchange
- Establishment of board



StatesWork



**Company
Profile**

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WHY STATESWORK?

Despite years of continued expansion of the federal role, states remain the primary regulators of the business of healthcare and health insurance in the United States. In an environment of historic shifts in health care policy, financing, and public health priorities—many of which are concentrated within the federal government—states today are struggling to keep pace. Healthcare leaders at all levels of state government have expressed concern that they are potentially missing important, far-reaching opportunities to maximize their state’s role in improving the health, safety, and wellbeing of their residents while safeguarding taxpayer funds.

StatesWork was established in 2021 in response to the growing demand from state healthcare leaders across the political spectrum wishing to re-assert the role of states in overseeing and implementing healthcare solutions. States desire to better understand major health policy changes and initiatives emanating from the federal government and to take greater ownership in shaping and executing those changes at the state level. The message from state leaders is clear: states must play a critical part in leading next generation health policy and health system reform. But the requisite resources, expertise, and space for effective collaboration within and among states are scarce. For states to fulfill their traditional, constitutional roles in leading healthcare transformation, they must have the following:

1. More state control over implementation of key aspects of federal statutes and regulations;
2. More flexibility to pursue state-level policies and programs aimed at increasing access, competition, and choice of quality healthcare for their residents; and
3. Better access to new, lower-cost technology enabling healthcare transformation that best meets the needs of the state.

As described in Our Mission, StatesWork works across the political spectrum to support states’ rights and leadership in the healthcare arena.

OUR MISSION

StatesWork's three-fold mission is to:

- 1) Support states in fulfilling their constitutional roles across the full range of issues affecting Americans' health, safety, welfare, and quality of life;
- 2) Provide a collaborative space and idea incubator for state leaders pursuing healthcare transformation aimed at increasing private sector competition, reducing costs, and promoting access to quality healthcare; and
- 3) Assist states in efforts to improve effective use of taxpayer resources devoted to programs of shared responsibility between the state and federal governments.

OUR EXPERTS

Randy Pate is the former Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight (CCIIO) at the Center for Medicare & Medicaid Services (CMS). In February 2021, Pate launched Randolph Pate Advisors LLC, a management and strategic consulting firm providing leadership in the healthcare sector to health insurers, healthcare providers, technology companies, and state governments.

Pate brings over two decades of public and private sector health care policy and regulatory experience to his new venture. In his most recent role at CMS as Director of CCIIO, Pate led the turnaround of the Health Insurance Exchanges within CMS and was instrumental in several major health policy initiatives. During Pate's tenure at CCIIO, premiums for benchmark plans on HealthCare.gov dropped for the first time, decreasing for three straight years. Competition on the Exchanges also increased, as the percentage of counties with one insurer offering coverage dropped from 52% in 2018 to only 9% in 2021. Pate also led the drafting of major regulations such as the 2017 Market Stabilization Rule, and played a key role in shaping federal policy on the HHS Risk Adjustment Program, Section 1332 State Innovation Waivers, Transparency in Coverage (Price Transparency), and Individual Coverage Health Reimbursement Arrangements (ICHRA). He also spearheaded the development of Enhanced Direct

Enrollment (EDE) at CMS, a private-sector technology pathway that enrolled over 1.3 million consumers into individual market coverage for 2021.

Earlier in his career, Pate served in a number of roles on Capitol Hill, including Public Health Counsel for the House Energy and Commerce Committee and later as Health Counsel for Rep. Kevin Brady (R-TX) during the debate over passage of the Affordable Care Act. Pate also worked at the Heritage Foundation and served as a Senior Advisor at the Department of Health and Human Services during the George W. Bush Administration. Pate helped to launch the MITRE Corporation's policy work with CMS and worked as Vice President of Public Policy for Health Care Service Corporation, the largest customer-owned health insurance company in the country.

Pate holds undergraduate and law degrees from The University of Alabama and a Master of Public Health from Johns Hopkins University.

Cheryl Smith Gardner is the founder of Gardner Strategies, a health policy and strategy business. Cheryl combines functional knowledge and experience in state health policy design with a notable background in strategic management and program administration. Her clients include state government agencies, technology firms, and policy shops.

Prior to founding Gardner Strategies, Cheryl served as the Chief Executive Officer at beWellnm (New Mexico's health insurance exchange), as the Executive Director of the Arkansas Health Insurance Marketplace (AHIM), as a Senior Practitioner at Deloitte Consulting, as a director in the Health

Insurance Exchange practice at Leavitt Partners, and in the Utah Governor's Office of Economic Development as the Director of Policy and Strategy of the Utah Health Exchange office.

Her leadership and expertise in the areas of state health policy, insurance exchanges, and health system reform often draws national attention as she has been cited in a number of respected publications including the Washington Post, Politico, The Wall Street Journal, USA Today, and the New York Times.

Cheryl is a highly sought-after public speaker and has participated multiple times as a presenter, panelist, and moderator at a number of national conferences including those sponsored by the National Conference of State Legislatures (NCSL), the Republican Governors Association (RGA), the National Conference of Insurance Legislators (NCOIL), and America's Health Insurance Plans (AHIP).

Cheryl holds an undergraduate degree in Political Science and a Master's Degree in Public Policy, both from Brigham Young University.

MEMBER STATES

Who Are Our Member States?

StatesWork is a nonpartisan, educational 501(c)(3) tax-exempt organization that works as a principle-based, mission-driven force in assisting states to improve and transform their healthcare systems. StatesWork member states work collaboratively with each other and with key policy, technical, and clinical experts, including private sector partners, who can identify, develop, and implement best-fit policy solutions that meet the unique needs of participating states.

What Do We Offer Member States?

StatesWork offers a wide range of services to health care leaders in members states, including:

- Issue education
- Technical assistance and advice from nationally recognized experts
- Quantitative and qualitative analysis of state and federal policy, including forecasting the impact of policy changes on state residents
- Collaboration opportunities with thought leaders from other member states

Through the support of our sponsors, StatesWork is able to offer these services **at no cost to states**.

What Do We Ask of Member States?

While StatesWork charges member states no dues or fees of any kind, we do ask, as a condition of membership, for each state's meaningful participation within the collaborative. This includes:

1. Assigning a primary point of contact for regular communication regarding upcoming meetings, updates, announcements, invitations, etc.
2. Meeting with StatesWork team leads for an initial meeting to develop a brief profile/overview of state health reform/health system reform history as well as a general overview of the state's health coverage landscape, including prior or current efforts to establish a State-Based Health Insurance Exchange
3. Participating in bi-monthly, one-on-one calls with StatesWork team leads for strategy sessions (sessions anticipated to last 30 minutes)
4. Participate in bi-monthly (EOM) collaborative sessions with other StatesWork members
5. Participate in annual meetings
6. Review, discuss, and provide input on public comment letters, position statements, and other communications regarding emerging federal and state policy including draft regulations, legislation, white papers, etc.
7. Provide input and direction to StatesWork team leads in developing toolkits, model language, and other materials

How Can My Organization Participate in StatesWork?

Any state entity that shares an interest in promoting state innovation and leadership in healthcare is welcome to participate in StatesWork. This may include:

- Legislators and legislative staff
- State insurance commissioners and staff
- Governors' chiefs of staff and/or policy staff
- State Medicaid officials

For more information, email us at states@stateswork.org.

Contact Us



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Agenda Item #4

Hear a Discussion on Medicaid Redeterminations Following the End of the COVID-19 Public Health Emergency (PHE)—*Miranda Motter (America's Health Insurance Plans—AHIP)*

NAIC Summer 2022 National Meeting

Health Insurance and Managed Care (B) Committee

The End of the Public Health Emergency: Medicaid Redeterminations

Thursday, August 11, 2022

Miranda C. Motter
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Today's Presentation Outline:

- **A Quick Review:** COVID-19 Authorities, Emergency Declarations, and the Public Health Emergency
- **Examples:** The Key Requirements and Flexibilities Tied to the Public Health Emergency
- **A Deeper Dive:** Medicaid Redeterminations

Authorities at Play in the COVID-19 Pandemic

- **Public Health Service Act (PHE)**
 - Declared on January 31, 2020
 - ***Last renewed effective July 15, 2022; extended through October 13, 2022***
 - Triggers a variety of federal emergency powers
 - Remains in effect for 90 days unless the HHS secretary renews/terminates
 - Although not required, HHS has indicated it would provide states with 60 days' notice of possible termination
- **National Emergencies Act (NEA)**
 - Declared on March 13, 2020
 - Last renewed on February 18, 2022, with “beyond March 1, 2022” with no specific end date
 - Activates emergency powers contained in other federal statutes
 - Allowed temporary waiver or modification of certain Medicare, Medicaid, and CHIP Program requirements and of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule
- **Stafford Act**
 - Declared on March 13, 2020
 - Enables FEMA to help deliver virus response funds to the state and local governments

Authorities at Play in the COVID-19 Pandemic

- **Public Readiness and Emergency Preparedness (PREP) Act**

- Invoked on March 10, 2022, with 10 additional amendments as well as corrections subsequently issued
- End date of October 1, 2024
- Authorizes HHS to limit legal liability for losses relating to the administration for medical countermeasures such as diagnosis, treatments, and vaccines

- **Emergency Use Authorization (EUA)**

- Declared on March 27, 2020
- Generally, continues until terminated - Notice of termination will be published in the Federal Register
- Allows FDA to authorize, when certain conditions are met, the emergency use of unapproved medical products or unapproved uses of approved medical products to be used in an emergency to diagnose, treat, or prevent serious or life-threatening disease or conditions

Authorities at Play in the COVID-19 Pandemic

- **Federal Legislative Changes & the PHE**
 - Families First Coronavirus Response Act (Families First Act), Coronavirus Aid, Relief, and Economic Security Act (CARES Act), American Rescue Plan Act of 2021
- **Administrative Changes that Waived or Modified Wide Range of Requirements under Medicare, Medicaid, CHIP, and HIPAA**
- **Administrative Changes that Provided Additional Flexibilities in the Commercial Health Insurance Markets**
- **State Emergency Declarations**

Pause...State Emergency Declarations

- *State actions varied significantly, particularly with respect to the cited authority*
 - Federal PHE
 - State PHE
 - Both – Federal and state PHEs
 - General COVID-19 public health challenge
 - Silent
- **Full review of individual state actions and the authority cited is necessary** to fully understand how a termination and/or non-renewal of the PHE or national emergency issued in connection with the COVID-19 pandemic will impact the various state emergency orders, bulletins, guidance, mandates, and other actions

Key Federal Legislative Provisions Tied to the PHE

- Coverage for COVID-19 testing and testing-related services without cost sharing in commercial plans and Medicare
- Coverage, without cost sharing, for nearly all Medicaid populations for the COVID-19 vaccine and administration costs (with 100% FMAP)
- Coverage for testing and treatment, including treatment of a condition that may seriously complicate COVID-19 treatment for nearly all Medicaid populations
- ***An increase of 6.2 percentage points in a state's FMAP provided certain maintenance of effort requirements are met, including the Medicaid enrollment for certain beneficiaries is maintained through the end of the month in which the PHE ends***

The End of the PHE – Important Dates

- The end date of the PHE was most recently extended to October 13, 2022
 - Once PHE ends, most requirements/flexibilities will likely end automatically
 - Re: *the increase of 6.2 percentage points in a state's FMAP*, if the PHE is not once again extended:
 - the continuous enrollment requirement will end October 31, 2022
 - the enhanced FMAP will conclude at the end of the quarter (December 31, 2022)
- The Administration has said that it will give states a 60-day notice before the PHE expires
- If the PHE is not extended, the current 90-day period will end **October 13**; 60-day notice would need to be given by **August 14**
- If the PHE is extended 90 days starting on October 13, 2022, the next 90-day period would end January 10, 2023; 60-day notice would need to be given November 12, 2022.

Medicaid Redeterminations - Overview

- **Pre PHE:** Before the public health emergency (PHE), states were required to annually verify Medicaid eligibility for most members.
- **What Changed:** As a condition of receiving the enhanced Federal Medical Assistance Percentage (FMAP) under the Families First Coronavirus Response Act, states are required to maintain enrollment for their Medicaid enrollees through the end of the PHE.
 - Very narrow exceptions, including if an individual moves out of state
 - No change to Medicaid coverage throughout the duration of the PHE
- **Post-PHE:** When the PHE ends, states must resume the Medicaid redetermination processes.
- **Why is this significant?**
 - The volume within the condensed time period is unprecedented
 - States will have 12 months to initiate and 14 months to complete a full renewal of all individuals enrolled in Medicaid, CHIP, and the Basic Health Program
 - States, counties, and beneficiaries have not done this in more than 2 years.

Medicaid Redeterminations – The Numbers

- Slightly more than 1 in 4 Americans rely on Medicaid for their coverage and care, making it an essential safety net for 87 million people – including women, children and veterans.
 - Total Medicaid/CHIP enrollment grew to 87.4 million, an increase of 16.1 million from enrollment in February 2020. **KFF Analysis of Recent National Trends in Medicaid and CHIP Enrollment**
 - Enrollment increases data by state
 - Enrollment data by state
- Increases in enrollment may be attributed to economic changes, policy changes, and the temporary continuous enrollment requirement under FFCRA.
- Between 5.3 million and 14.2 million Medicaid enrollees could be disenrolled in the months following the end of the continuous enrollment requirement.
 - **KFF Analysts Find:**
 - February 2022 – State officials projected that median enrollment would decline by 5% next year following the end of the PHE. This translates into decline of 5.3 million enrollees
 - January 2022 – States expected on average about 13% of enrollees to be disenrolled following the end of the MOE requirements (estimates ranged from 8% to over 30%). This translates into a decline of 14.2 million enrollees.
- State Planning: **KFF 50 State Survey**

Medicaid Redeterminations – The Process (in general...)

- Federal requirements and state requirements
- State processes to verify eligibility will differ (income, waiver, disability status)
- State Medicaid Agency may use the information they have through other sources to decide if individual still qualifies for Medicaid or CHIP coverage
- If more information is needed, the state will contact the individual requesting additional information
- **State Medicaid Enrollment Information**

Medicaid Redeterminations - The Stakes Are High

- Eligible patients will be deemed ineligible because verification was unsuccessful
- Ineligible patients will become uninsured and may not be able to “find” another source of coverage
- Providers who have been treating once-eligible patients now may not have a reimbursement source
- Individuals will lose access to health insurance coverage, thus increasing states’ uninsured rates
- Affordability of other types of coverage may be impacted due to uninsured cost shifting

10 Fundamental Actions for States to Prepare for Unwinding

1. **Create a Comprehensive State Unwinding Operational Plan** describing how the state will complete outstanding work, ensure continuity of coverage for eligible individuals, and facilitate transitions for individuals who become eligible for other forms of coverage.
2. **Coordinate with partners, including state, Tribal, and government partners.** States can:
 - engage and leverage program information from sister state agencies including human services, information technology, public health, child welfare, justice, and education agencies.
 - consult with Tribes to support strategic planning and partnerships with Tribes and Indian health care providers (IHCP).
 - Leverage government agencies, such as state or local health departments, Indian health care providers, and social services agencies that contact beneficiaries can amplify messaging around renewing coverage.
 - Coordinate with the federally facilitated marketplace (FFM) or engage their state-based marketplace (SBM) to facilitate coverage transitions. States that operate SBMs may have additional opportunities to share resources for outreach and messaging to promote continuity of coverage. For example, Medicaid agencies can share information about individuals losing coverage due to a procedural reason with SBMs (including via account transfers) as a way to sustain coverage.
3. **Implement and strengthen automated processes**, including *ex parte* renewals, increasing methods for no touch case processing (acceptance of applications and renewals online and via phone), and automated beneficiary communications.

<https://www.medicaid.gov/resources-for-states/downloads/top-10-fundamental-actions-to-prepare-for-unwinding-and-resources-to-support-state-efforts.pdf>

10 Fundamental Actions for States to Prepare for Unwinding

4. **Work early and closely with eligibility system vendors** to identify changes, start planning, and perform robust end-to-end testing.
5. **Establish a renewal redistribution plan** distributed across a sufficient period of time and in a manner that mitigates churn, accounts for workforce and system capacity limitations, and establishes a sustainable renewal structure for future years.
6. **Engage community partners, health plans, and the provider community** to develop and implement beneficiary outreach and communication strategies for unwinding.
7. **Obtain updated contact information** by using multiple strategies to mitigate coverage losses at renewals. Strategies could include managing returned mail, partnering with plans, using multiple modalities to reach individuals (mail, email, text) and maintaining beneficiary contact.
8. **Launch effective communication strategies**, including consumer outreach and revised notices so beneficiaries know what to expect and what is needed to maintain coverage during unwinding.
9. **Assess eligibility, enrollment and fair hearings workforce capacity and ensure adequate staffing and sufficient training.**
10. **Develop a robust monitoring strategy, including ensuring infrastructure for timely required reporting to CMS.**

<https://www.medicaid.gov/resources-for-states/downloads/top-10-fundamental-actions-to-prepare-for-unwinding-and-resources-to-support-state-efforts.pdf>

Questions?

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Agenda Item #5

Hear an Update from the Federal Centers for Medicare & Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight (CCIIO)—*Dr. Ellen Montz (CCIIO)*

Agenda Item #6

Hear an Update from the Federal Legislative and Regulatory Issues and on Federal No Surprises Act (NSA) Implementation—*Brian R. Webb (NAIC)*

Agenda Item #7

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

Agenda Item #8

Receive an Update on the Special (EX) Committee on Race and Insurance Workstream Five's Work—*Commissioner Kathleen A. Birrane (MD) and Commissioner Grace Arnold (MN)*

Agenda Item #9

Discuss Any Other Matters Brought Before the Committee
—*Commissioner Glen Mulready (OK)*