HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee March 23, 2023, Minutes
  Consumer Information (B) Subgroup March 2, 2023, Minutes (Attachment One)
  Consumer Information (B) Subgroup Jan. 31, 2023, Minutes (Attachment One-A)
Health Innovations (B) Working Group March 22, 2023, Minutes (Attachment Two)
The Health Insurance and Managed Care (B) Committee met in Louisville, KY, March 23, 2023. The following Committee members participated: Anita G. Fox (MI); Jon Pike, Co-Vice Chair (UT); Mike Kreidler, Co-Vice Chair (WA); John F. King (GA); Dean L. Cameron (ID); Kathleen A. Birrane (MD); Grace Arnold (MN); Chris Nicolopoulos (NH); Glen Mulready (OK); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Alexander S. Adams Vega (PR); and Allan L. McVey represented by Ellen Potter (WV). Also participating were: Lori K. Wing-Heier (AK); Michael Conway (CO); Paul Lombardo (CT); Andria Seip (IA); LeAnn Crow (KS); Cynthia Amann (MO); and Troy Downing (MT).

1. **Discussed its 2023 Activities**

Director Fox outlined the Committee’s activities and focus for 2023. She said that in accordance with its charges, the Committee will continue to monitor the activities of its task forces and be responsive to any health insurance-related federal initiatives. She also noted that the Committee’s charges include coordinating with the Market Regulation and Consumer Affairs (D) Committee, chaired by the Health Insurance and Managed Care (B) Committee’s co-vice chair, Commissioner Pike. She said such coordination provides an opportunity for the Committee to work, as necessary, with the Market Regulation and Consumer Affairs (D) Committee on health benefit plan and producer enforcement issues and to monitor market conduct trends on non-federal Affordable Care Act (ACA) plans.

Director Fox said she anticipates the Committee working closely with the Special (EX) Committee on Race and Insurance’s Health Workstream as that Workstream continues its work this year on health equity issues involving underserved and traditionally underrepresented populations. She noted that Committee members Commissioner Birrane and Commissioner Arnold are co-chairs of the Health Workstream. As such, this is a great opportunity for the Committee to collaborate and work with the Health Workstream as it completes its work this year.

Director Fox explained that she would like the Committee to work together this year to focus on several topics raised by Committee members that have been ranked in order of importance based on a recent survey of the Committee membership. Those topics, in order of importance, are: 1) network adequacy; 2) Medicaid unwinding due to the pending end of the COVID-19 public health emergency (PHE); 3) state-based marketplaces (SBMs); 4) pharmacy benefit manager (PBM) regulation; and 5) essential health benefits (EHBs).

Director Fox said that prior to the Spring National Meeting, the Committee met with the NAIC consumer representatives focused on health. She said this meeting provided an opportunity for the Committee and the NAIC consumer representatives to discuss priorities and focus for 2023. She said she plans to continue such outreach to enable the Committee to hear a consumer point of view, which can often be difficult to obtain without such meetings. Director Fox noted that one result of this interaction was the invitation to the Kaiser Family Foundation (KFF) to discuss one of its recently published issue briefs on claims denials and appeals for ACA marketplace plans in 2021 during today’s Committee meeting.

Director Fox said that to ensure Committee members remain current on Committee meetings and other activities, she asked each Committee member to designate staff to act as a point of contact. She said she plans to use this group to preview Committee meeting agendas and other items. This group met prior to the Spring National Meeting and will continue to meet on an as-needed basis throughout the year. Lastly, Director Fox said she is instituting interim regulator-to-regulator meetings to allow Committee members and interested state insurance...
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regulators to have more in-depth discussions about topics of interest particularly related to presentations the Committee hears during its open meetings. She said the first of these meetings is March 24. During this meeting, KFF representatives will be available to listen and answer questions on claim denials and appeals from an individual state perspective. The Committee will also discuss in more depth its focus for the year.

Director Fox also discussed a meeting with the Center for Insurance Policy and Research (CIPR). She said that during this meeting, she discussed what the CIPR can do to support the Committee’s work this year and learned what research the CIPR has already done or plans to do in the areas Committee members have identified as important topics to focus on this year.

2. Adopted 2022 Fall National Meeting Minutes

Commissioner King made a motion, seconded by Commissioner Mulready, to adopt the Committee’s Dec. 14, 2022, minutes (see NAIC Proceedings – Fall 2022, Health Insurance and Managed Care (B) Committee). The motion passed unanimously.

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

Commissioner Pike made a motion, seconded by Commissioner King, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its March 2 minutes (Attachment One); 2) the Health Innovations (B) Working Group, including its March 22 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.

4. Heard a Discussion on the KFF Issue Brief

Karen Pollitz (KFF) and Kaye Pestaina (KFF) discussed findings from the recently published KFF issue brief “Claims Denials and Appeals in ACA Marketplace Plans in 2021.” Pestaina explained that Section 2715A of the ACA requires ACA-compliant plans, including employer-sponsored plans and health insurance marketplace plans, to report certain ACA transparency in coverage data—including data on the number of claims denied—to health insurance marketplace plans, the Secretary of the U.S. Department of Health and Human Services (HHS), and state insurance commissioners, as applicable, and to also make it available to the public. She explained that although the data reporting requirement applies more broadly, to date, the HHS is only requiring federally facilitated marketplace (FFM) plans to submit this data. She said that since 2016, the federal Centers for Medicare & Medicaid Services (CMS) has specifically required only FFM plans to submit a subset of the claims transparency data—claim denials and appeals data—to it. In addition, the data is limited to in-network claims, which combine both medical and pharmaceutical claims. The CMS takes the data submitted and makes it available to the public in public use files (PUFs), which is what the KFF has been examining since 2016.

Pestaina discussed the potential uses of the data, such as using it as a tool for enforcement and oversight. She said that the KFF is not sure if the CMS is using the data for such a purpose. She said some states are using transparency data as part of their oversight responsibilities related to mental health parity plan compliance. Pestaina highlighted other state uses of other non-CMS transparency data, such as the data collected and reported by the NAIC through its Market Conduct Annual Statement (MCAS). She also said that some SBM plans, such as those in California and possibly Minnesota, are collecting claims denial and appeals data.

Pollitz discussed the KFF’s findings from its review of the data reported by insurers for the plan year 2021 and posted in the PUF. She said that across HealthCare.gov insurers, approximately 230 major medical issuers, with complete data, nearly 17% of in-network claims were denied in 2021. Insurer denials rates varied widely around this average, ranging from 2% to 49%. She explained that the CMS requires insurers to report reasons for claims
denials at the plan level. Of in-network claims, about 14% were denied because the claim was for an excluded service, 9% due to lack of preauthorization or referral, and only about 2% based on medical necessity. She highlighted that insurers classified most plan-reported denials (about 82%) as “all other reasons.” She explained that this “all other reasons” category could include claim denials due to billing or coding errors, duplicate claims, or coverage eligibility. Pollitz said that in analyzing the 2021 plan data, as in its previous analyses, the KFF found that consumers rarely appealed their denied claims. In 2021, HealthCare.gov consumers appealed less than two-tenths of 1% of denied in-network claims, which is about only 1 in 500 denied in-network claims. Insurers upheld most denials (around 59%) on appeal.

Director Fox asked Pollitz if she had any thoughts about what the states can do to increase consumer awareness of their rights to appeal claims denials. Pollitz said it is perplexing as to why consumers do not appeal claim denials. She said the KFF recently completed work on a survey targeted at obtaining information from consumers on their experiences with health insurance. One of the questions to be asked is whether consumers understand their appeal rights, how the process works, and/or who or what agency to contact for assistance. She said the KFF plans to release the results of the survey at some point later this year.

Pollitz said she believes there could be other factors beyond consumers being simply overwhelmed and confused about health insurance, such as the fact that because there is a claim, the consumer or a family member is sick and, as such, may not have the wherewithal to investigate next steps and navigate the appeals process. She said that, in addition, the explanation of benefits (EOB) document consumers receive includes information on appeal rights, but it is typically presented in insurance-related jargon and/or found on the last page of a multi-page EOB document. Pollitz said there are consumer assistance programs in many states that could possibly assist consumers in understanding their appeal rights, but the federal government no longer funds these programs. Those programs in existence since 2010, for the most part, still exist due to state funding. She said that state insurance regulators in states that have these programs might want to reach out to them and work together to figure out how to better educate consumers in this area.

Director Fox asked Pollitz if she knew if there ever has been any engagement or ways to engage the provider community to assist consumers in filing appeals of claim denials. Pollitz said she is not aware of any such engagement. However, she believes that the CMS may be engaging with providers as part of implementing the federal No Surprises Act (NSA). Pollitz said that potential insurer engagement with providers could be beneficial in addressing possible issues in the way claims are submitted to insurers for payment, which could be a reason for certain types of denials, and engaging and educating providers on insurer claim submission requirements could resolve some of those issues.

Commissioner Kreidler asked if the KFF knew if SBMs who tracked claim denials and appeals had findings similar to those of the HealthCare.gov insurers. Pollitz said that among the SBMs KFF knows have similar data reporting, Covered California, the findings look roughly the same. She reiterated that she believes the Minnesota SBM may have similar data reporting requirements, but the KFF has not had the opportunity yet to review its data to determine if there are any similarities. Commissioner Kreidler suggested that of those states that have an SBM, the state department of insurance (DOI) may want to reach out to see if the SBM collects this data in order to understand better what is happening in the state as far as the number of claims denials and appeals and whether there is a need to find ways to educate consumers on their appeal rights.

Carl Schmid (HIV+Hepatitis Policy Institute) expressed appreciation for the Committee inviting the KFF to present its findings. He said the KFF findings highlight a number of troubling issues, such as the high percentage of claim denials and how few consumers appeal such denials. He said he hopes state insurance regulators try to address this issue. He offered a few recommendations to address this, such as the NAIC reviewing its appeal models to see if any revisions need to be made or looking at definitions of “medical necessity.”
5. **Heard a Discussion on a State Checklist of Actions Related to the Medicaid Unwinding Process**

Sabrina Corlette (Georgetown University, Center on Health Insurance Reforms—CHIR) discussed a recently published issue brief from the State Health and Value Strategies (SHVS) titled “Secrets to a Successful Unwinding: Actions State-Based Marketplaces and Insurance Departments Can Take to Improve Coverage Transitions.” She highlighted the extraordinary work state Medicaid agencies will have to undertake over the next year to reassess the eligibility of approximately 95 million people to retake Medicaid coverage because of the impending end of the COVID-19 PHE. She estimated that approximately 15 million to 18 million of these individuals will be terminated from Medicaid coverage, with many of them being eligible for coverage either through ACA marketplace plans or employer-sponsored insurance (ESI). She discussed the steps state DOIs—along with other partners, such as SBMs and carriers—can take to reduce gaps in coverage and avoid disruptions in care.

Corlette provided a timeline for the Medicaid unwinding process, including the dates certain states plan to begin redeterminations of Medicaid coverage eligibility and terminations of coverage for those deemed ineligible for coverage. Also shown was the decrease in the percentage of the enhanced federal Medical Assistance Percentage (eFMAP) during the time of the Medicaid unwinding process. She discussed temporary and/or short-term actions state DOIs can take to ease transitions, including monitoring the cadence of Medicaid renewals, monitoring qualified health plan (QHP) issuers’ financials and network capacity, and guarding against deceptive marketing of unregulated products. Corlette stressed that it is important that state DOIs communicate early and often with their state and federal partners. She also discussed temporary and/or short-term actions SBMs can take.

Corlette discussed actions state DOIs can take to mitigate the ill effects of churn long-term. Those actions include: 1) expanding continuity of care requirements; 2) requiring QHPs to honor prior authorizations and step-therapy/prescription drug formulary exception decisions; 3) considering the pro-ration of deductibles and maximum out-of-pocket (MOOP) for mid-year transitions; and 4) supporting auto or EZ Enroll initiatives. She discussed similar actions that SBMs can take.

Commissioner Kreidler expressed appreciation for the presentation. He asked Corlette if she has any additional recommendations for the states, particularly those that are actively engaged in the process and are already working with their SBM to smooth the transition process. Corlette said she did not, but she urged state insurance regulators to expect that the process will not go smoothly and to be flexible and maintain lines of communication with their sister agencies, such as the state Medicaid agency.

Director Fox asked about any Special Enrollment Periods (SEPs) for Medicaid recipients that became eligible for Medicare. Corlette said the CMS has instituted such an SEP. She also noted that the CMS has established an SEP for “exceptional circumstances” for FFMs from April 2, 2023, to July 31, 2024. Commissioner Mulready noted that each state will have to decide whether to establish an SEP for enrollment into Medicare supplement (Medigap) plans. He said some states might be able to establish an SEP by rule, which is what Oklahoma did.

6. **Heard an Update from the CCIIO on its Recent Activities**

Jeff Wu (federal Center for Consumer Information and Insurance Oversight—CCIIO) and Jeff Grant (CCIIO) provided an update on activities of interest to the Committee. Grant focused his remarks on the pending released Notice of Benefit and Payment Parameters 2024 proposed rule, which the CCIIO hopes will be finalized soon. He discussed a few of the proposed changes included in the proposed rule, including proposals that expand access to affordable coverage, but in a way designed to improve consumers’ experiences throughout the process of determining eligibility, choosing a plan, and completing enrollment. The goal is to simplify the enrollment process for consumers and improve the quality of care available. A key rationale for many of these proposed policy and operational changes is to enhance health equity and reduce disparities in health coverage and access.
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One proposal central to this goal is enhancing network adequacy and essential community provider (ECP) requirements for individual market QHPs, stand-alone dental plans, and small business health options programs (SHOPs) to ensure consumers have access to a sufficient choice of providers. With the goal of expanding access to services for low-income and medically underserved consumers, CMS proposes to add mental health facilities, substance use disorder (SUD) treatment centers, and rural emergency hospitals to the list of current ECPs.

Grant said that as part of this shift, the CMS is proposing to limit the number of non-standardized plan options to streamline consumer plan choices. He said the CMS is proposing two alternative policies to reduce the number of duplicative or very similar plans currently being displayed to marketplace consumers. SBMs are not impacted. One alternative the CMS proposes is to limit the number of plans insurers can offer at each metal level, product type, and service area to two. Alternatively, the CMS proposes to reinstate a requirement that there be a “meaningful difference” between plans offered on the FFM and the state-based marketplace-federal platform (SBM-FP). Grant reiterated that the proposed rule is not final yet, but explained that these proposed changes reflect CMS’ concern with the proliferation of plans consumers are not able to choose from as opposed to the limited number of plan choices when the health insurance marketplaces first became operational.

Grant said this rule proposes to give health insurance marketplaces the option to implement a special rule giving people who lose Medicaid or the federal Children’s Health Insurance Program (CHIP) 90 days, instead of the typical 60 days, to enroll in a QHP. He also referred to the implementation of the network adequacy wait time requirements, noting the concerns expressed by some commenters about the ability and challenges of the states to have the appropriate tools and resources to assess compliance with the requirements and the burden on providers to get information to insurers in a timely manner, along with other operational challenges.

Grant also touched on: 1) the CMS’ work to modernize the QHP certification process; 2) the independent dispute process under the NSA and the impact of the Feb. 6 Texas court ruling on the ability of the CMS to make payment determinations; and 3) the CMS’ work related to Medicaid unwinding, including improving the transition process for consumers and closing the information gap among the federal and state agencies involved. He closed his remarks by discussing the CCIO’s work related to health equity.

Commissioner Pike asked about the proposal to limit the number of non-standard plan options. He asked whether there is any consideration to provide flexibility for those states that may have only one or two insurers to permit, if the insurer wishes to do so, more than two plan options. Wu noted the issue’s complexity, explaining that the CMS is carefully weighing all the comments it has received. He pointed out that the proposed rule does not limit the number of standardized plans. An insurer can offer an unlimited number of standardized plans. As such, there are multiple ways for insurers to provide robust competition and choice for consumers in the marketplaces through this mechanism.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met March 2, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Debra Judy (CO); Randy Pipal (ID); Alex Peck (IN); Mary Kwei (MD); Carrie Couch (MO); Mike Rhoads and Rebecca Ross (OK); David Buono (PA); Jill Kruger (SD); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating were: Susan Brown (MT); and Cynthia Cisneros (NM).

1. **Adopted Its Jan. 31 Minutes**

   The Subgroup met Jan. 31 to discuss the results of a survey of states’ consumer engagement activities.

   Rhoads made a motion, seconded by Trice, to approve the Subgroup’s Jan. 31 minutes (Attachment One-A). The motion passed unanimously.

2. **Discussed Potential Subgroup Activities**

   Crow reviewed ideas raised during the last meeting for the Subgroup’s next projects. She listed ideas including a resource document on using social media, a guide to forming partnerships with other agencies, methods for measuring the effectiveness of outreach, and creating alternate versions of existing documents. She also raised the idea of an education piece for consumers who may lose Medicaid.

   Rhoads said the most pressing issue for Oklahoma and many states is helping consumers find coverage after they come off Medicaid. He said assisting consumers who lose access to Medicaid will be a critical priority in the coming months. Other states agreed that it would be helpful to have something in this area fairly quickly. Cisneros said New Mexico has worked with its state-based Marketplace and Medicaid agency, which has developed a toolkit to guide activities.

   Bonnie Burns (California Health Advocates—CHA) said that consumer representatives would be happy to assist in developing a document. She said consumers are looking for answers to questions, so a document should be designed to give answers to specific questions.

   Eric Ellsworth (Consumers’ Checkbook) said there is a lot of messaging already from the Centers for Medicare & Medicaid Services (CMS) and state-based marketplaces. He said information dilution is a risk. He said state insurance regulators should consider what they can do that is additive to what has been produced already (e.g., compelling insurers to add messages to their websites). Kruger said consumers will be directed to Marketplaces, not individual carrier websites. She said a risk to consider is that consumers may end up on scam websites rather than Marketplace sites. Ellsworth said consumers may or may not read a letter from the Medicaid agency, but they may need help in avoiding scam websites when they seek new coverage. He said state insurance regulators should consider asking Google to mark official government sites so they can be easily distinguished. Burns said consumers have been attracted to health care sharing ministries (HCSMs) because they search for something inexpensive, so consumers should be warned what they should not do in addition to learning about official resources.
Cisneros said New Mexico has been working proactively to steer consumers away from HCSMs and scam plans with webinars and advertising. Crow said consumers may not seek help or information until it is too late.

Couch suggested the Subgroup could consider reworking its older document on shopping for low-cost health plans.

Harry Ting (Health Care Consumer Advocate) said a frequently asked questions (FAQ) document would be a more effective format and said dual eligible individuals should be addressed.

Kris Hathaway (AHIP) said her organization has been spending a lot of time on redeterminations. She said the Subgroup should not reinvent the wheel and instead make use of materials that have already been developed. She said timing and alignment with Medicaid agencies and Marketplaces are concerns, so the Subgroup should consider a library of resources rather than a new document.

Ross said states have navigators involved already and that states should help consumers find navigators.

Crow asked for volunteers to help with the project. Ross, Brown, and Burns said they would help. Burns said the Subgroup could produce multiple documents, one for consumers and one for state insurance regulators.

Ellsworth suggested that the Subgroup later in the year could work to analyze the barriers to consumers getting the information they need. The intention would be to make policy changes (e.g., requiring issuers to include Health Insurance Oversight System [HIOS] identification numbers on the Summary of Benefits and Coverage [SBC]).

Having no further business, the Consumer Information (B) Subgroup adjourned.
Consumer Information (B) Subgroup  
Virtual Meeting  
January 31, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Jan. 31, 2023. The following Subgroup members participated: Mary Kwei, Chair, and Joy Hatchette (MD); Tara Smith (CO); Ryan Gillespie (IL); Alex Peck (IN); Carrie Couch (MO); Kathy Shortt (NC); Jennifer Ramcharan (TN); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating were: Cynthia Cisneros and Paige Duhamel (NM).

1. **Discussed the Results of a Survey of States’ Consumer Engagement Activities**

Kwei reminded the Subgroup that members had worked in 2022 to understand better how state departments of insurance (DOIs) engage with consumers on health insurance topics. She said the Subgroup is interested in understanding what states are doing and how the Subgroup can be most helpful. She said that the Subgroup had convened focus groups and conducted a survey of public information officers (PIOs).

Brenda J. Cude (University of Georgia) provided a summary of the findings of the survey. She said 13 individuals from 12 states responded. She said website content, social media, and partnerships with other government agencies were the most commonly mentioned means of outreach. Dr. Cude said participants were asked to rate the effectiveness of different methods of outreach, and those most identified as effective were online public meetings and website content, followed by social media and advertising.

Dr. Cude said Facebook was the social media used most often, followed by Twitter and LinkedIn. She said YouTube, TikTok, and Nextdoor were also mentioned. She said states that use Nextdoor rated it highly effective. She said states evaluate the effectiveness of their methods by using counting, whether of social media engagement, website hits, or event participants. Dr. Cude said counting is not necessarily the best way to rate effectiveness, even though it is the easiest. She said the Subgroup could consider providing tools to states that help in using other ways to evaluate efforts.

Dr. Cude said respondents generally reported using NAIC materials. The one state that did not said the materials were not useful because of cultural and other differences in the state. Dr. Cude said states most commonly link to NAIC documents or adapt them and use them on their own websites. She said that choosing plans and how to use health insurance were the most frequently requested topics for new content.

Kwei said the Subgroup should think through ways to deliver content on choosing and using health plans that are accessible in different ways. Duhamel asked how states use the Nextdoor app. Hatchette said Maryland tried other types of social media, but Nextdoor provides a unique opportunity because it allows government entities to post statewide, rather than in limited neighborhoods. She said Maryland uses it for both property/casualty (P/C) and health. She suggested that states reach out to Nextdoor to be registered as a government entity.

Harry Ting (Health Consumer Advocate) said that he recently calculated the number of complaints and inquiries to state DOIs per population for each state. He said there is a lot that goes into the numbers, but higher rates of complaints and inquiries could indicate more success in engaging consumers who then contact the DOI.

Dr. Cude said states could benefit from education on: ways to evaluate effectiveness; how to use any social media, not just Nextdoor; and how to partner with other organizations. Kwei said the Subgroup could consider how to repurpose and repackage some of the content that has already been developed and find other ways to distribute...
it. Bonnie Burns (California Health Advocates—CHA) said consumers are often seeking the answer to a particular question rather than looking for an overall guide. She said a Q&A type of document may be more helpful.

2. Discussed Other Matters

Kwei said that this would be her last meeting as Subgroup chair. She said she is proud of the work the Subgroup has accomplished. Members of the Subgroup thanked her for her work. Joe Touschner (NAIC) said that the role of vice chair is also becoming vacant and encouraged interested state insurance regulators to reach out if they would like to be considered for the role of chair or vice chair.

Kwei said there is a lot of interest in topics around health insurance and that people need information in different ways and at different times. Therefore, she said the Subgroup should continue to work on materials similar to what it has produced in the past.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Louisville, KY, March 22, 2023. The following Working Group members participated: Nathan Houdek, Chair, Jennifer Stegall, and Sarah Smith (WI); Amy Hoyt, Vice Chair (MO); Sarah Bailey (AK); Kate Harris (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes and Craig VanAalst (KS); Jamie Sexton (MD); Marti Hooper and Robert Wake (ME); Chad Arnold (MI); Ross Hartley (ND); Jennifer A. Catechis and Paige Duhamel (NM); Daniel Bradford (OH); TK Keen (OR); Rachel Bowden and R. Michael Markham (TX); Mike Kreidler and Lichiou Lee (WA); and Erin K. Hunter (WV). Also participating was: Patrick Smock (RI).

1. **Adopted its 2022 Fall National Meeting Minutes**

Hoyt made a motion, seconded by Peck, to adopt the Working Group’s Dec. 13, 2022, minutes (see NAIC Proceedings – Fall 2022, Health Insurance and Managed Care (B) Committee, Attachment Four). The motion passed unanimously.

2. **Heard Presentations on EHBs**

Commissioner Houdek said essential health benefits (EHBs) are of interest to state insurance regulators because states are interested in updating them, federal officials are considering revising rules, and the defrayal requirement for state-mandated benefits continues to cause concerns.

Harris reviewed Colorado’s process for updating its EHB benchmark plan. She said the state started the process in the fall of 2020 using a federal grant. She said three public town halls gathered feedback on what to add or remove from the EHB. Three themes emerged, including improving mental health benefits, improving access to alternatives to opioids for pain management, and adding gender-affirming care for transgender individuals. She said the third was the most important and was driven by both input at the town halls and complaints received by the Division of Insurance. She said services varied from carrier to carrier, but many needed services were excluded as cosmetic. She said major medical associations have classified this care as medically necessary. She said the state worked to satisfy the technical requirements related to the generosity test and the typicality test. The cost for the added benefits was determined to be 64 cents per member per month. She said Colorado was the first state to explicitly include gender-affirming care to treat gender dysphoria in its benchmark plan.

Hoyt asked whether Colorado looked at other benefits before deciding on the three changes to make. Harris said the state considered more than 20 different changes but wanted to narrow the list before completing an actuarial analysis. She said the state used public feedback to help narrow the list. Seip asked if the per member per month figure was informed by the actual costs reported by insurers. Harris said Colorado’s actuaries used internal data as well as carrier data. Commissioner Houdek asked how much pressure the state received from stakeholders on what to include. Harris said there were many valid requests to add benefits. She said it was helpful to walk stakeholders through the generosity test to show the guardrails. She said providers, payers, brokers, and advocates participated, and the state asked that attendees participate in all three meetings, which most did.
Wayne Turner (National Health Law Program—NHeLP) presented recommendations for improving EHBs for consumers. He said many plans excluded important benefits before the federal Affordable Care Act (ACA). The ACA establishes a coverage requirement and a cost-sharing requirement. He said the law tasks the Secretary of the U.S. Department of Health and Human Services (HHS) with defining the 10 categories of EHB. He said it further requires HHS to periodically review and update EHBs. He said EHB compliance and enforcement are up to the states. He said his organization has seen problems, including pharmacy benefit managers (PBMs) declaring some drugs to be non-EHB. He said there is not a loophole in the law that allows this. Instead, it is against the law, and these drugs are still subject to the cost-sharing protections applicable to EHBs. He said benefits must be clinically based to be nondiscriminatory.

Turner said the benchmarking process is not in the statute. Rather, it is a policy decision to give states more flexibility. He said using commercial plans as benchmarks, particularly small group plans, can embed discriminatory provisions in the plans. He said his organization has recommended national standards. He said the defrayal requirement for state-mandated plans is part of the law, so it cannot be avoided entirely. He said adding benefits to comply with federal requirements does not trigger defrayal, so states could make additions to ensure plans are nondiscriminatory or to comply with federal mental health parity standards without requiring defrayal of their cost. He said that changes in cost sharing also do not trigger defrayal.

Turner said updating EHBs is a good use of state flexibility grants. He said many states do not have a formal process for selecting a benchmark plan. He said federal rules require public notice, and he recommends prioritizing health equity and transparency. He said the benchmarking process can be used to address unmet health needs. He said there would be winners and losers in the process, and the winners should not automatically be the best-funded lobbyists. He pushed for full transparency and providing easy ways for consumers to inform the process. He said the NAIC could consider establishing best practices for states in reviewing and updating EHBs.

Hoyt asked what kinds of data states should consider when starting the process. Turner said population-wide health data is a good starting point. He said states could also consult with academic institutions in the state. He warned that some well-funded groups might have good data, but they may leave out important information. Harris asked how long the process generally takes. Turner said there is a range, and it can be difficult when states do not have an existing process in place. He said Oregon has created an ongoing committee to keep the process going between updates. Commissioner Houdek asked about cost-sharing flexibility for states. Turner said states have authority over cost sharing, which does not trigger defrayal. He said preventive services coverage is under legal challenge, but EHBs also include preventive services. He said regulators can require no cost sharing for preventive services in the event the ACA’s preventive services coverage requirement is invalided. Bailey asked what challenges states have encountered in the update process. Turner encouraged talking to other states who have gone through the process. He said Vermont reported difficulties in the application of the typicality test. He said the test is an important consumer protection, but its application should be clarified.

Kris Hathaway (AHIP) discussed AHIP’s recommendations to the federal Centers for Medicare & Medicaid Services (CMS) on EHBs. She said AHIP advocated for maintaining the core structure of EHB selection, with an emphasis on state flexibility. She said state insurance regulators should continue to be the primary regulators. She said the current structure meets local needs. She said additional conversations on defrayal would be appreciated and encouraged states to look at updates to their benchmarks every three years. She said telehealth can be a cost-saving tool, and its continued use should be allowed. She said previously controversial definitions, such as for habilitative services and pediatric services, have gone smoothly. She said that in Colorado, health plan actuaries computed different numbers for the cost of added benefits than the state used.
Harris asked whether health plans have measured cost savings due to added benefits. Hathaway said AHIP had looked at cost-saving measures like ending facility fees and improving transparency but not adding benefits. Commissioner Houdek asked about modifications to the update process. Hathaway said her organization is concerned with making updated benchmarks similar in cost to existing plans. She said patients have needs, but care needs to be affordable at the end of the day.

Holmes said Kansas is in the process of updating EHBs and is hoping to submit them to the CMS by the deadline in May. She said one issue was narrowing down what the updated benefits should be, and the state looked at consumer complaints going back 10 years to decide.

Wake said states are frustrated that the temporary concept of requiring defrayal for new mandates was continued. He said this leads to states mandating benefits through sub-regulatory guidance rather than legislation or regulations. He said CMS should recognize that the process for updating EHBs can replace the initial grandfathering standard that discourages new mandates. He said states with lean EHBs should have the opportunity to make their plans more generous rather than tying them to decisions made 20 years ago. He said it is difficult to quantify the generosity of a set of benefits without considering cost sharing.

Jackson Williams (Dialysis Patient Citizens—DPC) said expanding EHBs would not inhibit alternative payment models or value-based insurance design. He said EHB changes would not tie insurers’ hands on medical management if they are done in good faith.

Randi Chapman (Blue Cross Blue Shield Association—BCBSA) said her organization supports the current regulatory structure for EHBs. She said it appropriately recognizes local markets and allows states to build on coverage that is already available in the market. She said BCBSA member plans are committed to using telehealth to expand access and to promoting health equity.

3. Discussed Potential Topics for Future Meetings

Bowden discussed efforts in Texas to adjust the relative affordability of plans by directing the premium load of cost-sharing reductions (CSRs). She said the legislature directed Texas to begin rate review in 2021 legislation, which also noted that silver plans were priced below the cost of providing CSRs. She said Texas adopted a rule to require plans to apply a uniform CSR to all silver plans in the exchange. She said silver plans, on average, provide an actuarial value of around 80%. She said the rule did not generate controversy, though there was some question of whether enrollment levels would change due to the rule. She said the result of the rule is that gold plans are now 11% less expensive in premium than silver plans, and the share of consumers who can purchase a gold plan with a $0 premium rose from 43% to 73%. She said there are many policy and actuarial considerations, but the Texas approach was driven by the direction of the legislature. She clarified that issuers apply the silver load only to on-exchange plans, so consumers can purchase silver plans with no CSR load off-exchange. Wake said Maine applies silver loading through rate review and also requires a silver option that does not include a CSR load. Commissioner Houdek asked if a more detailed presentation on this topic at a future meeting would be useful and Working Group members agreed that it would.

Hoyt provided information on Project Extension for Community Healthcare Outcomes (ECHO). She said Missouri has a program called Show Me ECHO based on New Mexico’s Project ECHO. She said the original Project ECHO was inspired by poor outcomes for hepatitis C patients. It connected primary care physicians with specialists so the primary care doctor could provide better care rather than the patient waiting eight to 12 months to see the specialist. She said it improved outcomes and changed lives. She said Show Me ECHO offers adult learning for
multidisciplinary teams. A hub team participates and provides advice to primary care providers on how to manage patients. She said it is a way to move knowledge rather than patients. She said Medicaid in Missouri has provided incentives to providers to participate in the program. She said every state has an ECHO program devoted to different diseases or treatments. Commissioner Houdek asked if others were interested in learning more about Project ECHO, and Working Group members said they are.

Keen said one topic to keep tabs on is Medicaid redeterminations and whether any innovative practices have emerged from that experience. Harris said looking at continuity of care or pro-rating of deductibles for enrollees who leave Medicaid are other issues of interest.

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) said that the Working Group should look at what states can do to remove barriers to preventive services.

Eric Ellsworth (Consumers’ Checkbook) noted that the CMS has done a great deal of work on the interoperability of healthcare data. He said the Working Group could look at how the oversight of insurers in this area is divided between states and federal agencies as well as look at the level of investment insurers are making to enhance their information systems.

Hathaway said AHIP may have more data to share on value-based care by the Fall National Meeting.

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