NAIC NATIONAL MEETING
FALL 2022

Draft date: 11/30/22

2022 Fall National Meeting
Tampa, Florida

HEALTH INNOVATIONS (B) WORKING GROUP
Tuesday, December 13, 2022
9:45 – 11:15 a.m.
HB Plant Ballroom E & F - Level 2 - JW Marriott

ROLL CALL

Andrew Stolfi, Chair	Oregon	Amy Hoyt	Missouri
Laura Arp, Vice Chair	Nebraska	Mark Garratt	Nevada
Nathan Houdek/Jennifer Stegall, Vice Chairs	Wisconsin	Maureen Belanger	New Hampshire
		Paige Duhamel/Viara Ianakieva/Margaret Pena	New Mexico
Anthony L. Williams	Alabama		
Sarah Bailey/Alida Bus	Alaska	Chrystal Bartuska	North Dakota
Howard Liebers	DC	Rachel Bowden/R Michael Markham	Texas
Alex Peck	Indiana		
Andria Seip	Iowa	Tanji Northrup	Utah
Julie Holmes	Kansas	Molly Nollette	Washington
Bob Wake	Maine	Joylynn Fix	West Virginia
Anita Fox	Michigan		
Galen Benshoof	Minnesota		

NAIC Support Staff: Joe Touschner

AGENDA

1. Consider Adoption of its Summer National Meeting Minutes—*Commissioner Andrew Stolfi (OR)* — Attachment A

2. Hear Presentations on Hospital Facility Fees—*Commissioner Andrew Stolfi (OR)*
   - Maureen Hensley-Quinn (National Academy for State Health Policy)
   - Molly Smith (American Hospital Association)
   - David Merritt (Blue Cross Blue Shield Association)
   - Miranda Motter (AHIP)

3. Hear a Presentation on Coverage of Drugs to Treat Obesity—*Commissioner Andrew Stolfi (OR)*

- Randy Pate (Randolph Pate Advisors)

4. Hear Presentations on Issues with Prescription Drug Formularies—
   Commissioner Andrew Stolfi (OR)
   - Gerard Anderson (Johns Hopkins University)
   - Carl Schmid (HIV and Hepatitis Policy Institute)

5. Discuss Any Other Matters Brought Before the Working Group—
   Commissioner Andrew Stolfi (OR)

6. Adjournment

Attachment A
Draft: 8/23/22

Health Innovations (B) Working Group
Portland, Oregon
August 10, 2022

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Portland, OR, Aug. 10, 2022. The following Working Group members participated: Andrew R. Stolfi, Chair (OR); Laura Arp, Co-Vice Chair (NE); Richard Wicka and Rachel Cissne Carabell, Co-Vice Chairs (WI); Sarah Bailey (AK); Yada Horace (AL); Howard Liebers (DC); Angela Burke Boston and Andria Seip (IA); Alex Peck (IN); Julie Holmes and Kenneth Scott (KS); Robert Wake and Marti Hooper (ME); Renee Campbell (MI); Peter Brickwedde (MN); Carrie Couch and Amy Hoyt (MO); Ross Hartley and Chrystal Bartuska (ND); Maureen Belanger (NH); Paige Duhamel (NM); Jack Childress (NV); Rachel Bowden, Valerie Brown, and R. Michael Markham (TX); Heidi Clausen, Tanji J. Northrup, and Shelley Wiseman (UT); Ned Gaines and Jennifer Kreitler (WA); and Joylynn Fix and Erin K. Hunter (WV). Also participating were: Troy Downing (MT); Glen Mulready and Rebecca Ross (OK); Richard L. Hendrickson and Lindsi Swartz (PA); and Jill Kruger (SD).

1. Adopted its Spring National Meeting Minutes

Mr. Wicka made a motion, seconded by Ms. Arp, to adopt the Working Group' April 4 minutes (*see NAIC Proceedings – Summer 2022, Health Insurance and Managed Care (B) Committee. Attachment XX*). The motion passed unanimously.

2. Heard a Presentation on the Colorado Option Waiver

Commissioner Stolfi said members of the Working Group are interested in learning more about the Colorado Option. Commissioner Conway said the state has been working on the Colorado Option for four years. He said the state's reinsurance program has reduced premiums, but there is no product that is guaranteed to be available off exchange in all parts of the state. He said the Colorado Option will be available for those eligible for federal Affordable Care Act (ACA) subsidies and those who are not. Commissioner Conway said the primary goals of the Colorado Option are to improve affordability and access. He said core components include a standardized plan design, required premium reductions, and expansion of eligibility regardless of immigration status.

Commissioner Conway said the state can continue to control costs through the reinsurance program, and it wants to use available pass-through funds to expand access and affordability. He said the state chose to keep it simple and continue to waive the same provision of the ACA as in the reinsurance waiver. He said the premium rate reductions would be achieved through public hearings. He said the law gives state insurance regulators authority over hospital and provider rates. Commissioner Conway said Colorado will improve access for state residents inside and outside the exchange, in the individual and small group markets. He said the Colorado Option cost controls will affect the market differently from reinsurance. He said all issuers participating in the individual and small group markets will be required to offer Colorado Option plans. He said competition will result in either fewer competing products or lower prices in competing products.

Commissioner Conway said Colorado expects $1.5 billion in savings from the Colorado Option and 12% higher enrollment. The savings will be reinvested in access and affordability and to boost health equity. The state will use a cost-sharing wrap to increase actuarial value beginning in 2023 and allow some ineligible for federal tax credits to access subsidies. He said state insurance regulators will hold a public hearing when issuers miss the required premium reductions. He said the state has authority to set provider rates (down to a floor specified in law) if provider rates are keeping premiums up. In addition, the state would seek to reduce insurers' administrative costs.

Ms. Seip asked for more details on how premium reductions would be achieved. Commissioner Conway said a formula in the law allows provider rates to be set down to 165% of Medicare rates for hospitals and 130% of Medicare for other providers. He said the hearings will allow a conversation around rates with these limits in mind.

Ms. Bartuska said North Dakota does not have many issuers and asked whether the waiver had encouraged more issuers to enter Colorado's market. Commissioner Conway said it has not led to more carriers coming into the state, but carriers have been expanding within the state, though not necessarily related to the Colorado Option. He said the waiver's competition comes from a new product everywhere in the state that is a better product competing against existing products. Ms. Bartuska asked about issuer participation in both individual and small group markets. Commissioner Conway clarified that the law requires carriers to offer the Colorado Option in the market or markets they participate in—not that they must offer it in both if they only participate in one.

3. Heard Presentations from Health Plans on Programs to Improve Access

Commissioner Stolfi said during this meeting, the Working Group would focus on the last part of its charge from the Special (EX) Committee on Race and Insurance. The Working Group is charged to evaluate mechanisms to resolve disparities through programs to improve access to historically underserved communities. He said the Working Group has not yet narrowed its focus in this work, but would hear presentations on it from both health plans and the federal Centers for Medicare & Medicaid Services (CMS). He said Oregon has a long history of innovation in both Medicaid and commercial markets. He said Oregon's Medicaid coordinated care model has been a proving ground for innovations that can make a difference in the commercial market.

Dr. Briar Ertz-Berger (Kaiser Permanente) said social health includes all aspects of a person's life outside of their physical and mental health. She said social health plays a key role in overall health, and it must be addressed to achieve health equity. She said most of what drives health is outside of the health care system and is instead related to social health, such as physical environment, social and economic factors, and health behaviors. She said structural and institutional racism compounds the barriers to health and social health. Dr. Ertz-Berger said the cost of racial inequities is in the hundreds of billions of dollars. She said patients from different ZIP codes have different outcomes due to different histories and exposures to violence and racism. She said Kaiser Permanente is making investments in improved care delivery and connecting people to social resources. She said patients are screened for social needs, and the results are documented for all clinicians. She said members are linked in Connect Oregon, which allows closed-loop referrals to community organizations.

Karis Stoudamire-Phillips (Moda Health) said Moda is focused on the way to better health, but with a different path for different individuals. She said Moda uses corporate responsibility dollars to fund community organizations across the state. She said the company is deliberate in looking at the connection between health, environment, and social equity. She said nonprofit organizations have connections to Moda employees like customer service workers and community outreach workers. Dr. Yale Popowich (Moda Health) said the company has implemented Moda 360, which shows providers a more complete view of patients. They help guide patients to care coordination interventions and provide health context to evaluate health equity. He gave an example of a member with diabetic status who has transportation challenges who can be referred to a diabetes management program that can be used at home through an app and provides testing supplies for free. He said that some programs carry over from Medicaid to the commercial market. He shared examples of a program to improve access to fresh produce when members have food insecurity and another to provide cribs for parents who cannot afford them. Ms. Stoudamire-Phillips said Moda also provides flex services, which include air purifiers, temporary housing, and cooking supplies. She said the company looks for organizations that are fulfilling community needs and funds them, such as organizations that provide air conditioners to help members deal with heat waves.

Erin Fair Taylor (PacificSource) said the Medicaid Coordinated Care Organizations (CCOs) are testing grounds that provide lessons that can be used across markets. She said the CCO model has been around for 10 years, and its goals are better health, better care, and lower costs. She said each CCO has a health council that is locally accountable and sets priorities. She said each region has unique needs, so solutions have to be local and responsive to community needs. She said hospitals, providers, enrollees, dental providers, and the company are represented on the health councils. She said there is shared decision-making on investments. She said the company's margin is limited, and any earnings above the limit go to the health council to invest in social determinants and addressing equity. She said community benefit initiatives include community health workers, community information exchange, and projects like parks and bike paths. She said getting more stakeholders at the table means it is not just clinicians making decisions to improve health.

Commissioner Stolfi asked how state insurance regulators can be helpful in work to address health equity and improve access. Dr. Ertz-Berger said there is opportunity in thinking about what mandated benefits could improve equity and how provider networks can improve social care access, not just health care access. Dr. Popowich agreed and said state insurance regulators should look to Medicaid because it has encouraged health plans to work closely with hospitals, social workers, and others. Ms. Fair Taylor said state insurance regulators should pay attention to incentives because when they are community-focused, they encourage meaningful change.

Ms. Duhamel asked what uptake has been in diabetes management. Dr. Popowich said plans ask whether they can operate these programs themselves or hire vendors. He said Moda's experience with a vendor, Livongo, has been phenomenal. It provides free supplies and gathers useful data on patients. He said other programs encourage lifestyle changes to prevent diabetes in the first place. He said uptake has been as high as 20%, which Moda considers a win for a new program.

Commissioner Stolfi asked if other states have seen learning from Medicaid spread to the commercial market and if the panel has suggestions for fostering the spread of best practices. Ms. Fair Taylor said community feedback has been standardized in Oregon, including how to perform on quality measures, and this could be used in other states. Dr. Popowich said Moda has spread is Oregon practices to Alaska and other states.

4. Heard a Presentations from CMS about Programs to Improve Access

Commissioner Stolfi introduced Jeff Wu (federal Center for Consumer Information and Insurance Oversight [CCIIO] at CMS). Mr. Wu said working with state insurance regulators is fundamental to CMS' work in health insurance markets. Mr. Wu said CMS has built health equity into its thinking and strategies going forward.

Mr. Wu said health equity work is in many cases complex and subtle. He said CMS has a strategic plan with six pillars, three of which are tied to health equity. He said President Joe Biden's first executive order established a commitment to advancing racial equity and support for underserved communities. Mr. Wu said CMS published a framework for health equity, and its first priority is to collect standardized data.

Mr. Wu outlined the CCIIO's health equity goals, including coverage, access, and consumer protection. He said that coverage has been improved by expanding the open enrollment period and introducing a special enrollment period (SEP) for low-income individuals. He said the SEP will be particularly important as the public health emergency ends and individuals' Medicaid coverage is redetermined. He said the agency has invested heavily in navigators, who may reach underserved communities more than agents and brokers. He said choice of issuers has increased in places where there previously was less choice, and the agency continues to work to increase choice in rural counties. He said that Federally Facilitated Marketplace (FFM) enrollment among underrepresented groups has increased by 25%.

Mr. Wu said many provisions of the last payment notice focus on access to care, including network adequacy. He said CMS has ongoing engagement with carriers where there are network challenges. He said CMS has focused its SEP verification efforts on the most common eligibility factor, loss of minimum essential coverage.

Mr. Wu said consumer protections promote health equity by protecting consumers from limited benefit designs and discriminatory provisions. He said CMS has collaborated with other colleagues in the U.S. Department of Health and Human Services (HHS) to finalize non-discrimination rules.

Mr. Wu said better data is needed to inform work internally and to share with stakeholders. He said the 2023 payment notice provides for expanded data collection through the edge server. This will include five new data elements, including ZIP code, race and ethnicity, and receipt of subsidies. He said CMS is working to increase consumers' completion of race and ethnicity fields in applications.

5. Heard an Update on its Memorandum to the Special (EX) Committee on Race and Insurance

Commissioner Stolfi said the Working Group would collect comments on the final part of its charge by email. He said work on the first part of the charge is closer to completion. He said Kelly Edmiston (Center for Insurance Policy and Research—CIPR) helped summarize findings on health disparities in a draft memorandum to the Special (EX) Committee on Race and Insurance.

Mr. Edmiston said the memorandum focuses on the efficacy of telehealth on reducing disparities and the impacts of alternative payment models on disparities. He said a full report on alternative payment models would be distributed to the Working Group soon. He said the memorandum documents limited access to providers in rural areas and some underserved communities in urban areas. Mr. Edmiston said the

greatest potential for telehealth is to increase access to care for many specialties, not just psychiatry and radiology. He said the most significant barriers to telehealth access are physical access to the required technology, privacy when using it, and digital literacy. He said regulatory barriers could include payment levels and licensing of providers.

Mr. Edmiston said that providers consider the quality of care they provide more important than financial incentives. He said alternative payment models were not designed to ameliorate disparities, but rather to increase quality of care and efficiency. He said incentives and disincentives to provide appropriate care vary by program.

Commissioner Stolfi asked Working Group members to send comments on the memorandum to NAIC support staff.

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

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