Draft: 4/19/22

Health Innovations (B) Working Group
Kansas City, Missouri
April 4, 2022

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Kansas City, MO, April 4, 2022. The following Working Group members participated: Andrew R. Stolfi, Chair (OR); Laura Arp, Co-Vice Chair (NE); Nathan Houdek and Jennifer Stegall, Co-Vice Chairs (WI); Sarah Bailey (AK); Anthony L. Williams (AL); Doug Ommen and Andria Seip (IA); Julie Holmes (KS); Chad Arnold (MI); Cynthia Amman (MO); John Arnold (ND); Maureen Belanger (NH); Nancy Clark and Chris Herrick (TX); Tanji J. Northrup (UT); Molly Nollette (WA); and Erin K. Hunter (WV). Also participating were: Weston Trexler (ID); and Katie Merritt (PA).

1. Adopted its 2021 Fall National Meeting Minutes

Mr. Houdek made a motion, seconded by Ms. Nollette, to adopt the Working Group' Dec. 11, 2021, minutes (*see NAIC Proceedings – Fall 2021, Health Insurance and Managed Care (B) Committee. Attachment Five*). The motion passed unanimously.

2. Heard Presentations on Coverage Changes Associated with the End of the COVID-19 PHE

Commissioner Stolfi said state Medicaid programs have been limiting redeterminations during the pandemic, but this pause will end after the COVID-19 public health emergency (PHE) ends. He said maintaining coverage for individuals who leave Medicaid will take coordination between federal officials, states, and health plans, as well as public education. He said a recent report from State Health and Value Strategies outlines steps state insurance regulators can take to aid in this transition.

Anne Marie Costello (federal Centers for Medicaid & Medicaid Services [CMS] Center for Medicaid & CHIP Services [CMCS]) presented on planning the CMS has performed to prepare for the resumption of redeterminations and resources available for states. She said the CMS is committed to ensuring that individuals remain covered as the PHE ends. She said states received enhanced federal match for Medicaid if they paused redeterminations. She said states will have 12 months to renew eligibility for all enrollees once the PHE ends. She said 15 million individuals will be at risk for Medicaid coverage terminations, about half of which are for procedural reasons. She said it may have been two to three years since state Medicaid agencies were in contact with some enrollees. She said states prepared communications strategies, but they are waiting for the PHE to end before launching public communications. She said the CMS gathered toolkits for states and other guidance at the website *Medicaid.gov/unwinding*. She said preparing for the end of the PHE is the highest priority for the CMS.

Jeff Grant (federal Center for Consumer Information and Insurance Oversight—CCIIO) presented on strategies for making Marketplace coverage accessible for individuals who leave Medicaid. He said the CMS is working to smooth transitions when appropriate, including implementing policy and operational flexibilities. He said the CCIIO paused certain data matching issues and Special Enrollment Period (SEP) verifications to prevent unnecessarily blocking people from getting coverage. He said the administration as a whole supports extending subsidies currently in place under the American Rescue Plan. He said the CCIIO is examining its data capabilities to keep track of coverage transitions and perform targeted outreach. He said the CMS Office of Communications is pursuing a chase campaign to encourage individuals to enroll. He said state-regulated plans are important partners, particularly those that offer Medicaid managed care plans, as well as Marketplace plans. He said the

CMS is asking such plans to coordinate across their lines of business and make a commitment to year-round enrollment. He said issuers should be aware of all the guidance the CMS is putting out.

Commissioner Stolfi asked if the CMS has identified what states can do beyond a communications and outreach campaign and how much flexibility would be available under a waiver. Ms. Costello said states are doing a lot in addition to communications, such as planning systems changes, making process improvements, working to improve renewal rates, and enhancing staff capacity. She said fair hearing processes are also being improved and streamlined. She said there are several suggestions for steps states can take besides waiver authorities outlined in a recent State Health Official letter. Mr. Grant said time is of the essence, so states should approach the CMS early if they want to do something different. He said some states with state-based exchanges are exploring streamlined applications and enrollment, which may be called auto-enrollment in some states. He said states would receive a 60-day warning before the PHE ends, so the current assumption is that the current deadline of April 16 will be extended, likely until July.

Jeremy Vandehey (Oregon Health Authority—OHA) presented on the OHA's preparations for the end of the PHE. He said every state is facing this issue. He said Oregon has 300,000 more Medicaid enrollees since before the PHE, and it is likely to lose a similar number once eligibility determinations resume. He said state survey data show Oregon has the lowest uninsured rate ever, largely due to the policy of pausing redeterminations, with disproportionate improvement among Black residents. He said Oregon saw gains in what had been called the "churn population," those who transition off and on Medicaid, sometimes moving to Marketplace eligibility. He said the Oregon legislature passed a bill to provide flexibility and direct the OHA to develop a new program to provide more continuous coverage to the churn population with income just over Medicaid eligibility. He said the legislature's goal is to maintain coverage as much as possible, rather than the prior practice of frequent coverage changes. He said Oregon will perform redeterminations first on those who are likely to remain eligible and only later address those at higher risk for coverage loss. He said the legislation also calls for a bridge plan that would be developed in a waiver application; i.e., either a basic health plan under the ACA or a state innovation waiver. He said most individuals go between Medicaid and no insurance, not Medicaid and Marketplace coverage. He said the bridge plan would allow them to continue to have coverage through their Medicaid managed care plan by allowing them to continue coverage even when an individual's income rises to 200% of the federal poverty level. He said this approach could be a pathway for other states in the future. He said the end of the PHE is an opportunity for Medicaid and other coverage sources to work together in ways they have not in the past. Commissioner Stolfi said Oregon's plan would address not only the end of the PHE, but the problem of churning coverage that pre-dated it.

Marissa Woltmann (Massachusetts Health Connector) gave a presentation on how the Massachusetts state-based marketplace is working to maintain coverage for individuals who leave Medicaid after the end of the PHE. She said both federal and state subsidies are available through the Connector. She said Connector enrollment has dropped as individuals who move to Medicaid have stayed there over the last two years. She said the Connector expects about 100,000 people to enroll after leaving Medicaid. She said the expiration of enhanced federal subsidies would complicate the transition to the individual market for many enrollees. She said the Connector worked to reduce the administrative burden, establish automatic SEPs for those losing Medicaid, and support individuals who need to use paper documents. She said the Connector is adding an option for automatic enrollment for those with $0 premiums and looking to maintain continuity of care for those who transition. She said clear messaging will be critical in reaching individuals who need to transition coverage. She said the transition is a high stakes project that requires collaboration across many entities. Commissioner Stolfi asked about how health insurance premium rates might be affected by the influx of enrollees from Medicaid. Ms. Woltmann said projections have not yet been developed, but because several Medicaid managed care plans also participate in the state's individual

market, they likely have good data on the expected cost of these enrollees. Commissioner Stolfi said Oregon expects that more enrollees from Medicaid could lead to a better risk pool in the individual market.

Wayne Turner (National Health Law Program—NHeLP) and Karen Siegel (Health Equity Solutions) presented on suggestions for state insurance regulators to address the end of the PHE. Mr. Turner said consumer representatives met over the last two months to develop recommendations for state insurance regulators. He said large coverage losses are possible. He said some individuals will transition coverage, but others will be unlawfully terminated from Medicaid, and maintaining coverage for them as they go through the process is important. He said some consumers may not know they have lost coverage until they need a service and are denied coverage, and these may be the ones who come to state insurance regulators. Ms. Siegel said people of color have less access to employer-sponsored coverage, while people with disabilities may have less access to receiving and understanding important information sent to them about their coverage. She said working with community-based organizations can help assist individuals who experience these challenges. She said frequently asked questions (FAQ) and other messaging should be clear, and community organizations can help workshop messaging. She said consumers will need assistance both in enrolling in plans and in using their coverage. Mr. Turner said transitions are often not smooth, so there will be disruptions to care. He referenced the NAIC's *Health Benefit Plan Network Access and Adequacy Model Act* (#74) and its provisions on continuity of care provisions, which have been adopted in some state laws. He said departments of insurance (DOIs) should link consumers to other resources, including Medicaid, the Marketplace, state prescription drug assistance programs, and others. He encouraged state insurance regulators to examine health insurers' payment of commissions for Marketplace products and network adequacy.

Jackson Williams (Dialysis Patient Citizens—DPC) urged state insurance regulators to consider the ongoing care needs of individuals with chronic diseases, not just continuity of care for patients who are in the middle of an acute care episode.

3. Received an Update on Research into Health Disparities

Kelly Edmiston (NAIC) presented an update on research he conducted with Center for Insurance Policy and Research (CIPR) colleagues on the health disparities effects of the rise in telehealth services and the move to alternative payment models. She said the end of the PHE has some implications for telehealth policy, as some restrictions on telehealth use were relaxed during the PHE.

Mr. Edmiston said CIPR's overall assessment on telehealth is that it provides a significant opportunity to increase access to care and reduce disparities, but at the same time, it creates the possibility for a new disparity among vulnerable populations who lack access to the digital tools or culturally competent care.

Mr. Edmiston said alternative payment models can be vulnerable to opportunistic behavior from providers, so the models should be adjusted to account for this challenge. He said different alternative payment models all have features that may create incentives to treat vulnerable populations differently and inequitably. He said value-based payments have pros and cons regarding health disparities. He said the highest cost patients have the greatest opportunity to reduce costs, and there are incentives for care coordination in value-based payments. He said risk adjustment mechanisms in value-based care are not sophisticated enough to remove incentives to avoid high-risk patients.

Mr. Edmiston said the CIPR could help in developing ideas for how the Working Group could present evaluation findings in response to its charges from the Special (EX) Committee on Race and Insurance. Commissioner Stolfi

said the Working Group would solicit feedback from members and interested parties, then he would work with the CIPR and the Working Group vice chairs and support staff to write an evaluation or recommendations for the Special Committee.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Spring National Meeting/Minutes – Final PDF/HInnMin 4.4

