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Health Innovations (B) Working Group
Tampa, Florida
December 13, 2022

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Tampa, FL, Dec. 13, 2022. The following Working Group members participated: Andrew R. Stolfi, Chair, Numi Griffith, and TK Keen (OR); Laura Arp, Co-Vice Chair, Michael Muldoon, and Maggie Reinert (NE); Nathan Houdek, Co-Vice Chair, and Jennifer Stegall (WI); Sarah Bailey (AK); Yada Horace (AL); Andria Seip (IA); Alex Peck (IN); Julie Holmes (KS); Sandra Darby and Robert Wake (ME); Sarah Wohlford (MI); Carrie Couch (MO); John Arnold and Chrystal Bartuska (ND); Maureen Belanger (NH); Paige Duhamel (NM); R. Michael Markham (TX); Ryan Jubber and Tanji J. Northrup (UT); Molly Nollette (WA); and Ellen Potter (WV). Also participating were: Chris Struk (FL); Randy Pipal (ID); and Michael Humphreys and Shannen Logue (PA).

1. Adopted its Summer National Meeting Minutes

Couch made a motion, seconded by Holmes, to adopt the Working Group's Aug. 10 minutes (*see NAIC Proceedings – Summer 2022, Health Insurance and Managed Care (B) Committee, Attachment One*). The motion passed unanimously.

2. Heard Presentations on Hospital Facility Fees

Commissioner Houdek said the Working Group had completed its work on a memorandum to the Special (EX) Committee on Race and Insurance on the health disparities impacts of telehealth and alternative payment models and that he would present the memorandum to the Special Committee at the Fall National Meeting.

Commissioner Houdek said the Working Group wished to hear more about whether site-neutral payment policies in Medicare would spread to state-regulated commercial market plans.

Maureen Hensley-Quinn (National Academy for State Health Policy—NASHP) presented on state policies to lower health care costs, including facility fees. She said consolidation among hospitals and health systems leads to increased costs. She said state stakeholders asked NASHP to develop a model law on facility fees. She said hospitals add additional facility fees after they acquire physician practices. She said the same services have higher costs when delivered by hospital outpatient departments. She explained that hospital facility fees were originally intended to pay for hospitals' costs for standby personnel and equipment, but they are now applied to pre-scheduled services outside the hospital.

Hensley-Quinn said it is often hard to determine the amount of facility fees from claims. She shared data from Massachusetts showing that facility fees ranged from $200–$1300. She reviewed the NASHP model law, which would disallow hospital facility fees under certain conditions. It would also require transparency and reporting of facility fees. She provided an example of action by Connecticut to prohibit facility fees for certain codes of outpatient services. She said Connecticut found that fees moved from evaluation and management codes to assessment codes.

Hensley-Quinn said facility fees incentivize further consolidation. She said states often ask how the model law can be enforced. She added that the model law on facility fees can be accompanied by further laws prohibiting

anti-competitive contracting between health insurers and hospitals. She clarified that facility fees should not be eliminated across the board and said they are appropriate in the context of emergency departments and urgent care.

Molly Smith (American Hospital Association—AHA) provided comments on patient access to care and health system financing. She said health systems need adequate funding to deliver on their mission of providing access to care for patients. She said hospitals have been squeezed by commercial payers, which increases patient costs and makes facility fees necessary.

Smith said hospitals are unique among health care providers in that they are available to patients 24/7, and they offer high-acuity care, advanced diagnostics, and training for clinicians. She said hospitals are large generators of employment and economic activity.

Smith described the role of hospital outpatient departments (HOPDs). She said patients in HOPDs tend to be older, sicker, and more likely to be covered by Medicare and Medicaid. She said facility fees emerged to close a gap in payments for hospitals that provide unique, high-acuity services. She said public programs pay less than the cost of care, saying that Medicare pays $0.84 on the dollar and that Medicaid pays $0.88 on the dollar. She said many patients remain uninsured or underinsured. She said commercial payers have applied utilization management and denials at higher rates. She said payers are working to send patients to the lowest-cost sites of care, which changes the mix of patients seen by hospitals and raises the average patient acuity.

Smith shared statistics showing that the cost of delivering care has risen by 20% due to higher costs of drugs and other supplies, sicker patients, and longer lengths of stay. She said hospital finances have become more precarious and that higher rates of hospitals have closed. She said that changes to payment policies should address root causes, not just remove an important funding source for hospitals.

David Merritt (Blue Cross Blue Shield Association—BCBSA) offered remarks on improving patient affordability through appropriate billing. He said rising costs threaten affordability for families and businesses, largely due to rising prices. He said market distortions and gaming are driving up the cost of hospital care. He said prices increase when hospitals acquire physician practices and that prices increase more quickly in HOPDs than in physician-owed practices. He said HOPDs use hospitals' National Provider Identifiers rather than the physicians', which makes it impossible to apply the correct payment rates and determine the right patient cost sharing. He said higher rates incentivize further acquisitions.

Merritt said BCBSA supports state action to require the use of the appropriate billing codes and unique National Provider Identifiers, allowing insurers to determine the correct site of service in a claim. He said Colorado and Nevada have adopted these policies.

Miranda Motter (AHIP) described AHIP's work related to facility fees. She said health insurance is the gateway to accessing health care. She said the cost of health insurance is a reflection of what it costs to purchase health care. She said hospital spending represents the second largest share of health care costs. She shared a comparison of Medicare payments for services in physician offices versus HOPDs. She said there is little reason to think health care consolidation will slow or stop, so hospitals are likely to gain additional market power.

Motter offered potential solutions and recommendations to restore competition and lower costs for both federal and state policymakers. She cited site-neutral payment reforms as a potential solution.

Arnold said North Dakota's insurance department does not have the authority to regulate providers, and he asked how state insurance regulators can address provider costs. Merritt said state insurance regulators carry influence with state lawmakers and executives, and they should approach them with some of the solutions mentioned in the presentations. Hensley-Quinn said oversight of providers is a perennial question. She said it takes collaboration in states between insurance departments, licensing bodies, and perhaps attorneys general. She said an increasing number of states have created offices specially tasked with addressing health care costs.

Commissioner Humphreys asked whether more can be done in insurance codes to address billing and costs. Motter said value-based relationships moving away from fee for service are important. She said sometimes market distortions need to be corrected, but other policies, like benefit requirements or provider reimbursement requirements, put pressure on costs. She said competition should be allowed to work. Smith said that different alternative payment models that are not aligned do not seem to be working. She said state governments should collaborate with federal officials and payers to encourage better alignment. Commissioner Houdek said insurance departments have a variety of new responsibilities under the federal No Surprises Act (NSA) and other legislation and will need the resources to implement any new policies they are asked to put in place.

3. Heard a Presentation on the Coverage of Drugs to Treat Obesity

Randy Pate (Randolph Pate Advisors) presented on a toolkit for states on broadening coverage for obesity treatment. He said that obesity rates continue to rise and that experts predict half of adults will have obesity by 2030. He said the cost of obesity and its comorbidities could overwhelm health care budgets. He said medical costs for those with obesity are $2000 per year higher than those with a healthy weight. He said all but three states have an obesity prevalence of 25% or higher, with 16 states higher than 35%. He said racial and ethnic disparities exist in obesity prevalence and that it is also linked to lower income.

Pate said new obesity treatments have entered the market that fill the gap between behavioral interventions and surgery. He said there is a patchwork of coverage rules for anti-obesity medications (AOMs) in different states. He said all essential health benefit (EHB) benchmarks cover some treatment for obesity, but only two require coverage of AOMs.

Pate reviewed state options for increasing coverage of AOMs. One option is updating EHB benchmark plans. He said a number of states have already updated EHBs and gave New Mexico as an example. He said any new benefits cannot cause an increase in premiums over 1%. He said expanded coverage for AOM in New Mexico was estimated to increase premiums by only 0.03%.

Pate described a second option of pursuing a state innovation waiver under Section 1332 of the federal Affordable Care Act (ACA). He said if a 1332 waiver reduces federal spending, states can receive the difference to implement a waiver. He said a reinsurance program can both reduce rates and give insurers confidence in offering new benefits. He said states could combine a reinsurance waiver with increased coverage for obesity treatments including AOMs. Such a plan could waive the EHB requirement to add coverage, which may raise premiums, but a reinsurance waiver could produce offsetting savings for the waiver overall. He said states could also use a waiver to adopt complex care plans. If the complex care plans improved treatment and reduced costs, it could generate pass-through savings for a state.

Paige Duhamel asked about drug supply issues with anti-diabetes medications. Pate said off-label uses of anti-diabetes drugs to treat obesity is not something he supports or advocates for. He clarified that AOMs are separate drugs specifically approved to treat obesity.

4. Heard Presentations on Issues with Prescription Drug Formularies

Gerard Anderson (Johns Hopkins University) presented on how insurance commissioners can help to lower prescription drug spending. He acknowledged that state insurance regulators are not experts in clinical issues or prescription drug formularies, but there are a number of things they can do to help with prices.

Anderson said pharmacy benefit managers (PBMs) sometimes put more expensive drugs on a formulary when there are equally good, less expensive drugs available. He said employer benefits managers want the least expensive options when drugs are equally beneficial. He said waste-free formularies put the lower-priced drugs on formularies, but PBMs have put roadblocks in the way of doing so.

Anderson said wasteful drugs are put on formularies because they allow PBMs to earn higher rebates. This can allow a plan to pay a lower price while the enrollee pays a higher price because cost sharing is based on the list price of the drug. He said his team has developed a process for identifying and removing wasteful drugs. He said after identifying wasteful drugs, the team worked with payers to remove them from formularies and save millions of dollars.

Anderson said the team is currently focused on PBM contracts. He said there is minimal transparency in PBM contracts, so plan sponsors do not know if they are getting a good deal. He said no payers he has worked with have the data to understand PBM contracts. He said that insurance commissioners should use regulation to make sure PBM contracts are transparent when they promise good deals to payers and that they should share actual rebate data with payers. He encouraged follow-up questions to be directed to his colleague, Mariana Socal, at Johns Hopkins.

Carl Schmid (HIV+Hepatitis Policy Institute) provided comments on discrimination and other barriers to access to prescription drugs. He said discrimination is prohibited under two separate sections of the federal ACA, the essential health benefits (EHBs) provisions, and Section 1557. He said some plans in Florida in 2015 put every HIV/AIDS drug on the highest cost tier, but his organization worked with the insurance commissioner to adopt requirements for reasonable copays and no prior authorization. He said Florida's action should be a model across the country. He said federal regulations like the 2016 and 2023 Notice of Benefit and Payment Parameters clarified that placing all drugs for a certain condition on the highest cost tier is a discriminatory practice. He said pending updates to Section 1557, regulations would apply non-discrimination protections to more plans as well as PBMs.

Schmid said colleagues across the country have worked to identify and eliminate discriminatory practices. He said plans in North Carolina in 2022 and 2023 put all HIV drugs, including generics, in the highest cost tiers. He said groups have filed discrimination complaints with North Carolina's insurance commissioner.

Schmid said other practices like utilization management, including step therapy, can be discriminatory. He cited the rising number of drugs excluded by PBMs, copay accumulator programs, and alternative funding programs that exclude some drugs from EHBs as other harmful practices.

Schmid said state insurance regulators can address these issues by fully reviewing plans for drug coverage and tier placement. He said they can also ban copay accumulator programs, ensure all drugs are part of EHBs, and review plans' utilization management practices.

Arp asked whether all drugs being on the highest cost tier is in itself discriminatory or whether it can be permissible if there is a legitimate reason, such as the high cost of the drugs. Schmid said there are clarifications regarding cost, but there are some drugs like PrEP that are low cost. Arp said some states have taken a different interpretation of what is discriminatory than federal officials. She said states should look at drugs that have the potential to be used discriminatorily and question why they are placed on a high tier. Schmid said there are differences in price among HIV drugs, but some plans place even generics on high tiers. He added that rebates also affect the cost of drugs, not just list price.

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

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