Draft: 12/21/21

Health Innovations (B) Working Group
San Diego, California
December 11, 2021

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in San Diego, CA, Dec. 11, 2021. The following Working Group members participated: Andrew R. Stolfi, Chair, and TK Keen (OR); Laura Arp, Co-Vice Chair, and Martin Swanson (NE); Nathan Houdek and Jennifer Stegall, Co-Vice Chairs (WI); Andria Seip (IA); Julie Holmes (KS); Robert Wake (ME); Cynthia Amman (MO); Jon Godfread (ND); Maureen Belanger (NH); Paige Duhamel (NM); David Buono and Shannen Logue (PA); Chris Herrick (TX); Tanji J. Northrup (UT); Molly Nollette (WA); and Joylynn Fix (WV). Also participating were: Lori K. Wing-Heier (AK); David Altmaier and Chris Struk (FL); Weston Trexler (ID); Stephanie McGee (NV); and Glen Mulready (OK).

1. Heard a Presentation on Health Plan Efforts to Address Health Disparities

Commissioner Stolfi reviewed the changes the Working Group received from the Special (EX) Committee on Race and Insurance. He said the Working Group plans to evaluate existing research on the health disparities impacts of telehealth and alternative payment models and hear from stakeholders on these topics.

Dr. John Lumpkin (Blue Cross and Blue Shield of North Carolina—BCBS NC) described his organization's work to develop a health equity index score. He shared a statement from BCBS NC that says, "[n]o community can truly be healthy until racism no longer exists." He said North Carolina counties can be divided into tiers based on their economic distress. He said a health equity index can provide accountability to measure what works. He said BCBS NC's index measures both racial and economic disparities and currently shows a summary score for overall equity of 87%. He said the index score would be used to support BCBS NC's priorities of improved data on race, ethnicity, and language; improve maternal care; increase behavioral health access; and increase immunizations and wellness visits. He described an example of work to improve maternal health, particularly for Black Americans.

Commissioner Stolfi asked how other states can develop similar health equity index scores. Dr. Lumpkin said health insurance plans cannot do it alone, and states should work with a range of stakeholders to develop coordinated measures. Commissioner Stolfi asked what strategies BCBS NC has used to collect data. Dr. Lumpkin said the biggest challenge in developing the index was that race and ethnicity data are not readily available. He said some data is self-reported by enrollees, and other data is calculated, but the best data is reported by consumers. Commissioner Stolfi asked what state insurance regulators can do to support industry efforts to reduce health disparities. Dr. Lumpkin said there must be an open partnership between state insurance regulators and regulated plans.

Dr. Darrell Gray (Anthem) presented on the company's efforts to improve health equity. He said Anthem has an integrated approach to whole health that includes physical, behavioral, social, and pharmacy health and incorporates consumers, communities, and associates. He described the difference between equality and equity, and he said Anthem's approach to equity is data-driven, inclusive, and nimble. He stressed the importance of addressing a variety of needs, including upstream (poverty, racism, and discrimination), midstream (housing, transportation, and violence), and downstream (chronic disease, poor nutrition, and poor mental health). He said Anthem is working to develop a Whole Health Index that includes measures of global health, social drivers, and clinical quality. He described three steps for identifying social needs, coordinating social care, and creating social interventions. He said health-related social needs contribute to 70–80% of clinical outcomes, while clinical care contributes only 20%.

Ms. Seip asked in what markets Anthem is applying its social interventions. Dr. Gray said the company's goal is to deploy them across all public and private markets in which it operates. Mr. Houdek asked what length of time the company expects to move from the first step of identifying social needs to the third step of creating social interventions. Dr. Gray said it varies greatly by the type of need, the population, and the insurance market being served. Commissioner Stolfi asked how state insurance regulators can support industry efforts to reduce health disparities. Dr. Gray said assisting with data definition and collection efforts would be helpful since the company does not have complete self-reported data on race and ethnicity or sexual orientation and gender identity. He said New York has been able to get better data on race and ethnicity in its individual market through updates to collection practices in its state-based exchange.

2. Heard a Presentation on the Health Disparities Impacts of Telehealth and Alternative Payment Models

Kelly Edmiston (NAIC) presented the findings of research he conducted with the Center for Insurance Policy and Research (CIPR) colleagues on the health disparities impacts of the rise in telehealth services and the move to alternative payment models. He said the key take-away is that both telehealth and alternative payment models have the potential to improve health and reduce disparities, but they must evolve to do so because they are not there yet. He said prior to the pandemic, the share of claims delivered through telehealth was minimal, grew enormously early in the pandemic, and has since declined but not to pre-pandemic levels. He said telehealth can provide greater access to culturally competent care based on language, race, or gender. He said telehealth is especially effective for chronic conditions, which disproportionately affect vulnerable populations. He said the potential of telehealth is limited by restricted access to broadband connections. He said telehealth requires significant upfront costs, and uncertainty in payment policies can limit needed investments.

Mr. Edmiston said alternative payment models seek to reduce the incentive to overtreat and the disincentive to treat underserved populations, which occurs because underserved or vulnerable populations may need more low-margin care. He said value-based payment models are intended to reduce the cost of care without reducing quality or improve quality without increasing cost. He said research has not shown value-based payments to be effective in reducing disparities, despite the potential to do so. He said models can include social risk factors, but they are not currently sophisticated enough due to data limitations.

Mr. Keen asked whether any single telehealth technology platform has emerged and whether it allows medical records to be easily exchanged between patients and providers. Mr. Edmiston said the fast adoption of electronic health records is a good sign for telehealth. He said there are multiple models that exist for telehealth, and some have higher sales than others. He said basic digital literacy is more important than the technology used. Ms. Seip asked whether alternative payment models that incorporate social determinants of health have better outcomes than those that do not. Mr. Edmiston said research on Medicare Advantage showed small effects of accountable care organizations overall, and the measurement of social determinants is not adequate yet to reach a conclusion. Mr. Trexler asked whether payment parity rules are related to the needed investments in telehealth. Mr. Edmiston said some states have added parity requirements since the pandemic, and they may be temporary. He said this may limit providers' willingness to make investments. Mr. Trexler asked whether telehealth could result in lower health care costs overall. Mr. Edmiston said telehealth use has leveled off in the last year and is likely here to stay. Mr. Wake said telehealth is different from in-person health care. He said Maine imposed temporary payment parity during the pandemic because telehealth needed to substitute for in-person care, but it does not always need to be a substitute. He said in cases where different services are provided through telehealth, payment parity is not appropriate because it is one-size-fits-all. He said telehealth providers need equity in payments, not equality. Ms. Arp asked about the age distribution of patients who use telehealth. Mr. Edmiston said consumers who use telehealth tend to be older than those who do not, and non-white populations are less likely to use it. He said urban consumers are more likely to use it, potentially due to a lack of broadband access in rural areas. Ms. Arp said state insurance regulators could look at telehealth as a bonus, requiring in-person networks to be adequate while offering access to more culturally competent or specialized providers through telehealth.

3. Discussed Other Matters

Commissioner Stolfi said NAIC staff would ask the Working Group what questions the presentations raised and how else members would like to dig into the issues highlighted. In addition, NAIC staff would ask members how they want to move toward developing recommendations related to race and insurance work.

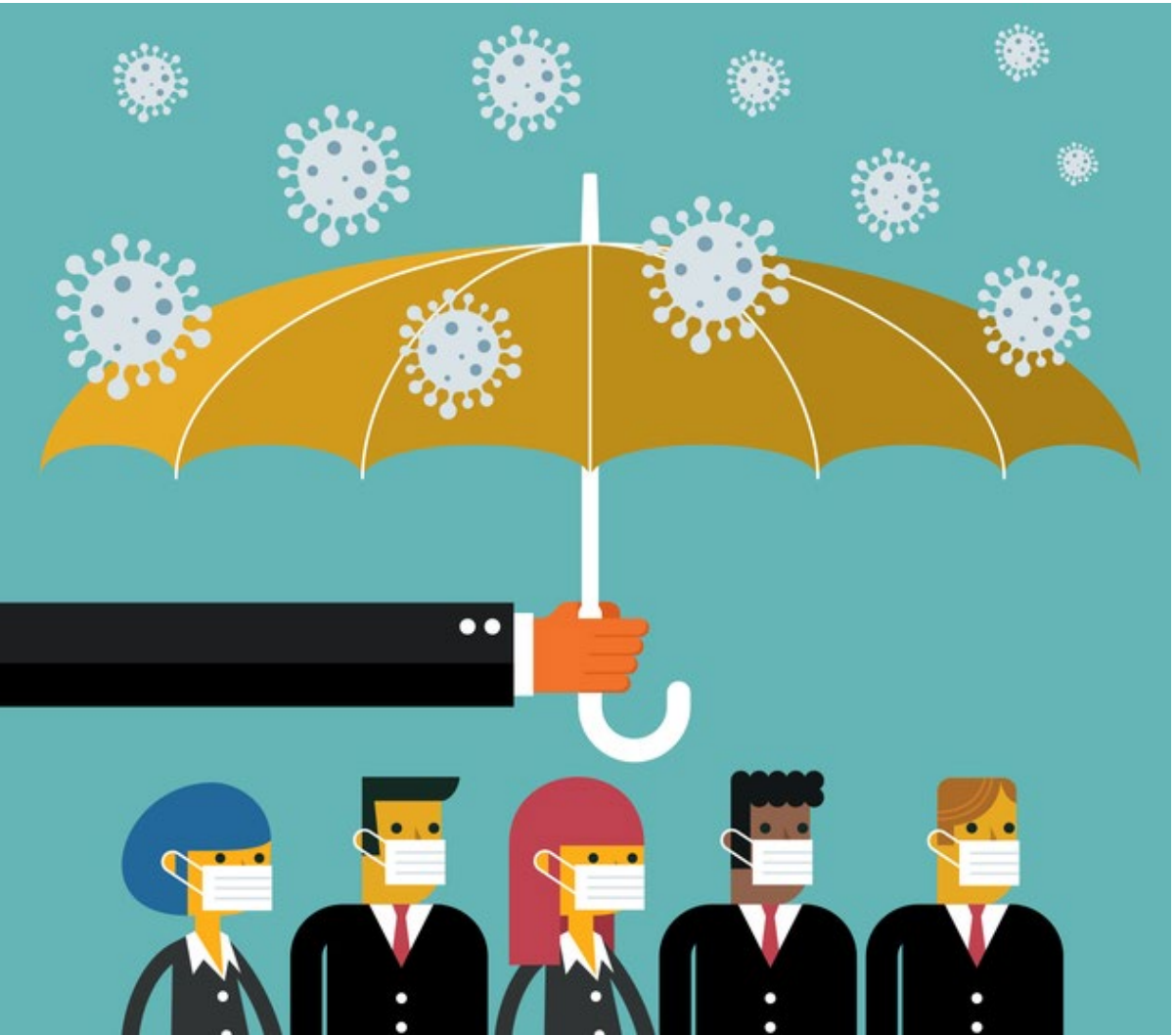
Having no further business, the Health Innovations (B) Working Group adjourned.

HInn Minutes 12.11

# Oregon Health Plan
# Post-Public Health Emergency
# Eligibility Redeterminations Planning

# Through the Public Health Emergency, people have had continuous Medicaid coverage



## Family First Coronavirus Recovery Act

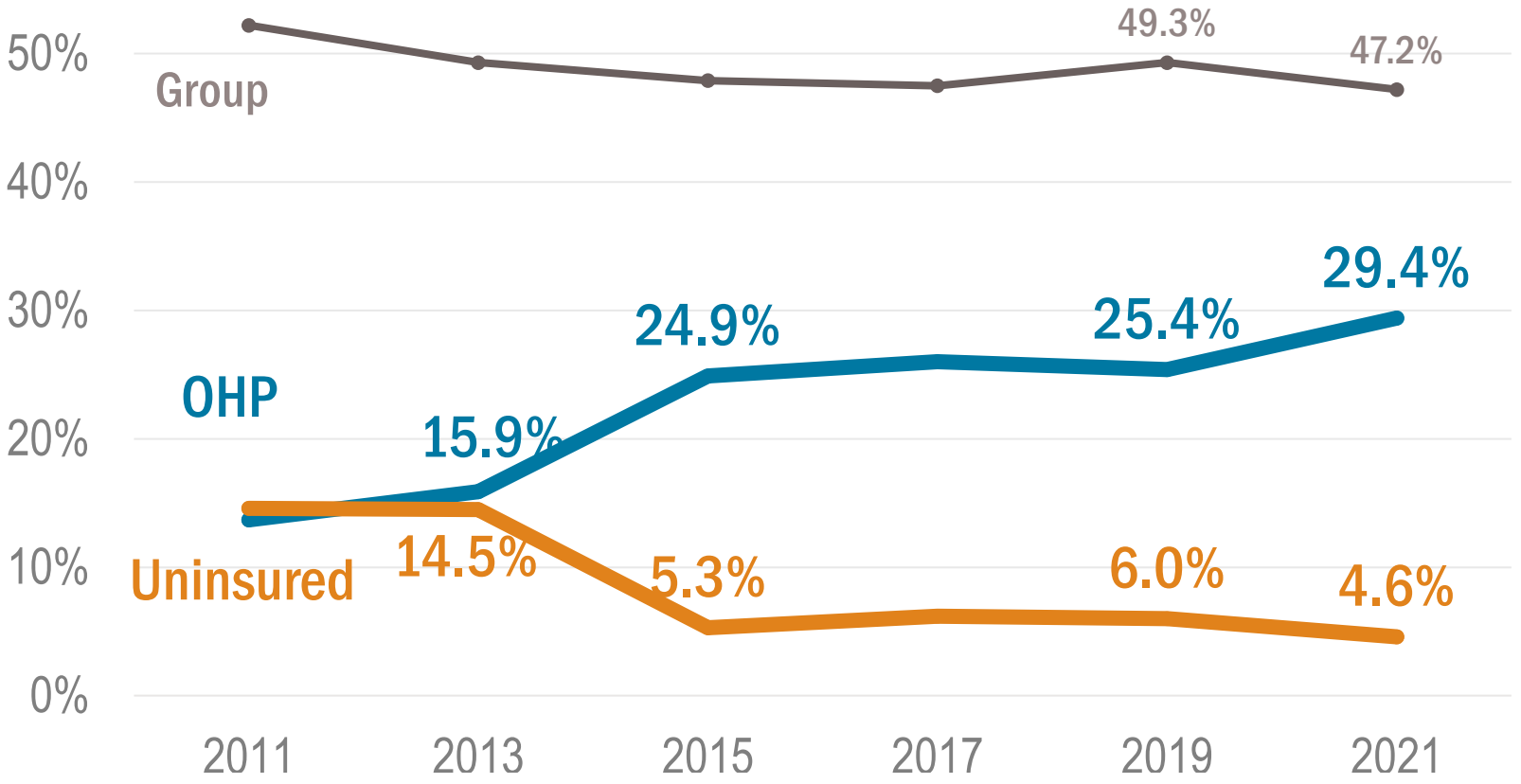
1. Provides continuous Medicaid coverage *for the duration of the federal public health emergency*.
2. Removes administrative barriers to enrollment

When PHE ends, states will have 12 months to redetermine eligibility for all members.

**Oregon will have to redetermine eligibility for all 1.4 million people on OHP.**

# During the PHE, the uninsured rate dropped to a record low of 4.6%.

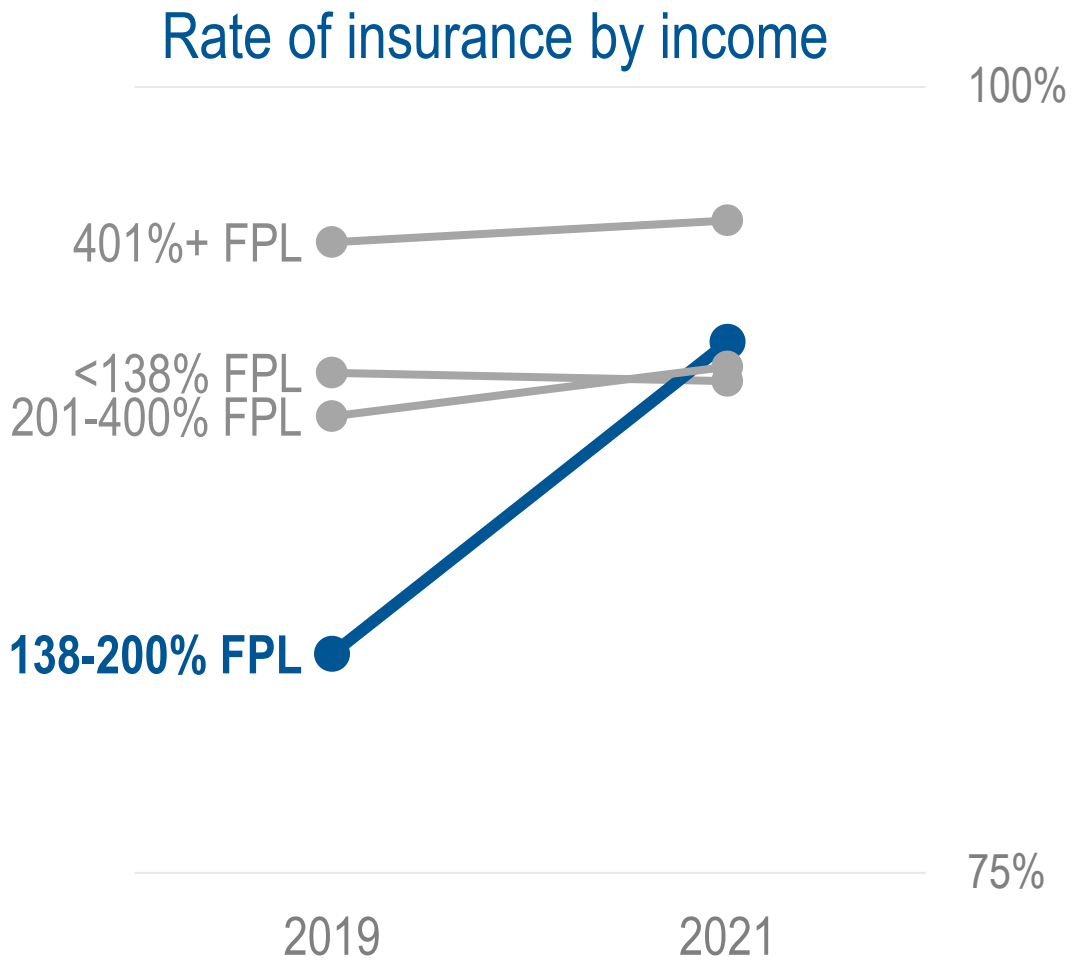
*For Black/African American individuals it dropped from 8% to 5%.*

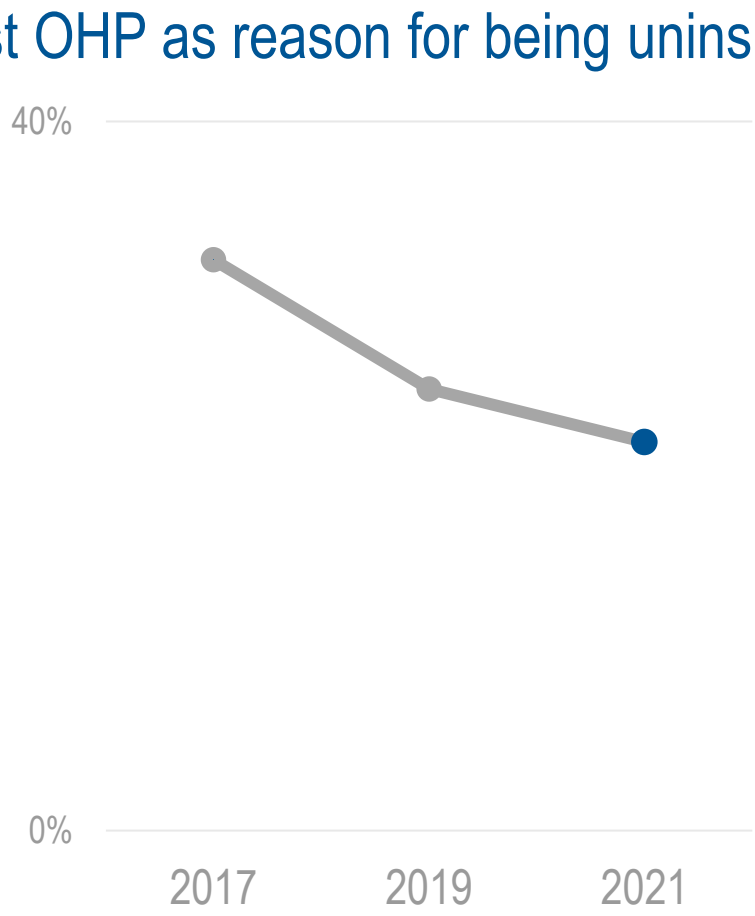



**Data is from the 2021 Oregon Health Insurance Survey. OHP caseload has continued to grow since this survey.**

*Source: Oregon Health Insurance Survey (OHIS)*

# The largest coverage gains were among adults with low income as fewer people reported being uninsured due to loss of OHP




*Source: Oregon Health Insurance Survey (OHIS)*

# HB 4035 approach to redeterminations

## Redeterminations Process

Under the normal (default) redeterminations process, the total caseload of 1.4 million would be spread over 12 months at random. Renewal notices go out beginning June 2022, closures begin in August. Approximately 120,000 members/month redetermined; 25,000 closures/month.

**HB 4035 Proposed Approach: Phase closures of OHP coverage by population** to maintain coverage longer for higher risk cases. Allows a ramp-up and more time to coordinate with partners. *Allowed without any additional federal approval.*

## New Bridge Plan for Churn Population

***Create a new "bridge" plan for churn population*** that "catches" individuals with low income (churn) under 200% of FPL exiting Medicaid to provide continuity of care and a more affordable option. *Use 1331 or 1332 options under the ACA to leverage federal ACA funding.*

If needed **temporarily expand OHP eligibility** to continue coverage for people lower-income (churn) individuals until transitioned to the new program. *Use a temporary 1115 waiver, if need to maintain coverage up to 200% FPL through redetermination period. Need/cost would be mitigated if PHE extended.*

# Develop new “bridge” plan for churn population

Seek federal approval to create a more affordable option that provides continuity of care in a CCO for low-income adults (138-200% of FPL) who are likely to “churn” in and out of OHP.

- Leverage federal Marketplace subsidies to provide an alternative coverage option aim to have a minimal cost to the state and members.
- Seek approval through a section 1331 or 1332 authority under the ACA.
- Aim is to “catch” (auto-enroll) eligible exiting OHP members with option to stay in CCO.
- Any plan would need to work for and address concerns of both OHA and DCBS.

# Why this matters for commercial insurers?

- Likely to be the largest shifts in health insurance since the ACA
- Many individuals eligible for Marketplace but high risk of becoming uninsured
- Smoothing transition requires Medicaid and commercial markets to work together (e.g. exchange information on enrollees)
- Opportunity for new collaboration that makes it easier to stay insured:
  - Comparing/aligning provider networks
  - Leveraging Medicaid managed care plans and commercial insurers to assist with outreach/enrollment assistance

MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

# Planning for the End of Continuous Medicaid Coverage

MARISSA WOLTMANN
Senior Director of Policy and Applied Research

NAIC Health Innovations Working Group, April 4, 2022

# Overview

**The Massachusetts Health Connector is working closely with other agencies and external stakeholders to ensure a smooth transition for Medicaid enrollees losing coverage at the end of the Public Health Emergency.**

- Background on the Health Connector
  - Who we are
  - How we work with MassHealth, Massachusetts's Medicaid program
  - Our experience during the federal Public Health Emergency (PHE)
- Preparing for the end of the PHE
  - Reducing administrative burdens
  - Streamlining enrollment
  - Creating effective messaging
- Wrap-up and Questions

# Background on the Health Connector

# Health Connector Overview

**The Massachusetts Health Connector is the state's health insurance Marketplace. It offers individuals, families, and small employers access to affordable health insurance and dental coverage.**

- Created in 2006 as part of a landmark state health reform law aimed at increasing access to health insurance in Massachusetts, and later adapted to incorporate the federal health reforms of the Affordable Care Act (ACA)
- In 2022, nine medical carriers offer Qualified Health Plans (QHPs) and serve roughly 242,000 enrollees at varying levels of subsidy based on income—about 82% of all individual market enrollees in the state

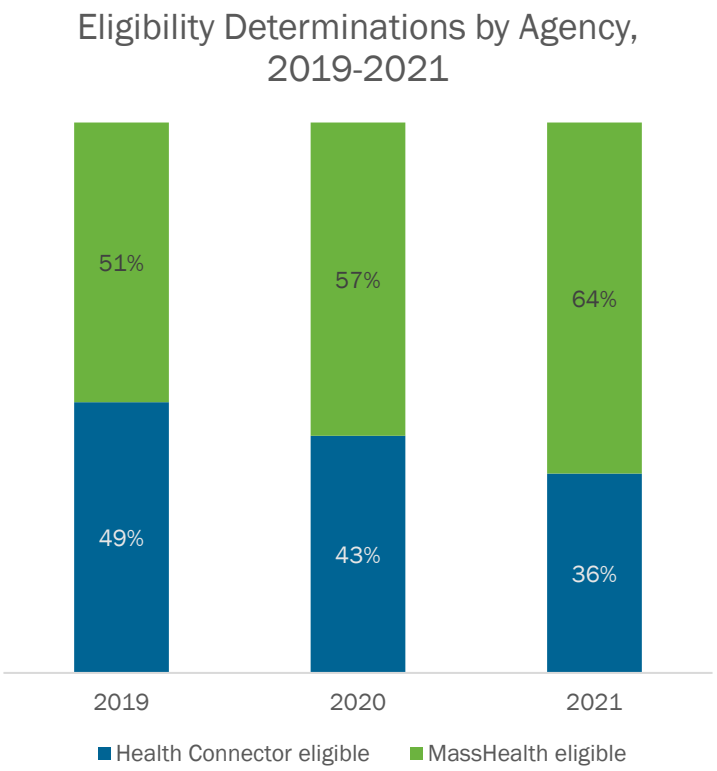
## Health Connector Programs

| Unsubsidized QHPs | QHPs with APTC | ConnectorCare |
|---|---|---|
| • Individual plans at all metallic tiers with no federal or state subsidies<br>• About 52,000 enrollees | • Individual plans at all metallic tiers with federal Advance Premium Tax Credits only<br>• About 35,000 enrollees | • State premium and cost sharing subsidies added to QHP+APTC Silver plans for those up to 300% FPL<br>• About 155,000 enrollees |

# Impact of the Public Health Emergency

**While overall insurance coverage in the state has increased over the last two years, commercial coverage has declined while public coverage has increased.**

- This trend is mirrored in the eligibility system the Health Connector shares with MassHealth, the state's Medicaid program
- Health Connector enrollment dropped by 58,000 from March 2020 to March 2022, largely driven by individuals continuing to qualify for Medicaid during the PHE
- Currently, over 600,000 individuals in our system have MassHealth coverage associated with coverage protections of the PHE
- The Health Connector expects to see upwards of 100,000 enrollees join over the course of the "unwinding" of the PHE



# Preparing for the End of the PHE

# Key Strategies to Smooth Transitions

**The Health Connector and MassHealth have been working closely to coordinate the process by which individuals will have their eligibility for MassHealth redetermined.**

- Three key areas of focus for us are:
  - Reducing administrative burdens
  - Streamlining enrollment
  - Creating effective messaging
- Alongside these efforts, extension of subsidy enhancements provided in 2021 and 2022 by the American Rescue Plan would be an important tool in helping individuals enter or stay in the individual market, as it ensures that no enrollee would have to pay more than 8.5 percent of household income on premiums
  - Health Connector members saw subsidy increases of $80 per month, on average, with individuals in high-cost regions and individuals over 55 seeing the biggest savings

# Reducing Administrative Burdens

**Reducing the administrative burdens associated with qualifying for and enrolling in coverage will help individuals complete the process.**

| Activity | How It Helps |
|---|---|
| Increased opportunities to verify eligibility with data sources | ▪ By considering income attestations verified as long as they are no more than 20% lower than state or federal income data, fewer individuals will experience subsequent eligibility changes for failing to return paperwork |
| Automated verification of qualifying loss of coverage to trigger special enrollment period | ▪ The shared eligibility system knows the date an individual newly eligible for QHP coverage lost Medicaid and can automatically open and close the associated 60-day special enrollment period without the applicant needing to request it or prove eligibility |
| Reviewing list of acceptable documents individuals can provide if needed to prove eligibility | ▪ Many individuals have experienced impactful and recent changes in their lives that are difficult to document, which may lead them to send incomplete verifications or not attempt to send them at all<br>  ▪ Example: newly established self-employment |

# Streamlining Enrollment

**Many individuals losing Medicaid may not realize the need to enroll in QHP coverage once they qualify or may need support in choosing a plan that meets their needs.**

| Activity | How It Helps |
|---|---|
| Implementing new automatic enrollment option for individuals eligible for $0 premiums | ▪ Pre-ACA auto-enrollment at the Health Connector was found to increase enrollment by 30-50% and disproportionately caught younger enrollees with lower costs[1] |
| Assessing overlap in the networks of plans participating in both Health Connector and MassHealth | ▪ Will allow for proactive messaging with the help of providers and health plans to support individuals to find new coverage with preferred providers and avoid disruptions of care |
| Providing tools to help individuals choose a health plan | ▪ Provider and formulary search options embedded in the plan shopping experience make it easy to see which plans meet individuals' needs<br>▪ Navigator organizations can add in-person support well-versed in community providers and member needs |

[1]Shepard, M. & Wagner, M. Working Paper. Reducing Ordeals through Automatic Enrollment: Evidence from a Subsidized Health Insurance Exchange. https://scholar.harvard.edu/mshepard/publications/economics-automatic-health-insurance-enrollment

# Creating Effective Messaging

**Clear and effective calls to action will be essential before and during the PHE unwinding so individuals are equipped to take the needed steps to maintain coverage.**

| Activity | How It Helps |
|---|---|
| Engaging focus groups | ▪ Testing messages with the right audiences will ensure broader campaigns communicate well to the diverse population transitioning off Medicaid and their diverse pandemic experiences<br>▪ Ensures messages translate well into languages other than English |
| Preparing community-level events with a data-driven approach | ▪ Relying on trusted community partners has proven highly effective both in prior campaigns and allows for events and materials tailored to a community's population |

# Wrap-up and Questions

**The Health Connector is preparing for the likelihood of a large-scale member transition over the course of 2022 and Open Enrollment 2023.**

- Staff are focused on reducing administrative barriers, streamlining enrollment, and creating effective messaging, all in conjunction with sister agencies and external stakeholders, to ensure the individual market is a hospitable landing place as they transition out of Medicaid

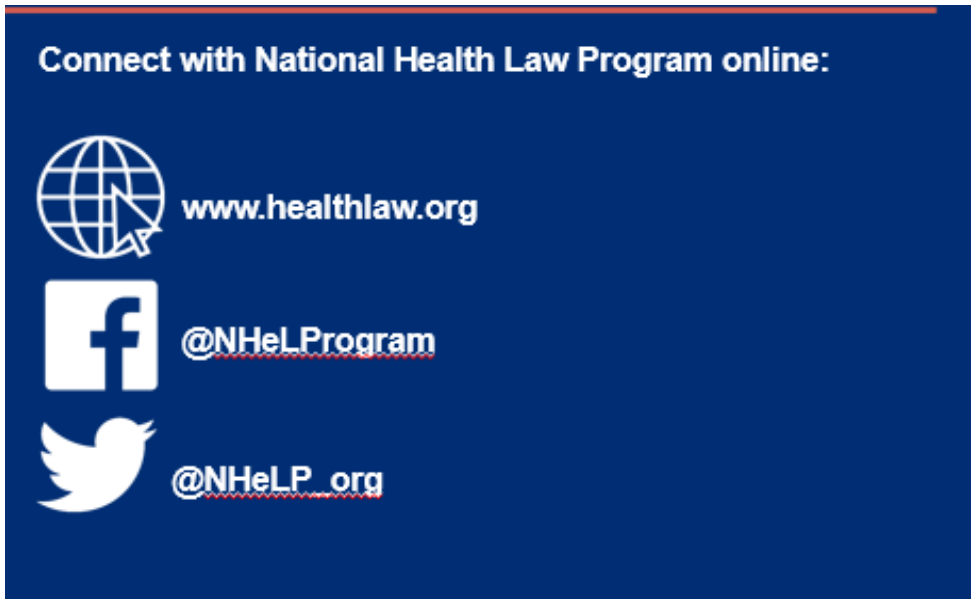
# Unwinding the Public Health Emergency: How Departments of Insurance Can Help Consumers

WAYNE TURNER, NATIONAL HEALTH LAW PROGRAM

KAREN SIEGEL, HEALTH EQUITY SOLUTIONS

**The National Health Law Program** (NHeLP) is a national non-profit committed to improving health care access and quality for underserved individuals and families

- State & Local Partners:
  - Disability rights advocates – 50 states + DC
  - Poverty & legal aid advocates – 50 states + DC
- National partners




Health equity is achieved when a person's characteristics and circumstances — including race and ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, health, immigration status, nationality, religious beliefs, language proficiency, or geographic location — do not predict their health outcomes.

https://healthlaw.org/equity-stance/

# Health Equity Solutions

HEALTH EQUITY SOLUTIONS

*VISION*

For every Connecticut resident to obtain optimal health regardless of race, ethnicity, or socioeconomic status.

*MISSION*

To promote policies, programs, and practices that result in equitable health care access, delivery, and outcomes for all people in Connecticut

# PHE unwinding: not just a Medicaid issue

- Up to 16 million people expected to lose coverage; including 6.7 million children
  - need to transition to other coverage (Marketplace plans, ESI)
  - terminated for procedural reasons, but still Medicaid eligible (*e.g.*, updating info)
  - unlawfully terminated (note - Medicaid due process incl. notice and fair hearing rights)
- People who lose coverage/fall through the cracks will turn to DOIs for assistance
  - Many won't learn of coverage termination until seeking care (e.g., filling prescriptions)
  - People don't necessarily identify their coverage as "Medicaid"
- DOIs should plan now to help prevent PHE coverage losses, help consumers transition to new coverage, provide assistance and resources for those who lose coverage

# Context: Disproportionate Impact

- Less access to employer-sponsored plans
- Disproportionate housing instability or relocation
- Accessibility of information–source & content

# Action: Community Engagement

**Why**: Proven strategy for addressing disparities

**What**:

1. Before end of PHE: Clear, coordinated communication
2. After end of PHE:
    a. Clear, coordinated communication
    b. Bidirectional information flow
    c. Collaboration with outreach efforts from Medicaid and SBMs

# Action: State Continuity of Care Laws

- Issue bulletins reminding issuers of their obligations under state continuity of care laws (*e.g.*, for persons undergoing active course of treatment for acute medical conditions, or for pregnant persons in their third trimester)
- Use authority, where possible, to expand conditions protected and plans covered
- Issue guidance encouraging plans to honor past prior authorization, allow consumers to access drugs already approved through an exceptions process, and avoid unnecessary repetition of step therapy.

# Action: Get Ready Before the Storm

- Update websites, FAQs, and consumer-facing resources
- Link to Medicaid, Marketplace, navigators, AIDS Drug Assistance Programs, legal services
- Monitor marketing to prevent adverse selection, unlicensed brokers, misleading information on non-compliant plans
- Enforce nondiscrimination protections
- Prepare for an increase in consumer calls seeking assistance/information when people lose coverage and train Call Center/other staff about unwinding issues
- Review network adequacy and plan capacity for influx of new enrollees
- Educate consumers on steps they can take to avoid disruptions in care (*e.g.*, prescription refills)

# Contact us

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# Questions? Comments?

March 25, 2022

Attn: NAIC Health Innovations Working Group
Andrew R. Stolfi, Chair
Laura Arp/Martin Swanson, Co-Vice Chairs
Nathan Houdek/Jennifer Stegall, Co-Vice Chairs

From: NAIC Consumer Representatives Ad Hoc Group on PHE Unwinding (Wayne Turner, Karen Siegel, Shamus Durac, Silvia Yee)

**Re: Unwinding the Public Health Emergency: How Departments of Insurance Can Help Consumers**

## Introduction

When the HHS Public Health Emergency (PHE) ends, the continuous eligibility requirement under the Families First Coronavirus Relief Act ends. State Medicaid programs will begin unwinding and conducting eligibility redeterminations, the first in many months for most enrollees. An estimated 16 million people will lose health coverage - some because they are no longer Medicaid eligible, and others because they do not complete the required paperwork to renew coverage.

State departments of insurance (DOIs) can play a key role to help prevent coverage losses, working with state Medicaid agencies and other partners, and helping consumers transition to new health coverage. DOIs will also likely be a first point of contact for consumers seeking assistance when they lose coverage.

NAIC consumer representatives appreciate this opportunity to provide the following best practices and recommendations for DOIs to prepare for PHE unwinding and to assist consumers who lose health coverage.

### 1. PHE unwinding will lead to significant health coverage losses

A recent study by the Urban Institute estimates that up to 16 million people will lose health coverage resulting from PHE unwinding. The Georgetown Center for Children and Families (CCF) projects that 6.7 million children are likely to lose their Medicaid coverage and are at risk for becoming uninsured for a period of time.

Some people who lose Medicaid coverage are no longer eligible for the program, for example, due to changes in income or aging out of eligibility categories (*e.g.*, Medicaid expansion enrollees are no longer eligible when they turn 65, but might be eligible for other Medicaid categories like Medicare Savings Programs). Others who lose Medicaid

are still, in fact, eligible. They may have not received notices sent by the state Medicaid agency, or did not understand and respond to requests for information as required.

Some states may unlawfully terminate individuals and families from Medicaid and the Children's Health Insurance Program (CHIP). The Centers for Medicare & Medicaid Services (CMS) recently warned states against terminating coverage for entire families without conducting individualized determinations, and reminded states of their obligation to consider all bases of eligibility before terminating, as required by law (see 42 C.F.R. § 435.916(f)(1)). States must also follow Medicaid due process protections, including pre-termination notice and hearing rights, required under federal law and the U.S. Constitution (see NHeLP's Unwinding the COVID-19 Public Health Emergency: Checklist for Redeterminations - National Health Law Program).

The people most impacted by PHE unwinding will be those who already face numerous challenges and obstacles to maintaining coverage and accessing health care. Medicaid enrollees experience economic and other challenges that make them especially vulnerable to coverage losses during PHE unwinding. Black, Indigenous, Latinx and other people of color; persons with chronic illness, complex medical conditions, and disabilities are overrepresented in Medicaid. As a consequence of systemic racism and other forms of discrimination, these populations are more likely to lack access to employer-sponsored insurance. People of color and LGBTQ+ households are also more likely to experience housing insecurity and, as a result, not receive mail. By definition, Medicaid enrollees are low income and can face significant other challenges, such as housing and food instability, low literacy, and limited English proficiency (LEP).

## 2. How DOIs can plan for PHE unwinding and help prevent coverage losses

Many Medicaid enrollees face termination because they do not respond to agency redetermination notices. Some may have moved during the pandemic and do not receive the notices; while others may simply not understand the notices and respond in time. Accordingly, many state Medicaid agencies are initiating consumer outreach and education efforts, encouraging Medicaid/CHIP enrollees to update their mailing addresses and other important information needed to renew their coverage. Such efforts can also help prepare enrollees who lose coverage at the end of the PHE by identifying resources and/or directing them to subsidized coverage options.

State DOIs should join these efforts, partnering with Medicaid programs, state based marketplaces, and other agencies, as well as navigator programs and other trusted community messengers. Best practices on outreach and education efforts include keeping messages and notices simple and not unduly alarming. Notices should be easy

to read, and meet requirements such as taglines for LEP individuals and accessibility for persons with disabilities, such as large print type.

Many DOIs already provide information and direct links to state Medicaid agencies, healthcare.gov or state exchanges, and should ensure that those links are up-to-date and prominently featured on DOI websites. DOIs should specifically refer to the insurance affordability programs (*i.e*. Premium Tax Credits and Cost Sharing Reductions) available with Qualified Health Plans (QHPs), but not through other forms of coverage. DOI websites should also encourage consumers to ensure their contact information is up-to-date with their insurers, urge consumers to respond to eligibility notices, and provide consumers tips to ease their transition to new coverage.

For example, Oklahoma's Insurance Department provides a "Get Ready Before the Storm" checklist for consumers to prepare for severe weather. DOIs could provide a similar checklist for consumers to prepare for PHE unwinding. Even consumers who seamlessly transition from Medicaid to other forms of coverage such as Marketplace plans for Employer Sponsored Insurance (ESI) face disruptions in care. DOIs should encourage consumers to take steps such as documenting their prescriptions, obtaining refills, and updating insurer information with providers.

DOIs can also disseminate this information to community-based organizations, community health centers, and other entities best positioned to reach the communities most likely to experience coverage loss. Partnering with state Medicaid agencies and state-based Marketplaces can both ensure consistency in messaging and improve dissemination efforts. Further, collaboration with other state agencies offers opportunities to elicit consumer feedback on transition plans and messaging to improve the effectiveness of these efforts. For example, Colorado has a stakeholder engagement plan and is incorporating feedback from its Medicaid Member Experience Advisory Councils in messaging toolkits and materials.

NAIC's Health Innovations work group should also partner with the Consumer Information Subgroup to update FAQs on health reform to include information on PHE unwinding.

### 3. How DOIs can help consumers who lose health coverage

Many consumers will not learn their Medicaid coverage has terminated until they seek services, such as refilling a prescription. Because state Medicaid programs are branded (*e.g*., Oregon Health Plan, BadgerCare), consumers may not reach out to state Medicaid agencies if their coverage has been terminated. Many of these consumers,

particularly those enrolled in Medicaid managed care plans, will likely turn to their state's DOI seeking assistance.

Consumers may also turn to their managed care plan. Some states have a distinct state agency or division regulating managed care plans across public and commercial lines of business. They can work directly with MCOs that also operate QHPs, to inform individuals who may lose their Medicaid coverage on how to obtain QHP coverage with the same issuer *before* a coverage gap occurs. Enrollees with disabilities and pre-existing conditions will especially need to avoid coverage gaps. Any state DOI or health care-specific state agency who proactively works with issuers that offer Medicaid managed care plans, as well as QHPs, will be in a better position to monitor for non-discrimination as well.

Again, consumer information is key. State DOIs should provide information on Special Enrollment Periods (SEPs), links to navigators/assisters, and provide consumer tips for people transitioning coverage. State DOIs should be adequately staffed to handle the influx of consumer calls, and collaborate with Medicaid agencies to increase navigator capacity during the redetermination period. DOIs should also provide links and referrals to other state safety net programs, such as the AIDS Drug Assistance Program (ADAP).

Many states have continuity of care laws (see NAIC Health Benefit Plan Network Access and Adequacy Model Act), for example, for persons undergoing active courses of treatment for acute medical conditions, or for pregnant persons in their third trimester. DOIs should issue bulletins reminding issuers of their obligations under state continuity of care laws. Where applicable, they should consider broadening the kinds of conditions protected, and closely examine which products are covered, to ensure these protections extend to the broadest possible set of plans. DOIs should also issue guidance encouraging plans to honor past prior authorization, and allow consumers to access drugs already approved through an exceptions process, and avoid an unnecessary repetition of step therapy.

State DOIs should also promote consumer resources warning against limited coverage plans, such as short term, limited duration plans, and sharing ministry plans. Tools from the Consumer Information Subgroup, including STOP, CALL, CONFIRM, can help consumers avoid junk plans and steer consumers to trusted sources of information, including navigator programs, licensed brokers, and the federal or state exchanges. DOIs also need to monitor smaller plans that might not have the financial capacity or network capacity (most plans have an internal network capacity number that they estimate when putting together their access plan) to handle an influx from PHE unwinding.

March 25, 2022

**Summary of recommendations for DOIs:**

1. Partner with state Medicaid/CHIP programs, ADAPs, brokers, navigators, and other trusted messengers on consumer education to update Medicaid information and what to do if terminated. If individuals are terminated for procedural reasons (*e.g.,* didn't return a form), they likely can get reinstated by providing needed information, and not just go uninsured or move to marketplace)
2. Ensure that messaging and consumer information is readable and accessible for persons with disabilities and LEP
3. Collaborate with Medicaid and Marketplace agencies to seek consumer input on messaging and disseminate information
4. Provide links to Medicaid/CHIP, ACA marketplaces, navigator programs, etc. from DOI website, and inform consumers they may qualify for financial help with purchasing insurance
5. Update FAQs and other consumer facing messaging with information on PHE unwinding, SEPs, appeal rights
6. Issue bulletins reminding issuers of continuity of care obligations (where applicable), and monitor compliance and enforcement
7. Prepare for an increase in consumer calls seeking assistance/information when people lose coverage and train call center/other staff about unwinding issues
8. Educate consumers on steps they can take to avoid disruptions in care (*e.g*., prescription refills)
9. For issuers in both MCO and QHP markets, DOIs should enforce nondiscrimination rules by monitoring marketing to ensure they are not selectively promoting their QHPs to the younger and healthier MCO enrollees losing eligibility using past claims data
10. DOIs should monitor junk plan marketing (*e.g*., STLDIs, health care sharing ministries) and 2023 rate filings for any increases based on increased enrollment because of PHE unwinding

**Resources**

- CMS - Dear State Health Official Letter, RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency
- KFF - Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey Unwinding the COVID-19
- Public Health Emergency: Checklist for Redeterminations - National Health Law Program

- State Health and Value Strategies Resources and Tools Related to PHE Unwinding
- Urban Institute Report funded by RWJ, on State Perspectives on the end of the PHE/ending of continuous Medicaid coverage requirement

# Update on Telehealth, APMs, and Health Disparities

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# Telehealth and Health Disparities

- **Previous presentation**
  - Telehealth provides a significant opportunity to improve access, giving it potential to reduce disparities in health and healthcare.
    - Disadvantaged populations are most likely to lack access to traditional care.
  - However, a digital divide in infrastructure and literacy may create another disparity where the most vulnerable find it most difficult to take advantage of telehealth opportunities.
- **Extensions**
  - Telehealth is important also in providing access to **culturally competent care**.
  - Mapping at a more granular level.
    - magnifies the share of the population without reasonable access to traditional care, particularly in rural areas.
    - Our previous discussion showed a lower density of physicians in the Black urban core. The situation is magnified for those who do not live near hospitals.

# Alternative Payment Models and Health Disparities

Not all healthcare practitioners are **opportunistic**, but some are, and payment systems need to **account for that reality**.

Healthcare practitioners should be rewarded for improving the things they can improve and not penalized or held accountable for the things over which they have no control.

Karen E. Joynt Maddox, MD, MPH

*New England Journal of Medicine*, 2018

# Alternative Payment Models and Health Disparities

- In the HIWG charge, the primary interest is **value-based payments** (**VBPs**), which **can be used with any payment model**.
- But fee-for-service (FFS) and the APMs each have **inherent incentives relevant for healthcare disparities**.
- An APM is anything other than a traditional FFS model (including PPOs).
- APMs include
  - case-based (bundled payment)
  - capitation, and
  - salary-based models.

# Alternative Payment Models and Health Disparities

- **FFS** - Many disadvantaged and marginalized populations need **low-margin care**.
- **Case-based/capitation** - Many disadvantaged patients are **especially costly to treat**. Often these patients have **poorer health outcomes for identical diagnoses and treatments**.
- **Salary-based** - There is **little incentive** to reduce costs and improve quality of care. Treating disadvantaged populations **may require greater commitment of the practitioners time and other resources**.
- **The end result is an inherent incentive to avoid disadvantaged patients**.

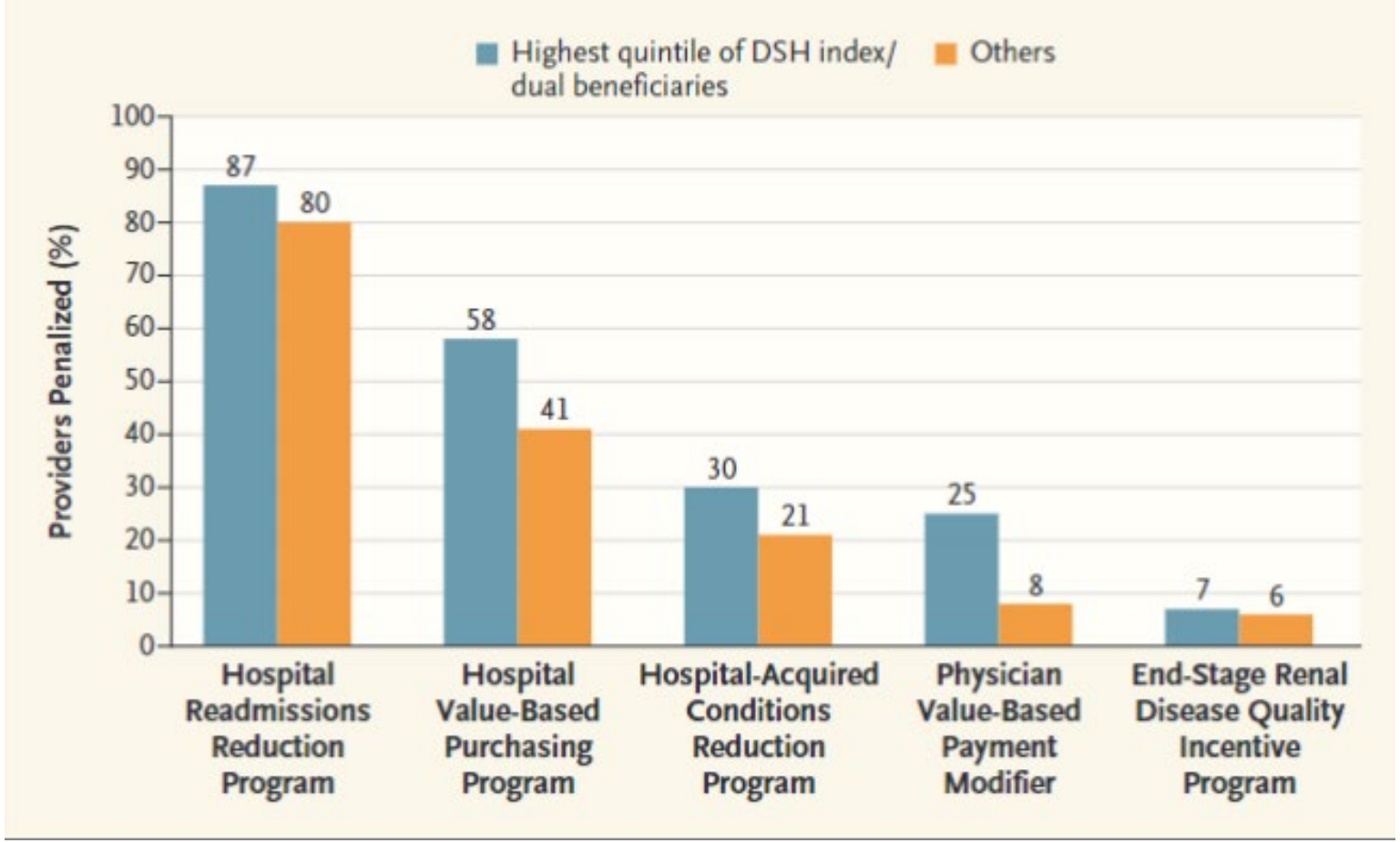
# Value-Based Payments and Health Disparities

- Additional compensation for **value**, defined as **outcomes or quality achieved in relation to the cost of care provided**.
- The CMS is the leader and standard-setter in this space.
- An example is MIPS (2019).
  - MIPS is a merit-based incentive program with payment linked to a composite score.
  - Exemption from MIPS is possible with participation in value-oriented alternative models.

# Value-Based Payments and Health Disparities

- Highest cost beneficiaries present the **greatest opportunities for cost savings**.
  - Reducing modifiable costs such as emergency department visits for
    - poorly controlled diabetes or hypertension, and
    - unmet behavioral health needs.
  - Provides **incentives to coordinate care**, such as behavioral health integration.
- But there is significant **potential for harmful effects** that must be addressed.
  - VBP systems are risk-adjusted, but
  - current **risk-adjustment methods are not sufficiently sophisticated to level the playing field** for those treating disadvantaged patients.
  - Thus, there is a **powerful incentive for providers to avoid high-risk patients**.

# Penalties are more common for providers treating disadvantaged populations.




The problem is often **socioeconomic factors over which providers have no control**.

The payment modifier reflects a penalty specifically to physicians for not meeting value targets.

Joynt Maddox, 2018, *NEJM*.

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