

## **HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE**

Health Insurance and Managed Care (B) Committee Aug. 11, 2022, Minutes

Health Innovations (B) Working Group Aug. 10, 2022, Minutes (Attachment One)

## Draft Pending Adoption

Draft: 8/22/22

Health Insurance and Managed Care (B) Committee  
Portland, Oregon  
August 11, 2022

The Health Insurance and Managed Care (B) Committee met in Portland, OR, Aug. 11, 2022. The following Committee members participated: Glen Mulready, Chair (OK); Troy Downing, Co-Vice Chair (MT); Russell Toal Co-Vice Chair, represented by Paige Duhamel (NM); Lori K. Wing-Heier (AK); Michael Conway (CO); Amy L. Beard represented by Alex Peck (IN); Anita G. Fox (MI); Grace Arnold (MN); Chris Nicolopoulos (NH); Andrew R. Stolfi and TK Keen (OR); Michael Humphreys (PA); Jon Pike (UT); Mike Kreidler and Molly Nollette (WA); and Allan L. McVey represented by Erin Porter (WV). Also participating were: Vicki Schmidt (KS); Larry D. Deiter (SD); and Cassie Brown (TX).

### 1. Adopted its Spring National Meeting Minutes

Director Wing-Heier made a motion, seconded by Director Fox, to adopt the Committee's April 7 minutes (see *NAIC Proceedings – Spring 2022, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

### 2. Adopted its Subgroup, Working Group, and Task Force Reports

Commissioner Pike made a motion, seconded by Ms. Peck, to adopt the following reports: 1) the Consumer Information (B) Subgroup; 2) the Health Innovations (B) Working Group, including its Aug. 10 minutes (Attachment One); 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.

### 3. Heard a Panel Discussion on Why States Should Create SBEs

J.P. Wieske (Horizon Government Affairs), Heather Korbolic (GetInsured), and Randy Pate (StatesWork) discussed options and opportunities for states to establish state-based exchanges (SBEs). Mr. Wieske outlined four reasons why states should set up their own SBE: 1) the cost of technology associated with operating an SBE has dropped, which means that a state most likely can operate an exchange at a cheaper rate than what a state is paying the federal government to operate an exchange in their state; 2) the ability to gather information and data directly to assist in understanding the state's own health insurance market rather than relying on what information and data a state may receive from the federal government; and 3) the ability to have control over what is going on in the state; and 4) flexibility for states to set their own rules.

Ms. Korbolic discussed the different SBE operation models. She said the move from HealthCare.gov to an SBE is risk-free now that end-to-end (call center, technology, and operations) solutions are readily available from private vendors with a proven track record. She explained that Healthcare.gov is built to support many states with an inflexible infrastructure that does not easily support policy flexibility. Ms. Korbolic reiterated some of the reasons Mr. Wieske discussed as reasons why states should establish an SBE, including: 1) cost savings, which can be repurposed for reinsurance; 2) independence from the federal government; 3) lower premium growth rates along with the ability to innovate with state policy; and 4) better churn management between Medicaid and commercial insurers. Ms. Korbolic said GetInsured has developed model legislation that states can tailor to fit their needs and use as the enacting legislation for an SBE.

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Mr. Pate also explained the benefits of a state establishing its own SBE already discussed. He also suggested that having an SBE would give states greater flexibility to innovate using the federal Affordable Care Act (ACA) Section 1332 waiver process.

Director Wing-Heier asked the panel how a state would begin the process of exploring establishing an SBE. Mr. Pate said a state should first look at its needs, population, enrollment, and the user fees it is paying the federal government to operate the federally facilitated exchange (FFE). He also suggested that if the “math” does not seem to work for a smaller state to establish an SBE, the state may want to consider establishing a shared services exchange. A shared services exchange would allow a small state to share with another state the costs of operating certain higher costs operations, such as call centers, to lower operational costs.

Commissioner Mulready asked the panel members what they have seen as the biggest hurdles for a state establishing an SBE. Ms. Korbolic said the biggest hurdles GetInsured has seen include: 1) political will; 2) making a financial argument; and 3) managing risk, particularly related to technology. Mr. Wieske said that with respect to political will, the ability to control their own market and wanting more flexibility will be important factors for states considering establishing an SBE.

Ms. Nollette said she knows there are vendors providing the websites and the technical support for multiple SBEs. She asked if any states are actually sharing the same platform. Ms. Korbolic said there are eight different SBEs on the GetInsured platform, and those states share in the cost of any technical changes or policy changes multiple states want to make.

#### 4. Heard a Presentation on Medicaid Redeterminations Following the End of the COVID-19 PHE

Miranda Motter (America’s Health Insurance Plans—AHIP) presented to the Committee on “The End of the Public Health Emergency: Medicaid Redeterminations.” She provided an overview of the COVID-19 authorities, federal and state emergency declarations, and the public health emergency (PHE). She also discussed and provided examples of key requirements and flexibilities tied to the PHE. She said that once the PHE ends, most requirements and flexibilities tied to the PHE will likely end automatically.

Ms. Motter said the end of the PHE was most recently extended to Oct. 13. She said the Biden Administration has said that it will provide the states 60-day notice before the PHE expires. She explained that to provide the promised 60-day notice, the Biden Administration would need to provide notice by Aug. 14 if the PHE is to end Oct. 13. If no notice is provided by that date, then the PHE is automatically extended for another 90 days ending Jan. 10, 2023. She said the Biden Administration would have to provide the states notice by Nov. 12 if the PHE is to end Jan. 10, 2023.

Ms. Motter provided an in-depth discussion of the Medicaid redetermination process, including the process pre-PHE, during the PHE, and post-PHE. She explained that the significant change in the process is that as a condition of receiving the enhanced federal medical assistance percentage (FMAP) under the federal Families First Coronavirus Responses Act, states are required to maintain enrollment of their Medicaid enrollees through the end of the PHE with no redeterminations. She said that when the PHE ends, states must resume the Medicaid redetermination processes.

Ms. Motter outlined the reasons why this is significant: 1) the volume of Medicaid redeterminations within the condensed time frame is unprecedented; 2) the states will have 12 months to initiate and 14 months to complete a full renewal of all individuals enrolled in Medicaid and the federal Children’s Health Insurance Program (CHIP); and 3) the states, counties, and beneficiaries have not done this over two years. She explained why the stakes are high for the states, counties, beneficiaries, providers, and other stakeholders with respect to Medicaid redeterminations.

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Ms. Motter listed 10 fundamental actions for states to take to prepare for the unwinding of the PHE, including creating a comprehensive state unwinding operational plan and coordinating with partners, including state, tribal, and state and federal government partners.

### 5. Heard an Update from the CCIIO on its Recent Activities

Ellen Montz (federal Center for Consumer Information and Insurance Oversight—CCIIO) provided an update on activities of interest to the Committee. She focused her remarks on the end of the PHE and the CCIIO's work to bring about a successful and smooth transition from Medicaid or CHIP to the private health insurance marketplace. Dr. Montz said this unwinding presents both an opportunity and a challenge. She said the federal Centers for Medicare & Medicaid Services (CMS) is committed to providing a 60-day notice of the ending of the PHE. As Ms. Motter noted, if the PHE is to end Oct. 13, the CMS would have to provide notice by Aug. 14. If the CMS does not provide that notice, then the PHE is automatically extended an additional 90 days to January 2023.

Dr. Montz said it is vitally important that all stakeholders plan and prepare for when the PHE ends. She said the CCIIO is developing a comprehensive plan for mitigating coverage lost. She said that part of CCIIO's preparation includes improving consumer notices and streamlining application processes to eliminate extra paperwork. She said the CCIIO is also planning aggressive outreach and enrollment strategies for unwinding. The CCIIO also will harness the power of its partnerships with stakeholders, including SBEs, state Medicaid agencies, health carriers, navigators, and state insurance regulators. She said the CCIIO's partnership with health carriers that offer Medicaid managed care organizations (MCOs) and qualified health plans (QHPs) will be vital because they can conduct outreach to Medicaid and CHIP enrollees during the redetermination process both before and after an individual loses coverage to assist in the transition to marketplace coverage. She said the CCIIO is also encouraging these health carriers to coordinate across their business lines and with their state Medicaid agencies and state departments of insurance (DOIs) to facilitate a smooth and seamless transition for consumers.

Dr. Montz encouraged state insurance regulators to work with these health carriers to assist them in their efforts. She said another area state insurance regulators can help will be outreach. She said it will be vital that there is open communication and successful feedback loop between all stakeholders involved in the redetermination process and unwinding to ensure a smooth transition and great consumer experience.

### 6. Heard a Federal Legislative and Regulatory Update

Brian R. Webb (NAIC) provided an update on federal legislative and regulatory activities of interest to the Committee. He focused his remarks on the recent extension of two subsidies for three additional years under the federal American Rescue Plan Act (ARPA) of 2021 due to the passage of the federal Inflation Reduction Act of 2022. He said this could be a challenge for the states in finalizing rates for 2023 because the deadline to submit those rates to HealthCare.gov is Aug. 17.

Mr. Webb provided an update on the status and attention received from the U.S. Congress on the letters the NAIC has sent to the Congress and federal agencies on addressing issues such as the so-called "family glitch." He said that just prior to the time the NAIC sent its letter, the CMS issued a proposed rule to address the issue. He said the public comment period has ended, and the CMS is reviewing the comments. It is anticipated that a final rule will be issued soon and apply for plans issued in 2023. He said the NAIC also sent letters on issues related to health savings accounts (HSAs) and the copayment accumulator. He said that to date, NAIC staff have not received any response related to the issues raised in this letter.

Mr. Webb said another letter the NAIC sent concerns Medicare Advantage marketing requesting that the federal government make the states the primary regulator because the states can more effectively address and resolve

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the marketing abuses that the states have been following and have documented. He said there has been a lot of interest from the Congress on this issue, and NAIC staff have been talking to key congressional staff about it as well. He said a similar issue getting a lot of attention is the improper marketing of health plans. He said NAIC staff have been talking to key congressional staff on ways that the federal government might be able to assist the states in addressing the issue, particularly when those engaging in these deceptive marketing practices are foreign entities and operating through the internet.

Mr. Webb said that another big issue NAIC staff are working with the CCIIO, and other federal agencies, is the implementation of the federal No Surprises Act (NSA). He said one of the main issues is enforcement and the role of, and how, the states can work with and coordinate with the CCIIO to enforce the rules.

Mr. Webb said another issue is the implementation of the federal network adequacy requirements beginning with the 2023 plan year. He said that for QHPs in FFEs, beginning with plan year 2023, the CMS will begin implementing time/distance standards for various types of providers and facilities, and beginning in plan year 2024, the CMS will begin implementing wait time standards. To comply with the time and distance standards, at least 90% of QHP enrollees must live within the maximum distance to at least one provider of each type. He said NAIC staff are working with the CCIIO as they move forward with implementation.

Mr. Webb also noted that health plan transparency requirements recently became effective July 1. He said the states are the primary regulators in enforcing these requirements. However, the CCIIO is conducting a thorough review of the information provided by the plans. He encouraged the states to reach out to the CCIIO if they receive complaints.

### 7. Received an Update on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's Work

Mr. Keen said the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup has been meeting to hear presentations from various stakeholder groups providing their perspective on the Subgroup's charge to develop a white paper examining pharmacy benefit manager (PBM) business practices. He said that to date, the Subgroup has heard presentations from about 17 stakeholder groups.

Mr. Keen said he anticipates the Subgroup holding at least one more meeting in late August during which it would hear from at least one additional stakeholder group on the Subgroup's upcoming work on the white paper. He said he anticipates the Subgroup beginning its work on the white paper in September. He said that on Aug. 15, the Subgroup plans meet in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals), paragraph 8 (consideration of strategic planning issues), and paragraph 9 (any other subject required to be kept confidential) of the NAIC Policy Statement on Open Meetings, to: 1) discuss its approach to the white paper; 2) discuss a draft white paper outline; and 3) seek volunteers from among the Subgroup members to begin drafting sections of the white paper. He said he hopes the Subgroup can complete its work on the white paper by the end of the year. However, to allow for robust discussion and comments from all stakeholders, the Subgroup's work on the white paper could extend into early 2023. He said he would continue to provide updates to the Committee and the Regulatory Framework (B) Task Force on the Subgroup's progress to complete the white paper.

### 8. Received an Update on the Special (EX) Committee on Race and Insurance Workstream Five's Work

Commissioner Arnold provided an update to the Committee on Workstream Five's work to date since her last update to the Committee at the Spring National Meeting. She said that since the Workstream's last update to the Committee at the Spring National Meeting, the Workstream announced the dates and times and focus of four meetings it plans to hold before the end of the year. She said the Workstream has held the first two meetings already. The first meeting was June 30. Its focus was on provider network composition.

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Commissioner Arnold said that during its June 30 meeting, the Workstream heard from two NAIC consumer representatives who discussed cultural competency in provider networks. The Workstream also heard from the Colorado DOI on its work through the Colorado Option to improve racial health equity for consumers purchasing health insurance in the individual and small group markets. She said the Workstream held its second meeting on July 26. The focus of this meeting was on barriers to care with respect to providers.

Commissioner Arnold said during its July 26 meeting, the Workstream heard a presentation from Quest Analytics on emerging ideas and approaches state insurance regulators might consider to close the health equity gap when developing plan network adequacy requirements. The Workstream also heard a presentation from an NAIC consumer representative, who discussed barriers that people of color and other historically underrepresented populations encounter when trying to obtain treatment from network providers, particularly for those who have plans with narrow networks. She said the American Medical Association (AMA) presented on the work it is doing related to provider directories and associated challenges, including their accuracy and issues associated with the inclusion of provider race and ethnicity information. The Blue Cross Blue Shield Association (BCBSA) and one of its member plans discussed challenges and efforts to mitigate race-based barriers to insurance. They also discussed ways that state insurance regulators can increase access to culturally competent care.

Commissioner Arnold said the Workstream's next meeting is Aug. 23. She said the focus of this meeting is on barriers to care related to benefit design. She said the Workstream has invited speakers to discuss what ways the structure of available benefits, such as cost-sharing or utilization management, can sometimes uniquely disadvantage communities of color, and what actions can state insurance regulators take to remedy such benefit designs. She said the Workstream anticipates hearing presentations from Mila Kofman (DC Health Benefit Exchange Authority—DCHBX), a representative from the American Academy of Actuaries' (Academy's) Health Equity Work Group, and a panel of NAIC consumer representatives. She said the Workstream's last scheduled meeting is Sept. 20, which will focus on innovations in benefit design. She said the Workstream's planned speakers for this meeting include speakers to discuss standardized plans and value-based insurance designs.

Commissioner Arnold said the Workstream's next series of meetings will focus on effective consumer education and engagement, as well as mechanisms to understand barriers at the community level. She said the Workstream is in the process of finalizing those meeting agendas.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/2022 Summer National Meeting/Final Minutes/08-Bmin

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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 Lindsy 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's April 4 minutes (*see NAIC Proceedings – Spring 2022, Health Insurance and Managed Care (B) Committee. Attachment Two*). 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

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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

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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 its 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

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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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