HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Draft Pending Adoption

Draft: 8/22/23

Health Insurance and Managed Care (B) Committee
Seattle, Washington
August 14, 2023

The Health Insurance and Managed Care (B) Committee met in Seattle, WA, Aug. 14, 2023. The following Committee members participated: Anita G. Fox (MI), Chair; Jon Pike, Co-Vice Chair (UT); Mike Kreidler, Co-Vice Chair (WA); Trinidad Navarro represented by Jessica Luff (DE); John F. King (GA); Dean L. Cameron (ID); Kathleen A. Birrane (MD); Grace Arnold (MN); Mike Chaney represented by Bob Williams (MS); D.J. Bettencourt (NH); Glen Mulready (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); and Allan L. McVey represented by Erin K. Hunter (WV). Also participating were: Paul Lombardo (CT); LeAnn Crow (KS); Troy Downing (MT); Eric Dunning and Martin Swanson (NE); and Scott A. White (VA).

1. Adopted its June 29 and Spring National Meeting Minutes

The Committee met June 29 and March 23. During its June 29 meeting, the Committee took the following action: 1) heard presentations on the Maryland, Michigan, and Nebraska state appeal programs; and 2) received an update on the Consumer Information (B) Subgroup's work to educate consumers on their claim appeal rights.

Williams made a motion, seconded by Commissioner King, to adopt the Committee's June 29 (Attachment One) and March 23 (*see NAIC Proceedings – Spring 2023, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

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

Williams made a motion, seconded by Commissioner King, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its May 25 minutes (Attachment Two); 2) the Health Innovations (B) Working Group, including its Aug. 14 minutes (Attachment Three); 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. Discussed Referrals to the Health Actuarial (B) Task Force

Director Fox said the Committee received a referral from the Financial Analysis (E) Working Group, asking the Committee to engage in a discussion with the federal Centers for Medicare & Medicaid Services (CMS) about state insurance regulators' concerns with how the risk adjustment formula impacts the current or prospective financial solvency position of new health insurers entering the health insurance marketplaces. She said that from the NAIC groups under the Committee, the Health Actuarial (B) Task Force is the group best suited to work on this referral. She said that assuming the Committee agrees to refer this issue to the Task Force, the referral will ask the Task Force to: 1) reach out to the CMS to discuss the issue; and 2) identify the changes, if any, in the formula to address the issue identified in the Working Group's referral to the Committee.

Director Fox said the second referral to the Health Actuarial (B) Task Force concerns how possible changes to the cost-sharing reduction subsidy, such as changes to silver loading, could impact plan options and costs to consumers. She said the Task Force has already heard from the American Academy of Actuaries (Academy) and other actuarial groups that silver loading has created odd incentives in the market. Because of this, Director Fox said she believes it would be beneficial for the Committee to know more about how changes in state silver loading policies or other changes, such as the elimination of the enhanced subsidies in 2026, could affect consumer

choices and the affordability of coverage. She said assuming the Committee agrees to this referral, the Committee would be asking the Task Force to review this issue and report its findings to the Committee.

Commissioner Stolfi made a motion, seconded by Commissioner King, to refer the issues identified in the Financial Analysis (E) Working Group referral letter to the Committee and the issue on how possible changes to the cost-sharing reduction subsidy could impact plan options and costs to consumers to the Health Actuarial (B) Task Force. The motion passed unanimously.

4. Received an Update on Market Regulation and Consumer Affairs (D) Committee Work of Interest to the Committee

Director Fox said that in accordance with the Committee's charge to coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues, she asked Commissioner Pike, chair of the Market Regulation and Consumer Affairs (D) Committee, to provide an update on the work of that Committee of interest to this Committee. Commissioner Pike asked Swanson to provide an update on the work of the Improper Marketing of Health Insurance (D) Working Group concerning revisions to the *Unfair Trade Practices Act* (#880). Swanson said that after several meetings and numerous discussions, during its meeting on Aug. 14, the Working Group adopted revisions to Model #880 to address regulatory and enforcement issues with health insurance lead generators.

5. Received an Update on the Consumer Information (B) Subgroup's Work Related to Educating Consumers on Claim Appeal Rights

Crow provided an update on the work of the Consumer Information (B) Subgroup related to educating consumers on their claim appeal rights. She said the Subgroup's small drafting subgroup, which the Subgroup established to review the Subgroup's previous work in 2021 on claims, has met three times since the Committee's July 29 meeting and plans to meet again after the Summer National Meeting. She said the small drafting group includes an array of stakeholders, including state insurance regulators and consumer representatives. She said the small drafting group decided to update its series of consumer guides on claims: 1) codes and claims; 2) explanation of benefits; 3) filing health insurance claims; 4) how to appeal a denied claim; and 5) understanding medical necessity. She said the 2021 version of these guides are available on the Subgroup's webpage on the NAIC website under the "Documents" tab.

Crow said the Subgroup hopes to have updated versions of the guides completed within the next few months. She said the Subgroup's goal is to create content that allows states to incorporate it into their own materials and to use it as-is with no additional configuration needed. The Subgroup is also considering ways to break the content into pieces that can be used in social media posts or in videos. She said that for the updated complete guides, the Subgroup wants to make them more interactive rather than the static PDF format. Crow said the NAIC Communications Division staff have been participating in the small drafting group meetings. She said the Subgroup plans to use their expertise and assistance in making the guides attractive and more accessible to consumers.

Crow said that as mentioned during her update to the Committee during its June 29 meeting, the Subgroup recognizes that developing documents like the guides is only one part of engaging consumers with health insurance issues. Consumers will only find its documents if they seek them out or if they come across communication from a state insurance department that engages them and inspires them to learn more. She said the Subgroup encourages the Committee and the NAIC to consider additional strategies for building knowledge among consumers and establishing state departments of insurance (DOIs) as a go-to source for assistance and education on health insurance.

Williams asked if the Subgroup's consumer guides could be shared with the Mississippi Insurance Department to possibly supplement the information it currently has on its website about health insurance. Crow said she would share this information with him. Director Fox agreed that one of the main goals of the Consumer Information (B) Subgroup's work is to be able to share the guides with state DOIs to better assist them with helping their consumers.

6. Heard a Panel Discussion on Preventive Services

Carl Schmid (HIV + Hepatitis Policy Institute), Amy Killelea (Killelea Consulting), and Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) gave a panel presentation on preventive services from a consumer-focused perspective. The presentation also discussed the methodology, findings, and recommendations included in the recently issued NAIC consumer representatives' report, *Preventive Services and Coverage and Cost-Sharing Protections Are Inconsistently and Inequitably Implemented: Considerations for Regulators*. Schmid provided an overview of the federal Affordable Care Act's (ACA's) preventive service requirements and the recent court case, *Braidwood v. Becerra*, challenging those requirements. He also discussed the health equity implications of increasing access to preventive services. Schmid cited the four preventive services examined in the NAIC consumer representatives' report that have such health equity implications: 1) smoking cessation; 2) pre-exposure prophylaxis (PrEP) for the prevention of human immunodeficiency virus (HIV); 3) colorectal cancer screening; and 4) postpartum depression screening. He explained that the NAIC consumer representatives commissioned the report because despite the ACA preventive care requirements for coverage and no cost-sharing for such services, compliance with such requirements has been a challenge for certain preventive services, particularly with respect to HIV preventive care services, including prescription drugs needed to manage the virus.

Killelea discussed the NAIC consumer representatives' preventive services report's methodology and findings. She said the report found that: 1) consumer-facing documents lace comprehensive preventive services descriptions; 2) plan formularies did not always describe zero-dollar cost-sharing preventive medications clearly and accurately; and 3) payer guidance documents that inform claims adjudication policies were often incomplete. She provided examples for each of these findings. She also explained why payer guidance matters because incomplete, unarticulated specific coverage payer policies that fail to inform claims adjudication policies for providers lead to arbitrary coverage decisions.

Howard discussed the recommendations included in the report for state insurance regulators to address the issues in the report's findings, which include using data calls and market conduct examinations to assess compliance, ensuring continued preventive protections with state legislative and regulatory action, establishing uniform billing and coding standards, and holding plans accountable for educating consumers and providers on preventive services requirements.

Schmid asked if the Consumer Information (B) Subgroup has developed materials on preventive services, and if not, if the Subgroup would consider developing such materials. Crow said that the Subgroup has not developed specific materials on preventive services, but because the Subgroup also believes this is an important consumer issue, she would ask the Subgroup to develop consumer education materials on it.

7. Heard an Update on the Medicaid Redetermination Process

Miranda Motter (America's Health Insurance Plans—AHIP) provided a status update on the Medicaid redetermination process following the end of the COVID-19 public health emergency (PHE). She discussed key findings from the first batch of Medicaid redeterminations data the CMS reported last month in accordance with the federal Consolidated Appropriations Act, 2023. She said that as of April 2023, based on 14 states, more than 2 million people have gone through the full renewal process. Of those, nearly half (45.5%) were successfully

reenrolled in Medicaid and Children's Health Insurance Program (CHIP), and more than half (55%) of those renewed were done automatically. She said that approximately, one-third (32.2%) lost their Medicaid and/or CHIP coverage and within that group, 79% of those terminations were for procedural reasons. Motter said that it is anticipated that the next CMS update will provide data on coverage transitions for those who were determined no longer eligible for Medicaid.

Motter discussed updated state renewal timelines. She also discussed new state flexibilities the U.S. Department of Health and Human Services (HHS) recently announced to help keep Americans covered as states resume Medicaid and CHIP renewals. She also provided information on federal, state, and health industry resources for consumers and employers to assist them with transitioning through the renewal process and maintaining coverage. She highlighted AHIP's Medicaid redetermination toolkit designed to assist consumers transitioning from Medicaid coverage because of redetermined ineligibility for such coverage to other types of coverage, such as employer-based health insurance and health insurance marketplace plans. She also discussed the work of the Connecting to Coverage Coalition (Coalition), which is a coordinating community for stakeholders working to minimize disruptions in coverage associated with Medicaid redeterminations. She said the Coalition includes broad representation from seniors, disability groups, patient groups, provider associations, employer-related organizations, consumer advocacy groups, and Medicaid trade associations.

8. Received an Update on the Work of the Special (EX) Committee on Race and Insurance Health Workstream

Commissioner Arnold and Commissioner Birrane provided an update on the Special (EX) Committee on Race and Insurance Health Workstream work since its last update to the Committee.

Commissioner Arnold said that after the Spring National Meeting, the Workstream met in a regulator-only session to discuss its activities and meetings for 2023, during which, the Workstream decided to: (1) continue its education on benefit design relating to specific areas of focus, such as preventative care and mental health coverage beyond pure parity; (2) explore the evolution of the ACA section 1332 waivers and innovative uses of them that can be implemented to lower the uninsured rate in states; and (3) continue to provide a forum for sharing innovative programs and initiatives that states are doing that are designed to promote health equity. She said the Workstream met July 24 to hear presentations focusing on preventative care and lowering barriers to such care, particularly with respect to chronic diseases. The presentations discussed the impact of lowering barriers to such care in increasing health equity and reducing disparities. The Workstream plans to hold a follow up meeting on this topic sometime in October or early November. Commissioner Arnold said the Workstream plans to meet sometime in late September or early October to hear presentations on initiatives and programs to reduce mental health disparities. The Workstream hopes to hear from a variety of stakeholders, including industry and consumers.

Commissioner Birrane said the Workstream plans to meet Sept. 19 to hear presentations on innovative uses for ACA section 1332 waivers and other market reforms, aimed toward lowering the uninsured rate in the states. She said during this meeting, the Workstream will hear from states that have found success in amending their state benchmark plans, what they changed, and what that process looked like. Further, the Workstream will hear from states that have implemented other market reforms to make health insurance more accessible. She said the Workstream looks forward to hearing what has proven successful, what challenges arose, and what recommended best practices emerged as these efforts were undertaken to assist the uninsured population in respective states.

Commissioner Arnold said the Workstream is also piloting a new collaboration space on the NAIC Connect platform to allow Workstream members and other NAIC members to discuss issues related to health equity and other related topics. She said this effort will provide a platform that Workstream members can use to share the information that has and will be captured during its past and future meetings on removing barriers to health insurance for historically disadvantaged communities with each other and other NAIC members. She said the

Workstream's NAIC Connect page will be a living resource for the NAIC membership on which the Workstream can continue to build content and resources for states seeking to address the equity gap in health insurance access and utilization.

Commissioner Arnold said that due to the hard work of the NAIC Member Services Division, the Workstream's NAIC Connect platform page is scheduled to go live within the next few weeks as part of the initial pilot rollout along with the Innovation, Cybersecurity, and Technology (H) Committee. She encouraged anyone interested to visit the Workstream's page and test it out during the pilot phase. The Workstream has planned a meeting on Sept. 21 to walk Workstream members through the features and content on the page.

Lastly, Commissioner Birrane said that the Workstream has been working in collaboration with the Committee and the Big Data and Artificial Intelligence (H) Working Group to prepare a survey of artificial intelligence (AI) use by health insurers. She said Maryland has been doing the initial coordination of this work with the assistance of the Johns Hopkins Bloomberg School of Health. She said Maryland expects to have a draft survey form soon to share with the collaborating groups as it finalizes a draft to share with the industry for refinement. She said Maryland's goal is to solicit participating states and have the survey out this year.

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

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Health Insurance and Managed Care (B) Committee
Virtual Meeting
June 29, 2023

The Health Insurance and Managed Care (B) Committee met June 29, 2023. The following Committee members participated: Anita G. Fox, Chair, and Laura Hall (MI); Jon Pike, Co-Vice Chair (UT); Mike Kreidler, Co-Vice Chair, represented by Jane Beyer and Ned Gaines (WA); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron represented by Shannon Hohl (ID) ; Kathleen A. Birrane and Louis Butler (MD); Grace Arnold represented by Julia Dreier (MN); Chris Nicolopoulos represented by Jason Dexter (NH); Glen Mulready (OK); Michael Humphreys (PA); and Allan L. McVey (WV). Also participating were: LeAnn Crow (KS); Troy Downing (MT); Maggie Reinert (NE); and Larry D. Deiter (SD).

1. Heard Presentations on State Appeals Programs

Director Fox said that during the Committee's meeting at the Spring National Meeting, it heard a presentation from the Kaiser Family Foundation (KFF) on findings from its issue brief "Claims Denials and Appeals in ACA Marketplace Plans in 2021." She said one piece of data from the presentation raising the Committee members' attention was that consumers rarely appeal claim denials. She said that because of that, the Committee wanted to have a broader discussion on: 1) what support the states offer to consumers in this area and how they are raising awareness to consumers of their options to appeal; and 2) what more the Committee and the groups reporting to it can do as well to raise consumer awareness. She said that during today's meeting, the Committee would hear from Maryland, Nebraska, and Michigan on their work to raise consumer awareness of their claim appeal rights.

Butler discussed Maryland's work, including statistics supporting the KFF's findings about the low percentage of consumer claim appeals. He said the Maryland Insurance Administration (MIA) has a dedicated unit, the Consumer Education and Advocacy Unit (Unit), whose mission is to educate Maryland residents about various insurance products and explain to consumers their rights and obligations under the terms of their insurance policies. The Unit travels to fairs, trade shows, and other events across the state to provide educational materials to consumers. It answers questions on various insurance issues, including health insurance and the right of consumers to appeal claim denials. Butler noted that based on questions during these events, it is shocking the low number of consumers who are aware of the MIA and their right to appeal claim denials. He said many consumers, who may know of their claim appeal rights, do not file internal appeals with their insurer because of a fear of retaliation. Butler explained how the Unit will walk a consumer through the process of filing an internal appeal with their insurer. He also discussed Maryland's external independent review process.

Reinert discussed Nebraska's work to educate and assist consumers in appeals of claim denials focusing on its external review program. She provided a history of the program and its steps toward implementation, including developing denial letter templates and working with major medical carriers on the language that the carriers must include in the appeals and grievances sections in their policies and certificates to ensure consumers have notice of their internal and external appeal rights. This information is also posted on the Nebraska Department of Insurance's (DOI's) website. She also discussed the Nebraska DOI's best practices with respect to external appeals, including recommending that consumers assign their doctor to be their authorized representative because provider participation is a vital part of the appeal process.

Reinert provided an overview of the Nebraska DOI's Health Division's efforts to raise consumer awareness of their appeal rights, including highlighting information on its website detailing the steps consumers can take to appeal

claim denials first internally through their insurer and then, if necessary, externally through an independent reviewer. She said that in addition, the Nebraska DOI Health Division conducts an annual "road show" during which it holds community meetings and makes presentations throughout the state to educate consumers on an array of insurance issues, including a consumer's right to appeal claim denials. Reinert also discussed the Nebraska DOI Health Division's use of social media—Facebook and LinkedIn—to educate consumers and increase awareness. Reinert highlighted the Nebraska external review program's successes. She said that since 2014, 786 internal claim denials were overturned. She said that in the past five years, Nebraska has consistently averaged about 250 external appeal cases per year. From that number, approximately 47% of eligible cases were overturned, and about 23% of those cases were not eligible for external review.

Hall discussed Michigan's efforts to educate and increase consumer awareness of their right to appeal claim denials beginning with changes to the Michigan DOI's website to make it more consumer-friendly. She said it was hard for consumers to find information on the old website, and the information on it was highly technical and hard for the average consumer to understand. She said the new website resolves these challenges. It has a modern look and feel and is mobile-friendly. She said the new website includes a step-by-step guide at a 7th-grade reading level with links for consumers to use and follow to appeal claim denials.

Hall also discussed the Michigan DOI's proactive outreach efforts. She said the Michigan DOI plans to continue these efforts and access other means to educate consumers, such as leveraging social media, public service announcements, and sharing information with stakeholders.

Director Fox asked the presenters about their consumer outreach efforts, including how it evaluates the success of those efforts and keeps track of what works. Butler said the MIA's Unit travels around the state to various events, which in many cases, it does not create, but it piggybacks on already planned events. He said the MIA recently did a podcast on medical necessity. He said that following that podcast, the MIA saw an increase in the number of appeals filed, which he believes is a direct correlation to the podcast's airing. He said that in addition, the MIA saw an increase in telephone calls from consumers asking for more information about their claim denial appeal rights and the internal and external appeal processes. He also noted that the MIA is on all the social media platforms, including Nextdoor. Reinert said that to increase awareness of planned events during its annual roadshow, the Nebraska DOI places advertisements in local newspapers and on the radio, and it posts information on social media. She said the Nebraska DOI has found that posting on Facebook produces the most engagement from the public, particularly if it does paid pushes that target certain areas in the state where it plans to host an event. She said the Nebraska DOI also reaches out to industry, such as the Independent Insurance Agents & Brokers of America (IIABA) and the National Association of Health Underwriters (NAHU). In addition, it sends out an email blast to insurers.

Hall discussed how Michigan evaluates its success in reaching out to consumers. She said Michigan tracks the number of attendees at its in-person events and has great participation in its virtual events. She noted that because of the COVID-19 pandemic, in-person events were eliminated for a few years, but in-person attendance is beginning to increase since it has recently restarted those events. She said that Michigan has experienced the most success in reaching consumers by using air media—local news station reporters and radio stations—interviews with Director Fox during which she discusses various insurance issues, including consumer appeal rights.

Commissioner Birrane discussed additional approaches the MIA uses to reach consumers. She described the MIA's LinkedIn platform profile. She also discussed the MIA's creation of an emoji character called MIA that it uses to interact with the public on Facebook and, as appropriate, other social medial platforms. Commissioner Birrane also noted that the MIA gives more than 600 presentations a year and specifically emphasizes to the public that the MIA is available 24 hours a day, seven days a week to assist consumers, providers, and other stakeholders.

She also noted the MIA's high reversal rate related to medical necessity determinations due to its involvement in assisting the consumer in navigating the appeals process.

2. Received an Update from the Consumer Information (B) Subgroup on its Work Related to Consumer Education on Claim Appeal Rights

Crow discussed the Consumer Information (B) Subgroup's work related to educating consumers on their appeal rights. She said that after the Committee's discussion of the issue at the Spring National Meeting, the Subgroup accelerated its work in this area. She said the Subgroup's most recent meetings have been devoted to this topic. Based on the discussions during these meetings, the Subgroup formed a small drafting subgroup to review the Subgroup's previous work related to this issue to determine whether the Subgroup needs to develop additional resources on the issue. She said that in 2021, the Subgroup developed a series of consumer guides on claims. The five guides were: 1) codes and claims; 2) explanation of benefits; 3) filing health insurance claims; 4) how to appeal a denied claim; and 5) understanding medical necessity.

Crow said the small drafting subgroup has met three times since the Spring National Meeting. During these meetings, the small drafting subgroup started reviewing the guides to see if additional content should be added. She said the small drafting subgroup is also interested in changing the format of the guides from a PDF document to a format that is more interactive for consumers. Crow explained that one example of such interactive content is the Subgroup's "How to Understand Your Insurance Card" document. She said that because of its interactive format, the document has been well received. Crow said the Subgroup has also been working with the NAIC Communications Division as it develops ideas for making the content of the guides more user-friendly. She said as Maryland, Michigan, and Nebraska discussed during their presentations, the Subgroup is exploring ways to leverage social media to let the public know about these resources.

Crow noted that the Subgroup's charge from the Committee is to develop information or resources that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance. She said it might be useful for the Committee to consider additional strategies for engaging consumers on claims and appeals and possibly other health topics. She said she would be happy to provide an update to the Committee on the Subgroup work during the Committee's meeting at the Summer National Meeting. Director Fox said that with respect to letting the public know about the guides and other resources the Subgroup has developed, the Subgroup could consider developing a tool kit with this information and making it available to NAIC members for them to use in their states because many NAIC members do not know this information exists.

Carl Schmid (HIV+Hepatitis Policy Institute) said the NAIC consumer representatives suggested that the Committee invite the KFF to present its findings to the Committee at the Spring National Meeting because they felt it was important for the Committee hear those findings. He said the NAIC consumer representatives believe this issue is of the utmost importance. Reflecting its importance, he said the NAIC consumer representatives have established a subgroup of NAIC consumer representatives focusing on prior authorization, medical necessity, and appeals and denials. The subgroup is developing recommendations for the Committee to consider addressing the low number of consumer appeals of claim denials and other issues related to prior authorization and medical necessity.

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

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Draft: 6/14/23

Consumer Information (B) Subgroup
Virtual Meeting
May 25, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met May 25, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony L. Williams (AL); Debra Judy (CO); Randy Pipal (ID); Alex Peck (IN); Judith Watters (ME); Joy Hatchette (MD); Carrie Couch (MO); Susan Brown (MT); Rebecca Ross (OK); Jill Kruger (SD); Scott McAnally (TN); and Christina Keeley (WI). Also participating was: Cynthia Cisneros (NM).

1. Adopted its April 25 and April 17 Minutes

The Subgroup met April 17 to discuss a guide on Medicaid redeterminations, titled *Resuming Medicaid Redeterminations: State Insurance Regulator Guide*, and it adopted the guide during an e-vote that concluded April 25.

Couch made a motion, seconded by Keeley, to adopt the Subgroup's April 25 (Attachment Two-A) and April 17 minutes (Attachment Two-B). The motion passed unanimously.

2. Discussed Consumer Assistance on Claim Denials and Appeals

Crow said the Health Insurance and Managed Care (B) Committee had asked the Subgroup to look into claim denials and appeals in response to a recent KFF report on the subject. She said the Subgroup had last addressed appeals in 2021 when it developed a guide for consumers on appealing denied claims.

Crow asked Subgroup members how departments of insurance (DOIs) assist consumers with appeals, how consumers find out about the assistance available, and what barriers prevent consumers from appealing. She also asked about the 2021 guide and whether states use it, including the template letter to request an appeal. Crow said that in Kansas, consumers must first appeal internally. She said most insurers include contact information for the DOI in denial letters. She said many consumers do not believe it is worth it to appeal. She said working with providers and asking them to encourage patients to appeal is one route Kansas has used. Couch said Missouri does not require exhaustion of internal appeals before external review and does not have time limits. She said Missouri also faces obstacles in making consumers aware that assistance is available from the Missouri Department of Commerce and Insurance . She said information in denial letters is one way they find out. Watters said Maine has a similar process to Missouri. She said a consumer advocacy group (Maine Consumers for Affordable Health Care) also provides information and assistance to consumers in filing appeals.

Harry Ting (Health Consumer Advocate) questioned whether all states require explanations of benefits to include contact information for DOIs. He said the 2021 guide is written with medical necessity denials in mind, but denials occur for many other reasons, including missed premium payments and late billing by providers. He suggested that the guide include language to address other denial reasons.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) said consumers should also be directed to their employers when they have employer-sponsored coverage. She said consumer representatives had originally requested that the Health Insurance and Managed Care (B) Committee consider the KFF report. They have formed their own ad hoc group to examine denial and appeals issues. She said the consumer group would be willing to partner with the Subgroup on any work in this area.

Crow said consumers need assistance navigating complicated processes, so it is important to develop a document that is usable and easy to understand. She said the 2021 guide is a good start. She said consumers often do not understand what type of plan they are enrolled in or whether they are eligible for state-based external review.

Crow said the guide could be revised into two separate documents, one shorter and one longer. Bonnie Burns (California Health Advocates—CHA) said many consumers struggle with written communications and do not know how to respond to a denial letter. She said shorter and longer versions would be helpful. She said help should be provided in a very simple way, and when possible, consumers should be connected with an organization like the one in Maine to assist.

Eric Ellsworth (Consumers' Checkbook) said consumers may not know anything about their medical bills. He said the Subgroup should consider the first communication consumers receive that tells them about denials or other forms of nonpayment. He said there is a need for better billing information earlier in the process, including explanations of benefits.

Brenda J. Cude (University of Georgia) said the existing guide makes assumptions, such as that consumers know what denial means. She said a more basic piece could help consumers understand what to look for to know that a claim is denied. She said one basic question for the Subgroup is whether it will develop a formatted guide or content that states can take and use to develop their own materials. Crow said she liked the idea of taking it back to the basics.

Keeley said having two versions would allow more examples and images. She said the term "grievance" should be included, as well as a link to the NAIC glossary. Brown said Montana performs a triage before a consumer files an appeal to ensure an appeal is appropriate or whether a coding issue means the consumer should go back to the biller. She said there are things consumers can do before an appeal to get things corrected.

Culp said her organization assists consumers in navigating care and coverage, and it often takes significant work to uncover the problem, which could be a denial or something else. She said there is high engagement with denial questions on social media and suggested that in addition to shorter and longer guides, bite-sized pieces geared toward social media may be helpful.

Crow said the Subgroup should consider a series of documents that starts pre-denial and walks consumers through the process.

Ellsworth said about 15% of claims face some kind of rejection, including denials and other types. He said over half of rejected claims are eligible for additional work but are not reworked. He asked whether states have authority over contracts that influence billing practices. Brown said it is beyond the insurance department's scope of authority, but they can refer consumers out for consumer protection from the attorney general's office.

Crow said the Subgroup should include something on prior authorization requests, as well as denials. She said the Subgroup may want to update all the documents in its series on claims from 2021. She asked for volunteers to identify gaps in the series and develop revised versions. Brown said the appeals guide may not need to be updated significantly, but all the documents should be reviewed at once.

Hatchette said the Subgroup should not think only about a written document. She said departments should meet consumers where they are with videos and social media. She said the key point to make is that there is somewhere to go for help and that consumers have a right to appeal. Dr. Cude said the first step should remain considering

what consumers need to know. Crow said the Subgroup should figure out its message first and potentially work with the NAIC's communications department to develop videos or other materials like snippets for social media.

Dr. Ting said no document will be as useful as assistance from the staff of an insurance department or State Health Insurance Assistance Program (SHIP). He said increasing the awareness of insurance departments, in general, should also be pursued.

Having no further business, the Consumer Information (B) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Committees/B Committee/National Meetings/2023 Summer National Meeting/Final Minutes/Cons Info 5.25.docx

Draft: 5/8/23

Consumer Information (B) Subgroup
E-Vote
April 25, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Apr. 25, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony L. Williams (AL); Randy Pipal (ID); Judith Watters (ME); Carrie Couch (MO); Nichole Faulkner (NC); David Buono (PA); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keely (WI).

1. Adopted a Guide on Medicaid Redeterminations

The Subgroup conducted an e-vote to consider adoption of the document titled *Resuming Medicaid Redeterminations: State Insurance Regulator Guide* (Attachment Two-A1). The guide is a resource for department of insurance (DOI) staff in understanding the return of eligibility redeterminations in Medicaid. The motion passed unanimously.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Resuming Medicaid Redeterminations

State Insurance Regulator Guide

Background

In March of 2020, and as part of the Families First Coronavirus Response Act, Congress created an incentive for state Medicaid programs to keep consumers continuously enrolled during the COVID-19 pandemic. As a result, states suspended redeterminations of eligibility and Medicaid now covers over 20 million more people than it did in 2019. On December 29, 2022, President Biden signed into law the Consolidated Appropriations Act, 2023 (CAA), which put an end to the Medicaid continuous enrollment provision on March 31, 2023. The CAA allows for states to resume redetermining the eligibility of Medicaid enrollees and to take up to 14 months to complete redeterminations. It also provides for a phased down approach for enhanced Medicaid funding for the States. When redeterminations resume, many Medicaid enrollees will remain eligible, but some will be disenrolled and need to find other coverage from an employer, a Marketplace plan, Medicare, or another source. Many will be eligible for other state or federal assistance with costs, such as premium tax credits or a Medicare Savings Program.

The NAIC's Consumer Information (B) Subgroup developed this resource to help state insurance regulators and their Departments plan for the impact of resumed Medicaid redeterminations. The information and answers below may also be helpful in responding to questions and concerns consumers may have, particularly those who have recently lost Medicaid coverage and are shopping for health insurance for themselves and their family.

State-specific Information on Medicaid Redeterminations

What is happening in my state and when?

- Unwinding Medicaid Continuous Coverage (Georgetown University)
  - Use this page to find information and resources, including a 50-State Unwinding Tracker with links to state plans, FAQs, and communications toolkits.

- State Approaches to the Unwinding Period, January 2023 (KFF & Georgetown University)
  - KFF lists the timeframe for each state to begin and complete redeterminations.

- Anticipated 2023 State Timelines for Initiating Unwinding-Related Renewals As of February 24, 2023 (CMS)

How many people may be impacted in my state?

- The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage
  - This Urban Institute report provides national estimates and state tables in Appendix B.

- Coverage Transition Modeling Dashboard (.xslx file)

- With funding from AHIP, NORC at the University of Chicago developed estimates for each state of the number of people expected to transition to other coverage sources. Methodology is discussed in a companion report.

Messages and Advice for Consumers

How can my department assist consumers if they receive notice they are losing Medicaid coverage?

- Many individuals who leave Medicaid or CHIP will be eligible for employer coverage. Deadlines for electing employer coverage have been extended. Those who lose Medicaid coverage before July 10, 2023, will have a special enrollment right to elect employer plans until September 8, 2023. After that, the standard special enrollment period of 60 days from the loss of other coverage will apply.
- Shopping for coverage
  - Marketplace. Some consumers may already be aware of the Marketplace; however, there may be some consumers who will need guidance on how to access the Marketplace. Marketplace plans or ACA plans on healthcare.gov are guaranteed issued. Some plans will have $0 premium after tax credits. Most will have either copays or deductibles.
    - A number of special enrollment periods (SEPs) for Marketplace coverage may be relevant for consumers leaving Medicaid.
      - The SEP for loss of minimum essential coverage (including Medicaid and CHIP) has been extended from 60 days before through 90 days after the coverage loss.
      - A separate SEP is available for those who lose Medicaid or CHIP through July 31, 2024.
      - Individuals with income less than 150% of the federal poverty level may enroll in Marketplace plans in any month.
    - https://www.healthcare.gov/medicaid-to-marketplace/
  - Agents, brokers, navigators, and assisters are available to assist consumers.
    - Confirm that the agent is licensed to sell the product.
    - Use Find Local Help for help with Marketplace plans.
  - NAIC Health Insurance Shopping Tool

- Tips to offer to consumers (taken from the 2019 "What to ask when Shopping for Health Insurance" document)
  - Is it a Short-Term, Limited Duration plan, a Sharing Ministry plan, or other limited-coverage plan? Is it sold through an association that requires a membership fee? If so, it could cover less than Marketplace plans.
  - Is the person selling the plan licensed in [STATE]? If so, ask for his/her state license number and contact [STATE DOI] at [phone number] to confirm.
  - What is the insurance company and is it licensed in [STATE]?
  - Does the plan require enrollment in an association or as a limited partner?
  - Does the plan cover your pre-existing conditions? Does it cover your medications?
  - What are the deductibles? There may be different deductibles for different services.
  - Does the plan set a limit on how much I have to pay out of pocket in a year (maximum out of pocket or MOOP)?

- What services DOESN'T the plan cover? Always ask about Exclusions and Limitations on non-ACA policies and whether a claim can be denied or not paid after the fact.
- For services that ARE covered, how much will the plan actually pay? Is there a limit on the total amount the plan will pay per person, per service, or per year?
- How long will the coverage last? Will you be able to keep or renew your coverage if you get sick?
- Does the plan have a provider network? If yes, how do you access the directory of providers and can you review the directory before signing up? Is your doctor or hospital in the network? If not, will doctors and providers agree not to bill for amounts above what the plan pays?

What messages are federal agencies using and recommending related to Medicaid redeterminations?

- Medicaid and CHIP Continuous Enrollment Unwinding – Toolkit
  - This toolkit includes key messages, drop-in articles, social media and outreach products, call center scripts, and more. A .zip file contains supporting materials and graphics. Materials are available in languages in addition to English on the CMS Unwinding page.

Medicare Issues

Where can I find a review of Medicare enrollment considerations for those losing Medicaid?

- ADvancing States published a brief guide for counseling Medicare-eligible individuals whose Medicaid benefits changed due to the end of the continuous coverage requirement.

Can states assist individuals who missed a period of guaranteed issue for Medicare supplement coverage while they were enrolled in Medicaid?

- A number of states (including Alaska, Delaware, Idaho, Kentucky, Maryland, New Hampshire, and Oklahoma) have issued bulletins to direct issuers to offer guaranteed issue of Medicare supplement plans for those who exhausted their open enrollment period as a result of their continued enrollment in Medicaid and who experience a change in Medicaid eligibility.

Additional Resources

- Connecting to Coverage Coalition has issued a set of resources.
  - The Coalition has compiled resources on redeterminations, including information on fraud prevention, guidance on texting consumers from the Federal Communications Commission, and How Health Insurance Providers Are Supporting Americans Through Medicaid Unwinding
- Unwinding and Returning to Regular Operations after COVID-19 (CMS)
  - CMS guidance and resources
- Unwinding resources for American Indians and Alaska Natives (CMS)

Draft: 5/8/23

Consumer Information (B) Subgroup
Virtual Meeting
April 17, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met April 17, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony L. Williams (AL); Randy Pipal (ID); Alex Peck (IN); Mary Kwei (MD); Carrie Couch (MO); Cuc Nguyen (OK); David Buono (PA); Jill Kruger (SD); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating were: Susan Brown (MT); and Cynthia Cisneros (NM).

1. Adopted its March 2 Minutes

The Subgroup met March 2 to discuss potential Subgroup activities for the year.

Couch made a motion, seconded by Pipal, to adopt the Subgroup's March 2 minutes (*see NAIC Proceedings – Spring 2023, Health Insurance and Managed Care (B) Committee, Attachment One*). The motion passed unanimously.

2. Discussed a Regulator Guide on Medicaid Redeterminations

Crow said the Subgroup identified a guide on Medicaid redeterminations as a top priority during its March 2 meeting. She said millions of people will leave Medicaid in 2023 and need to find new coverage. She said a small group met to draft a guide for state insurance regulators to aid in understanding the resumption of redeterminations. She said many other groups have developed materials aimed at consumers.

Crow said the guide focuses on providing links to existing useful tools. Couch said the guide is a good resource for those who take calls from consumers. She said the draft guide lacks information on navigators and assisters.

Bonnie Burns (California Health Advocates—CHA) said she applauds the group for developing the document. She said people dropped from Medicaid may not know they remain eligible for Medicare Savings Programs or other state-based assistance with health costs. She recommended that the guide refer readers to State Health Insurance Assistance Programs (SHIPs) to check into other programs that may offer benefits. Harry Ting (Health Care Consumer Advocate) agreed that SHIPs should be referenced and provided a suggested resource for assisting Medicare-eligible individuals.

Crow said other emailed suggestions included adding references to enrolling in employer-sponsored plans. Kris Hathaway (AHIP) also recommended adding information on employer coverage. Burns said individuals who lose Medicaid after a redetermination may not have a total loss of assistance due to eligibility for other benefits. She added that not all insurance departments have SHIPs within their departments, so it would be useful to link to them.

Crow asked whether the guide should mention coverage of preexisting conditions since it is not an issue under plans under the federal Affordable Care Act (ACA), but it is for other plans. Subgroup members agreed that there should be information on preexisting condition exclusions.

3. Discussed Other Matters

Crow said the Health Insurance and Managed Care (B) Committee had discussed statistics on claim denials and appeals. She said they showed that consumers appeal very few denials. She said the Subgroup may wish to consider how to assist consumers in understanding denials and making appeals. She reminded the Subgroup that it has already produced a guide for consumers on how to appeal denied claims.

Dr. Ting said it would be a good idea to refresh the denials guide and also to encourage consumers to appeal denials because there is a good chance that a denial would be overturned. He said communications outreach around the value of appealing would be useful in addition to updating the guide. Couch said social media can be a good avenue for reaching consumers.

Cisneros said overall health insurance literacy is also important and that the appeals guide could be part of a larger set of resources. Crow said the Subgroup had put out a more comprehensive guide to using insurance in the past. Buono said Pennsylvania uses a similar comprehensive guide.

Katie Dzurec (Regulatory Insurance Advisors) said information on coverage for preventive services may be useful for state insurance regulators and consumers after the recent *Braidwood* decision.

Crow asked Subgroup members and interested parties to suggest over email other topics for the Subgroup to take up.

Having no further business, the Consumer Information (B) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Committees/B Committee/National Meetings/2023 Summer National Meeting/Final Minutes/Cons Info 4.17.docx

Draft: 8/29/23

Health Innovations (B) Working Group
Seattle, Washington
August 13, 2023

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Seattle, WA, Aug. 13, 2023. The following Working Group members participated: Nathan Houdek, Chair, and Jennifer Stegall (WI); Amy Hoyt, Vice Chair (MO); Sarah Bailey (AK); Jimmy Gunn (AL); Debra Judy (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes and Craig VanAalst (KS); Jamie Sexton (MD); Marti Hooper (ME); Chad Arnold and Sarah Wohlford (MI); Chrystal Bartuska (ND); Paige Duhamel (NM); Daniel Bradford (OH); TK Keen (OR); Rachel Bowden (TX); Mike Kreidler and Ned Gaines (WA); and Joylynn Fix and Erin K. Hunter (WV). Also participating were: Michael Muldoon (NE); and D.J. Bettencourt (NH).

1. Adopted its 2023 Spring National Meeting Minutes

Keen made a motion, seconded by Peck, to adopt the Working Group's March 22 minutes (*see NAIC Proceedings – Spring 2023, Health Insurance and Managed Care (B) Committee, Attachment Two*). The motion passed unanimously.

2. Heard Presentations on Prior Authorizations

Commissioner Houdek said health plans are using new methods to review prior authorizations, and providers are calling for more consistency and certainty in the process. He said gold-carding allows plans to recognize providers with a high rate of successful prior authorizations and reduce prior authorization requirements for them. He said some states have adopted gold card programs in law.

Bowden presented on Texas' gold card law and its implementation. She said Texas passed its gold card law in 2021. She said the law applies to state-regulated health plans and state employee plans. She said health plans are obligated to provide an exemption from prior authorization to providers who receive approval more than 90% of the time. Plans are required to evaluate and provide exemptions even without a request from a provider. She said many providers believed they would qualify, but often they did not meet the threshold of providing the same service five times in a six-month period under a state-regulated plan.

Bowden said Texas conducted a survey of prior authorization practices before and after the law took effect. She said three out of four providers who met the evaluation threshold received exemptions. However, because many providers did not meet the threshold, only 3% of providers received an exemption.

Bowden said the law's impact could be increased by extending the evaluation period, aggregating services, or looking to claims across all affiliated entities, not just state-regulated plans. Bowden said the law does not carve out any types of providers or services. She said services are defined at the Current Procedural Terminology (CPT) code level, so it is very granular. Also, providers are defined based on the billing National Provider Identifier (NPI) number.

Bowden said that once an exemption is issued, a plan may not deny claims for medical necessity. However, retrospective reviews are permitted, which can impact the provider's exemption. Plans may rescind exemptions, but providers may request independent reviews of rescissions.

Commissioner Houdek asked if providers may appeal a plan's decision not to grant an exemption. Bowden said providers may complain to both the plan and the Texas Department of Insurance (DOI) in such cases.

Duhamel asked how many staff are dedicated to the program in Texas. Bowden said no additional staff were assigned under the law. She said the number of requests so far has not significantly affected workloads, and existing staff handled an ad hoc data call and reporting on it.

Houdek asked about stakeholders' views on the law. Bowden said health plans did not support passage of the bill and needed to make complicated updates to their systems to comply. She said providers are disappointed by the limited impact.

Gaines asked whether information on exemptions appears in provider directories. Bowden says it does not, and such information may not be helpful for consumers because the exemption only applies to particular services, not all services delivered by a provider.

Fix presented on West Virginia's prior authorization laws, one passed in 2019 and an update in 2023. She said West Virginia requires prior authorization on episodes of care rather than specific services. She said the initial law required all insurance companies to create online portals for prior authorization, and the updated law requires providers to use the electronic portal for all prior authorization requests. She said the portal must stay updated with the current status of the request. The law also sets timelines for insurers to respond to requests. She said West Virginia has a gold-carding program. She said gold cards are available when a provider averages 30 procedures per year and achieves 90% success in prior authorization requests. Fix said the initial law required 100% prior authorization success, but the state found no providers qualified and the threshold was reduced to 90%. She said there is a procedure for revoking gold cards if warranted. Fix said insurers must report quarterly on prior authorization statistics, broken down by provider. She said one staff member works on prior authorization implementation, and a contractor collects quarterly report filings.

Miranda Motter (AHIP) presented on prior authorization. She said AHIP has partnered with doctors, hospitals, and pharmacies to reduce the administrative burden. She said a 2018 consensus statement with the American Medical Association (AMA) and hospital and pharmacy groups recognizes that prior authorization can be burdensome for all involved. The statement also notes variation in medical practice and adherence to evidence-based practice standards. The statement identified five areas for improvement in prior authorization.

Motter said the industry has taken many steps since the 2018 statement, including increasing the adoption of electronic prior authorization. AHIP launched Fast PATH, a program to place technology in provider offices to streamline prior authorization. She said low quality care can increase costs and can harm patients. She said a 2020 study showed about 10% of physicians provided care inconsistent with evidence-based standards.

Motter said AHIP surveyed its members on prior authorization in 2022. She said the survey asked about gold-carding due to recent laws and proposals. She said the survey showed more plans are using more evidence-based resources to guide their prior authorization programs. She said the services most subject to prior authorization include genetic testing and specialty drugs. The survey also showed plans streamlined prior authorization in a variety of ways, including using electronic prior authorization. She said barriers to electronic prior authorization include providers using systems that do not have electronic prior authorization functionality and compatibility between systems. She said the use of gold-carding has increased since the last survey in 2019, and 62% of members have gold card programs. Motter said health plans have refined their gold card programs to target the

right services and the right providers, so they do not have negative impacts for patients. She said opportunities for further improvement include moving to electronic prior authorization and value-based relationships.

Duhamel asked how reliably plans apply their own clinical review criteria and provided an example of a plan asking providers for three years of history on infants in order to receive a certain benefit. She said failures of inter-rater reliability cause frustration. She also asked how plans can comply with mental health parity laws if gold card programs only apply to physical health services. Motter said there is a huge opportunity in electronic prior authorization to reduce burden on providers. She said gold card programs have the most impact when there is consistent review.

Commissioner Houdek said providers continue to complain that getting prior authorization is more challenging than it has ever been and asked how that aligns with the improvements cited in the presentation. Motter said plans continue to evaluate where prior authorization is warranted. She said new drugs and therapies require prior authorization reviews. She said prior authorization also serves as a touch point for communication between plans and providers. She said utilization management techniques like prior authorization are reduced when providers enter into value-based arrangements where they are accountable for the quality of care they provide.

3. Heard a Presentation from ArrayRx on Multistate Prescription Drug Purchasing

Trevor Douglass (ArrayRx) presented on his organization's purpose and development. He said ArrayRx is operated for states, by states and has long incorporated transparency into its practices. He said the organization began in 2003, before Medicare Part D existed, to provide seniors with discounts on prescription drugs. The Northwest Prescription Drug Consortium (NW Consortium) grew from an intergovernmental agreement between Washington and Oregon. The Consortium wanted to provide its benefits to other states, so it has expanded, changed its name to ArrayRx, and now can serve any state or public entity. He said Nevada is also a member, and Connecticut is in the process of joining.

Douglass said ArrayRx is an expert in the field of prescription drugs and public servants. He said other states can trust that their values align with the organization. He said the organization is committed to accountability and auditability and requires contractors to allow audits to the claim level. He said public sector experts in the pharmacy space are the ones who create contract terms.

Douglass said ArrayRx oversees the entire contract process and works with state Departments of Justice (DOJ) to review terms and conditions of contracts. He said ArrayRx provides states with predictability, transparency, and auditability. He said the organization's goal is to work with the rest of the states. It does not impose one solution but works with states to mold solutions to meet their needs. He said ArrayRx does not capture or allow spread pricing and does not charge a fee to its partner states.

Douglass said pharmacy benefit managers (PBMs) usually capture spread prices, but ArrayRx's contracts have allowed it to avoid $155 million in such costs and generated about $100 million per year in rebates. He said public programs have struggled with PBMs capturing spread, but ArrayRx's terms and conditions protect its partners. He said the organization allows states to leverage best practices from other states and modern technology from contractors. He said the PBM status quo is not useful, and his organization is pushing for innovations.

Duhamel asked about incorporating point-of-sale (POS) rebate reimbursement into member cost sharing. Douglass said he has not worked on this previously but would be happy to engage with New Mexico on the issue.

Seip asked about the process for purchasing drugs and distributing them to pharmacies. Douglass said ArrayRx does not make bulk purchases. Instead, it contracts with a PBM under its own specific terms.

4. Heard a Presentation from PhRMA on Health Equity Efforts

Courtney Christian (Pharmaceutical Researchers and Manufacturers of America—PhRMA) presented on the organization's efforts to advance health equity in clinical trials. She defined equity as the absence of avoidable, unfair, and remediable differences, such as everyone having a fair opportunity to achieve their full health potential. She said PhRMA has 800 drugs in development that are intended to treat diseases that disproportionately effect racial and ethnic minorities. She said common conditions, as well, have a disproportionate impact on black communities.

Christian said PhRMA is working to increase diverse representation in clinical trials. She shared statistics on representation in current trials, which showed lower participation from minority communities. She said structural racism underlies social determinants of health and drives inequities in health care. She said income and education, the digital divide, and environmental factors are all social determinants of health. She described barriers to equity in health care.

Christian said one way to improve access is to share drug rebates directly with patients. She said reducing patient costs by sharing rebates can improve their adherence to medications.

Christian said the drug industry is not immune to systemic racism. She said PhRMA's work for solutions includes clinical trial diversity, health equity, and talent in member companies. In clinical trial diversity, PhRMA is seeking to stay invested in communities, providing resources to providers, and setting up a network of community ambassadors to encourage participation in clinical trials. Other solutions include grants to historically Black schools of medicine and grants to community-based projects on the treatment of chronic disease and access to COVID-19 vaccines. Christian said PhRMA developed a Pathways to Success Summit to help diverse students discover career pathways within the industry.

Christian shared statistics on the savings available from reducing disparities and improving health outcomes, including $3.8 trillion from reducing the effects of chronic conditions.

Sylvia Yee (Disability Rights Education and Defense Fund—DREDF) asked about efforts to include people with disabilities in clinical trials. Christian said PhRMA is working to provide materials in accessible formats to attract a broader universe of individuals into clinical trials.

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

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