HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Draft Pending Adoption

Draft: 12/22/22

Health Insurance and Managed Care (B) Committee
Tampa, Florida
December 14, 2022

The Health Insurance and Managed Care (B) Committee met in Tampa, FL, Dec. 14, 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 represented by David Bettencourt (NH); Andrew R. Stolfi and TK Keen (OR); Michael Humphreys (PA); Jon Pike (UT); Mike Kreidler represented by Molly Nollette (WA); and Allan L. McVey represented by Ellen Potter (WV). Also participating were: Paul Lombardo (CT); Vicki Schmidt (KS); and Laura Arp and Maggie Reinert (NE).

1. Adopted its Nov. 10 and Summer National Meeting Minutes

The Committee met Nov. 10. During this meeting, the Committee took the following action: 1) adopted the revisions to the *Actuarial Guideline XLIV—Group Term Life Waiver of Premium Disabled Life Reserves* (AG 44) and its accompanying new tables and adjustments, the new 2022 Group Term Life Waiver Mortality and Recovery Tables (2022 Tables); 2) adopted the Health Actuarial (B) Task Force's 2023 proposed charges; 3) adopted the Regulatory Framework (B) Task Force's 2023 proposed charges; 4) adopted the Senior Issues (B) Task Force's 2023 proposed charges; and 5) adopted its 2023 proposed charges.

Director Wing-Heier made a motion, seconded by Director Fox, to adopt the Committee's Nov. 10 (Attachment One) and Aug. 11 minutes (*see NAIC Proceedings – Summer 2022, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

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

   a. Consumer Information (B) Subgroup

The Consumer Information (B) Subgroup met Oct. 20 and Sept. 28. During these meetings, the Subgroup adopted a frequently asked questions (FAQ) document about health care reform and discussed sharing a survey on consumer engagement activities with state department of insurance (DOI) public information officers (PIOs) during an October PIO meeting.

   b. Health Actuarial (B) Task Force

Lombardo discussed the work of the Health Actuarial (B) Task Force since the Summer National Meeting and its plans for 2023. He said the Task Force met Sept. 28 and Sept. 6. During these meetings, the Task Force took the following action: 1) adopted the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute Group Life Waiver of Premium Valuation Table (GLWPVT) Work Group proposal for valuation tables to replace the 2005 Group Term Life Waiver Mortality and Recovery Tables in AG 44; and 2) adopted its 2023 proposed charges.

Lombardo said that in 2023, the Task Force plans to hear updates on the SOA Research Institute's 2022 Individual Life Waiver of Premium (ILWOP) Experience Study and consider whether to develop new valuation tables to replace the 1952 SOA disability table. He said the Task Force also plans to review and consider changes to VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the *Valuation Manual* to incorporate mortality and lapse tables from the Academy and SOA Research Institute's Final Long-Term Care Insurance (LTCI) Mortality

and Lapse Study. The Task Force also plans to provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements, LTCI rates, rating practices, and rate changes.

Lombardo said the Task Force will continue its work to provide support for issues related to the implementation of, and/or changes to, the federal Affordable Care Act (ACA) and provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary to other NAIC groups relative to their work on health actuarial matters.

c. Health Innovations (B) Working Group

Arp said the Health Innovations (B) Working Group met earlier today. During the meeting, the Working Group took the following action: 1) adopted its Summer National Meeting minutes; 2) heard presentations on hospital facility fees from the National Academy for State Health Policy (NASHP), the American Hospital Association (AHA), the Blue Cross Blue Shield Association (BCBSA), and America's Health Insurance Plans (AHIP); 3) heard a presentation from Randolph Pate Advisors on coverage of drugs to treat obesity; and 4) heard presentations from the Johns Hopkins University and from the HIV+Hepatitis Policy Institute on prescription drug formularies.

Arp said that throughout the year, the Working Group has heard presentations on topics of interest to its members and other stakeholders, including presentations on the unwinding of the public health emergency (PHE) and Colorado's public option work. She said the majority of the Working Group's meetings this year have focused on hearing from various stakeholders on topics related to the charges the Working Group received from the Special (EX) Committee on Race and Insurance. The Working Group also heard presentations and received information from the Center for Insurance Policy and Research (CIPR). The Special Committee charged the Working Group in 2021 to evaluate mechanisms to resolve disparities through improving access to care, including the efficacy of telehealth as a mechanism for addressing access issues; the use of alternative payment models and value-based payments and their impact on exacerbating or ameliorating disparities and social determinants of health; and programs to improve access to historically underserved communities. She said the Working Group prepared a memorandum to the Special Committee summarizing its findings on the first two mechanisms referenced in the charges, telehealth services, and alternative payment models.

Arp said the memorandum provides a summary of the overall evaluations of telehealth services' and alternative payment models' impacts on health disparities based on the assessments in the CIPR reports and presentations to the Working Group. She said the memorandum does not include explicit recommendations to the Special Committee. Rather, it seeks to inform the Special Committee and allow it to determine any next steps. She said the Working Group presented the memorandum to the Special Committee for its consideration during the Special Committee's meeting earlier today. The Special Committee adopted the memorandum. Arp said that among the Working Group's findings from its work was that telehealth has the potential to close coverage gaps for underserved populations, but issues related to access to technology to be able to access this service, including broadband access, should be addressed. She said that with respect to alternative payment models, the Working Group found that such payment models could ameliorate or exacerbate health disparities depending on how they are designed. She said the Working Group identified options for state insurance regulators to address this issue, including more closely monitoring health insurers' use of alternative payment models and the implementation of more effective risk adjustment mechanisms for alternative payment models.

d. Regulatory Framework (B) Task Force

Commissioner Schmidt said that this year, the Task Force has focused on hearing presentations from various stakeholders on issues related to the Task Force's mission to: 1) develop NAIC model acts and regulations for state health care initiatives; and 2) consider policy issues affecting state health insurance regulation. She said that as

part of its oversight responsibilities, at each of its meetings during the national meetings, the Task Force receives status updates from each of the groups reporting to it on their work related to their 2022 charges.

Commissioner Schmidt said that as the Committee members probably know, because of the number of their staff participating in the meetings, all the Task Force's groups are very active and will continue to be active in 2023. She said she and Commissioner Sharon P. Clark (KY), the Task Force vice chair, are grateful for their participation and contributions to this important work.

Commissioner Schmidt said that during its meeting yesterday, the Task Force heard a presentation from Dialysis Patient Citizens (DPC) on a suggested consumer disclosure and labeling regime for ancillary health products. The Task Force was interested in hearing this presentation because it touches on the work the Accident and Sickness Insurance Minimum Standards (B) Subgroup plans to begin next year to revise the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act's* (#171) consumer disclosure provisions for supplementary health products and short-term, limited-duration (STLD) plans. The Task Force also heard a presentation on individual coverage health reimbursement arrangements (ICHRAs) and how employers view them.

Commissioner Schmidt said the remainder of the Task Force's meeting included updates from each of the groups that report to the Task Force. She said the Accident and Sickness Insurance Minimum Standards (B) Subgroup plans to continue its work on revising Model #171 and hopes to complete that work by the end of 2023. She said that as far as the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's work is concerned, the Subgroup just released an initial draft of the pharmacy benefit manager (PBM) white paper. The Subgroup plans to discuss the working draft during its meeting on Dec. 15. Commissioner Schmidt said the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group continues to serve as a forum and the opportunity for Working Group members and interested state insurance regulators to discuss MHPAEA enforcement and compliance issues. She said that in addition, the Working Group continues to facilitate discussions between state insurance regulators and the federal regulators charged with implementing the MHPAEA.

e. Senior Issues (B) Task Force

Commissioner Pike said the Senior Issues (B) Task Force has met nine times in 2022, including its in-person meeting yesterday on Dec. 13. He said that during these meetings, the Task Force discussed several issues of interest to its members and stakeholders, including the federal Centers for Medicare & Medicaid Services' (CMS') proposed rule on stricter marketing guidelines for Medicare Advantage plans. The Task Force developed and adopted a letter in support of the proposed rule. The Task Force also adopted a letter to the CMS regarding the treatment of non-participating durable medical equipment (DME) suppliers under Medicare's beneficiary limitation on liability (LOL) provisions. The Task Force also discussed the CMS' proposed rule on Medicare Part B enrollment, which aims to simplify Medicare enrollment rules. The Task Force agreed to send a letter to the CMS on the proposed rule.

Commissioner Pike said the Task Force also discussed the difficulties some workers and retirees face with the transition to coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) accompanied by eligibility for Medicare. He said the Task Force heard a few presentations from NAIC consumer representatives on this issue. The Task Force also heard presentations on: 1) Medicare Part D and auto-enrollment; and 2) home care plans and marketing insurance. Commissioner Pike said the Task Force also agreed to disband the Long-Term Care Insurance Model Update (B) Subgroup because the Subgroup completed its work. However, the Task Force agreed to reestablish the Subgroup if the Task Force believes it is necessary based on any referrals from other NAIC groups working on issues related to LTCI or as part of its continuing work to review LTCI materials, including the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641), and to study and evaluate evolving LTCI product design, rating, suitability, and other related factors.

Commissioner Pike said that for 2023, the Task Force plans to continue to review the *Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) to: 1) determine if amendments are required based on changes to federal law; 2) advance appropriate regulatory standards for Medicare supplement and other forms of health insurance applicable to older Americans; 3) monitor the Medicare Advantage and Medicare Part D marketplace; and 4) monitor developments concerning State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs.

Director Wing-Heier made a motion, seconded by Commissioner Conway, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its Oct. 20 (Attachment Two) and Sept. 28 (Attachment Three) minutes; 2) the Health Innovations (B) Working Group, including its Dec. 13 (Attachment Four) and Oct. 3 (Attachment Five), minutes; 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 Discussion from a Large, Multistate Employer on PBM Regulation

Teah Corley (EmployerAdvocates) and Brandon Long (ERISA Counsel) discussed the impact of state PBM regulation from a large, multistate employer perspective. The presenters discussed the rationale and need for such regulation for reasons such as the lack of transparency, the rising cost of prescription drugs, and the use of certain self-serving, competition-stifling trade practices at the PBM level. The presenters discussed the findings and impact of recent court rulings, such as the U.S. Supreme Court's ruling in *Rutledge vs. the Pharmaceutical Care Management Association* (PCMA), related to state PBM laws and the ability of the states to regulate PBM business practices. The presenters highlighted some of the challenges large, multistate employers, such as Hobby Lobby, have encountered because of such regulation, including administrative challenges due to the loss of regulatory uniformity across the states and increased costs. The presenters said that on their face, not all state laws regulating PBMs are problematic, but the problem with some of these laws is that they remove the employer from being able to make decisions based on their knowledge of their employees' needs. The presenters suggested these issues could be remedied by the recognition of ERISA preemption for self-funded employers, which would reestablish and reinforce uniformity of regulation across state lines and encourage state legislators to allow the NAIC to issue uniform guidance to help synchronize state laws relating to PBMs.

Keen asked the presenters to provide their perspectives on state PBM transparency laws. Corley said such laws are helpful and important, but to the extent that they could be used by some in the prescription drug supply chain, such as pharmaceutical manufacturers, not to provide information because they consider such information to be proprietary information and as a result stop offering rebates, this could result in increased costs. She noted that to date, she has not seen this happening. Long agreed with Corley's remarks. He said his clients welcome more transparency and the ability to obtain more information.

Commissioner Schmidt asked the presenters about a statement in a letter included in the Committee's meeting materials from a representative of Hobby Lobby stating that "legislators—and frankly, insurance departments—have used Rutledge to act as if ERISA does not exist at all and pass laws and regulations specifically targeting self-funded employers (under the cloak of laws and regulations supposedly targeting "PBMs")." She expressed disagreement with the statement. She said state insurance regulators do not pass the laws; state legislators pass the laws. State insurance regulators enforce the laws. Long agreed but said state departments of insurance (DOIs) interpret the laws and adopt regulations and issue bulletins based on such interpretations. He said to address these issues, it is important to have conversations with stakeholders during the development of regulations and other regulatory guidance about how a law is to be interpreted and enforced. Commissioner Schmidt agreed about the need and usefulness of open communication. However, with respect to mail-order pharmacies, she said she

believes that independent pharmacies provide better opportunities for consumers to communicate their issues and concerns with their prescriptions than through a mail-order pharmacy.

4. 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. Montz provided a status update on the current open enrollment period. She said that as of last week, 5.5 million people have signed up for coverage, including 1.2 million enrollees who are new to the Marketplace. She said that the CCIIO believes this is a result of the Biden-Harris Administration's commitment to strengthening the ACA, including through the President's Inflation Reduction Act, which included critical tax credits to millions to enable them to obtain affordable coverage through the state and federal individual market health insurance marketplaces.

Montz said the CCIIO also launched its standardized plan options for 2023. She said with these plans, consumers will have access to new plan options on HealthCare.gov, which offer the same cost-sharing design as other standardized plan options within the same health plan category, making them easier to compare across health insurance issuers.

Montz also discussed steps the CCIIO is taking to prepare for the unwinding and the Medicaid redetermination process at the end of the PHE, including using the current open enrollment period to pilot some of the CCIIO's planned enhanced outreach to ensure consumers, who have been denied or terminated from Medicaid or federal Children's Health Insurance Program (CHIP) coverage, can successfully transition to the marketplace wherever possible. She discussed the CCIIO's work related to implementing the new network adequacy rules. She noted how beneficial it has been to be able to collaborate with the states in reviewing consumer complaints and reaching determinations of any potential violations of the rules.

Montz also discussed highlights from the recently released Notice of Benefit and Payment Parameters 2024 proposed rule. She discussed changes to the network adequacy requirements to provide increased access to care for low-income and medically underserved consumers and changes to the consumer shopping experience to maximize the power of consumer preference to drive competition.

Director Fox asked about the numbers of individuals who would lose Medicaid or CHIP coverage at the end of the PHE and be eligible for subsidies to obtain affordable coverage through the individual market health insurance marketplaces. Montz explained and provided rough numbers of individuals losing Medicaid and CHIP coverage who will be eligible for employer-sponsored coverage, those who would be eligible to receive subsidies and affordable coverage through the individual market health insurance marketplaces, and those who will fall through the gaps and have no coverage.

Director Fox also asked about the numbers of individuals who have filed complaints with the CMS related to surprise bills. She specifically asked what Montz meant about certain claims being "ineligible." Montz explained that a certain number of complaints do not meet the requirements of the federal No Surprises Act (NSA) to be considered a "surprise" bill. She said other complaints are considered ineligible because they have been filed through the federal dispute resolution process rather than the state's process and need to be forwarded to the appropriate entity for a determination and resolution.

Commissioner Conway asked about the pilot program Montz referenced that the CCIIO plans to use during the current open enrollment period to assist it when the PHE ends and the redetermination process begins. He asked when the CCIIO would share information with stakeholders about the results of the program. Montz said the CCIIO plans to launch the educational outreach related to the program Dec. 15, telling recipients to apply for coverage as soon as possible to have coverage beginning Jan. 1, 2023. She said the CCIIO hopes to have a few weeks to a

month of experience to review the enrollment numbers to determine if the outreach was effective. She said the CCIIO could possibly be able to share its findings in February or March 2023.

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

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Draft: 11/15/22

Health Insurance and Managed Care (B) Committee
Virtual Meeting
November 10, 2022

The Health Insurance and Managed Care (B) Committee met Nov. 10, 2022. The following Committee members participated: Glen Mulready, Chair (OK); Russell Toal, Co-Vice Chair (NM); Lori K. Wing-Heier represented by Sarah Bailey (AK); Michael Conway represented by Tara Smith (CO); Amy L. Beard (IN); Anita G. Fox (MI); Grace Arnold represented by Galen Benshoof (MN); Chris Nicolopoulos represented by Michelle Heaton (NH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Sandra L. Ykema (PA); Jon Pike (UT); Mike Kreidler (WA); and Allan L. McVey (WV). Also participating was: Paul Lombardo (CT).

1. Adopted the Revisions to AG 44 and the New 2022 Tables

Lombardo said the Health Actuarial (B) Task Force is asking the Committee to consider adoption of *Actuarial Guideline XLIV—Group Term Life Waiver of Premium Disabled Life Reserves* (AG 44) and its accompanying tables and adjustments, the new 2022 Group Term Life Waiver Mortality and Recovery Tables (2022 Tables). He said the *Health Insurance Reserves Model Regulation* (#10) and the NAIC *Valuation Manual* (VM-25, Health Insurance Reserves Minimum Reserve Requirements) contain requirements for the calculation of waiver of premium due to disability reserves on group life insurance policies. The current version of AG 44 prescribes the use of the 2005 Group Term Life Waiver Mortality and Recovery Tables. He said the American Academy of Actuaries (Academy) and the Society of Actuaries Research Institute (SOARI) Group Life Waiver of Premium Valuation Table (GLWPVT) Work Group proposed new 2022 Tables that were developed using more recent experience data. The use of the 2022 Tables, as adopted by the Health Actuarial (B) Task Force on Sept. 28, required modifications to AG 44 to accommodate their application.

Lombardo said the Academy and the SOARI GLWPVT Work Group drafted the AG 44 proposed revisions. The Health Actuarial (B) Task Force exposed the draft actuarial guideline revisions on July 11 for a public comment period ending Aug. 11. He said additional revisions were proposed during the Task Force's Sept. 6 meeting, which the Task Force exposed for a public comment period ending Sept. 22. He said the AG 44 revisions received substantial vetting during the Task Force's meetings. The Health Actuarial (B) Task Force adopted the final version of the AG 44 during its Sept. 28 meeting.

Superintendent Toal made a motion, seconded by Commissioner Pike, to adopt the revisions to AG 44 and the new 2022 Tables. The motion passed unanimously.

2. Adopted the Health Actuarial (B) Task Force's 2023 Proposed Charges

Lombardo said the Health Actuarial (B) Task Force discussed and adopted its 2023 proposed charges during its Sept. 28 meeting. He said the 2023 proposed charges are essentially the same as its 2022 charges.

Commissioner McVey made a motion, seconded by Superintendent Toal, to adopt the Task Force's 2023 proposed charges. The motion passed unanimously.

3. Adopted the Regulatory Framework (B) Task Force's 2023 Proposed Charges

Jolie H. Matthews (NAIC) said the Regulatory Framework (B) Task Force's 2023 proposed charges are substantively the same as its 2022 charges. She said the Task Force discussed and adopted the charges unanimously during its Oct. 11 meeting.

Commissioner Pike made a motion, seconded by Superintendent Toal, to adopt the Task Force's 2023 proposed charges. The motion passed unanimously.

4. Adopted the Senior Issues (B) Task Force's 2023 Proposed Charges

Matthews said the Senior Issues (B) Task Force discussed and adopted its 2023 proposed charges during its Oct. 17 meeting. She said the Task Force's 2023 proposed charges are the same as its 2022 revised charges.

Commissioner McVey made a motion, seconded by Commissioner Pike, to adopt the Task Force's 2023 proposed charges. The motion passed unanimously.

5. Adopted its 2023 Proposed Charges

Commissioner Mulready said NAIC staff distributed and posted the Committee's 2023 proposed charges on the Committee's web page prior to the meeting. He said the 2023 proposed charges are the same as its 2022 charges.

Superintendent Toal made a motion, seconded by Commissioner McVey, to adopt the Committee's 2023 proposed charges (Attachment One-A). The motion passed unanimously.

6. Discussed the NAIC/American Indian and Alaska Native Liaison Committee's Oct. 28 Meeting

Commissioner Mulready discussed the NAIC/American Indian and Alaska Native Liaison Committee's Oct. 28 meeting, which was held in regulator-to-regulator session. He said that for those who missed the meeting, there was a lot of valuable information discussed and shared concerning legal issues with the Sovereign Nations Health Consortium's (SNHC's) plan to have Sovereign Nations Insurance (SNI), which the SNHC characterizes as a tribal insurer, to offer and sell certain health insurance products to tribal members and potential non-tribal members without obtaining an insurance license from state departments of insurance (DOIs).

Commissioner Kreidler said he is meeting with representatives of the SNHC next week. He also thanked Commissioner Mulready for inviting the speaker who spoke during the NAIC/American Indian and Alaska Native Liaison Committee's Oct. 28 meeting about legal issues related to the SNHC and the SNI. He said he appreciated the opportunity to ask questions and thought it was a valuable discussion. He also said the information provided during that meeting will be useful for his upcoming meeting. Commissioner Mulready asked Commissioner Kreidler if he would be willing to provide a summary of his meeting with the SNHC to the Committee members and interested state insurance regulators. Commissioner Kreidler agreed to provide such a summary.

7. Discussed the Committee's Tentative Fall National Meeting Agenda

Commissioner Mulready said that although the Committee's meeting agenda for the Fall National Meeting is still being finalized, he has invited representatives of a large group employer to speak to the Committee about pharmacy benefit managers (PBMs) and their business practices from a large employer perspective. He said he invited them to speak because, to date, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup has not

heard from this stakeholder group, and he thought it would be beneficial to the Committee to hear their perspective. He said representatives of the federal Centers for Medicare & Medicaid Services (CMS) have been invited to provide an update to the Committee on its recent activities.

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

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Adopted by the Executive (EX) Committee and Plenary, Dec. __, 2022
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 10, 2022

2023 Proposed Charges

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

The mission of the Health Insurance and Managed Care (B) Committee is to consider issues relating to all aspects of health insurance.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
   A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC's position through letters and testimony, when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   C. Monitor the activities of the Regulatory Framework (B) Task Force.
   D. Monitor the activities of the Senior Issues (B) Task Force.
   E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
   F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
   G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.

2. The **Consumer Information (B) Subgroup** will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.

3. The **Health Innovations (B) Working Group** will:
   A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
   B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.

C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2022 Fall National Meeting/009-BCmte.docx

Draft: 10/26/22

Consumer Information (B) Subgroup
E-Vote
October 20, 2022

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Oct. 20, 2022. The following Subgroup members participated: Mary Kwei, Chair (MD); Debra Judy, Vice Chair (CO); Anthony L. Williams (AL); Randy Pipal (ID); Michelle Baldock (IL); Alex Peck, (IN); LeAnn Crow (KS); Judith Watters (ME); Carrie Couch (MO); Kathy Shortt (NC); David Buono (PA); Vickie Trice (TN); Shelley Wiseman (UT); Todd Dixon (WA); and Christina Keely (WI).

1. Adopted Frequently Asked Questions About Health Care Reform

The Subgroup conducted an e-vote to consider adoption of the document titled Frequently Asked Questions about Health Care Reform, a resource for state department of insurance (DOI) staff in understanding the federal Affordable Care Act (ACA) and related laws and rules. The motion passed unanimously.

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Draft: 10/13/22

Consumer Information (B) Subgroup
Virtual Meeting
September 28, 2022

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Sept. 28, 2022. The following Subgroup members participated: Mary Kwei, Chair (MD); Debra Judy, Vice Chair (CO); Yada Horace and Anthony L. Williams (AL); Randy Pipal (ID); Jenifer Groth (IN); LeAnn Crow (KS); Gregory Maus (MN); Amy Hoyt, Jeana Thomas, and Michelle Vickers (MO); Mike Rhoads (OK); Lars Thorne (PA); Gretchen Brodkorb, Candy Holbrook, and Jill Kruger (SD); Brian Hoffmeister, Scott McAnally, and Jennifer Ramcharan (TN); Heidi Clausen (UT); and Monica Hale, Christina Keeley, Jody Ullman, and Jennifer Stegall (WI).

1. Discussed Work on a Survey of States' Consumer Engagement Activities

Ms. Kwei reminded the Subgroup that it discussed a plan in March to survey states on their methods for engaging with consumers on health insurance. She said a group of volunteers discussed the issue and decided to start with focus groups to have more open-ended conversations with staff in state departments of insurance (DOIs). She said two focus groups were conducted with representation from states in each of the NAIC zones, including Colorado, Kansas, Maryland, and North Carolina.

Ms. Crow said the focus groups offered good information about the ways states reach out to constituents regarding health insurance. Brenda J. Cude (University of Georgia) said the focus groups revealed many good ideas that can and should be shared with other states.

Ms. Kwei said the Subgroup still wants to go forward with a survey, using information learned in the focus groups. She said the smaller group has developed a draft set of survey questions. She said the questions seek to learn what states are doing to engage consumers, what they would like to do in the future, and how they use materials developed by the Subgroup. She said the plan is to distribute the survey to public information officers (PIOs).

Ms. Keely asked if the survey would ask on what occasions states undertake outreach, such as during open enrollment or when there is new information to share. Ms. Kwei said DOIs usually have ongoing communications efforts. She said the focus groups asked whether states tie their efforts to open enrollment. Dr. Cude said there is a mix of outreach efforts related to events and a baseline of ongoing efforts that happen regardless of time of year.

Ms. Kwei said the survey would be sent to PIOs, and she asked whether it should be sent to other contacts in state DOIs. Dr. Cude suggested that instructions indicate that either PIOs or others in departments who engage with consumers may respond to the survey. Ms. Ramcharan said PIOs have working relationships with others, and she said opening responses to others involved in outreach is a good idea. Dr. Cude asked whether the Subgroup would ask for one response per state or allow multiple responses from a single state. The Subgroup agreed that there should be one response per state, but it should remain open to asking follow-up questions if more information is needed. The Subgroup also agreed to add a question to gather contact information from respondents.

Harry Ting (Health Consumer Advocate) suggested that the invitation make it clear that the survey is focused on health insurance rather than other lines.

Dr. Cude asked how the survey would be made available to PIOs. Ms. Kwei said it would be sent by email after the Oct. 20 PIO call. Dr. Cude suggested that an email be drafted to PIOs that establishes a deadline for responses. She said the survey should be tested before it is sent out.

2. Discussed the "Frequently Asked Questions about Health Care Reform" Document

Ms. Kwei said the Subgroup annually updates the "Frequently Asked Questions about Health Care Reform" document. She said it is intended for DOI staff, not for direct distribution to consumers. However, insurance department staff may use it in responding to consumer questions. She said the document should be updated for the year before the beginning of open enrollment on Nov. 1. She said NAIC staff started working on updates for the year.

Ms. Kwei said there are not many changes for the document this year. She said some federal regulations have been proposed, but not finalized, including one on the family glitch and nondiscrimination rules under Section 1557 of the federal Affordable Care Act (ACA).

Ms. Kwei asked how the document should address areas where rules are not final. Subgroup members agreed that the document should include a statement that revised rules had been proposed but not made final. Ms. Keely said she would send suggested changes by email. Ms. Ramcharan asked if the document is intended to be printed. Ms. Kwei said it is not intended to be public, but it is posted on the Subgroup's website.

The Subgroup agreed that NAIC staff should make final updates and send them for review to Dr. Cude and federal Centers for Medicare & Medicaid Services (CMS) officials before sending them to the Subgroup for an e-vote.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2022 Fall National Meeting/Final Minutes/Minutes 9.28 reviewed.docx

Draft: 1/4/23

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

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

1. Adopted its Summer National Meeting Minutes

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

2. Heard Presentations on Hospital Facility Fees

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Heard Presentations on Issues with Prescription Drug Formularies

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

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

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

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

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

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

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

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

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

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

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Draft: 11/1/22

Health Innovations (B) Working Group
E-Vote
October 3, 2022

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Oct. 3, 2022. The following Working Group members participated: Andrew R. Stolfi, Chair (OR); Nathan Houdek, Vice Chair (WI); Anthony L. Williams (AL); Alida Bus (AK); Andria Seip (IA); Julie Holmes (KS); Anita G. Fox (MI); Amy Hoyt (MO); Galen Benshoof (MN); Chrystal Bartuska (ND); Molly Nollette (WA); and Joylynn Fix (WV).

1. Adopted a Memorandum to the Special (EX) Committee on Race and Insurance on Health Disparities

The Working Group conducted an e-vote to consider adoption of a memorandum (Attachment Five-A) on its findings related to telehealth and alternative payment models and their potential effects on health disparities. The memorandum is in fulfillment of the Working Group's charges from the Special (EX) Committee on Race and Insurance. The motion passed unanimously.

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

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NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

October 3, 2022

To: Members of the Special (EX) Committee on Race and Insurance
From: Health Innovations (B) Working Group
RE: Mechanisms to resolve disparities through improved access to care

With this memo, NAIC's Health Innovations (B) Working Group conveys a summary of its findings on certain mechanisms to resolve disparities by improving access to care. In 2021, the Special (EX) Committee on Race and Insurance assigned charges to the Working Group requesting an evaluation of these mechanisms. The charges are as follows:

*The **Health Innovations (B) Working Group** will evaluate mechanisms to resolve disparities through improving access to care, including the efficacy of telehealth as a mechanism for addressing access issues; the use of alternative payment models and value-based payments and their impact on exacerbating or ameliorating disparities and social determinants of health; and programs to improve access to historically underserved communities.*

This memo focuses on the first two mechanisms referenced in the charges, telehealth services and alternative payment models. The Working Group has met several times since 2021 and heard numerous presentations on these topics. In March 2021, the Working Group heard from a telehealth expert with the Center for Connected Health Policy, a provider viewpoint from the American Psychiatric Association, and about health plan experiences from Regence and Asuris Health Plans. In December 2021, it gathered further input from health plans from Blue Cross Blue Shield-North Carolina and Anthem. NAIC's Center for Insurance Policy and Research (CIPR) also presented to the Working Group in December 2021 on its detailed research on telehealth and updated its findings with additional information on alternative payment models in April 2022. To supplement these presentations, CIPR further developed written reports for the Working Group on the impact on health disparities of telehealth services and alternative payment models.

- Trends in Telehealth and Its Implications for Health Disparities
- Alternative Payment Models and Health Disparities

This memo provides a summary of the overall evaluations of telehealth services' and alternative payment models' impacts on health disparities based on the assessments in the CIPR reports and presentations to the Working Group. The Working Group does not provide explicit recommendations to the Special Committee. Rather, it seeks to inform the Special Committee and allow the committee to determine next steps. The evaluations contained here could be used in a report of the committee, recommendations for NAIC action, to charge another NAIC group with further investigation, or for other purposes as the Special Committee finds appropriate.

Key findings include:

Telehealth

- While there are many barriers to health equity, we find physical access to care to be the most substantial and pervasive obstacle that could be alleviated with the increased use of telehealth.
- Telehealth has great potential to bridge the gap in access to care by connecting isolated people with culturally competent health practitioners and reducing the need for transportation to receive such care.
- Insurance regulators may choose to support increased access to telehealth services with regulations that require it to be covered or offered with favorable cost sharing.
- To help assure that greater use of telehealth does not exacerbate disparities, regulators should be aware of the limitations and consider steps to increase digital literacy and access to the technology needed by the patient to support the delivery of telehealth services, such as hardware, software, and broadband access. Regulators should also recognize the patient's need for privacy for such a visit.

Alternative Payment Methods/Value Based Payments

- Alternative payment models (APMs) and value based payments (VBPs) have incentives that could either ameliorate or exacerbate health disparities.
- While designed to create value rather than to eliminate or mitigate disparities, APMs and VBPs have *potential* to reduce disparities because these same patients present the greatest opportunities to realize savings.
- A provider could seek to better manage high-cost conditions and capture a share of the savings, which can reduce health disparities. Or it could seek to avoid treating such populations, leading to continued disparities.
- Populations with a high cost to treat and a low likelihood of producing savings or improving quality can challenge provider finances under APMs or VBPs. Risk adjustment programs seek to ameliorate these concerns, but to date have done so incompletely.
- As they seek to reduce the racial and ethnic disparities that stem from health insurance, state regulators may choose to:
    - more closely monitor health insurers' use of APMs and VBPs;
    - seek to better understand how their regulatory tools can be used to encourage models that promote greater provider engagement with disadvantaged populations and reform models that can lead to providers avoiding high-need populations; and
    - seek ways to promote the testing and implementation of more effective risk adjustment mechanisms for alternative payment models.

This memo does not address the final portion of the charge, "programs to improve access to historically underserved communities." Many programs result in improved access for historically underserved communities, from government-supported health care financing efforts like Medicare, Medicaid, and premium tax credits under the Affordable Care Act to local efforts like community health workers and mobile clinics. The Working Group continues to work to define the scope of the charge and gather information from stakeholders. The Working Group plans to follow up with additional assessments once this work advances.

Health Disparities

Health disparities are *avoidable* differences among demographic and socioeconomic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality. Health disparities in the United States are well-documented. Health disparities have narrowed over time, but significant disparities remain. For example, the most recently available data show life expectancy at birth is 3.5 years shorter for

Black individuals than for Whites, and Native Americans have a lower life expectancy than Black individuals. Disparities evident during the COVID-19 pandemic have served to amplify the issue in the last two years. Recent research projects that the decline in life expectancy at birth due to COVID-19 would be 0.68 years for the White population but 2.10 years for the Black population and 3.05 years for the Latino population.

There are also disparities in *health care*. While these have declined over time, they persist across numerous domains within the health care system. For about 40 percent of 250 health care quality measures tracked by the U.S. Agency for Healthcare Research and Quality (AHRQ), Black patients receive "worse care" than White patients. Latinos receive worse care than Whites for more than one-third of quality measures and Asians for nearly 30 percent. The quality differential in health care across race and ethnicity is pervasive. A voluminous research literature shows that hospitalized Black patients and other racial and ethnic minorities receive less intensive care across numerous procedures and have been reported to receive less aggressive treatment, for example, for cancer and HIV. There are also marked disparities in health care *utilization* by racial and ethnic minorities, which leads to worse health outcomes.

Telehealth and Health Disparities

In general terms, "telehealth" refers to "the use of medical information exchanged via electronic communications to support and provide health care." Broadly defined, examples include direct provider-to-patient interactions via videoconferencing (virtual visits), chat-based interactions, remote patient monitoring, physician-to-physician consultations, patient education, data transmission and interpretation, and digital diagnostics (algorithm-based support), whether alone or in combination with conventional modalities.

The pace of expansion in telehealth accelerated rapidly with the onset of the COVID-19 pandemic. While utilization of telehealth has since moderated, it remains exceptionally high compared with pre-pandemic levels (about 17 percent of physician visits, much of which is for mental or behavioral health). We find that telehealth has great *potential* as a mechanism for ameliorating disparities and the social determinants of health, but the benefits telehealth could bring are limited by disproportionately inadequate broadband access at home for disadvantaged and marginalized populations and insufficient levels of digital literacy.

Prospects for Reducing Disparities. The accelerated development and substantial increase in the utilization of telehealth during the COVID-19 pandemic has sparked considerable interest in telehealth, and along with that interest, questions about the implications of increased telehealth utilization for socioeconomic and demographic health disparities.

While there are many barriers to health equity, we find physical access to care to be the most substantial and pervasive obstacle that could be alleviated with the increased use of telehealth. A critical problem facing rural areas is an insufficient supply of physicians and other healthcare professionals. Large areas with sparse populations lack the capacity to support many health care services. In particular, the overall distribution of physicians in the United States is exceedingly uneven. We also find substantially lower concentrations of physicians in areas with high Black and Hispanic populations.

The problem of a dearth of physicians and other health care professionals in rural and high-minority-concentrated areas is exacerbated by transportation deficits in these same areas, particularly *access* (not ownership) to private vehicles. Lack of vehicle access corresponds closely with race and ethnicity. Arguably, telehealth has great potential to bridge the gap in access to care by connecting isolated people with health practitioners and reducing the need for transportation to receive care. Existing research shows that lessening the necessity of physical transportation to access medical care improves access and mitigates disparate health outcomes.

While access to any kind of care often is problematic for vulnerable populations, for some, what is lacking is not access to health care *per se*, but rather, access to *culturally competent* health care; that is, "the ability

of systems to provide care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs." Telehealth has great potential to bridge the gap in access to care by connecting isolated people with culturally competent health practitioners and reducing the need for transportation to receive such care.

Limitations. One of the most pressing concerns in the evolution of the digital economy, which has persisted throughout the internet's history, is that of a digital divide, or a gap in internet access and digital literacy, across economic, demographic, and social lines. More advantaged individuals historically have been the first to adopt and benefit the most from the introduction of new technologies. Lack of broadband access, particularly at home—and privacy is a significant concern with telehealth—is considerably more pronounced among vulnerable populations, including racial and ethnic minorities, lower-income individuals, and seniors. The communities likely to benefit the most from telehealth—these groups as well as those in rural areas—also are the least likely to have access to broadband internet.

A lack of digital literacy for vulnerable populations also stands in the way of more universal access to care through telehealth. To have successful telehealth appointments, patients need to understand digital technology generally and how telehealth platforms work. Research finds disproportionately low digital literacy in the health context among the less educated and those who are members of racial or ethnic minority groups. Research also suggests those with lower levels of digital literacy are less engaged and receive fewer psychological benefits from telehealth interactions even when they participate.

Insurance regulators may choose to support increased access to telehealth services with regulations that require it to be covered or offered with favorable cost sharing. To help assure that greater use of telehealth does not exacerbate disparities, regulators should be aware of the limitations noted above and consider steps to increase digital literacy and expand broadband access.

Alternative Payment Models, Value-Based Payments, and Health Disparities

Payment Models and Value Based Payments Described. A payment model is the process in which physicians, hospitals, and other health care providers are compensated for the care they provide. We define an alternative payment model (APM) as any model that deviates from the fee-for-service (FFS) model, under which providers are paid for each service delivered. Although FFS is the prevailing payment model, a consensus has developed among patients and third-party payers, as well as many health care practitioners, that a transition away from the FFS model to APMs is necessary to "bend the cost curve" and improve treatment outcomes.

Incentives for Quality Improvement and Cost-Efficiency. Our focus in this memo and the associated report is the implications of APMs and value-based payments (VBPs) for ameliorating or exacerbating racial and ethnic health disparities. First, we briefly describe basic payment models.

From a broad perspective, there are three types of payment models: fee-for-service (FFS), case-based, and capitation. All of these payment models are *volume-based*. That is, there are financial rewards for increasing the *quantity* of care provided. Each payment model also has implicit (dis)incentives for reducing costs or improving quality of care.

Under FFS systems, provider compensation is determined by the quantity of specific services they provide. Outside of Medicare, the FFS model is the standard payment model in the United States. Most fees per service are pre-negotiated through networks such as preferred provider organizations (PPOs). FFS models incentivize providers to deliver more services, which increases the cost of health care. There is little, if any, incentive to control costs.

With case-based models, providers are compensated for the quantity of care *episodes* encountered and their diagnoses. An episode of care includes all health care related to a single health care "event." The provider receives a standardized "bundled payment" that compensates them for usual cost of care. If actual costs are lower than the bundled payment, the provider profits. Likewise, if costs exceed the bundled payment, the provider takes a loss on the case. Case-based models incentivize providers to undertreat, a phenomenon that is supported by empirical research.

Capitation models compensate providers for the quantity of individuals under the provider's care, regardless of the amount of care the individuals require. The most common capitation system is the HMO. Providers reimbursed on a capitation basis are incentivized to increase the number of individuals in their organization, not only to increase the volume of capitation payments, but also to spread risk across a larger pool. The model incentivizes providers to minimize the provision of services to participants. Further, capitation models may incentivize providers to keep costs below a fixed capitation level through favorable risk selection rather than through cost-efficient provision of services. That is, they may be encouraged to attract people who are least likely to use medical care while devising ways to avoid enrolling people most in need of services.

Provider compensation can also be salary-based. Over 60 percent of physicians receive salaries, but most physicians report being paid by multiple methods. Strictly salaried providers do not have incentives to increase the volume of patients or services, but they also have little incentive to create value through cost reduction or enhanced quality of care. Research suggests some salaried physicians use resources other than their own time and effort to meet their customers' needs, such as excess referrals to specialists. These alternatives likely would increase costs.

Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs) are additional innovations designed to promote improved quality of care and cost-efficiency, although compensation typically follows one of the payment models described above. An ACO is a group of physicians, hospitals, and other providers who voluntarily join as a legal entity and contract with insurers to coordinate care for a defined patient population. An ACO that keeps spending below a financial benchmark while meeting quality standards shares the savings with a payer. But they also bear the risk of sharing losses with the payer. Although the ACO resembles capitation, most make volume-based payments (such as FFS) to providers. A PCMH is similar in many ways to an ACO in that both are characterized by multidisciplinary, coordinated care and a focus on primary care. But rather than sharing gains or losses, financial incentives in the PCMH generally come in the form of "enhanced" payments.

Value-Based Payments (VBPs) reward providers financially for achieving quality goals and delivering more cost-efficient care, and providers can be penalized for failing to do so. A VBP can be an adjunct to any payment model, including FFS. Because APMs and VBPs are conceptually similar, we do not differentiate them in our discussion of implications for racial and ethnic health disparities, as the issues are the same.

Potential for Ameliorating or Exacerbating Health Disparities. Each of the payment models and VBPs have incentives that could either ameliorate or exacerbate health disparities. We organize the discussion around the mechanisms for affecting disparities rather than type of model. Often multiple models have the same incentives with similar consequences. We have little reason to suspect differential treatment of disadvantaged or marginalized patients in salary-based models (notwithstanding individual prejudices).

APMs and VBPs were designed to create value rather than to eliminate or mitigate disparities. In some sense, the focus on value is a drawback of these programs when considering health disparities. This is because the incentives to surpass quality metrics or cut costs lead some providers to avoid delivering health care services to disadvantaged and marginalized populations, who are more likely to have poor treatment outcomes and socioeconomic circumstances that make them more expensive to treat. Still, APMs and VBPs have *potential* to reduce disparities because these same patients present the greatest opportunities to realize savings.

Consider the cases of chronic diabetes and hypertension. Members of racial and ethnic minority groups are disproportionally affected by these conditions compared with non-Hispanic Whites. The incidence of diabetes is 11.8% in the Hispanic population, 12.1% in the non-Hispanic Black population, and 14.5% in the American Indian population, compared with 7.4% for non-Hispanic Whites. The Black population in the United States has the highest rate of hypertension worldwide, approaching 60% of adults.

Both emergency department visits and hospitalizations are more common with among individuals with diabetes. Non-Hispanic Blacks and Hispanics also have the highest rates of hospitalization for diabetes. Moreover, both diabetes and hypertension often complicate other illnesses and injuries, therefore raising the cost of treatment for those cases. But lower-cost treatments are available for these conditions. Diabetes and hypertension usually can be controlled well with comparatively much lower-cost pharmaceutical and lifestyle regimens. Providers offering more intense monitoring and aggressive management of these chronic conditions could reduce emergency department visits and hospitalizations, which would reduce the costs associated with these conditions dramatically and generate savings. One study suggests that an increase of 10% in the medication possession ratio (total usage over a year/requirement for a year with strict adherence) for diabetics could halve the cost.

Providers operating under APMs or VBPs can respond to populations with higher costs in different ways depending on how the payment model is structured and the provider's strategy. A provider could seek to better manage high-cost conditions and capture a share of the savings, which can reduce health disparities. Or it could seek to avoid treating such populations, leading to continued disparities.

Moving away from FFS to APMs/VBPs can reduce a provider incentive to provide the services that are most valuable to the provider rather than the patient. The FFS model rewards the provision of high-margin services and large turnover. The margin is a measure of the efficiency with which a provider can turn services into profits. For FFS providers, there may be a financial disincentive to treat disadvantaged and marginalized populations because these populations often need low-margin services such as primary care, monitoring of chronic diseases like hypertension and diabetes, and behavioral health care.

However, APMs and VBPs can introduce their own disincentives that discourage providers from serving disadvantaged and marginalized populations. Populations with a high cost to treat and a low likelihood of producing savings or improving quality can challenge provider finances under APMs or VBPs. Risk adjustment programs seek to ameliorate these concerns, but to date have done so incompletely.

The proximate cause of health disparities is, in large part, disparities in socioeconomic conditions, although disparities also appear within socioeconomic groups. The incidence of specific diseases varies significantly across races and research suggests that traditionally disadvantaged and marginalized groups tend to have worse health outcomes even with the same treatment.

Because of disparities in health status and the socioeconomic environment in which they often live, traditionally disadvantaged and marginalized groups have higher-than-average medical needs and incur disproportionately high health costs. Research shows, for example, that health care for people who are dually enrolled in Medicare and Medicaid costs more than those who are beneficiaries of Medicare only, even after accounting for coexisting conditions.

APMs and VBP systems make adjustments for patient risk in an effort to account for socioeconomic determinants of health that are outside the provider's control. Risk adjustment systems assign patients a risk score based on demographic factors and health status. But current risk-adjustment methods are not sufficiently sophisticated to reliably distinguish poor-quality care or cost inefficiencies from high medical and/or social risk. The American Medical Association reports that most risk adjustment systems only predict about 20% to 30% of the variation in services and spending across patients. Moreover, AMA argues that these risk-adjustment methods are designed to predict spending on a large insured patient population, not

to adjust for differences in patient needs. Reports to Congress in 2016 and 2020 both emphasized a "consistent finding that social risk adjustment in current programs would be unlikely to substantially improve financial circumstances for safety-net providers."

As a consequence of inadequate risk controls, health care providers with high proportions of disadvantaged patients are likely to *lose* money under APMs and VBP systems without improved risk adjustment. Indeed, VBPs have been shown to disproportionately penalize providers that serve the poor. Consider Medicare's Physician VBP Modifier. One in four physicians who care for the most dual-eligible enrollees would be penalized under the VBP system, compared with 1 in 12 for all other physicians. As APM and VBP design currently stand, health care providers have incentives to avoid treating disadvantaged and marginalized populations, including racial and ethnic minorities.

Providers can avoid disadvantaged populations both in their choice of where to participate in APMs (provider selection) and who to serve under such models (patient selection). Research evidence seems to validate both types of avoidance. For example, ACOs are less likely to form in high poverty areas than in more affluent areas. This evidence is consistent with provider selection. ACO-attributed patients are less likely than other patients to be Black, disabled, or socioeconomically vulnerable, and patients with higher clinical risk scores are more likely to exit an ACO than those with lower clinical risk scores, which is suggestive of patient selection. Evidence abounds of the effects of the unintended incentive of APMs and VBPs to avoid treating vulnerable populations. Thus, APMs and VBPs will be more likely to avoid exacerbating existing health inequities if their risk adjustment practices are reformed.

As they seek to reduce the racial and ethnic disparities that stem from health insurance, state regulators may choose to more closely monitor health insurers' use of APMs and VBPs. They could seek to better understand how their regulatory tools can be used to encourage models that promote greater provider engagement with disadvantaged populations and reform models that can lead to providers avoiding high-need populations. In particular, state insurance regulators may wish to seek ways to promote the testing and implementation of more effective risk adjustment mechanisms for alternative payment models.

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