

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

Health Insurance and Managed Care (B) Committee April 7, 2022, Minutes

Consumer Information (B) Subgroup March 22, 2022, Minutes (Attachment One)

No Surprises Act Presentation Handout (Attachment One-A)

Health Innovations (B) Working Group April 4, 2022, Minutes (Attachment Two)

## Draft Pending Adoption

Draft: 4/12/22

Health Insurance and Managed Care (B) Committee  
Kansas City, Missouri  
April 7, 2022

The Health Insurance and Managed Care (B) Committee met in Kansas City, MO, April 7, 2022. The following Committee members participated: Glen Mulready, Chair (OK); Troy Downing, Co-Vice Chair (MT); Russell Toal Co-Vice Chair (NM); Lori K. Wing-Heier (AK); Michael Conway (CO); John F. King represented by Steve Manders (GA); Amy L. Beard (IN); Anita G. Fox (MI); Grace Arnold (MN); Chris Nicolopoulos (NH); Andrew R. Stolfi (OR); Michael Humphreys (PA); Jon Pike (UT); Mike Kreidler (WA); and Allan L. McVey (WV). Also participating were: Karima M. Woods (DC); Dana Popish Severinghaus (IL); Vicki Schmidt (KS); and Edward M. Deleon Guerrero (NMI).

### 1. Adopted its 2021 Fall National Meeting Minutes

Commissioner McVey made a motion, seconded by Director Wing-Heier, to adopt the Committee's Dec. 15, 2021, minutes (*see NAIC Proceedings – Fall 2021, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

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

Commissioner Stolfi made a motion, seconded by Commissioner McVey, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its March 22 minutes (Attachment One); 2) the Health Innovations (B) Working Group, including its April 4 minutes (Attachment Two); 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. Received an Update on the Special (EX) Committee on Race and Insurance Workstream Five's Work

Commissioner Arnold provided an update to the Committee on Workstream Five's work to date as the new Workstream co-chair for 2022. She said that along with Commissioner Birrane, the other Workstream Five co-chair for 2022, she met with the Workstream's 2021 co-chairs, Commissioner Ricardo Lara (CA) and former Commissioner Jessica K. Altman (PA), to discuss the Workstream's 2021 work and potential 2022 work. She said that following this meeting, the Workstream met in a regulator-to-regulator session to discuss its focus and work plan for 2022.

Commissioner Arnold said the Workstream discussed and agreed its focus should center on: 1) identifying demographic-based barriers to the acquisition and use of health insurance and creating strategies for mitigating or removing such barriers; and 2) understanding the role health insurance can play in addressing inequities in health outcomes and social determinates of health. She said the Workstream also agreed on a framework for executing on those objectives, including the specific topics it will cover this year.

With respect to the first objective, Commissioner Arnold said the Workstream decided that the topics it will focus on this year will be: 1) benefit design, which includes examining provider network design and benefit structures; and 2) consumer empowerment and engagement. She said the first topic is foundational because it is critically important that products are inclusive in design and that carriers consider the actual health needs of certain communities. She provided examples of what the Workstream would be examining: "Are prescription drug formularies designed to assure that medications that treat conditions more prevalent among Black or Brown people are offered with no or minimal co-pays?" and "What do preventative services look like, and how are wellness programs designed and promoted?" She said the use of scales and Fitbits in wellness programs may be a great incentive for some people to focus on their health, but nutritional support and transportation may be far

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more important for people whose health is affected by their environment. Similarly, the Workstream will be considering, with respect to benefit design, what the network looks like, not only in the traditional sense of the availability of appointments, but also looking at the impact of the kinds of providers and the cultural competency of providers on the willingness and ability of people to use services.

Commissioner Arnold said that with respect to the second topic, consumer engagement and empowerment, the Workstream will be looking at successful strategies for enrollments and for facilitating consumer understanding of how to access care through insurance and how to navigate claim issues.

Commissioner Arnold said the Workstream also discussed what its end work product should be. She said the Workstream is considering developing a guide for state insurance regulators that compiles information about barriers and presents potential tools and strategies for state insurance regulators to use to address them. She said the Workstream is mapping out a schedule for completing its work before the end of the year. The Workstream hopes to meet at least monthly to hear from various stakeholders—such as consumer groups, academics, and industry—on the topics it has identified as its focus for this year: benefit design and consumer empowerment.

Commissioner Arnold said that with respect to the second objective, the Workstream also discussed holding listening sessions, potentially in conjunction with Zone member meetings, with community-based individuals and organizations who work with racially disadvantaged and historically underserved and underrepresented populations to facilitate a ground zero understanding of the determinants of health and how insurance can affect that.

#### 4. Heard an Update from the CCIIO on NSA Implementation

Jeff Wu (federal Center for Consumer Information and Insurance Oversight—CCIIO) provided an update on the steps the federal Centers for Medicare & Medicaid Services (CMS) has taken to date in implementing the federal No Surprises Act (NSA) since its launch Jan. 1.

Mr. Wu said the CMS created a No Surprises Help Desk, which consumers and providers can call to ask questions or file complaints. Consumers and providers can also file a complaint online. He said the CMS created a consumer web form and a provider web form to assist in submitting online complaints. He said the CMS also has created a document providing helpful tips on how to complete a complaint form. The CMS also has developed several sets of frequently asked questions (FAQ)—provider FAQ, good faith estimates FAQ, and independent dispute resolution (IDR) updates FAQ.

Mr. Wu discussed the CMS' NSA outreach and education efforts targeted at consumers and providers. He also said the CMS also has specifically conducted lots of outreach to consumers and providers related to the good faith estimates for uninsured or self-pay individuals provision. He said the CMS is leveraging its contacts with organizations such as the Kaiser Family Foundation (KFF), the federal Consumer Financial Protection Bureau (CFPB), and the Commonwealth Fund to assist it in these education efforts.

Mr. Wu discussed NSA enforcement and its interaction with state law. He reiterated that the states are the primary enforcers of the NSA. Under the statute, the CMS will only enforce a provision with respect to the applicable regulated parties if the CMS determines that a state is not substantially enforcing a provision. He said that the CCIIO recognizes that the states are in different positions as far as NSA enforcement is concerned and that it is committed to working with the states to address any implementation and enforcement issues. He explained that the CCIIO has held meetings with the states to discuss NSA enforcement and recently published a series of Consolidated Appropriations Act of 2021 (CAA) enforcement letters that outline the CMS' understanding of the federal Public Health Service Act (PHSA) provisions, as extended or added by the CAA, that each state is enforcing directly or through a collaborative enforcement agreement and the provisions the CMS will enforce. These letters

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also communicate whether the federal IDR process and federal patient-provider dispute resolution process apply in each state and in what circumstances.

Commissioner Mulready asked about the status of, and timeline for resolving, the *Texas Medical Association (TMA) v. United States Department of Health and Human Services (HHS)* case, which challenged the Biden administration's Sept. 30, 2021, interim final rule that directed arbiters under the IDR process to presume that the median in-network rate is the appropriate out-of-network rate and limit when and how other statutory factors come into play. The U.S. District Court for the Eastern District of Texas, Tyler Division, ruled Feb. 23 that the NSA unambiguously establishes the framework for deciding payment disputes and concluded that the interim final rule conflicted with the statutory text and must be set aside under the federal Administrative Procedure Act (APA). The court also ruled that the HHS improperly bypassed the APA's notice and comment requirements, and thus the interim final rule must be set aside for this additional reason. Mr. Wu said the HHS has no idea when there could be a final resolution of the case, but meanwhile, the CMS is moving forward with implementing the NSA provisions, including the IDR process provisions.

Commissioner Mulready asked about the nature of the calls the CMS has received through the No Surprises Help Desk. Mr. Wu said the calls received have changed over time. He said that initially, the calls involved general questions about the NSA. He said that currently the Help Desk is receiving more specific questions about the NSA's provisions and complaints, which are mostly complaints about billing and related issues.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned into regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Statement on Open Meetings.

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Draft: 4/12/22

Consumer Information (B) Subgroup  
Virtual Meeting  
March 22, 2022

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met March 22, 2022. The following Subgroup members participated: Mary Kwei, Chair, and Joy Hatchette (MD); Debra Judy, Vice Chair, and Jill Mullen (CO); Yada Horace and Anthony L. Williams (AL); Kathy McGill and Randy Pipal (ID); Patrice Dziire (IL); Jenifer Groth and Alex Peck (IN); LeAnn Crow and Brenda Johnson (KS); Judith Watters (ME); Gregory Maus and Sherri Mortensen-Brown (MN); Camille Anderson-Weddle, Carrie Couch, Amy Hoyt, and Michelle Vickers (MO); Charlette C. Borja (MP); Robert Croom and Kathy Shortt (NC); Michael Anderson, Laura Arp, and Jordan Blades (NE); Donna Dorr, Cuc Nguyen, Kelli Price, Mike Rhoads, and Rebecca Ross (OK); David Buono (PA); Gretchen Brodkorb, Candy Holbrook, and Jill Kruger (SD); Brian Hoffmeister and Scott McAnally (TN); Heidi Clausen, Ryan Jubber, and Shelley Wiseman (UT); Jane Beyer (WA); and Barbara Belling, Diane Dambach, Monica Hale, and Darcy Paskey (WI). Also participating was: Jana Jarret (OH).

1. Discussed Potential Work Products for the Year

Ms. Kwei asked the Subgroup to think through projects it could take on for the year. She reviewed projects from 2021, including an addendum to the Frequently Asked Questions on Health Care Reform (FAQ) document, five consumer guides on the claims process, updates to the main body of the FAQ document, and a consumer alert on the federal No Surprises Act (NSA).

Ms. Kwei asked for ideas for new projects. She said the consumer alert on the NSA focused on the basics, but there is a lot more in the law. She said good faith estimates and continuity of care provisions were two topics the Subgroup may want to address this year.

Ms. Judy said the two provisions would be helpful, but there is uncertainty on timing because of the lack of federal rules, as well as what consumer guidance federal officials may release on these topics.

Ms. Kruger said the presentation from Brenda J. Cude (University of Georgia) and Lisa Groshong (Center for Insurance Policy and Research—CIPR) could inform the Subgroup's choice of projects for the year.

Harry Ting (Health Consumer Advocate) said the Subgroup should consider strategies to encourage consumers to consult more often with departments of insurance (DOIs). He suggested efforts to quantify consumer contacts with DOIs to identify which states are especially effective in engaging consumers. He said this could be done through a survey of states. Ms. Judy said she would appreciate knowing which states do consumer engagement well. Ms. Shortt and Ms. Kruger agreed that this would be valuable information.

Dr. Ting said Subgroup members should think about what the best way is to measure these issues. Ms. Arp said states may not track web access to materials, which is likely the most common way consumers access information from DOIs. She said reaching out to the provider community could also be useful because they are important stakeholders in balance billing protections.

Dr. Cude suggested collecting information about the barriers to measuring impact, such as why states cannot track website usage. Eric Ellsworth (Consumers Checkbook) said much previous work has focused on helping consumers

understand the current system, not in making the system easier to navigate for consumers. He said DOIs should seek to close gaps on behalf of consumers. Ms. Kwei said such work may exceed the charge of the Subgroup. Mr. Ellsworth asked what group at the NAIC would be more appropriate for work to simplify consumer processes. Ms. Kwei said she would follow up to suggest other groups.

Ms. Kwei asked for volunteers to work on a draft survey of states to collect information on their consumer engagement practices. Ms. Shortt, Ms. Judy, Mr. Williams, Holly Blanchard (Regulatory Insurance Advisors LLC), and Dr. Ting said they would be happy to work on a survey. Dr. Cude said she would be interested in reviewing initial ideas from the volunteers.

Ms. Kwei said the survey work would be the Subgroup's initial priority, and the Subgroup could look at other topics under the NSA once there is more clarity on federal actions. She said the Subgroup would consider updates to the FAQ document later in the year.

## 2. Heard a Presentation on Consumer Understanding of Surprise Bills and Balance Bills

Ms. Kwei said Dr. Cude and Ms. Groshong collaborated on a survey of consumers and asked to share results with the Subgroup.

Dr. Cude said a handout (Attachment One-A) has the key information from the presentation. She said surprise billing is harmful to consumers, and \$88 billion in medical bills appears on consumer credit reports. Ms. Groshong said the CIPR provides data and research on insurance topics, and she works on consumer issues and understanding. She said a survey collected information from more than 2,000 adults in 2020; it included questions on health insurance and specifically surprise billing. She said consumers have reasonable knowledge of basic insurance terms like co-pay and deductible. However, they generally were not able to define surprise medical bills in the way the term is used in the NSA.

Ms. Groshong said respondents were provided with the formal definition of surprise (out-of-network) medical bills. She said about 40% said they received a surprise bill under this definition, and 15% were unsure. She said media coverage of surprise billing may have increased since the survey was fielded and added to consumer understanding. She said both the NSA and state legislation addresses surprise billing, but there is still a need for more consumer education on the topic.

Ms. Groshong said she and Dr. Cude identified several states that have worked to educate consumers on surprise bills. Dr. Cude said state DOI websites may confuse consumers with different headlines for surprise bill sections. She said it is useful for states to provide a definition of surprise bills at the outset so consumers understand the circumstances covered by state or federal law protections. She said consumers will use their own definition if they are not provided with the correct one. She said they may believe they are protected against any bill that is a surprise. She encouraged states to use 8th or 9th grade level writing to ease understanding. She said the Subgroup's 2021 document on the NSA may be somewhat confusing because it begins by discussing balance billing rather than surprise billing.

Ms. Groshong said there are ways to educate consumers by using plain language and clear definitions. Dr. Cude said there is no common understanding without a clear definition.

Ms. Kwei asked about the most useful way to present a definition. Dr. Cude said state insurance regulators should use any and all ways to reach consumers (e.g., social media and website users may be different audiences). Ms.

Groshong said the most effective way can be to use storytelling about consumers who have received surprise bills. She said myth-and-fact sheets are not effective because they reinforce myths as well as facts. Dr. Cude said many state DOI websites are not using the Subgroup's consumer guide on the NSA.

Mr. Ellsworth asked what evidence is available on how consumers understand explanations of benefits and other insurance documents. Dr. Cude said studies that ask consumers to apply knowledge from documents would be more helpful in addressing that question than the 2020 consumer survey. She said consumers' estimation of themselves as a financial manager is more important than their knowledge as measured by a multiple-choice survey.

Ms. Groshong said further research could investigate consumers' understanding of issues beyond surprise billing.

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

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## Surprise Billing Presentation to NAIC's Consumer Information (B) Subgroup

March 22, 2022

**Brenda J. Cude**, PhD, NAIC Consumer Representative and Professor Emeritus, University of Georgia;  
bcude@uga.edu

**Lisa Groshong**, PhD, Communication Research Scientist, NAIC's Center for Insurance Policy and  
Research; lgroshong@naic.org

### Surprise medical billing hurts consumers

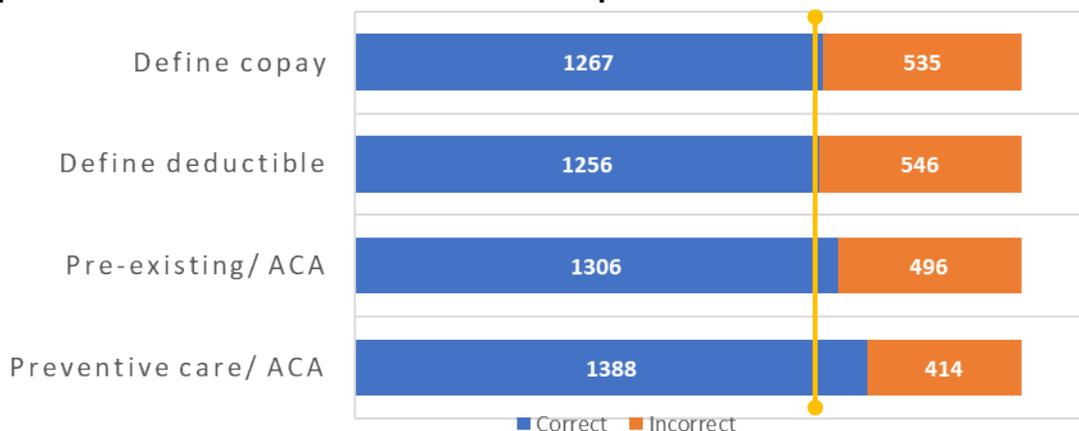
Surprise medical bills are a major source of financial hardships for patients (Cooper et al., 2018). According to a Kaiser Family Foundation survey, one-third of the large troubling medical bills received by insured, working-age adults are charges from out-of-network providers (Hamel et al., 2016). Unexpected medical bills harm consumers; 37% of adult Americans could not cover an unexpected \$400 expense without borrowing or selling assets (Board of Governors of the Federal Reserve System, 2020).

### CIPR surprise billing survey

NAIC's [Center for Insurance Policy and Research](#) is the research group within NAIC that provides data and analysis about insurance issues and topics, including a [recent overview of the No Surprises Act](#).

In July 2020, [CIPR surveyed](#) about 2,000 people about their health insurance knowledge and experience, using SurveyMonkey's Audience Panel.

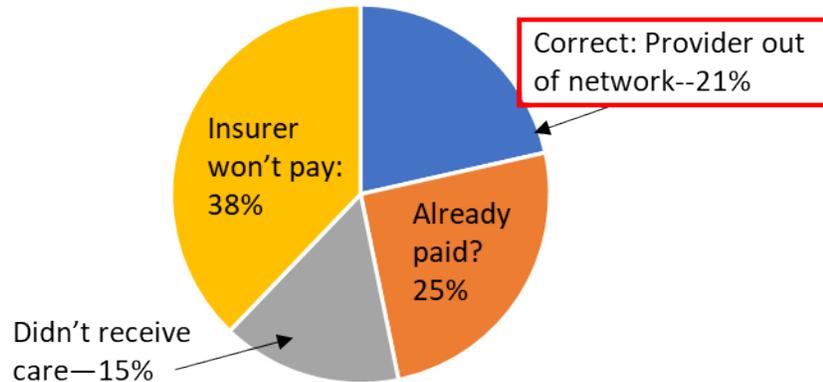
### About 70% of survey respondents correctly answered questions about health insurance concepts.



The majority of respondents correctly answered questions about health insurance concepts, including the definitions of deductibles and copay. And they knew that insurance must cover pre-existing conditions and preventive care under the Affordable Care Act.

But only about one in five respondents chose the correct definition of “surprise medical bill” (a bill for the charges when you use a provider who is outside your health insurance network, even if you didn’t choose the outside provider) from among four choices. In fact, the correct definition ranked third among the four options.

### Only about 20% of respondents correctly defined “surprise medical bill”

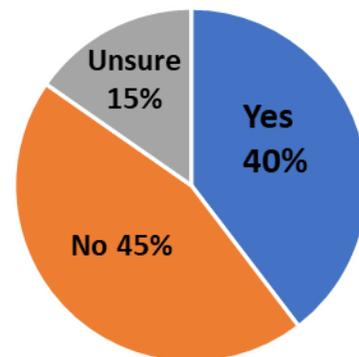


The other answer choices were *A bill for charges you think your insurance company has already paid*, *A bill for services or medications that you don't think you ever received*, and *A bill for services or medications that the insurance company said it would pay but now it won't* (the most popular choice).

### Surprise bill receipt

After we asked respondents to try to define the term, we provided our definition. We then asked if respondents or their family members had ever received a surprise out-of-network medical bill. Forty percent reported that they or a family member had; another 15% weren't sure.

### About 40% of respondents have received a surprise out-of-network medical bill; another 15% are not sure



In our further analysis, we used a subsample of people who had health insurance through an employer. In that group, respondents ages 45 to 60 were more likely to report having received a surprise medical bill than those ages 18 to 29. Given that 40% of medical procedures at hospitals and surgery centers are performed on patients aged 45-64, it makes sense that people in this age group are more likely to encounter surprise billing (Hall et al., 2017).

### Legislation

We fielded our survey in 2020, well before the federal No Surprises Act went into effect in January 2022. Under the act, providers and health plans treat many out-of-network services as if they were in-network in terms of patient cost-sharing, except related to ground transportation. Unlike existing state legislation, the federal law protects consumers with employer-sponsored health plans.

We don't know how consumers would respond to our survey today, but we suspect that news coverage has increased general awareness of surprise billing. But we're still uncertain how well people will

understand what's meant by surprise billing given the general lack of understanding we saw in the survey.

## Consumer outreach

Rules about surprise billing are now being enforced through both state and federal legislation. This may result in ongoing consumer confusion. Further, a lack of uniform understanding of the term indicates a need for more consumer information and education efforts related to surprise medical billing.

The next section highlights some useful examples of surprise billing consumer outreach, both as models to emulate and cautionary examples to avoid.

The Alabama Department of Insurance uses a [straightforward definition](#):

Surprise billing occurs when a patient receives a balance bill after unknowingly receiving care from an out-of-network provider or an out-of-network facility, such as a hospital. This can occur in emergency and non-emergency situations.

Montana's department offered a [concise yet detailed overview](#) of the federal legislation:

On January 1<sup>st</sup> of this year, the No Surprises Act (NSA) went into effect protecting individuals with private health insurance from surprise medical bills. In other words, if you are insured from a company that is not Medicare or Medicaid and receive emergency medical care or a scheduled procedure at an in-network facility then, in most circumstances, you will not be billed at 'out of network' rates.

New Mexico also offers a straightforward [definition](#):

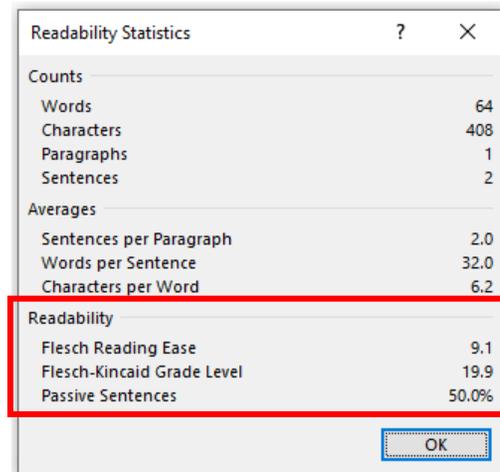
A surprise bill is when a person, through no fault of their own, unknowingly or unavoidably receives health care services from providers outside their insurance company's network and then is billed directly for that care.

Messages should be crafted carefully to ensure they are easy for consumers to interpret. For example, this description of the legislation could easily be misinterpreted:

Effective January 1, 2022, the federal No Surprises Act provides new protections for unexpected or excessive medical bills consumers may receive from health care providers, including hospitals, physicians, ambulances, and other medical professionals.

This example provides valuable information—but is written at about a 20th grade reading level, far above the 8th grade level that readability experts recommend:

The law protects patients from receiving and paying surprise medical bills above the patient's in-network rate from health care providers for emergency care or, in certain circumstances, unanticipated out-of-network care, such as at an in-network health care facility from an out-of-network provider and including lab/pathology services. Cost sharing amounts, which include coinsurance, copayments, and deductibles, are limited to the patient's lower in-network amounts.



Readability Statistics	
Counts	
Words	64
Characters	408
Paragraphs	1
Sentences	2
Averages	
Sentences per Paragraph	2.0
Words per Sentence	32.0
Characters per Word	6.2
Readability	
Flesch Reading Ease	9.1
Flesch-Kincaid Grade Level	19.9
Passive Sentences	50.0%

## NAIC Consumer Information Subgroup Resource

In 2020, the NAIC Consumer Information Subgroup created [New Protections from Surprise Medical Bills](#), a two-page document plus two pages of examples of surprise medical billing. This document includes clear and concise language about surprise medical billing. In hindsight and with the insights gained from this survey, Brenda Cude would now recommend flipping the first two sections (What is balance billing? What is surprise billing?) to discuss surprise billing first.

## Readability resources

Microsoft Word includes a tool that will display readability scores with documents. [Instructions are here](#).

Resources for writing in plain language to a wide range of readers are available at the Centers for Disease Control and Prevention's [health literacy website](#).

The digital publication *The Pudding* has an interesting [resource about writing in plain language](#).

## References

Board of Governors of the Federal Reserve System. (2020, May). *Report on the economic well-being of U.S. households in 2019, featuring supplemental data from April 2020*. Board of Governors of the Federal Reserve System. <https://www.federalreserve.gov/publications/files/2019-report-economic-well-being-us-households-202005.pdf>

Cooper, Z., Scott Morton, F., & Nathan, S. (2018). *Surprise! Out-of-network billing for emergency care in the United States* (NBER Working Paper No. 23623). <http://doi.org/10.3386/w23623>

Hall, M. J., Schwartzman, A., Zhang, J., & Liu, X. (2017, February 28). Ambulatory surgery data from hospitals and ambulatory surgery centers: United States, 2010. CDC National Health Statistics Reports Number 102. <https://pubmed.ncbi.nlm.nih.gov/28256998/>

Hamel, L., Norton, M., Pollitz, K., Levitt, L., Claxton, G., & Brodie, M. (2016). *The burden of medical debt: Results from the Kaiser Family Foundation/New York Times medical bills survey*. Kaiser Family Foundation. <https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey/>

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Health Insurance and Managed Care (B) Committee  
4/7/22

Draft: 4/19/22

Health Innovations (B) Working Group  
Kansas City, Missouri  
April 4, 2022

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Kansas City, MO, April 4, 2022. The following Working Group members participated: Andrew R. Stolfi, Chair (OR); Laura Arp, Co-Vice Chair (NE); Nathan Houdek and Jennifer Stegall, Co-Vice Chairs (WI); Sarah Bailey (AK); Anthony L. Williams (AL); Doug Ommen and Andria Seip (IA); Julie Holmes (KS); Chad Arnold (MI); Cynthia Amman (MO); John Arnold (ND); Maureen Belanger (NH); Nancy Clark and Chris Herrick (TX); Tanji J. Northrup (UT); Molly Nollette (WA); and Erin K. Hunter (WV). Also participating were: Weston Trexler (ID); and Katie Merritt (PA).

### 1. Adopted its 2021 Fall National Meeting Minutes

Mr. Houdek made a motion, seconded by Ms. Nollette, to adopt the Working Group' Dec. 11, 2021, minutes (*see NAIC Proceedings – Fall 2021, Health Insurance and Managed Care (B) Committee. Attachment Five*). The motion passed unanimously.

### 2. Heard Presentations on Coverage Changes Associated with the End of the COVID-19 PHE

Commissioner Stolfi said state Medicaid programs have been limiting redeterminations during the pandemic, but this pause will end after the COVID-19 public health emergency (PHE) ends. He said maintaining coverage for individuals who leave Medicaid will take coordination between federal officials, states, and health plans, as well as public education. He said a recent report from State Health and Value Strategies outlines steps state insurance regulators can take to aid in this transition.

Anne Marie Costello (federal Centers for Medicaid & Medicaid Services [CMS] Center for Medicaid & CHIP Services [CMCS]) presented on planning the CMS has performed to prepare for the resumption of redeterminations and resources available for states. She said the CMS is committed to ensuring that individuals remain covered as the PHE ends. She said states received enhanced federal match for Medicaid if they paused redeterminations. She said states will have 12 months to renew eligibility for all enrollees once the PHE ends. She said 15 million individuals will be at risk for Medicaid coverage terminations, about half of which are for procedural reasons. She said it may have been two to three years since state Medicaid agencies were in contact with some enrollees. She said states prepared communications strategies, but they are waiting for the PHE to end before launching public communications. She said the CMS gathered toolkits for states and other guidance at the website [Medicaid.gov/unwinding](https://www.cms.gov/unwinding). She said preparing for the end of the PHE is the highest priority for the CMS.

Jeff Grant (federal Center for Consumer Information and Insurance Oversight—CCIIO) presented on strategies for making Marketplace coverage accessible for individuals who leave Medicaid. He said the CMS is working to smooth transitions when appropriate, including implementing policy and operational flexibilities. He said the CCIIO paused certain data matching issues and Special Enrollment Period (SEP) verifications to prevent unnecessarily blocking people from getting coverage. He said the administration as a whole supports extending subsidies currently in place under the American Rescue Plan. He said the CCIIO is examining its data capabilities to keep track of coverage transitions and perform targeted outreach. He said the CMS Office of Communications is pursuing a chase campaign to encourage individuals to enroll. He said state-regulated plans are important partners, particularly those that offer Medicaid managed care plans, as well as Marketplace plans. He said the

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CMS is asking such plans to coordinate across their lines of business and make a commitment to year-round enrollment. He said issuers should be aware of all the guidance the CMS is putting out.

Commissioner Stolfi asked if the CMS has identified what states can do beyond a communications and outreach campaign and how much flexibility would be available under a waiver. Ms. Costello said states are doing a lot in addition to communications, such as planning systems changes, making process improvements, working to improve renewal rates, and enhancing staff capacity. She said fair hearing processes are also being improved and streamlined. She said there are several suggestions for steps states can take besides waiver authorities outlined in a recent State Health Official letter. Mr. Grant said time is of the essence, so states should approach the CMS early if they want to do something different. He said some states with state-based exchanges are exploring streamlined applications and enrollment, which may be called auto-enrollment in some states. He said states would receive a 60-day warning before the PHE ends, so the current assumption is that the current deadline of April 16 will be extended, likely until July.

Jeremy Vandehey (Oregon Health Authority—OHA) presented on the OHA's preparations for the end of the PHE. He said every state is facing this issue. He said Oregon has 300,000 more Medicaid enrollees since before the PHE, and it is likely to lose a similar number once eligibility determinations resume. He said state survey data show Oregon has the lowest uninsured rate ever, largely due to the policy of pausing redeterminations, with disproportionate improvement among Black residents. He said Oregon saw gains in what had been called the "churn population," those who transition off and on Medicaid, sometimes moving to Marketplace eligibility. He said the Oregon legislature passed a bill to provide flexibility and direct the OHA to develop a new program to provide more continuous coverage to the churn population with income just over Medicaid eligibility. He said the legislature's goal is to maintain coverage as much as possible, rather than the prior practice of frequent coverage changes. He said Oregon will perform redeterminations first on those who are likely to remain eligible and only later address those at higher risk for coverage loss. He said the legislation also calls for a bridge plan that would be developed in a waiver application; i.e., either a basic health plan under the ACA or a state innovation waiver. He said most individuals go between Medicaid and no insurance, not Medicaid and Marketplace coverage. He said the bridge plan would allow them to continue to have coverage through their Medicaid managed care plan by allowing them to continue coverage even when an individual's income rises to 200% of the federal poverty level. He said this approach could be a pathway for other states in the future. He said the end of the PHE is an opportunity for Medicaid and other coverage sources to work together in ways they have not in the past. Commissioner Stolfi said Oregon's plan would address not only the end of the PHE, but the problem of churning coverage that pre-dated it.

Marissa Woltmann (Massachusetts Health Connector) gave a presentation on how the Massachusetts state-based marketplace is working to maintain coverage for individuals who leave Medicaid after the end of the PHE. She said both federal and state subsidies are available through the Connector. She said Connector enrollment has dropped as individuals who move to Medicaid have stayed there over the last two years. She said the Connector expects about 100,000 people to enroll after leaving Medicaid. She said the expiration of enhanced federal subsidies would complicate the transition to the individual market for many enrollees. She said the Connector worked to reduce the administrative burden, establish automatic SEPs for those losing Medicaid, and support individuals who need to use paper documents. She said the Connector is adding an option for automatic enrollment for those with \$0 premiums and looking to maintain continuity of care for those who transition. She said clear messaging will be critical in reaching individuals who need to transition coverage. She said the transition is a high stakes project that requires collaboration across many entities. Commissioner Stolfi asked about how health insurance premium rates might be affected by the influx of enrollees from Medicaid. Ms. Woltmann said projections have not yet been developed, but because several Medicaid managed care plans also participate in the state's individual

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market, they likely have good data on the expected cost of these enrollees. Commissioner Stolfi said Oregon expects that more enrollees from Medicaid could lead to a better risk pool in the individual market.

Wayne Turner (National Health Law Program—NHLP) and Karen Siegel (Health Equity Solutions) presented on suggestions for state insurance regulators to address the end of the PHE. Mr. Turner said consumer representatives met over the last two months to develop recommendations for state insurance regulators. He said large coverage losses are possible. He said some individuals will transition coverage, but others will be unlawfully terminated from Medicaid, and maintaining coverage for them as they go through the process is important. He said some consumers may not know they have lost coverage until they need a service and are denied coverage, and these may be the ones who come to state insurance regulators. Ms. Siegel said people of color have less access to employer-sponsored coverage, while people with disabilities may have less access to receiving and understanding important information sent to them about their coverage. She said working with community-based organizations can help assist individuals who experience these challenges. She said frequently asked questions (FAQ) and other messaging should be clear, and community organizations can help workshop messaging. She said consumers will need assistance both in enrolling in plans and in using their coverage. Mr. Turner said transitions are often not smooth, so there will be disruptions to care. He referenced the NAIC's *Health Benefit Plan Network Access and Adequacy Model Act (#74)* and its provisions on continuity of care provisions, which have been adopted in some state laws. He said departments of insurance (DOIs) should link consumers to other resources, including Medicaid, the Marketplace, state prescription drug assistance programs, and others. He encouraged state insurance regulators to examine health insurers' payment of commissions for Marketplace products and network adequacy.

Jackson Williams (Dialysis Patient Citizens—DPC) urged state insurance regulators to consider the ongoing care needs of individuals with chronic diseases, not just continuity of care for patients who are in the middle of an acute care episode.

### 3. Received an Update on Research into Health Disparities

Kelly Edmiston (NAIC) presented an update on research he conducted with Center for Insurance Policy and Research (CIPR) colleagues on the health disparities effects of the rise in telehealth services and the move to alternative payment models. She said the end of the PHE has some implications for telehealth policy, as some restrictions on telehealth use were relaxed during the PHE.

Mr. Edmiston said CIPR's overall assessment on telehealth is that it provides a significant opportunity to increase access to care and reduce disparities, but at the same time, it creates the possibility for a new disparity among vulnerable populations who lack access to the digital tools or culturally competent care.

Mr. Edmiston said alternative payment models can be vulnerable to opportunistic behavior from providers, so the models should be adjusted to account for this challenge. He said different alternative payment models all have features that may create incentives to treat vulnerable populations differently and inequitably. He said value-based payments have pros and cons regarding health disparities. He said the highest cost patients have the greatest opportunity to reduce costs, and there are incentives for care coordination in value-based payments. He said risk adjustment mechanisms in value-based care are not sophisticated enough to remove incentives to avoid high-risk patients.

Mr. Edmiston said the CIPR could help in developing ideas for how the Working Group could present evaluation findings in response to its charges from the Special (EX) Committee on Race and Insurance. Commissioner Stolfi

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said the Working Group would solicit feedback from members and interested parties, then he would work with the CIPR and the Working Group vice chairs and support staff to write an evaluation or recommendations for the Special Committee.

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

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