

Draft Pending Adoption

Attachment **XX**
Health Insurance and Managed Care (B) Committee
3/23/23

Draft: 4/5/23

Health Innovations (B) Working Group
Louisville, Kentucky
March 22, 2023

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Louisville, KY, March 22, 2023. The following Working Group members participated: Nathan Houdek, Chair, Jennifer Stegall, and Sarah Smith (WI); Amy Hoyt, Vice Chair (MO); Sarah Bailey (AK); Kate Harris (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes and Craig VanAalst (KS); Jamie Sexton (MD); Marti Hooper and Robert Wake (ME); Chad Arnold (MI); Ross Hartley (ND); Jennifer A. Catechis and Paige Duhamel (NM); Daniel Bradford (OH); TK Keen (OR); Rachel Bowden and R. Michael Markham (TX); Mike Kreidler and Lichiou Lee (WA); and Erin K. Hunter (WV). Also participating was: Patrick Smock (RI).

1. Adopted its 2022 Fall National Meeting Minutes

Hoyt made a motion, seconded by Peck, to adopt the Working Group's Dec. 13, 2022, minutes (*see NAIC Proceedings – Fall 2022, Health Insurance and Managed Care (B) Committee, Attachment One*). The motion passed unanimously.

2. Heard Presentations on EHBs

Commissioner Houdek said essential health benefits (EHBs) are of interest to state insurance regulators because states are interested in updating them, federal officials are considering revising rules, and the defrayal requirement for state-mandated benefits continues to cause concerns.

Harris reviewed Colorado's process for updating its EHB benchmark plan. She said the state started the process in the fall of 2020 using a federal grant. She said three public town halls gathered feedback on what to add or remove from the EHB. Three themes emerged, including improving mental health benefits, improving access to alternatives to opioids for pain management, and adding gender-affirming care for transgender individuals. She said the third was the most important and was driven by both input at the town halls and complaints received by the Division of Insurance. She said services varied from carrier to carrier, but many needed services were excluded as cosmetic. She said major medical associations have classified this care as medically necessary. She said the state worked to satisfy the technical requirements related to the generosity test and the typicality test. The cost for the added benefits was determined to be 64 cents per member per month. She said Colorado was the first state to explicitly include gender-affirming care to treat gender dysphoria in its benchmark plan.

Hoyt asked whether Colorado looked at other benefits before deciding on the three changes to make. Harris said the state considered more than 20 different changes but wanted to narrow the list before completing an actuarial analysis. She said the state used public feedback to help narrow the list. Seip asked if the per member per month figure was informed by the actual costs reported by insurers. Harris said Colorado's actuaries used internal data as well as carrier data. Commissioner Houdek asked how much pressure the state received from stakeholders on what to include. Harris said there were many valid requests to add benefits. She said it was helpful to walk stakeholders through the generosity test to show the guardrails. She said providers, payers, brokers, and advocates participated, and the state asked that attendees participate in all three meetings, which most did.

Draft Pending Adoption

Attachment XX
Health Insurance and Managed Care (B) Committee
3/23/23

Wayne Turner (National Health Law Program—NHeLP) presented recommendations for improving EHBs for consumers. He said many plans excluded important benefits before the federal Affordable Care Act (ACA). The ACA establishes a coverage requirement and a cost-sharing requirement. He said the law tasks the Secretary of the U.S. Department of Health and Human Services (HHS) with defining the 10 categories of EHB. He said it further requires HHS to periodically review and update EHBs. He said EHB compliance and enforcement are up to the states. He said his organization has seen problems, including pharmacy benefit managers (PBMs) declaring some drugs to be non-EHB. He said there is not a loophole in the law that allows this. Instead, it is against the law, and these drugs are still subject to the cost-sharing protections applicable to EHBs. He said benefits must be clinically based to be nondiscriminatory.

Turner said the benchmarking process is not in the statute. Rather, it is a policy decision to give states more flexibility. He said using commercial plans as benchmarks, particularly small group plans, can embed discriminatory provisions in the plans. He said his organization has recommended national standards. He said the defrayal requirement for state-mandated plans is part of the law, so it cannot be avoided entirely. He said adding benefits to comply with federal requirements does not trigger defrayal, so states could make additions to ensure plans are nondiscriminatory or to comply with federal mental health parity standards without requiring defrayal of their cost. He said that changes in cost sharing also do not trigger defrayal.

Turner said updating EHBs is a good use of state flexibility grants. He said many states do not have a formal process for selecting a benchmark plan. He said federal rules require public notice, and he recommends prioritizing health equity and transparency. He said the benchmarking process can be used to address unmet health needs. He said there would be winners and losers in the process, and the winners should not automatically be the best-funded lobbyists. He pushed for full transparency and providing easy ways for consumers to inform the process. He said the NAIC could consider establishing best practices for states in reviewing and updating EHBs.

Hoyt asked what kinds of data states should consider when starting the process. Turner said population-wide health data is a good starting point. He said states could also consult with academic institutions in the state. He warned that some well-funded groups might have good data, but they may leave out important information. Harris asked how long the process generally takes. Turner said there is a range, and it can be difficult when states do not have an existing process in place. He said Oregon has created an ongoing committee to keep the process going between updates. Commissioner Houdek asked about cost-sharing flexibility for states. Turner said states have authority over cost sharing, which does not trigger defrayal. He said preventive services coverage is under legal challenge, but EHBs also include preventive services. He said regulators can require no cost sharing for preventive services in the event the ACA's preventive services coverage requirement is invalidated. Bailey asked what challenges states have encountered in the update process. Turner encouraged talking to other states who have gone through the process. He said Vermont reported difficulties in the application of the typicality test. He said the test is an important consumer protection, but its application should be clarified.

Kris Hathaway (AHIP) discussed AHIP's recommendations to the federal Centers for Medicare & Medicaid Services (CMS) on EHBs. She said AHIP advocated for maintaining the core structure of EHB selection, with an emphasis on state flexibility. She said state insurance regulators should continue to be the primary regulators. She said the current structure meets local needs. She said additional conversations on defrayal would be appreciated and encouraged states to look at updates to their benchmarks every three years. She said telehealth can be a cost-saving tool, and its continued use should be allowed. She said previously controversial definitions, such as for habilitative services and pediatric services, have gone smoothly. She said that in Colorado, health plan actuaries computed different numbers for the cost of added benefits than the state used.

Draft Pending Adoption

Attachment XX
Health Insurance and Managed Care (B) Committee
3/23/23

Harris asked whether health plans have measured cost savings due to added benefits. Hathaway said AHIP had looked at cost-saving measures like ending facility fees and improving transparency but not adding benefits. Commissioner Houdek asked about modifications to the update process. Hathaway said her organization is concerned with making updated benchmarks similar in cost to existing plans. She said patients have needs, but care needs to be affordable at the end of the day.

Holmes said Kansas is in the process of updating EHBs and is hoping to submit them to the CMS by the deadline in May. She said one issue was narrowing down what the updated benefits should be, and the state looked at consumer complaints going back 10 years to decide.

Wake said states are frustrated that the temporary concept of requiring defrayal for new mandates was continued. He said this leads to states mandating benefits through sub-regulatory guidance rather than legislation or regulations. He said CMS should recognize that the process for updating EHBs can replace the initial grandfathering standard that discourages new mandates. He said states with lean EHBs should have the opportunity to make their plans more generous rather than tying them to decisions made 20 years ago. He said it is difficult to quantify the generosity of a set of benefits without considering cost sharing.

Jackson Williams (Dialysis Patient Citizens—DPC) said expanding EHBs would not inhibit alternative payment models or value-based insurance design. He said EHB changes would not tie insurers' hands on medical management if they are done in good faith.

Randi Chapman (Blue Cross Blue Shield Association—BCBSA) said her organization supports the current regulatory structure for EHBs. She said it appropriately recognizes local markets and allows states to build on coverage that is already available in the market. She said BCBSA member plans are committed to using telehealth to expand access and to promoting health equity.

3. Discussed Potential Topics for Future Meetings

Bowden discussed efforts in Texas to adjust the relative affordability of plans by directing the premium load of cost-sharing reductions (CSRs). She said the legislature directed Texas to begin rate review in 2021 legislation, which also noted that silver plans were priced below the cost of providing CSRs. She said Texas adopted a rule to require plans to apply a uniform CSR to all silver plans in the exchange. She said silver plans, on average, provide an actuarial value of around 80%. She said the rule did not generate controversy, though there was some question of whether enrollment levels would change due to the rule. She said the result of the rule is that gold plans are now 11% less expensive in premium than silver plans, and the share of consumers who can purchase a gold plan with a \$0 premium rose from 43% to 73%. She said there are many policy and actuarial considerations, but the Texas approach was driven by the direction of the legislature. She clarified that issuers apply the silver load only to on-exchange plans, so consumers can purchase silver plans with no CSR load off-exchange. Wake said Maine applies silver loading through rate review and also requires a silver option that does not include a CSR load. Commissioner Houdek asked if a more detailed presentation on this topic at a future meeting would be useful and Working Group members agreed that it would.

Hoyt provided information on Project Extension for Community Healthcare Outcomes (ECHO). She said Missouri has a program called Show Me ECHO based on New Mexico's Project ECHO. She said the original Project ECHO was inspired by poor outcomes for hepatitis C patients. It connected primary care physicians with specialists so the primary care doctor could provide better care rather than the patient waiting eight to 12 months to see the specialist. She said it improved outcomes and changed lives. She said Show Me ECHO offers adult learning for

Draft Pending Adoption

Attachment XX
Health Insurance and Managed Care (B) Committee
3/23/23

multidisciplinary teams. A hub team participates and provides advice to primary care providers on how to manage patients. She said it is a way to move knowledge rather than patients. She said Medicaid in Missouri has provided incentives to providers to participate in the program. She said every state has an ECHO program devoted to different diseases or treatments. Commissioner Houdek asked if others were interested in learning more about Project ECHO, and Working Group members said they are.

Keen said one topic to keep tabs on is Medicaid redeterminations and whether any innovative practices have emerged from that experience. Harris said looking at continuity of care or pro-rating of deductibles for enrollees who leave Medicaid are other issues of interest.

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) said that the Working Group should look at what states can do to remove barriers to preventive services.

Eric Ellsworth (Consumers' Checkbook) noted that the CMS has done a great deal of work on the interoperability of healthcare data. He said the Working Group could look at how the oversight of insurers in this area is divided between states and federal agencies as well as look at the level of investment insurers are making to enhance their information systems.

Hathaway said AHIP may have more data to share on value-based care by the Fall National Meeting.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/Health Innovations WG/HInnMin3.22