

Draft Pending Adoption

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

Attachment A

Draft: 8/25/23

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

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

1. Adopted its 2023 Spring National Meeting Minutes

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

2. Heard Presentations on Prior Authorizations

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

Bowden presented on Texas' gold card law and its implementation. She said Texas passed its gold card law in 2021. She said the law applies to state regulated health plans and state employee plans. She said health plans are obligated to provide an exemption from PA to providers who receive approval more than 90% of the time. Plans are required to evaluate and provide exemptions even without a request from a provider. She said many providers believed they would qualify, but often they did not meet the threshold of providing the same service 5 times in a 6 month period under a state regulated plan.

Bowden said Texas conducted a survey of PA practices before and after the law took effect. She said 3 out of 4 providers who met the evaluation threshold received exemptions. However, because many providers did not meet the threshold, only 3% of providers received an exemption.

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

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

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

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

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

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

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

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

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

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

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providers so they don't have negative impacts for patients. She said opportunities for further improvement include moving to electronic PA and value-based relationships.

Duhamel asked how reliably plans apply their own clinical review criteria and provided an example of a plan asking providers for 3 years of history on infants in order to receive a certain benefit. She said failures of inter-rater reliability cause frustration. She also asked how plans can comply with mental health parity laws if gold card programs only apply to physical health services. Motter said there is huge opportunity in electronic PA to reduce burden on providers. She said gold card programs have the most impact when there is consistent review.

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

3. Heard a Presentation on Multi-State Prescription Drug Purchasing

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

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

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

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

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

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

4. Heard a Presentation on Health Equity Efforts

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

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

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

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

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

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

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/Health Innovations WG/HInnMin8.13