

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee March 18, 2024, Minutes

Consumer Information (B) Subgroup Feb. 27, 2024, Minutes (Attachment One)

Health Innovations (B) Working Group March 17, 2024, Minutes (Attachment Two)

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Health Insurance and Managed Care (B) Committee
Phoenix, Arizona
March 18, 2024

The Health Insurance and Managed Care (B) Committee met in Phoenix, AZ, March 18, 2024. The following Committee members participated: Anita G. Fox (MI), Chair; Grace Arnold, Co-Vice Chair (MN); Glen Mulready, Co-Vice Chair (OK); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron (ID); D.J. Bettencourt (NH); Alice T. Kane (NM); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Alexander S. Adams Vega (PR); Jon Pike (UT); Mike Kreidler represented by Ned Gaines (WA); and Allan L. McVey represented by Joylynn Fix (WV). Also participating were: Paul Lombardo (CT); Andria Seip (IA); Patrick Smock (RI); and Jennifer Stegall (WI).

1. Heard Opening Remarks

Director Fox said she believes the Committee was able to accomplish many things in 2023. She hopes to continue the collaboration with each other and senior staff and connections this year by continuing to hold virtual and in-person regulator-to-regulator meetings to allow time for more in-depth discussion on its 2024 priority issues. She said the Committee also was able to be more connected with other stakeholders across the NAIC on issues of mutual interest, such as the NAIC consumer representatives, the Center for Insurance Policy and Research (CIPR), and other NAIC committees, including the Market Regulation and Consumer Affairs (D) Committee and the Special (EX) Committee on Race and Insurance's Health Workstream, which she also hopes to continue in 2024.

She said that, like last year, she surveyed Committee members on the priorities and issues they would like to focus on and discuss this year. She explained that the survey results identified many of the same priorities as last year—mental health, ground ambulances, network adequacy, pharmacy benefit managers (PBMs), long-term care insurance (LTCI), prior authorization, and cost transparency. She said that during this meeting, the Committee will discuss two of these priorities—ground ambulances and LTCI.

Director Fox said that, like last year, the Committee is dealing with an unexpected issue. Last year, it was issues related to the low number of consumer appeals of claim denials. She said this year, it concerns the Change Healthcare cybersecurity attack, which is greatly affecting health care operations across the nation given the scope of Change Healthcare's involvement in claims processing and other services it provides to payers and providers.

2. Adopted its 2023 Fall National Meeting Minutes

Commissioner Arnold made a motion, seconded by Commissioner King, to adopt the Committee's Dec. 2, 2023, minutes (*see NAIC Proceedings – Fall 2023, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

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

Commissioner Stolfi made a motion, seconded by Commissioner Pike, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its Feb. 27 (Attachment One) minutes; 2) the Health Innovations (B) Working Group, including its March 17 minutes (Attachment Two); 3) the Health Actuarial (B) Task Force; 4) the Long-Term Care Insurance (B) Task Force; 5) the Regulatory Framework (B) Task Force; and 6) the Senior Issues (B) Task Force. The motion passed unanimously.

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4. Received an Update on the Long-Term Care Insurance (B) Task Force's and the Long-Term Care Actuarial (B) Working Group's Work

Lombardo provided an update on the work of the Long-Term Care Insurance (B) Task Force and the Long-Term Care Actuarial (B) Working Group. He said both the Task Force and the Working Group are focusing their work on developing a single LTCI multistate actuarial (MSA) rate review approach. He said that during its March 15 meeting, the Working Group exposed the Minnesota approach, with modifications to align with agreed-upon concepts, for a 45-day public comment period ending April 3. He encouraged state insurance regulators and interested parties to engage in these discussions and provide feedback to the Working Group on the exposure draft. The goal is to finalize the development of a single approach by the end of 2024.

Lombardo said the Task Force supports the Working Group's work in developing a single LTCI MSA rate review approach and the Working Group's continued consideration of addressing issues related to 80+ attained age considerations, long duration, and cumulative increases, as it develops the single LTCI MSA approach. He said the Task Force also discussed the timeliness of LTCI rate reviews. During that discussion, the Task Force encouraged state insurance regulators to: 1) consider the impact of the timeliness of LTCI rate reviews on future loss ratios and future rate increases that may be requested by insurers; 2) coordinate between rate review and form review staff; communicate to the industry on the best time frames to submit rate filings; and 3) engage with internal staff at all levels about rate filings. He said the Task Force also suggested to industry that when submitting LTCI rate filings, they consider the timing of such filings with other filing deadlines, such as federal Affordable Care Act (ACA)-plan filing deadlines, because if these filings are made at the same time, there could be a delay in reviewing them.

Lombardo said the Task Force also received an overview of a consumer notices and reduced benefit options (RBOs) research project that the CIPR is conducting. He said the survey will begin next week, and preliminary results are anticipated later in April.

Director Fox asked about the purpose of having a single LTCI MSA rate review approach. Lombardo described the MSA rate review process, noting that it is not going to be a model that NAIC members would be required to adopt. He said the company will continue to file its LTCI rate request with each state either after the MSA process is complete or concurrent with that process. He said the Task Force and Working Group are looking to create a single methodology that the states can use to conduct and incorporate into their LTCI rate reviews. The process is not a mandate. Director Fox asked if the materials the LTCI MSA rate reviewers use in their rate review will be available to the states. Lombardo confirmed that those materials are already available to the states through the Interstate Insurance Product Regulation Commission (Compact) to help reduce redundancy in the rate review process.

5. Heard a Presentation on Understanding the Basics of How Ground Ambulance Services Work in the U.S.

Jack Hoadley (Georgetown University's Health Policy Institute at the McCourt School of Public Policy) provided an overview of how ground ambulance services work in the U.S. He highlighted the lack of protections for consumers in the federal No Surprises Act (NSA) from receiving surprise bills for ground ambulance services. Hoadley said it is important to fill this gap in protections because: 1) patients rarely have a choice of ground ambulance provider; 2) emergency situations limit opportunities for patient disclosure; and 3) many public-sector providers lack resources to contract with ground ambulance service providers. He discussed the level and types of ground ambulance services, explaining that only 10% of patients arrive at the emergency room using a ground ambulance. Hoadley discussed what commercial insurers typically cover for ground ambulance service claims using Washington state as an example. He also discussed the share of ground ambulance rides by ownership type—private equity or publicly traded, facility, nonprofit, public sector, and independent.

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Hoadley provided information on the share of out-of-network use for ground ambulance services and potential surprise bills from 2014–2017 versus the share of ambulance rides with an out-of-network charge in 2018. He discussed state consumer protections and state models—California, Colorado, New York, and Texas—for rate reimbursement guidance.

Hoadley suggested certain factors for policymakers to consider when seeking to protect consumers from out-of-network ground ambulance services: 1) the applicability to public/private ground ambulance providers or both; 2) the applicability to non-emergency services (e.g., interfacility transfers); 3) the applicability to circumstances where the patient refuses medical attention or is treated but not transported; and 4) the applicability of negotiation/arbitration process.

Commissioner Mulready said he anticipates legislation being introduced in the Oklahoma legislature modeled after the Texas law, which requires reimbursement of ground ambulance services based on the rate set by a local subdivision or the lesser of 325% of Medicare or the provider’s billed charge. He asked Hoadley if that is the trend he is seeing in those states trying to address reimbursement issues. Hoadley said that seems to be the trend since last year. He also noted that the federal Advisory Committee on Ground Ambulance and Patient Billing (GAPB) also appears to support such a reimbursement structure. Hoadley said that some policymakers have raised concerns about the potential inflationary effects of such a reimbursement model.

Director Fox asked if concerns have been raised that setting and possibly locking in local reimbursement rates, particularly if they are low reimbursement rates, could adversely affect consumer access to ground ambulance services, particularly in underserved areas. Hoadley said that, to date, he has not heard of any such concerns, but he could envision it if the local reimbursement rates are locked in at such a level that they do not cover the provider’s cost of providing the service.

Gaines said Washington recently passed a ground ambulance billing bill, which will be effective in 2025. He said he forwarded a link to a study Washington completed on the reimbursement issue that he believes will be useful to states considering such legislation to NAIC staff for distribution to Committee members.

6. Heard a Presentation from the Consumer Perspective on the ACA’s Section 1557 Nondiscrimination Proposed Rule

Amy Killelea (NAIC consumer representative), Carl Schmid (HIV+Hepatitis Policy Institute), and Kellan Baker (Whitman-Walker Institute) discussed the ACA’s Section 1557 nondiscrimination proposed rule from a consumer perspective. They provided a timeline for Section 1557 and the prior federal rules promulgated for this section. The current notice of proposed rulemaking (NPRM) was issued in 2022. It is anticipated that the final rule will be issued in the next few months. The panelists discussed the proposed changes in the rule related to Section 1557’s applicability, discriminatory benefit design, and prescription drug access.

The panelists highlighted the importance of enforcement by state departments of insurance (DOIs), the federal Centers for Medicare & Medicaid Services (CMS), and the federal Office of Civil Rights to ensure compliance with Section 1557’s requirements. They suggested that compliance can be attained through health plan reviews, approvals, and complaints. The panelists also highlighted, consistent with the 2020 U.S. Supreme Court decision in *Bostock v. Clayton County*, the restoration of the full scope of sex nondiscrimination protections in the 2022 rule.

The panelists included recommendations for what state insurance regulators can do to ensure compliance with Section 1557’s nondiscrimination requirements and, when issued, the final rule, including: 1) ensuring that insurers are aware of the new protections; 2) reviewing plans for discriminatory benefit design as part of the ACA

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plan certification process; and 3) monitoring and enforcing compliance through the complaint process, data calls, and market conduct examinations.

7. Heard an Update from CMS' CCIIO on its Recent Activities

Jeff Wu (CCIIO) updated the Committee on the CCIIO's recent activities of interest. He said he did not have any updates on the proposed Notice of Benefit and Payment Parameters (NBPP) proposed rule for 2025. The CMS hopes to finalize the rule by the end of March or early February. Wu focused the remainder of his comments on CMS' response to the Change Healthcare cybersecurity attack and its impact on operations.

Wu said that when the Change Healthcare cyberattack was revealed a few weeks ago, CMS' immediate concern was patients' access to prescriptions. He said the cyberattack exposed the vulnerabilities, underpinnings, and infrastructure that underlie a lot of the health care system, and the extent to which players like Change Healthcare are such a huge part of it. Wu said CMS has been able to get a sense of the scope of Change Healthcare's involvement in the health care system as a very large clearinghouse for claims processing on both the provider side and the payer side. As such, CMS has been in discussions with providers and vendors to think of alternative ways to provide those services.

Wu noted the financial impact for providers, who are providing services and not receiving reimbursement for those services. He said some providers have been able to manage this situation, but others, particularly rural providers and smaller providers that provide services to some of the most vulnerable populations, who do not have the capital resources to weather such a disruption, are at risk. He said CMS has been taking steps to try to loosen up cash flow to assist such providers. One such step is providing Medicare Part A and Medicare Part B advance payments to those providers. Wu said CMS has also recently issued guidance providing flexibility to state Medicaid agencies to take similar actions. He said CMS has also reached out to insurers pushing them to provide similar flexibilities to assist providers with their cash flow issues. He also said CMS wants to work with state insurance regulators to identify and assist any providers they might have in their state experiencing cash flow issues.

Director Fox asked what pressures CMS is putting on UnitedHealthcare (UHC) and Change Healthcare to assist providers with their cash-flow problems and what efforts they are taking to resolve the problem. She said the money that would have been paid to providers for services provided is in the system somewhere, and that money should be flowing to providers. Wu agreed with Director Fox's comments and noted that CMS acknowledges this is an issue, but decided to move forward with what it could do to address the problem. He said CMS would be happy to work with state insurance regulators to address these issues.

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

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Consumer Information (B) Subgroup
Virtual Meeting
February 27, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Feb. 27, 2024. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony Williams (AL); Terri Smith (MD); Carrie Couch (MO); Nichole Faulkner (NC); Donna Dorr (OK); Jill Kruger (SD); Vickie Trice and Jennifer Ramcharan (TN); Ryan Jubber (UT); and Christina Keeley (WI). Also participating were: Susan Jennette (DE) and Susan Brown (MT).

1. Discussed Subgroup Activities for the Year

Crow reviewed the documents the Subgroup completed in 2023, including a guide for state insurance regulators on Medicaid redeterminations, an updated version of Frequently Asked Questions (FAQ) about Health Care Reform, and revisions to a series of consumer guides on health insurance claims and appeals.

Crow said that during the work on the appeals guides, the Subgroup discussed the need for an additional guide on prior authorization. She said the Subgroup decided in 2023 that a prior authorization guide should be a goal of the Subgroup in 2024. She asked the Subgroup whether should consider any other topics to work on in 2024.

Harry Ting (Individual Health Care Consumer Advocate) asked whether the Subgroup should return to the focus groups and surveys it conducted in 2022 and share feedback received. Joe Tuschner (NAIC) noted that Brenda Cude had written up themes from the focus groups and her compilation was shared with Subgroup interested parties and posted on the Subgroup's website.

Wayne Turner (National Health Law Program) said that, during its revisions to the FAQ, the Subgroup considered whether to develop a guide on preventive services. He also noted that NAIC Consumer Representatives authored an analysis of preventive services that showed low consumer understanding of coverage for preventive services. Joe Tuschner added that state and federal regulators have been discussing problems with coverage of colonoscopies as preventive services. He said the Subgroup could consider a guide for different audiences, including consumers, state insurance regulators, insurers, or providers. Wayne added that CMS guidance has covered a number of issues related to colonoscopies.

Crow asked the group which guide should be the first to be taken up during the year. She said her preference would be to start with a prior authorization piece since the group agreed on the need for it last year. Bonnie Burns (California Health Advocates) asked whether the prior authorization guide would be oriented toward consumers or to state insurance regulators. Crow said she understood the consensus of the group to be that a consumer-facing guide is needed.

Crow said it may be helpful to start with a guide on what prior authorization is and provide a definition. Joe Feldman (Individual Consumer Advocate) said the document should tell consumers what is reasonable to expect during a prior authorization request and what to do about it if the expectation is not met. Crow said states may have different laws that set different timelines. Feldman said a document could reference the maximum timeline or provide a range of time limits across state laws, as long as it establishes the idea that there is a limit.

Couch suggested that the document outline the types of services that are commonly subject to prior authorization. Ting said his research has shown that states do have different timelines for different services, particularly for prescription drugs.

Crow said that covering the topic may require a series of guides that break down different pieces, including what prior authorization is, when it applies, who submits requests, and options for responding to denials.

Katie Dzurec (Examination Resources) said that providers' roles and responsibilities should be covered. Jennette said Delaware has specific laws that differ based on whether the services are pharmaceutical, mental health, emergency or other factors. She said any document on colonoscopies should clarify the distinction between routine and follow-up services. She said consumers also have difficulty when a provider recommends a treatment, but the insurer finds that the treatment is experimental. Crow said the Subgroup will aim to create a document that is useful for all states, even if they have differing laws.

Crow said a prior authorization guide will be more challenging than the appeals guides because the Subgroup may have to start from scratch rather than revising existing documents. Brown said consumers can get trapped if they receive emergency treatment, but an insurer later decides treatment or further treatment is not medically necessary. She said the document is needed because regulators have heard many examples of issues consumers have run into and consumer representatives have raised them, as well.

Kristen Hathaway (AHIP) said her organization has many existing resources that help explain prior authorization concepts.

Crow asked Subgroup members and interested parties to join a drafting group to develop a first draft of a guide or series of guides on prior authorization. She said the drafting group would aim to meet soon after the Spring National Meeting, pending any further direction from the B Committee on priorities for the Subgroup for the year. She asked members and interested parties to send any template of existing documents that could help in drafting a guide.

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

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Health Innovations (B) Working Group
Phoenix, Arizona
March 17, 2024

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Phoenix, AZ, March 17, 2024. The following Working Group members participated: Nathan Houdek, Chair, and Jennifer Stegall (WI); Amy Hoyt, Vice Chair, and Jo LeDuc (MO); Sarah Bailey (AK); Debra Judy (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes (KS); Kathryn Callahan (MD); Chrystal Bartuska and Karri Morris (ND); Todd Rich (NV); Daniel Bradford (OH); TK Keen (OR); Ryan Jubber, Tanji J. Northrup, and Shelley Wiseman (UT); Ned Gaines (WA); and Joylynn Fix (WV). Also participating were: Maggie Reinert (NE); Glen Mulready (OK); and Michael Humphreys (PA).

1. Adopted its 2023 Fall National Meeting Minutes

Northrup made a motion, seconded by Hoyt, to adopt the Working Group's Dec. 1, 2023, minutes (*see NAIC Proceedings – Fall 2023, Health Insurance and Managed Care (B) Committee, Attachment One*). The motion passed unanimously.

2. Heard Presentations from the AIC, CHIR, and PESP on Private Equity in Health Care

Commissioner Houdek said that private equity investments in health care companies have grown significantly. He said there may be impacts on consumers and market competition from private equity practices. He said federal agencies have announced a request for information on potential impacts on consumer access to care and other effects.

Jamal Hagler (American Investment Council—AIC) presented to define private equity and describe the private equity industry's benefits for investors and consumers. He outlined the distinction between private equity and the private equity industry. He said private equity is a source of capital, while the industry is a group of investment advisors who raise capital from institution investors using a fund vehicle with a terminal date. He said researchers often fail to make this distinction.

Hagler said the private equity industry is different from other investors. He said private equity managers work with companies to create value. He said investors work with doctors and hospital executives to make health care more efficient without jeopardizing the quality of care.

Hagler said investors, business owners, workers, and consumers all benefit from private equity investments. He said positive spillover effects occur when private equity invests in a company. He said private equity has been transformative for a variety of health care organizations, allowing practitioners to focus on practicing medicine rather than paperwork. He said private equity-backed companies represent a small share of health care businesses.

Hagler said that health care providers must deal with challenges like low margins, high labor costs, and low payment rates from government payors. He said private equity can add efficiencies that allow providers to better respond to these challenges. He cited research that shows private equity investment in hospitals is associated with greater efficiency without a reduction in quality of care. He said private equity owns about 5% of nursing

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homes and that research has shown they perform similar or better than their peers. He said private capital is crucial for modernizing medical practices.

Hagler said some have used anecdotal evidence to demonize private equity investments. He said recent studies focusing on patient mortality in hospitals and nursing homes were flawed. He said his organization's report on health care showed improved access to care through urgent care centers.

Commissioner Humphreys asked whether facility closures are more or less likely when private equity invests in a facility type. Hagler said private capital helps businesses generally expand, increase their footprint, and invest in new technology. Humphreys asked whether there are more balance billing disputes among private equity-backed providers compared to others.

Seip asked for examples of private equity increasing employee productivity. Hagler said new technologies can allow providers to see more patients in the same amount of time.

Maanasa Kona (Center on Health Insurance Reforms—CHIR) presented on trends in private equity's investments in health care, as well on emerging evidence of its impacts. She cited large investments from private equity in health care in recent years. She said investments occur in a wide range of health care companies, including hospitals, physician practices, revenue management, nursing homes, hospice, and others.

Kona described common private equity strategies. She said most investors make short-term investments, such as for three to seven years. She said private equity firms add debt to the companies they own and sometimes charge them fees, while the investor is shielded from liability.

Kona cited a study that found a 10% increase in mortality among Medicare patients at private equity-owned nursing homes and another that found an increase in hospital-acquired infections.

Kona described potential private equity impacts on markets, including bankruptcies and closures of facilities, vertical and horizontal consolidation, and increased leverage in price negotiations with payors. She said that price transparency data is essential to understand the impacts of consolidation and private equity acquisitions.

Kona said her colleagues will soon publish a paper with more details on the impacts of private equity in health care.

Commissioner Houdek asked how greater price transparency will help to mitigate the impacts of private equity. Kona said the price and cost implications of private equity are not well understood and that having price transparency data will help make those connections.

Michael Fenne (Private Equity Stakeholder Project—PESP) presented on private equity impacts on hospitals, balance billing disputes, and Medicare Advantage. He said New Mexico recently passed legislation to give the state insurance commissioner authority over hospital mergers.

Fenne reviewed recent news on Steward Health Care, which is owned by a private equity firm. He said Steward's experience shows private equity tactics. He said the private equity owner required Steward to pay rent to the owners of its real estate. He said the company now has inadequate staffing and is in danger of closure.

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Fenne showed the geographic distribution of private equity-owned hospitals, which account for about 8% of all hospitals. He shared the results of studies on adverse events that occur in private equity-owned hospitals, which indicate greater adverse events in such hospitals.

Fenne highlighted the frequency with which a small number of private equity-backed companies use the independent dispute resolution process under the federal No Surprises Act. He said four companies accounted for 70% of disputes in the first half of 2023. He said that overall, the provider prevailed in 77% of disputes.

Fenne outlined private equity investment in Medicare Advantage. He said private equity was involved in Medicare Advantage at a lower level until 2018. He said private equity often buys marketing companies or brokerages, consolidating them and then selling to a large insurer. He said private equity investments in Medicare Advantage has declined since 2021.

Fenne offered recommendations for policymakers, including greater antitrust enforcement and joint liability for portfolio companies.

Commissioner Houdek asked about any other recommendations for state insurance regulators, particularly regarding oversight or data collection. Fenne said greater transparency in facility ownership would be helpful because it is hard to know which hospitals have private equity owners.

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

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