

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
JERSEY CITY, NEW JERSEY
JULY 14, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the Hyatt Regency in Jersey City, New Jersey on Thursday, July 14, 2022 at 2:00 p.m.

Assemblywoman Pam Hunter of New York, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)	Sen. Jerry Klein (ND)
Sen. Jason Rapert (AR)	Sen. Bob Hackett (OH)
Asm. Ken Cooley (CA)	Rep. Wendi Thomas (PA)
Asm. Tim Grayson (CA)	Rep. Carl Anderson (SC)
Rep. Stephen Meskers (CT)	Rep. Lacey Hull (TX)
Rep. Tammy Nuccio (CT)	Rep. Tom Oliverson, M.D. (TX)
Rep. Rod Furniss (ID)	Rep. Dennis Paul (TX)
Rep. Matt Lehman (IN)	Rep. Jim Dunnigan (UT)
Sen. Beverly Gossage (KS)	Sen. Mary Felzkowski (WI)
Rep. Derek Lewis (KY)	Del. Steve Westfall (WV)
Rep. Rachel Roberts (KY)	
Rep. Edmond Jordan (LA)	

Other legislators present were:

Asm. Mike Gipson (CA)	Sen. Siah Correa Hemphill (NM)
Rep. Roy Takumi (HI)	Asw. Elaine Marzola (NV)
Sen. Katy Duhigg (NM)	

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

Upon a Motion made by Rep. Carl Anderson (SC), and seconded by Rep. Derek Lewis (KY) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Matt Lehman (IN), NCOIL Immediate Past President, and seconded by Sen. Jerry Klein (ND), the Committee voted without objection to adopt the minutes of the Committee's March 6, 2022 meeting in Las Vegas, NV.

PRESENTATION OF LEGISLATIVE TOOLKIT ON DEVELOPMENTS IN MEDICAL COVERAGE FOR OBESITY

Randy Pate, Founder of Randolph Pate Advisors, LLC and former Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight (CCIIO) at the Center for Medicare & Medicaid Services (CMS), thanked the Committee for the opportunity to speak and stated that as some of you may recall, last year I had the opportunity to testify on this same issue before this Committee. So, I'm really excited to be back but based on some of the conversations that I had with some of you and others I've put together a tool kit of options for state policymakers who really want to dig into some of the barriers for obesity coverage in particular in their states. The toolkit I've put together, which Will Melofchik, NCOIL General Counsel, I believe is going to post it following this meeting, is about 30 pages long and it focuses on a number of practical solutions that I think can really help to address some of these barriers in financing and coverage. I think there's some innovative proposals in here that I want to talk about but, I think they are achievable and I think the recommendations will really balance both affordability and access to care.

So, this slide shows that today over 42% of Americans have obesity and that's defined as having a body mass index (BMI) of 30 or higher and experts predict that by the end of this decade fully half of Americans will have a BMI of 30 or higher which is really shocking and as you can see from this slide obesity prevalence is higher in the South and the Midwest but it is a nationwide problem. Back in 2000, which doesn't seem like that long ago, no state in the union had an obesity prevalence of over 25%. Right now, all but three states now have crossed that threshold. 2020 Centers for Disease Control and Prevention (CDC) data showed that right now there are 16 states with an obesity prevalence of 35% or higher which was an increase of four states in just one year. The available data are clear that racial and ethnic disparities play a role in the nation's obesity crisis. African Americans have a 51% higher obesity prevalence and Hispanics have a 21% higher obesity prevalence than whites.

This slide illustrates the path that we're currently on. Using current trends, it projects what the most common BMI will be in each state by the year 2030. You can see the projection for African Americans on the far left wherein the majority of states the most common BMI for African Americans will be 35 or higher which is considered severe or morbid obesity. Looking at all these groups none of them are on a good pathway when it comes to obesity but using the current trends the predictions are particularly dire for African Americans and Hispanic American populations. This slide shows the most common BMI prevalence in each state again projected to 2030 but this time by income group. For nearly all of the states severe obesity will be the most common BMI for Americans making less than \$20,000 a year by the end of this decade. The map does get slightly better as you go up the income scale but clearly, we can see that obesity is a disease associated with socioeconomic status and for all of us in this country the cost of obesity is high and growing. While we spend roughly \$480 billion a year on direct medical costs of obesity, including over \$60 billion through Medicare and Medicaid alone, the cost to individuals and to the economy is even greater.

A recent study found that health care costs for people with obesity are around \$3,500 a year higher than those with normal weight and when the indirect costs are included such as negative labor market outcomes like absenteeism and lower earning potential, the total economic costs of obesity are truly staggering, estimated at nearly \$1.4 trillion dollars per year. Or roughly \$4,300 for every man, woman, and child in the U.S. In the past we viewed obesity primarily as resulting from lack of character or lack of willpower. This view has really perpetuated a lot of the stigma and shame for people both inside and outside of the healthcare system and unfortunately today it continues to deter millions of people from seeking medical help that they need. Instead of seeking advice and care rooted in sound medicine, Americans with obesity have often resorted to unsustainable fad diets, dangerous supplements and other potentially harmful approaches

based on risky or false assumptions. But to effectively address the obesity crisis in this country we have to change our attitudes especially when it comes to our healthcare system and public policy. There's a recent Wall Street Journal editorial by University of Chicago Economist and former member of the President's Council of Economic Advisors, Tomas Philipson in which he cites two major economic shifts as the primary root causes of the obesity crisis.

First, technological advancement which has caused American's work to become more sedentary. And second, increased agricultural output that greatly reduced the cost of food. Supporting his thesis is the fact that obesity as an epidemic is not merely an American problem anymore but one observed in many other developed countries where these same shifts have occurred. In his piece, Philipson proposes that programs like Medicare and Medicaid as well private insurers should increase coverage on new anti-obesity medications (AOMs) as a means to reverse obesity and lower overall healthcare costs. Thankfully, a number of key developments have really helped to reshape attitudes towards obesity and seeking medical treatment. For example, in 2013, the American Medical Association officially recognized obesity as a chronic disease and while there's still a lot to be done to continue to shift attitudes in the healthcare system, this change represents a shift in the view toward obesity away from purely a matter of personal choice or character towards a treatable disease the healthcare system and those of us who oversee it should work to address. Like other chronic diseases obesity treatment requires a continuum of care including primary care, AOMs, and surgical interventions. In particular, some of the new and more effective AOMs coming on the market promise to bridge the gap in obesity treatment options between behavioral interventions and more invasive options like bariatric surgery.

While these new interventions can be highly effective, numerous barriers remain in the way of patients receiving them. Insurance coverage for obesity treatment which is the focus of my toolkit is often limited. This has resulted in a patchwork of coverage for the continuum of obesity care treatments across the states. For example, while every state's essential health benefits benchmark plan which governs Affordable Care Act (ACA) compliant plans in the individual and small group health insurance markets covers basic obesity screening and counseling to some degree, only 38 states' benchmark plans include coverage for nutritional counseling and only 23 states cover bariatric surgery and only two currently cover AOMs. But increasingly policymakers at both the State and Federal levels are looking at these barriers and taking action to address them. Just to cite a couple of recent examples, New Mexico amended its essential health benefits benchmark plan to extend coverage for AOMs and anti-obesity programs with those changes going into effect for plan year 2020. And earlier this year, the Federal Office of Personnel Management required insurers participating in the Federal Employee Benefits Program to provide adequate coverage of FDA approved AOMs on formulary.

State policymakers wishing to address insurance barriers to effective obesity treatment do have the ability to do so. The toolkit sets forth some options including a number of innovative approaches that state policymakers can use to expand coverage for obesity treatment in a cost effective and fiscally responsible way. But rather than simply listing out options, the toolkit discusses best practices amongst states when available and it makes specific recommendations for implementing each option. It also offers guidance on practical considerations including timelines and who can act within each state and it also includes a glossary of terms on the first page to make it easier for state policymakers to use the toolkit. And because every state is different, each recommendation is adaptable for the state's needs including the discussion of potential variations and sub-options. And perhaps most importantly this toolkit does not shy away from taking on costs and utilization concerns recognizing that in order for any state anti-obesity program to be successful it must be both affordable and sustainable. It does not

recommend simply legislatively mandating new coverage for obesity treatment. Rather it is cognizant of the trade-offs inherent in expanding benefits and uncovering new drugs and therapies and discusses the payer perspective on these issues as well.

For each option, the toolkit provides a simple explanation of the background and the problem focusing in on options that are feasible, achievable, and realistic. Several of the options included in this toolkit are bold and innovative, but each recognizes tradeoffs and the need for states to manage costs. In the interest of time, and to leave time for questions, I just want to briefly highlight a couple of the options in the toolkit. First of all, states can broaden coverage for obesity as I mentioned through state and employee benefit plans. States do have great latitude in this area in how they choose to finance and operate their public employee health plans. For example, most states self-fund their employee plans and contract with a third party to process their claims. This basically means that states can largely decide what services they want to cover and to which employees they want to offer coverage. Using this flexibility state policymakers have the opportunity to pursue innovative strategies for controlling costs while maintaining or increasing health plan quality. Not only that, but because state governments are often the largest employers in the state, these state employee plans provide an excellent opportunity to test the effectiveness of innovative policy reforms.

And next as I mentioned, states can also amend their essential health benefits (EHB) benchmark plans to broaden coverage. New Mexico took that option a couple years ago. But if you go back most states initially choose their benchmark plans based on the most popular small group plan available in 2013 and while many of them have updated their benchmarks over the years most of these benchmark plans were selected before obesity was designated as a chronic condition or before the availability of some of these new more effective AOMs on the market. Therefore, many of the benchmark plans entirely exclude or greatly limit coverage for obesity treatments. Starting in 2020 the Federal government provided new options for states to make adjustments to their existing EHB benchmark plans. So far as I mentioned, two states have changed their benchmark plans specifically to cover obesity treatment and those are New Mexico and North Carolina.

In order to receive approval under federal regulations for this change, the state's benchmark plan amendment must meet a generosity test meaning that the cost of any new benefit to be included in the benchmark plan cannot have a material impact on premium rates. This means that any premium impact must be less than a 1% increase. In submitting a successful application, New Mexico relied on an independent actuarial study finding that expanding weight loss drug coverage to patients with obesity rather than those with just morbid or severe obesity alone would not materially impact premiums. And finally, states can leverage ACA Section 1332 waivers to reduce pricing uncertainty and incentivize private insurers to cover obesity treatments. The states may apply for these states innovation waivers otherwise known as Section 1332 waivers to modify many of the ACA central coverage provisions. These provisions may be waived as part of a state's plan under the waiver to implement innovative programs that best fit the state's unique healthcare needs. If a Section 1332 waiver results in a reduction of Federal spending on premium tax credits, small business, health insurance tax credits, or cost sharing reductions, states can receive the difference in passthrough funding to support the state's waiver plan.

In 2022 the Federal government awarded states over \$1.87 billion in passthrough payments to carry out their Section 1332 waivers. Since 2017, the Federal government has approved 18 Section 1332 waivers. Sixteen of these are for state reinsurance programs aimed at improving affordability of coverage. In addition to placing downward pressure on insurance premiums,

reinsurance programs can make insurers and plan actuaries more comfortable about incorporating new therapies into coverage by reducing some of the risk involved. Analysis of CMS data has shown that not only do reinsurance programs result in lower premiums, but they're also associated with increase insurer competition in those markets. The more competition in the market the more likely insurers will be willing to adopt new therapies or broaden coverage. States wishing to go further to provide coverage for obesity treatments can explore even more innovative approaches through Section 1332 waivers. For instance, states could directly combine a reinsurance waiver with increased coverage for comprehensive obesity care, or specific treatment such as AOMs. Under such a hybrid reinsurance EHB waiver approach the state would first waive the definition of EHB to require insurers to incorporate obesity coverage into the benchmark.

Now, on its own, waiving the benchmark to broaden coverage of health care services or add new benefits would potentially violate the law's deficit neutrality guardrail because it would likely lead to some level of increase premiums and federal outlays. But the next step would be to combine the EHB waiver with a state reinsurance program that lowers premiums across the board in the market. This reduces federal outlays resulting in passthrough funding for the state to carry out its waiver. In the third step, the state could then use a small portion of the passthrough funds to offset any higher costs of covering obesity treatments such as AOMs. This high-rate approach and others like it offer a low risk high reward pathway for states to expand coverage for obesity treatment while lowering overall premiums in the individual market. Today state policymakers around the country, you're all grappling with runaway healthcare costs and the resulting pressure on state budgets. But in doing so, we should all not lose sight of the end goal to help our citizens lead healthier and more productive lives. The cost of inaction on obesity grows every day and can no longer be ignored. In fact, there's mounting evidence that greater coverage for effective obesity treatments can actually help to lower healthcare costs and increase economic efficiency over time. If undertaken carefully and appropriately these options and others not only promise to help state residents lead healthier and more productive lives, but can also save money in the long run.

Asw. Hunter asked if the toolkit includes any considerations or factors like emergency health issues like COVID. People have the COVID weight. I think a lot of times we're not taking into consideration other factors that contribute other than poverty relative to weight gain. I also wanted to know if there's anything in the toolkit relative to inflation where people have less disposable income where they may not make as good healthy food choices with less resources. Mr. Pate stated I do talk about those issues in the toolkit. People with COVID were more likely to be hospitalized, and more likely to die from the disease as a result of being obese. And certainly coming out of the epidemic and of the pandemic all of us have experienced the weight gain or the COVID weight as you said. I see it as part of an overall trend in the data when you look back 20 years ago we still are on the same trend of half of the country being obese by the end of this decade. And so the toolkit is really looking at a number of different options. Through Section 1332 waivers, for example to get to your other question, I think there are probably opportunities to look at things like social determinants of health and other sorts of broader efforts to try and get at some of these issues with food security and things like that as well.

Rep. Stephen Meskers (CT) stated that obesity as an addiction and a social policy issue, it's one we need to address and deal with. I can see that in a constituent base in service to the community but when I'm listening to your presentation, we're not talking about incremental or supplemental costs to resolve the issue. So, I think we have to be frank about that. So, it's a social and an addiction issue that we're thinking of dealing with. The subsidies and workarounds because at least in the current environment the insurance companies don't see ultimately the

treatment versus the cost of obesity as being equally measurable and that can be externalities that insurance companies don't bear and that surprises me given the cost of insulin, given the cost of hospitalization, given knee replacements, hip replacements, everything associated with aging and obesity. So, I'm surprised - is there any kind of measurement, without taking externalities, of the cost differential between the demands and claims on the insurance industry - and the medical costs versus the obesity and the treatment? Do you have a rough estimate of what that cost looks like?

Mr. Pate stated that a study came out looking at Medicare and Medicaid coverage of the full range of obesity treatments and found that for those programs over I think it was a 10 year window that it would actually save those programs money when you talk about not having as high rates of heart disease, and diabetes and these other attendant conditions. So, I look at it sort of like drugs for hypertension, for example. Hypertension on its own it gets bad but it's called the silent killer because it shows up in other health problems like stroke and heart disease. I think it's the same thing with obesity. And I agree that there is an issue and I talk about it in the toolkit of any time an insurance company's looking at covering a new therapy, the actuaries are trying to see what the utilizations going to be and predict what it's going to be and it's really difficult when you don't have that solid data although we're starting to get it we don't have necessarily the solid data and experience on that. But I think the 1332 waiver idea I'm proposing and some of the other ideas are designed to sort of provide a little cushion for the pricing actuaries, for the insurance companies to cover it and then see what the experience is over time. And hopefully, the value proposition will be there. I think it will be, as that Wall Street Journal editorial was talking about as well. I think the value proposition will be there. But these are ways to test it out and get it into coverage.

Sen. Mary Felzkowski (WI) stated that one of my largest concerns is as a policymaker, if we say that, okay now take a pill and we're going to help you with your obesity. And you're saying that within the ten years that we can actually show that we're going to reduce costs because we're going to save it on the heart disease and everything else. But at what point then do people stop trying to curb it on their own and we're just exacerbating it and 90% of the U.S. is taking a pill for obesity instead of getting at the root cause: cheap food, processed food, lack of exercise and education. It's a slippery slope and that concerns me as a legislator.

Mr. Pate stated that first of all there's no magic pill to solve the problem and my suggestion is not that it just be covered and that be the end of the discussion at all. The way the continuum of care really is supposed to work is you start with diet and exercise, you start with nutrition counseling, you start with these less invasive interventions. Now, I do believe the healthcare system needs to do a better job of when you go to the doctor, screening you and explaining your options and getting you plugged into these things. I think we can do a much better job of that. But really, the AOMs, the medications, are really just designed to be there when those things have failed and I talk about in the toolkit ways to make sure that that's the way the prescription works and that's the way the utilization management works. But I absolutely agree with you that all of these other factors have to be addressed as well. This is just part of how the healthcare system can hopefully step up on this epidemic.

Sen. Felzkowski stated that I understand and there are some people where it's a genetic issue no matter what they do but I think for the majority of people, and you can see it in the trending obesity - go back 50 years and this was not the issue that it is today. So, it's very much lifestyle, calories and calories without exercise. But when you use a term "supposed to work," that's a huge red flag for me because we as a society have gotten very lazy. We go to the doctor and we want a pill to take care of everything without putting in the work to do it and the pressure will be

for that pill not doing the work. Mr. Pate stated that I don't think we're lazy. When I think about the economic factors, it used to be that most people in this country, part of your job involved some sort of strenuous physical activity for eight hours minimum a day probably five or six days a week. And we just don't live like that anymore. I don't think that we have less character, less willpower that we've had in the past. I think we've got different problems and complex problems that technology can hope to address. I mean technologies are part of the reason we got into this mess and hopefully it should be part of the answer to get us out of it. But overall I think all of these things should be part of the discussion. They should all be options. The toolkit's focus is really on how can we better engage the healthcare system and bring some of these technologies to bear on the problem.

Rep. Tammy Nuccio (CT) stated that we've looked at legislation similar to this in our state. We're a small state of 3.6 million people if we had mandated something like this, first of all it's only going to affect, which we all know in this room, 15% of the population – about 220,000 people in the state of Connecticut. And the cost is well over \$4 million a year to do something like this. So, that's a problem for me especially when I hear doctors who say, like the bariatric surgery, it's a 60% success rate, and 50% of those people will gain the weight back. So, it's like a cycle and the problem that I have with the drugs is I'm not sure whether or not there's enough research there to show whether it's going to have long term sustaining effects. But, I'm also under the impression that a majority of insurance companies pay for bariatric surgery. It's actually part of a benefit structure that is included in it. So, is this just the AOM drugs and what is the cost of those drugs?

Mr. Pate stated that it depends on the market you're looking at. The EHB benchmark applies to the individual health insurance market and the small group market and then you've got the large group self insured and fully insured markets. So, it's kind of a patchwork and I can get the data on that. I don't have it in front of me. But, the idea is that when I say it's a patchwork that means some states may cover bariatric surgery but they may not cover the nutrition counseling. Some states maybe cover the nutrition counseling but they don't cover the AOMs. So, the point I'm trying to make is when you look at, and I'm not a clinician and I don't have all the data but from what I've read, you really have to have the continuum there. You have to have all of those options there available to people to really get the long term results so you don't have people gaining the weight back and it it's sustainable over time which is really what I'm arguing in this toolkit.

Rep. Dennis Paul (TX) stated that I've enjoyed the discussion and it's good to hear about how this works and I'm interested in going back to your data of you calculated of how we got to this point now and why are we here and I think a lot of it was like you said the work. Maybe nowadays there's working families where both the man and woman are working so there's less good prepared meals. But, the slide where you're showing the income levels that was dramatically worse with income, and also for different races, what is the majority factor in that? Is the fact that these races might be lower income and that's why they're higher? Or is it a race has a higher reason over the income? Which one is controlling there? Mr. Pate stated that I've read literature. I haven't done my own studies on this. I will say exactly to your point, it's very, very complicated. It seems to be related to lack of education, lack of income, and lower access to recreational facilities. There are all sorts of factors that go into it. But again, it's very complex and there are a lot of us who have plenty of access to all those things and we still struggle so I would say it's a very complex problem. I don't think we're fully there in terms of how do we fix it and really understand it but I do think some of these things and ideas I'm talking about ought to be first steps that we should look at in order to try to get a handle on this.

PRESENTATION ON USING HEALTH INSURANCE RATE REVIEW AUTHORITY TO CONSTRAIN HEALTH CARE COSTS

The Hon. Chris Koller, President of the Milbank Memorial Fund (Fund) and former Rhode Island Health Insurance Commissioner thanked the Committee for the opportunity to speak and stated that I'm going to speak from the experience of both the Fund and then my own experience as Health Insurance Commissioner in Rhode Island from 2005 to 2013. I have four main points to make. I think health insurance is fundamentally different from other kinds of insurance so we ought to have a policy that reflects that. We've got a real problem with commercial health insurance affordability. You can use health insurance rate review as a tool to get at that and that's in points three and four. So, this is what the Fund is about. We are an independent operating foundation. We're just across the river here in Manhattan. We work on health policy leadership. We work on specific state issues like state health policy issues like affordability and primary care and then we publish communications. Our mission is to improve population health and health equity by collaborating with folks like yourselves and connecting you with sound evidence and experience.

So, my first point - health insurance is fundamentally different. We don't mandate insurance coverage for oil changes but we mandate insurance coverage for preventive services. We don't require body shops to treat anyone who comes in but we require it of emergency room doctors. And we don't treat roofers in a special way to make sure that they get paid adequately. All those are things that we do for healthcare in our public policy. It says that we look at health insurance in a fundamentally different way and I think that was the genesis that inspired Rhode Island legislatures to actually break out health insurance regulation from the rest of insurance regulation - give it a different set of charges and that leads to how you look at rate review. So, what's the problem we're trying to solve? We have an issue with affordability. It has permeated these conversations. We talked about it in terms of obesity. We talked about it the Spring with 340B. You've all seen data such as this and I like this one because it indexes everything to general price inflation and you can see the employees are bearing the cost of that. So, as healthcare costs go up, employees are bearing a bigger portion of it. The causes are systemic and they're getting worse. This is my version of the obesity map. This is just showing how we've got an affordability issue that's getting worse over time. This is data from the Commonwealth Fund of the average employee share of premium plus deductible. So, it's all the cost sharing as a percentage of median income. Dark is worse and we're getting more and more dark.

So, this is an increasing problem. I'm here to say that the problem is mostly in commercial health insurance as opposed to Medicaid and Medicare and analysis would say that the two major drivers of this are health systems and pharmaceuticals. This is a lot of data by state each of these vertical lines is a state. The red triangle is the average hospital payments inpatient, and outpatient indexed to Medicare. So, the average overall commercial payment is 235% roughly of what Medicare pays and there's enormous variation by state and there are a lot of reasons for this kind of variation. The main story though is it was Medicaid and Medicare constraining prices. Health systems are consolidating and extracting prices from commercial health insurance and employers and employees are paying the cost. Actually, employers pay the cost for it. They pass it to employees and they pass it to customers in terms of what we pay for our prices. The other culprit is pharmacy. I know we have Representatives here from Connecticut. This is data from Connecticut that looks at different cost drivers. The horizontal axis is cost per member per year. And the axis is the trend over time. The orange dot is pharmacy and the blue is hospital outpatient.

So, you can see that it is where our money is going when we talk about affordability issues. Don Berwick, who has served a number of different positions in Federal government and thought leadership positions stated that healthcare is confiscatory. This is data that he got from Massachusetts that shows it has a stayed budget. You can see that all the things that we want to spend money on we're skimping on. This is pre-COVID so this is older data. Because the money's going into healthcare. It's worth noting that all those things on the right, human services, public health, mental health, and education are all things that actually improve health over time but we've been busy pumping it into the healthcare system. So, we can think about in general, when we think about affordability, historically there've been three strategies around affordability. We play whack-a-mole and we go after specific areas. We toss the hot potato to somebody else whether it's an employee, an employer, and we get someone else to pick up the cost. Medicaid's very good at that - get someone else to do it. Or we have magical thinking and we put forth non-evidence-based policies and hope that it makes a difference.

Our position is that systemic problems require systemic solutions. You must start with good data to get a common view of reality. You must get alignment of policies across payers - Medicare, Medicaid, and commercial. And there is still room for competition but it's with some referee and rules. Commercial health insurance rate review can be part of that. It can get commercial health insurance into the game to start getting at the systemic affordability issues and that's why we talk about rate review as a tool to improve affordability. The system needs a sheriff, particularly on the commercial side because what you have is kind of the wild west out there and you need some folks making sure everybody is playing by the rules and we're moving in a direction towards affordability. I'm going to put forth some language and items to consider as you think about rate review and the job of health insurance. I want to make the case that the traditional charge of how insurance regulators work with the standards you've given them doesn't work for healthcare. They traditionally have these first two. Their job is to guard the solvency of insurers and to protect the public interest and the interest of consumers by making sure contracts are honored.

I think for healthcare you need some other things. We care about the treatment of providers and we care about the system as a whole and we want to direct health plans and the players and the systems towards affordability. Those are statutory standards that ensure regulators can't assume, they have to be given them by you as the legislators. And when you do that then you can have expectations of what happens in your rate review process. Then when you think about rate review, you have to understand the scope of it. Our federal colleagues can talk about what's required under Federal law to demonstrate that you have adequate rate review for the individual market but think about your other markets, your small group, your large group - what type of rate review do they have? Is it file and use and does it vary by market authority? Think about the scope. In Rhode Island we work with individual, small group, and large, and that gives us a consistent way of directing the insurers and working with the providers. And think about consumer protection authority and do you have specific requirements for affordability. I won't get into the detail but this is from our colleagues at the National Academy of State Health Policy (NASHP). This is sample language of what you could put in to increase those standards and to have broader standards for health insurance than what you have for other lines of insurance.

So, what's been the experience of states as they've done this rate review, whether it's in Rhode Island where we have rate review for individual, small group, and large group. Colorado does not have it for large group. Colorado uses rate review to balance transparency and proprietary information. So, they're the referee. And I think what they're doing is promoting more transparency than previously existed so the folks can understand what actually is driving the cost increases and understand price and utilization trend by a hospital and by provider so that you

can understand and get that kind of data that we had earlier to understand what's really driving premiums.

Comprehensive rate review is part of affordability strategy. Here are some specific things that you can either require in statute or direct your regulators towards and they consider this notion of prior approval. Do the rates have to be approved before they can be implemented? A public analysis of submissions, trends, and driver analysis. In my experience this is really important. Folks have to understand what's driving healthcare costs and get away from simple solutions like well let's just eliminate the CEO's salary from Blue Cross and that'll make healthcare affordable. No, it won't, and we need to understand that it is provider rates, it's pharmacy utilization. And then if you're particularly ambitious you can develop affordability standards that you or your regulators want the entire system working towards. What are things that will get at the underlying drivers of affordability? These are things that have been tried in different states. Delaware and Rhode Island is in the middle and actually Oregon is actually telling the insurers to spend more on primary care as a portion of their total budget to transfer money from other places to put more in primary care. In Rhode Island and Delaware, we've actually limited the rate of growth at which hospital prices can grow. It's been in place in Rhode Island for ten years. You can use the legislation to advance provider payment reforms to get providers off of fee for service. You can use the rate review to encourage participation in your state-based exchange and there's been a lot of topics about public option products now on the exchange.

We work at the Fund particularly closely with the eight states that are listed at the bottom around understanding underlying cost drivers and getting a common view of reality so you can focus policy on the areas that will get at systemic costs. I'm happy to talk more about that. So, what have been some of the results. This is the history in Delaware. They actually started out with a separate office of health based, healthcare affordability or healthcare delivery. They developed affordability standards. Then the legislature actually gave the department of insurance (DOI) the ability to enforce those standards put in place the way it exists for other lines of insurance. And enforcement is due to begin. In Colorado, this points to the savings that they have versus what was submitted versus what it was decided in their small and large group rates amounting to half a billion dollars over the nine years and affecting three million Colorado citizens. And then in Rhode Island, this is trending overall all in per capita costs compared to a control group that's the same population, same age and sex demographics. You can see that in 2011 when we implemented hospital rate caps, our trend flattened and we went below our control group. That is real dollars that's delivered to employers and to employees. We can document less cost sharing that's going on to employees and delivery system improvements.

Let's be careful, health insurance rate review isn't going to save everything. We get resistance from health insurers in some places when we try to put this in. There's concern about consistent enforcement as well as larger providers who have frankly had a pretty good time working in the system the way that it is now and it's not going to solve for monopoly providers. It raises the risk of regulatory capture. It doesn't solve for self-insured employers who are over half of the market although they sometimes benefit. In Rhode Island, the self-insured folks have benefited from these rate caps. And everything else that your voters don't like about healthcare. Because you get complaints all the time about stuff and rate review is only a partial solution. So, while I close, this really is an important policy issue. I'm happy and very privileged to be able to speak with you folks about it. We fundamentally have to decide is healthcare a tool for economic growth? In which case, we have to live with increasing disparities and affordability issues. Or, is it something that everyone is entitled to and that we want to have reasonable access to so that we can use money for employees that they can take home and spend with their families and we can

spend on social services because that's not what we have right now with our healthcare economy.

Sen. Felzkowski stated that one of the things you said is alignment of policies between Medicare, Medicaid, and commercial. Can you expand on what you mean by that? Cmsr. Koller stated that let's say you and your legislators say to your regulators, "Look, get the insurers in line, get them doing the same thing." What that gives the regulator the authority to do is to get the insurers in the same room and adopt consistent policies that treat providers in the same way. If you talk to providers, they will say what really drives them crazy is different policies from different insurers. We get different things from different Medicaid managed care sections. Different prior authorization requirements, different administrative requirements, different goals around payment reform. Different formulated drug lists. The providers are saying stop the madness. Get some force to get them together, and this gives your regulator the authority to get folks in a room and say, "Okay, let's all get on the same page." In Rhode Island, there are 12 quality measures that all insurers have to report on. Nothing more, and the providers love it because they get an aligned set of measures that they're held accountable for and one way of paying for primary care, that's the kind of alignment that we're talking about. And if you're getting a blueprint from Medicare, let's just align with Medicare and try to further get some synergies. It's this cost of confusion that we're trying to get rid of.

Rep. Derek Lewis (KY) stated that on the presentation you had listed a provider growth cap. What is that and how does that work? Cmsr. Koller stated that as a result of the data that we are collecting in rate review, we can document that insurers were expecting an 8% to 9% price increase in their hospital contracts. And I could use that to go to employers and say, "Okay, 40% of your insurance premium is going to go up by 8% or 9%." That's 3% on your base right there before any money goes to any place else. What are we going to do about that? And so that created frankly the political will for me to turn to the insurers and say, "You know what, from here on out, only give the providers consumer price index plus one. If it's good enough for Medicare, it's good enough for you." And so, the insurers implemented that and that's what resulted in that flatten of the curve. So, this was our attempt to address some of the price discussions that we're now we're finding throughout the country on these hospital prices. And Delaware is following suit and some other people are talking about it.

Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer, stated that you mentioned in here under your obstacles, I think it was your last slide you were talking limitations and self-insured employers - obviously you were referencing the Employee Retirement Income Security Act (ERISA). So, I know in my state we're down to less than 20% of our marketplace is actually fully insured. So, what's the net effect of this type of regulation in terms of shifting the balance for or against self-insured plans? Because I think that would be one of my concerns is just that going to force more employers out and into this self-insured market. Cmsr. Koller stated that I'll only speak for Rhode Island because that's the place that I'm most familiar with. I would argue that the steps that we've taken in Rhode Island have benefited self-insurers because the insurers are the administrators and they impose those same price caps on their self-insured contracts as on their fully insured contracts. So, the self-insured are getting a free ride, basically. Rhode Island has the same issue of an erosion of that fully insured market. I don't think these regulations have led to it. I think it's frankly a favorable selection. Rep. Oliverson asked if it has reversed the trend. Cmsr. Koller replied no, it hasn't reversed the trend because if you've got an insurance pool half of those people are going to be below cost and those employers are going to get cherry picked. They're going to get approached by a broker who's going to say, "You know, I can get you a better deal if you self-insure." And that's a bigger issue than frankly what you can solve with your insurance commissioner.

DISCUSSION ON PREPARATIONS FOR/IMPLICATIONS OF END OF PUBLIC HEALTH EMERGENCY

Miranda Motter, Senior VP of State Affairs and Policy at America's Health Insurance Plans (AHIP) thanked the Committee for the opportunity to speak and stated that I'm very grateful for the opportunity to speak and have a conversation about what Asw. Hunter said is really sitting in front of every single state in terms of the work that needs to be done once the public health emergency ends. I did want to just take a couple of quick moments to run through just really as a reminder for everybody to sort of remember what I'm going to call emergency waivers and flexibilities that were put in place once the COVID pandemic hit. Because I do think that it's really important to remember the series of things that happened. And then obviously very close attention and focus on the public health emergency (PHE) is warranted and how that will impact Medicaid specifically on the redeterminations that will need to take place all across the country. Here are two or three slides to walk through all of the authorities that were at play or are at play as a result of the COVID pandemic. Obviously, the public health emergency, which is the one we will come back to, provided certain things and triggered certain issues. The National Emergencies Act. was declared in March of 2020. There was a renewal date and then an additional renewal for March 1st with no specific end date.

And again, it activated specific things under the federal statute particularly allowing temporary waivers, or modifications of certain requirements of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) program. The Stafford Act was declared in March 13, 2020 which enabled the Federal Emergency Management Agency (FEMA) to help deliver virus response funds to state and local governments. The Public Readiness and Emergency Preparedness (PREP) Act was invoked in March as well. It provided ten additional amendments. That will end October 1st of 2024 and it essentially authorizes Health and Human Services (HHS) to limit certain legal liabilities. And then Emergency Use Authorization (EUA) which were incredibly important as it related to vaccines was declared on March 27, 2020 and allowed the FDA to authorize when certain conditions were met the emergency use of certain medical products or on unapproved uses of approved medical products to diagnose, treat and prevent serious life threatening diseases and conditions. The other thing that it's really important to remember is there were also a couple of major Federal legislative actions that tied into the public health emergencies - the Families First Coronavirus Response Act, or the Coronavirus Aid Relief and Economic Security Act referred to as CARES and the American Rescue Plan Act. There were also a series of changes that waived or modified things at the administrative level under Medicare, Medicaid, CHIP, and The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Those administrative changes provided some additional flexibility particularly in the commercial insurance markets. And then I also think it's really important to remember that in each one of your states there were a variety of mechanisms that the Governors or the legislatures put forward to make sure that there were certain authorities available during COVID. So, as it relates to the state emergency declarations, I do think it's really important as you think about your own state situation to really go back to those original authorities and understand what triggered them and what was the basis of them to really help you understand once we unwind some of these things. Some of the state emergency declarations reference the Federal PHE. Some of them referenced a specific state PHE. Some of them referenced both actions by the State and the Federal Government. Some of them were just general COVID-19 public health challenges. And then some of those were silent. A full review of individual state actions and the authority cited is necessary to fully understand how a termination and/or non-renewal of the PHE

or national emergency issued in connection with the COVID19 pandemic will impact the various state emergency orders, bulletins, guidance, mandates, and other actions

Going back to some of those changes that I referenced by the federal legislation I wanted to just quickly mention with most emphasis on the fourth bullet, key federal legislative provisions that were tied to that Federal PHE. So, coverage for COVID testing and testing related services without cost sharing in the commercial market and for Medicare. Coverage without cost sharing for nearly all Medicaid populations for the COVID vaccine and the administration costs that were associated with that. Coverage for testing and treatment for Medicaid populations. And this last bullet is where we're going to focus on - an increase of 6.2 percentage points in the states Federal Medical Assistance Percentage (FMAP) provided that states maintain what you'll hear referred to as a maintenance of effort requirement. So, in other words, making sure that everybody who is on Medicaid stays on Medicaid and does not get bumped off of Medicaid during the PHE crisis. So, those things have to be met through the end of the month in which the PHE ends. So, that's the trigger in terms of time and the additional federal resources that were available but they were contingent upon state's making sure that individuals that had access to Medicaid coverage continued to have access to that coverage.

I also wanted to run through a couple of important dates both for now and then certainly as we think about the future. The end date of the PHE was most recently extended to July 15th which is actually tomorrow. Once the PHE ends, most of the flexibilities and requirements will end automatically. Relative to that increase of that 6.2 percentage points that I talked about, if the PHE is not once again extended, I just wanted to provide some dates to give you some context in terms of what the triggers will start to look like. So, the continuous enrollment requirement will end on August 1st. The enhanced FMAP will conclude at the end of the quarter – September 30 of 2022. I will reiterate and many of you are probably aware of this - the administration has indicated that they would give states a 60 day notice to help plan and prepare before the PHE actually expires. The states were not notified on May 16th, so I say here we are assuming that the PHE will be extended at least once again. And then in terms of future dates that you should also be attuned to, if it is extended for another 90 days, that 90 day period will end on October 13th. And that 60 day notice out to states would be given on August 14. So, again just a couple of dates to keep in mind as we move forward.

Medicaid redeterminations - just a quick overview of what it is and why it has to be done. So, before the PHE, states were required to annually verify that the individuals that had Medicaid coverage were eligible for that coverage. What has changed? I talked about what had changed as a condition of receiving additional funds, the states had to maintain those individuals and make sure that they continued to receive coverage through Medicaid. Post PHE when it ends, the states will resume the processes. So, why is that significant? First of all, the volume in terms of the number of individuals that will need to be redetermined is significant and we'll talk about that here in just a moment. The second thing is that states will have 12 months to initiate and then 14 months to complete. So, 12 months to initiate and then an additional two on top of that to complete the full renewal of individuals that are currently enrolled in Medicaid, CHIP, and the basic health plan. So, now we have a time frame by which it has to be done and then States, counties, and beneficiaries have not had to do this or have not done this in two years. And so, as you think about staffing within Medicaid agencies, as you think about staffing at the county level if the counties are the ones that are actually performing the Medicaid redeterminations. And then similarly, those individuals that are receiving coverage through Medicaid, they have not had to go through this verifying process in order to maintain their coverage in two years.

So, let's talk a little bit about the numbers. So, how many individuals are we talking about in terms of that volume? Slightly more than one in four Americans rely on Medicaid for their coverage and care today making it an essential safety net for 87 million individuals. We I think firsthand now understand how important health care coverage is coming out of a pandemic and understand how important it is to have access to healthcare which is made possible through health insurance. You'll see here that I've cited some numbers from the Kaiser Family Foundation. So, the total Medicaid and CHIP enrollment has grown approximately 87.4 million. So, that's an increase of 16.1 million from enrollment from February 2022. That increase may be attributed to a couple of different things - economic conditions, policy changes, postpartum coverage. In many states I know right now either legislatures or through waiver plans, states are allowing 12 months of postpartum coverage. Or as I talked about this temporary continuous enrollment requirement. So, all of those things are contributing to this increase. Between 5.3 million and 4.2 million Medicaid enrollees could be disenrolled in the months following the end of the PHE. I know that this is a big delta but you'll see there again, those numbers are from analysis that Kaiser Family Foundation put forward and they actually did a survey of state officials from January 2022 and then February 2022 and it's those two numbers that provide the range of which we think individuals potentially could lose coverage.

The other thing that may be interesting for you to look at is there is a 50 state survey that provides a lot of good information if you want to look at your own individual state in terms of what those numbers look like. The redetermination process at very high level, there are Federal and State requirements as it relates to what needs to be done for Medicaid redeterminations. Those processes do vary depending upon eligibility based on income, waiver or disability status. And your Medicaid agency may be using information or they can use information through other sources to decide whether or not somebody may be eligible for Medicaid or CHIP. If more information is needed the state will reach out to that individual and ask for that additional information so that they can verify that that individual is still eligible for Medicaid. Again, I put a link here to very basic enrollment information and there is also a link here on what each different state requires for that too if you're interested. The stakes are high. I talked about how the volume is significant. I talked about how this hasn't been done in two years and the number of individuals that are at risk. The stakes are high because you'll have individual patients that might be deemed ineligible because their verification was unsuccessful.

So, in other words, you might have an individual who is now not eligible for Medicaid coverage just because they weren't able to verify their eligibility. They may still be eligible for Medicaid coverage. You're going to have ineligible patients who will become uninsured and may not be able to find another source of healthcare. The other thing that will be very important to remember and understand is there will be providers on the ground in the states who have been treating individuals who had a reimbursement source for their healthcare coverage and now may not. The other thing is obviously those individuals that lose their healthcare coverage, it will increase states uninsured rates. And then we talked a little bit earlier about how affordability and uninsured rates are obviously and ultimately going to impact other kinds of health insurance coverage because of the cost shifting that happens and takes place. I just wanted to spend a couple of my last minutes on 10 fundamental actions that states can take as they are preparing to unwind. This is information that CMS has made available to states. There are a number of different state toolkits that are out there.

So, first is creating a comprehensive state unwinding operational plan. That seems to be a no brainer. But really, states need to sit down and understand how they are going to accomplish that and how they're going to make sure that there's continuity of coverage and actually facilitate the transitions of coverage that individuals are going to need to have. Second is to coordinate

with partners including the state, tribal, and government partners - working with state sister agencies and leveraging other government agencies and coordinating with your exchange marketplace whether that's a federally facilitated marketplace or state based marketplace. Consulting with tribes to help support what that strategic planning looks like is really going to be very important. Third is implementing and strengthening automated processes. So, this includes ex-parte renewals, you might hear this term which is essentially doing as much of this as possible without having to touch the person, whether it's online, whether it's via phone so that process is as automated as possible for the beneficiary. Fourth is work early and closely with eligibility system vendors to identify the changes and the starts and the planning and really performing that robust testing that needs to be done end to end. Fifth is establishing a renewal redistribution program. So, understand how a state's going to account for and mitigate churn and account for any workforce challenges or system challenges that they may have due to capacity.

Sixth is engaging with community partners, health plans and providers in the community. And many of your states are doing this in a terrific way working with the community partners, working with hospitals, working with providers, working with health plans. So, making sure that they're working with the Medicaid managed care plans, making sure that they're working with the health plans that might be providing products or coverage through the exchange marketplace on the qualified health plans (QHPs) and really leveraging those constituencies to serve as workforce arms of the states to help them do this. Seven is obtaining updated contact information which will probably be the most challenging issue. So, really implementing and utilizing multiple strategies to make sure that there's mitigation of coverage losses and using those strategies to make sure that you can have the most recent contact information and are trying to contact that eligible beneficiary in multiple different ways. Eight is launching an effective communication strategy. You've probably seen this in many of your states already where there are multiple strategies and messaging communications on the ground to make sure that there is, first and foremost, an awareness that this is coming, and then what needs to be done. Nine is assess eligibility enrollment and fair hearing work capacity. This is just making sure that there are sufficient workforces in place and ensuring that there's adequate staffing and sufficient training to complete this work. Finally, develop a robust monitoring strategy so that there is an approach and a framework in place to make sure that the reporting that will need to be done to CMS is ready. I am really hopeful that this is the start of a couple of conversations as this gets closer to sort of understand how this is going and certainly the work that is being done on the ground.

Asw. Hunter stated that it's almost inconceivable at least in my state that they would be prepared to re-enroll millions of people within that short time frame even when engaging community partners and our counties that are responsible for enrollments. So, this is very urgent that we're having this conversation. Is there money from the Federal government given to states to help implement or to cover gaps that are going to be put in place? Ms. Motter stated that I think the answer in terms of direct dollars is no. That additional FMAP money will go away but there may be other dollars that states can use in terms of infrastructure preparedness and those sorts of things that they can use to get ready and help systems and those sorts of things and I do believe some states are actually utilizing some of those dollars.

Rep. Oliverson stated that you gave a lot of reasons why this is going to create a lot of issues for a lot of people and I guess the thing that just kept popping in my head was given the administration and the current thought process and the folks that are kind of in power - what's the rush? You have all these people that are continuously eligible right now for going on two years, including states that have stubbornly refused to expand Medicaid, like my home state and now you have people that can't roll off the roll. Have you heard anything and has there been any

discussion about whether the administration will keep kicking the can down the road because maybe it's politically good to do that?

Jeff Wu, Deputy Director for Policy at CCIO stated that I think the rush is caused by the way the statute is structured. This FMAP goes away and this continuous meetings of effort requirements goes away. And then in fact, the normal Medicaid standards which require redeterminations kick in at which point we'll have this big issue. Now, normally this is an incremental thing that happens every month but now, we're going to have a situation where because the law has called for states not to do this we will have a two year backlog and a giant tidal wave of folks to handle and that's going to be a big challenge. Rep. Oliverson stated that you're saying that statutorily at the Federal level that there's nothing that can be done from an agency standpoint - this is going to happen? I got the impression from your presentation, Ms. Motter, that it's just kind of in this cycle of well we're just going to keep renewing it and renewing it. Mr. Wu asked Rep. Oliverson if he was talking about the renewal of the PHE. Rep. Oliverson replied yes and stated that my question is, not that I'm necessarily in favor of it as a Texan, but I'm just thinking based on kind of where things are at the national level, what's the hurry? Mr. Wu stated that I can't speak with a lot of details of this but I do think a lot of factors go into this determination of whether or not to extend the PHE. This obviously is one of them. This is a big deal but as Ms. Motter noted, there's a lot of flexibilities out there that are in place and I do think that the PHE is not intended to go on forever and at some point we'll have to turn off and at which point, this whole cascade of work is going to have to happen and that's why agencies in all of your states and the federal government and so many private sector entities have been furiously working together to try to get ready knowing that there's a deadline coming at an uncertain point.

Sen. Bob Hackett (OH) stated that a lot of this is because of competition. We pay much better wages and people are making more money. But one thing I don't see you talking about is Medicaid is really good health coverage and people are going to get forced off to higher deductible plans and coverage. Why don't we talk about the cliff effect that actually we're going to have a number of people who take home less money even though they're making more money. Is the protection already in there that we don't have the cliff effect problem? Ms. Motter stated that as I talked about the transitions to other coverage, if we're talking about somebody who is deemed ineligible, the goal would be that they would go to one or two markets. One would be the marketplaces where it will be really important for the American Rescue Plan Act (ARPA) subsidies to get extended as well because those subsidies have really helped the exchange marketplace become more affordable. But to your point, the other option for some of those may be access to employer coverage. If they've gotten a job, if they're economic situation has changed, it may be that they have access to that employer coverage. And to your question about what to be done in terms of high deductibles or the high-cost sharing, I do think that goes back to a lot of the conversation that we've been having today. Those issues are a direct reflection of the affordability of the underlying cost of care. I always say cost sharing and deductibles plus premiums equals your health insurance costs, it's the underlying cost of healthcare until we sort of get at that, but individuals who are going to lose that hopefully will have options under those two marketplaces.

Sen. Hackett stated that Medicaid is great coverage. Medicaid doesn't cost them anything. Now, they get worse coverage that they have to pay out of their pocket even though they're making more money and not eligible for Medicaid so the net result to the worker is the income went up but less take home dollars. How are they going to get through that? Ms. Motter stated that I would reiterate certainly with the ARPA subsidies and that help for so many it made that coverage much more affordable and for many of them it is very minimal f not zero. So, that has helped many individuals that have to move over to that exchange marketplace but it's a

challenge. Sen. Hackett asked if there are cases where the subsidy pays the entire thing? Ms. Motter replied yes and we've got some information about that in terms of how it's impacted different states and I'm happy to share that with you as well.

Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary, stated that the thing I haven't heard you discuss, and maybe Arkansas is an outlier, but you talked about ramifications for patients. But Arkansas is a small state and we're making about \$75 million a quarter because of the 6.2% enhanced reimbursement. Is that typical of other states? It's going to be a huge financial loss for us to lose the enhanced reimbursement. Ms. Motter stated that I don't know the specific answer in terms of where the different states are relative to that number. I'm sure we can get that for you in terms of where different states fall as it relates to that increased FMAP amount. I would just like to leave you with again, hopefully we can have this as a continued conversation, but the other thing I would encourage you as legislators to do is if you are getting calls once this starts, if you start to get questions, I do think there's a real opportunity to work with your Medicaid agencies or your sister agencies to make sure that either you or your staff have some really good talking points for some answers as your going to be getting some of these calls because I really do think that will help arm and really help understand the constituencies that you're going to hear from understand what's happening.

HEALTHCARE MARKETPLACE PRIORITIES: VIEWS FROM CCIIO

Mr. Wu thanked the Committee for the opportunity to speak and stated that in the interest of time, I will hit on a couple of highlights really focusing on the big priorities we have this year and The No Surprises Act (NSA). I'll touch a little bit further on the Medicaid unwinding process, which really is a major priority of ours. I'll talk a little bit about Section 1332 waivers and then I'll talk just a few sentences about our regulatory priorities going forward as well. And in each of these areas I think there are opportunities for coordination, and cooperation between the federal levels and the state levels. So, let me start with the NSA. It's been a very busy year. A year and a half ago Congress in a bipartisan manner passed the NSA and we have been implementing furiously this very complex statute ever since. At the beginning of this year the consumer protections of that law went into place and some number of months after that we put in place the arbitration process. But there are many other transparency and consumer protection aspects of this law that are to come and we're going to be very busy working on those. Of course, this is not a new issue. Many of your states have laws in place, and had laws in place for a number of years providing consumers protections against surprise billing. Those laws have worked very well and we have looked very closely at many of those laws and their operations in helping us understand how to implement our law. But now that there's a federal structure in place, the landscape becomes much more complicated because states that have their own provisions, those provisions apply, and then otherwise the federal provisions apply. And in many states it's sort of a patchwork. It kind of depends on which providers and which types of plans and other circumstances and so there's an extensive process of cooperation and coordination happening right now between regulatory agencies and authorities in your states and CMS.

And defining those lines and making sure that handoffs and enforcement occurs and the consumers get the protections of this law is very important. So, there is lots more to come in this area. It is a really remarkable change to the way commercial health insurance works in this country and it is going to have big effects. To the extent that any of you are interested in working on measures or legislation in this area to make these regimes align better together, I will say we are very happy to work with you. We're happy to provide our thoughts and our advice on the way these regimes can work together better and there will be many years of work on this structure to make sure that it works well for consumers.

Secondly, regarding the unwinding effort, Ms. Motter through the issue that is happening. I can assure you that at CMS and across the entire federal government we're taking a whole of government approach to this issue. We think it is extremely important. It is nearly inevitable that some people will fall through the cracks as we look at the millions of people that will be going through a mandatory re-enrollment process and so we're working very hard with our partner exchanges in the states as well as all of the state Medicaid agencies. We're working on things like making sure that the quality of the data transfer between those entities is consistent and clear. That's sort of the foundation of this issue. We want the exchanges, we want the Medicaid agencies to sort of know which people are being re-determined. What is happening to those people? And we're building out a process to track all of those folks so that we can continue to conduct outreach on those folks and have as few of those people fall through the cracks as possible but it's a real challenge and in some sense for the exchanges that we run, it's an opportunity to really make sure that all those folks are picked up and continue to have high quality coverage. As Ms. Motter was noting, if the ARPA subsidies are extended, in fact the cliff effect that we were talking about a little bit earlier really is mitigated and it can be a very smooth transition to high quality very affordable coverage.

Let me say a couple of sentences about state innovation waivers. We continue to be very busy as we have been for many years now working with states on Section 1332 waivers. So, these are opportunities for states to craft their own programs and waive certain provisions of the Affordable Care Act (ACA) and receive pass through funding to the extent it saves the federal government any money on premium tax credit subsidies. The process here can be complicated and it involves a lot of discussions with states especially when implementing ambitious, thoughtful waivers. Now, many of our waivers are fairly cookie cutter. We have now 16 and counting reinsurance programs across states that are fairly straightforward to implement at this point and have had very positive impacts on premiums and affordability for consumers. But I will also note that we're very interested in partnering with states to put in place other sorts of waivers. I'll note that we have recently approved a waiver in Colorado to implement what they call the Colorado option. It has the effect of lowering premiums and healthcare costs within that state - putting in place a standard set of benefits available to all consumers across the state and it mandates the lowering of healthcare premiums over a course of three years. And so, we'll be working very closely with that state and the implementation of this waiver. Any of these Section 1332 innovation waivers requires legislative work. They require the passage of a law to point the state, and start the state down this process and often we can be helpful in helping make sure that all the required triggers in that law are there giving the state maximum flexibility to do what they want.

Regarding our regulatory agenda going forward, every year CCIO puts out a Notice of Benefit and Payment Parameters which is the main rule that governs payment parameters across the individual market in particular but the commercial market generally as last year's rule put in place or re-instituted standardized plan options on healthcare.gov as well as reinstated network adequacy provisions. Those are very significant provisions. We're going to be continuing to look very hard at the implementation of those provisions and any tweaking that is required there. I'll also note that our regulatory agenda as listed has pointed out the fact that we plan to regulate on short term limited duration plans and mental health parity in the coming months so you can expect that as well. Finally, I'll say just a sentence about individual coverage health reimbursement arrangements, ICHRA's, which continues to be a new form of coverage available to small businesses and any businesses as it allows them to have their employees select the coverage that's right for them in the individual market and have funds flow to those accounts. We're very interested in continuing to promote and monitor this market and we have put in place

a number of data collection mechanisms to allow us to track this more closely but we continue to be very interested in this and are also interested in partnering with states and private institutions on this front as well.

Sen. Beverly Gossage (KS) stated that I just want to say in our state I serve on the Bob Bethell Committee which is a committee that looks at these issues and our Medicaid program has already been all along looking to see who didn't qualify. This is not going to be a two year all of a sudden we're doing it. They know who they are, they already have the list. They have been keeping track of this all along anyway and I don't know if other states have been doing that, but I think that's a really good idea. We have a 12 month period to where they're going to look at the ones who probably have the highest income to take them off first, and take them off in a regimented way. So, I appreciate the discussion on that. And I just want to say as far as ICHRA's go, unfortunately there are so many regulations on that and with the subsidization of the ARPA funds that have gone to the marketplace you have very few people who would qualify for those. And then the last thing I'll say is in the marketplace, because we too have not expanded Medicaid, we find it easier for people who meet certain poverty level guidelines that they basically get a free private health insurance plan with \$250 total out of pocket - free doctor's visits, \$4 prescriptions and generics are free as well, and \$5 for specialist visits. So, they already have really low cost plan that they can buy. Mr. Wu replied yes and it's good coverage.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Rep. Oliverson, the Committee adjourned at 3:30 p.m.