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Cassandra Cole and Kathleen McCullough □  
Co-Editors

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The COVID-19 Pandemic and Health  
Insurance Regulation

*Joshua D. Frederick*  
*J. Bradley Karl*



National Association of  
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# The COVID-19 Pandemic and Health Insurance Regulation

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Joshua D. Frederick\*  
J. Bradley Karl\*\*

## Abstract

With projections of costs in the billions for COVID-19 treatments alone, and heightened scrutiny on COVID-19-related health insurance coverage, the National Association of Insurance Commissioners (NAIC) convened in March 2020 to discuss how the industry could best deal with a pandemic. While the ramifications of the COVID-19 event are in their infant stages, it is important to consider the implications such catastrophic risks have on an insurance market. We evaluate state-level changes presented by the NAIC in response to the COVID-19 pandemic and use prior research to offer insight into health insurance in a post-COVID-19 world. This manuscript aims to provide a summary of the NAIC's current standing during the pandemic, while presenting insight into policy implications regarding regulation in health insurance markets during catastrophic events.

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## I. Introduction and Background

On March 20, 2020, the NAIC convened as part of a special spring session to examine states' responses to the COVID-19 pandemic. The NAIC has historically offered comprehensive insight on insurer best practices, industry breakdowns and regulatory supervision. This special assembly, however, had a more specific purpose—to provide knowledge, assistance and information pertinent to the impact of the pandemic on the U.S. insurance industry. The March 2020 session offered information regarding general pathology, virus advancement and pandemic modeling. Following the meeting, the NAIC provided literature acknowledging the impact COVID-19 would have on various lines of business—life insurance, annuities, travel insurance and business interruption insurance.<sup>1</sup> However, a primary focus was the responsiveness of health insurance markets to the pandemic, as four of the six COVID-19 guidelines listed by the NAIC related to health insurance. The four guidelines were to: 1) maximize access to health coverage; 2) find ways to ease financial strain; 3) ensure coverage of important health benefits related to COVID-19; and 4) continue to protect consumers from fraud and other COVID-19 scams.

The health insurance industry had \$919.6 billion in direct written premiums in 2019, with total industry claims payouts of \$684.7 billion.<sup>2,3</sup> Therefore, it is not surprising health coverage continued to be a primary focus following the NAIC's March discussion. In fact, policy analysts for the NAIC outlined additional guidelines that states should follow during the pandemic, with two principles focusing on health insurance access and coverage specifically.<sup>4</sup> Among the summaries, newsletters and pamphlets, the NAIC further codified a list of state actions taken by states that provides a synopsis of regulatory actions in response to COVID-19. This NAIC document is the primary focus of our study.

The actions reported in the NAIC COVID-19 document for health insurance provide a summary of changes to cost sharing, telehealth, premiums and cancellations, prescriptions, special enrollment periods (SEPs), ratemaking, and form filing.<sup>5</sup> These compiled changes are all sanctioned actions that supplement current regulation in the health insurance market, but with the sole purpose of addressing patient care during the pandemic. The scope of these actions varies by state. The actions are classified by the NAIC Coronavirus Research Center as being an order, request or notice. The strictest actions are orders, which are actions that require, direct or instruct health insurers to take action. Requests are actions that

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1. *COVID-19 and Insurance*, NAIC, 2020.

2. *2020 Insurance Fact Book*, Insurance Information Institute, 2020.

3. This includes private health insurance, Medicaid, Medicare and accident/health written by life, annuity and/or property/casualty (P/C) insurers.

4. <https://www.bakertilly.com/insights/naic-special-session-on-covid-19>

5. Additionally, the federal Families First Coronavirus Response Act was signed into law by President Donald Trump on March 19, 2020. The law requires health insurers to provide full coverage (i.e., no cost sharing) for any U.S. Food and Drug Administration (FDA)-approved COVID-19 test.

ask, request or encourage insurers to act. Notices are actions that advise insurers or consumers of relevant information. From requiring insurers to provide both in- and out-of-network coverage cost sharing to form filing extensions up to 60 days, each order is indicative of a significant industry response to the pandemic.<sup>6,7</sup>

The goal of this paper is to provide a summary of each tier of changes listed in the NAIC COVID-19 document, while presenting insight into policy implications of said changes. To do this, we evaluate each category of state-level directives and use prior research to offer insight into what these changes in health insurance indicate for a post-COVID-19 world. The primary source of data guiding our discussion is the State Bulletin and Alerts Life and Health spreadsheets obtained from the NAIC's Coronavirus Resource Center.<sup>8</sup> The policy discussions have been separated into three sections: 1) health care costs; 2) health care services; and 3) health insurer filings. In each section, we consider each set of orders, provide an overview of the mechanics, discuss institutional details, and summarize relevant research in the area. We conclude the paper with a brief discussion on future policy implications.

## II. Health Care Costs

### *Consumer Cost Sharing*

Cost sharing in health insurance comes by way of deductibles, copayments and coinsurance. These contractual provisions offer insurers an avenue to control adverse selection while also maintaining equity amongst policyholders. While adequate cost sharing mitigates the effects of overuse,<sup>9</sup> suboptimal consumer cost sharing can lead to underutilization of health benefits, delay of care and higher rates of preventable illnesses (Baicker & Goldman, 2011). Lack of testing has remained a primary concern during the pandemic, and through the federal Families First Coronavirus Response Act (FFCRA) and the federal Coronavirus Aid, Relief, and

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6. As of May 2, 2020, New York requires insurers to offer full coverage of FDA-approved COVID-19 tests out-of-network.

7. Many states (e.g., Ohio, Oklahoma and South Carolina) extended statutory filing requirements by up to 60 days to allow insurers adequate time to prepare for shocks due to the pandemic.

8. We refer to the spreadsheet that was last updated Dec. 5, 2020. The NAIC Coronavirus Resource Center can be accessed via the following link: [https://content.naic.org/naic\\_coronavirus\\_info.htm](https://content.naic.org/naic_coronavirus_info.htm).

9. O'Grad et al., *The Impact of Cost Sharing on Emergency Department Use*, *The New England Journal of Medicine* (1985).

Economic Security Act (CARES), U.S. Food and Drug Administration (FDA)-certified COVID-19 tests are 100% covered by health insurers.<sup>10,11</sup>

Coverage extensions for testing are not the only important factor, however, as COVID-19 hospitalizations are often lengthy, with more extreme cases requiring dedicated care and in-patient services.<sup>12</sup> It is not unsurprising that costs related to caring for severely sick patients are on the forefront of discussions. In fact, some projections estimate COVID-19-related industry costs of \$17 billion, and \$10,000 at the per-patient level.<sup>13</sup> Therefore, more steps have been taken by the NAIC to ensure equitable cost sharing during the pandemic and that insureds have access to care. The proactive cost-sharing alterations are being implemented to increase the speed of delivery, reducing patient burden related to testing, treatment, primary care services, telehealth and future vaccines related to COVID-19.

Extant literature analyzing cost-sharing dynamics generally aims to tease out the negatives on both sides of the coin—namely the consequences of under and overutilization of services. High cost sharing can lead to underutilization, resulting in delayed care, preventative ailments becoming more serious and, ultimately, increasing health care costs in the long run. Moreover, reduced demand via increased cost sharing has also been shown to have little effect on overall health outcomes (Keeler, 1992). Conversely, lower cost sharing is associated with overutilization, resulting in increased moral hazard, with some markets experiencing higher spending and costs (Leibowitz, Manning, & Newhouse, 1985).<sup>14</sup> Therefore, an ideal cost-sharing plan would prevent moral hazard while not disincentivizing preventative measures. This is the primary tension in most insurance markets, and the perfect cost-sharing balance is often difficult to find in the presence of imperfect information (Pauly & Blavin, 2008).

With a pandemic, however, a push for overutilization may be warranted, as cost-sharing reduction provisions in the federal Affordable Care Act (ACA) led to increased flu vaccinations, which, in turn, reduces infection rates (Han et al., 2015). It is probable, therefore, that a similar approach may increase the likely hood of vaccinations, slowing the spread of the virus. Additionally, cost-sharing reductions in the 2006 Massachusetts health care expansion resulted in fewer hospitalizations for preventable conditions (Kolstad and Kowalski, 2012). Furthermore, reduced consumer cost sharing is associated with greater use of preventative clinical measures and overall reduced health care costs (Maciosek et al., 2010).

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10. The FFCRA, which was passed on March 18, 2020, states all health insurance plans must cover FDA-approved COVID-19 tests and costs associated with diagnostic testing.

11. The CARES act extends on the FFCRA and, among other things, expands protections to out-of-network testing facilities.

12. <https://www.kff.org/coronavirus-covid-19/issue-brief/five-things-to-know-about-the-cost-of-covid-19-testing-and-treatment/>.

13. <https://www.npr.org/2020/03/29/823438983/what-is-the-cost-of-covid-19-treatment>.

14. (Leibowitz, Manning, & Newhouse, 1985) find that overall drug expenditures are higher for insureds with more generous coinsurance, with increased drug purchases and prescriptions accounting for most of the effect.



Pursuant to the importance of cost sharing, the NAIC, state insurance commissioners and insurers have been working together to further reduce costs for insureds during the pandemic. The extensions vary across plans, with several providers waiving cost sharing for not only testing, but also treatment and telehealth visits. In fact, several insurers have even announced plans to extend coverage by eliminating all cost sharing for primary care visits related to COVID-19.<sup>15</sup> Additional variation exists within policy type as well, with cost-sharing differences existing across employer-sponsored, private and Medicare plans.<sup>16</sup>

Though the variation in cost sharing presents some discrepancies in coverage across individuals, the NAIC requires all plans cover testing to some extent in order to encourage preventative measures and quick identification of the virus. Some states have responded accordingly. For example, Georgia's insurance commissioner directed health insurers to reimburse COVID-19 testing labs using in-network rates, regardless of lab affiliation.<sup>17</sup> In light of new pharmaceutical developments, many states have preemptively moved to disallow cost sharing for any and all future vaccines.<sup>18</sup>

### *Premium and Cancellation Changes*

In order to maintain health insurance coverage, policyholders must make the required premium payments by the due dates specified in the policy. Depending on the regulations in a given state, most health insurers are required to give a short grace period (e.g., 30 days) such that if the premium is paid after the due date but within the grace period, the insured retains coverage (Rejda, McNamara, Rabel, 2020). Therefore, grace periods benefit the insured by restricting the ability of the insurer to immediately terminate health insurance coverage due to nonpayment of premium. From the perspective of paying health insurance premiums on time, the economic shutdown associated with COVID-19, therefore, represents a major issue for individuals and business struggling to pay bills—including health insurance premiums.

Many states have mandated or encouraged health insurers to offer leniency to policyholders who are unable to pay premiums on time during the pandemic. Currently, 36 states have taken at least one action aimed at reducing the burden of paying health insurance premiums on time. Maine enacted the first measure on March 12, 2020, and because some states took multiple actions, 55 actions have been taken across all states. All but four of these actions have been instituted by

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15. Effective May 13, 2020, Aetna will be waiving Medicare Advantage member out-of-pocket costs for all in-network primary care visits, for any reason, to encourage members to seek preventative care, <https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/>.

16. <https://www.healthaffairs.org/doi/10.1377/hblog20200413.783118/full/>.

17. *Directive 20-EX-4*, Georgia Office of Insurance and Safety Fire Commissioner, March 16, 2020.

18. NAIC, *A Report of the NAIC on the State Insurance Regulatory Response to COVID-19*, Update 2, September 2020.

insurance departments or insurance commissioners' offices. However, in Connecticut, Indiana, New Hampshire and New York, the governors have also issued an executive order pertaining to the payment of premiums and cancellation of health insurance policies.

The specific nature of these actions varies, but most actions specifically address the payment of health insurance premiums and are aimed at helping insureds maintain health insurance coverage during the period of financial uncertainty caused by COVID-19. For example, many actions restrict termination of health insurance coverage for nonpayment of premiums (e.g., Alaska Bulletin B 20-08; Delaware Bulletin 117). Other actions require or request that insurers extend the grace period (e.g., Illinois Company Bulletin 2020-11; Washington Emergency Order 20-02).

A variety of other actions have also been taken that aim to provide relief to policyholders. The NAIC indicates that 28 orders regarding premium payments and coverage cancellations have been issued, and the scope of these actions varies by state. For example, Alabama encouraged insurers to permit employers to continue covering employees under group health insurance policies even though the employee may have become ineligible due to decreases in hours worked per week brought on by COVID-19. Another example is Wisconsin, whose Office of the Commissioner of Insurance (OCI) has encouraged insurers to offer flexibility to policyholders via measures such as deferred premiums or premium holidays. Furthermore, Louisiana ordered that insurers must not cancel, non-renew or reinstate policies in effect as of March 12, 2020. Insurance Departments and governors have also made 25 requests pertaining to premium payments and cancellation. For instance, Indiana's governor made a request that insurers institute a 60-day moratorium on policy cancellations resulting from nonpayment of premiums. Only two states have issued notices, both of which relate to changing previously issued COVID-19 orders.

To a significant degree, the financial well-being of a health insurance company is dependent on the timely payment of premium. Premium/cancellation measures may further insulate policyholders from the true cost of health insurance, which could lead to increased adverse selection and moral hazard. If the prohibitions on policy cancellations (due to nonpayment of premiums) or the extended grace periods enacted during COVID-19 continue to this point, then insurance companies will be required to provide policyholders with short-term, interest-free premium loans. Currently, however, the NAIC notes that health insurers are not financially strained, are not exposed to significant liability risk<sup>19</sup> and do not face major liquidity constraints (Wong and Kaminski, 2020).

### *SEPs*

The ACA established open marketplaces for individuals to easily shop for health insurance. These marketplaces have annual open enrollment periods during

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19. NAIC, *A Report of the NAIC on the State Insurance Regulatory Response to COVID-19*, Update 2, September 2020.

which individuals may purchase health plans. Enrollment, however, is limited to reduce adverse selection. For those seeking plans outside of the open enrollment period, SEPs are offered in all state exchanges. SEPs are intended to provide amnesty to those who have lost coverage or eligibility due to elements beyond their control. To be eligible for SEPs, individuals must experience a qualifying event such as losing health insurance coverage, moving, getting married, having children, adopting children or losing Medicaid eligibility.

Specifically, regarding loss of health insurance due to unemployment, one of the primary economic factors in dealing with COVID-19 relates to job loss due to shutdowns and social distancing. In April 2020, the U.S. saw the highest unemployment rates since the Great Depression. In fact, severe spikes in unemployment have been observed to affect health insurance coverage (Gangopadhyaya & Garrett, 2020). This is particularly concerning as more than 70% of Americans have health insurance through their employers. While not all job loss also guarantees the loss of health coverage, coverage during the pandemic is likely to decrease significantly, with some projections suggesting as many as 27 million workers could lose health insurance due to COVID-19 (Garfield, Claxton, Damico, & Levitt, 2020). Loss of coverage during a pandemic could result in reduced testing and treatment, further complicating the crisis.

Taking into consideration the correlation between job loss and the uninsured rate, many states have offered enrollment extensions and/or SEPs specifically for job loss due to COVID-19. Marketplace enrollment periods have seen alterations in the past years, but generally in reductions rather than extensions.<sup>20</sup> While President Donald Trump did not extend SEPs at the federal level, the NAIC and state insurance regulators have promoted emergency extensions of SEPs for health insurance exchanges since the beginning of the pandemic.<sup>21</sup> The majority of states that chose to extend SEPs primarily offered enrollment during the onset of the pandemic. For example, Colorado, Connecticut and Minnesota offered enrollment through the months of March and April. The primary push, however, is to urge the federal government to extend open enrollment for the 2021 policy period, as only 12 states have extended SEPs as of September 2020.

### III. Health Care Services

#### *Telehealth*

According to the National Institutes of Health (NIH), telehealth is “broadly defined as the use of communications technologies to provide and support health

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20. Since 2017, the Trump administration has shortened open enrollment periods.

21. For example, Gov. Gretchen Whitmer of Michigan urged the federal government to permit SEPs during the pandemic.

care at a distance.”<sup>22</sup> The motivating idea behind telehealth is to facilitate a broad range of patient-to-provider or provider-to-provider interactions in a variety of settings, including the patient’s home, a clinic or a hospital (Weigel et al., 2020). The American Academy of Pediatrics (AAP) also notes that telehealth “encompasses a growing number of applications and technologies including two-way live or streaming video, videoconferencing, store-and-forward imaging along with the internet, email, smart phones, wireless tools and other forms of telecommunication.”<sup>23</sup> In this way, telehealth leverages technology in a way that promotes positive health outcomes in a remote environment.

Before the age of COVID-19, the use of telehealth was minimal, with some estimates suggesting that less than 3% of enrollees in large group health plans utilized telehealth services (Weigel et al., 2020). However, since the onset of the COVID-19 pandemic, there has been a rapid expansion of telehealth due to the fact that telehealth allows providers to meet the ongoing health care needs of patients in a socially distanced manner (Cubanski, 2020). For example, “virtual visits,” whereby a patient consults with a provider via phone or videoconference, can be used to address health concerns that are routine or not urgent in nature. According to Weigel et al., 2020, telehealth is also being used in many ways to directly treat/address COVID-19 issues.<sup>24</sup> Telehealth has, therefore, become an important tool for ensuring the health of patients during the epidemic.

Given the importance and increased demand for telehealth services during the COVID-19 pandemic, state insurance regulators have been forced to address policies pertaining to telehealth and the health insurance industry. Currently, 45 states have taken regulatory action as it relates to telehealth and health insurers. In total, 46 orders have been issued, 21 requests have been made, and 14 notices have been given related to telehealth. Many of these actions direct carriers to cover telehealth services that would otherwise have limited or no coverage. Many other actions also direct carriers to reduce or eliminate the imposition of cost sharing when telehealth is utilized.

### *Prescription Drug Coverage*

Access to prescription drugs during the COVID-19 crisis is often difficult, as many patients face difficulties in accessing prescription drugs out of fear of contracting the virus. Moreover, this procurement difficulty often disproportionately affects lower income, elderly, chronically ill or high-risk patients. And while certain coverages must provide a three-month minimum of

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22. <https://www.nibib.nih.gov/science-education/science-topics/telehealth>.

23. <https://www.aap.org/en-us/professional-resources/practice-transformation/telehealth/Pages/What-is-Telehealth.aspx>.

24. For example, a patient with mild respiratory symptoms may receive a telehealth evaluation. Also, an asymptomatic patient who had contact with an infected person may wish to have a virtual consultation with a physician. A quarantined provider may also continue to see patients virtually using telehealth.

supplies for prescription drugs, this is not federally mandated for all plans.<sup>25</sup> Therefore, the NAIC and state insurance commissioners have focused on utilization management, ensuring those in need can have their prescriptions filled.

While the immediate importance of prescription drug coverage is not as imperative as testing and mitigating spread, the secondary effects of reduced access to medication can lead to higher expenditures and reduced quality of care (Copeland, 1999). Many Americans rely on medication for physical and mental well-being,<sup>26</sup> and limited access can lead to reduced care, health status and increased reliance on more costly services (Soumerai, 2004). Therefore, most state insurance offices, in conjunction with NAIC suggestions, formed significant changes to current coverages regarding prescription drugs and other pharmaceutical needs. For most states, the focus is primarily on maintaining supply to insureds and ensuring there are no short- or long-term supply chain disruptions from pharmaceutical companies to patients.

In order to preserve supply and reduce supply chain interruptions, current NAIC guidelines and state mandates focus on ensuring prescription drug access, commonly requiring that insurers provide continuing access to medications, such as prescriptions for chronic illnesses and treatments for opioid disorders. Insurers are encouraged to offer lengthened refills, allowing customers to have extended access to medications. For example, Michigan requires that insurers allow up to a 90-day supply for all maintenance drug prescriptions.<sup>27</sup> In addition to refill extensions, insureds also have expanded access to home delivery or mail order for their prescription needs to encourage social distancing and protect at-risk populations. State insurance regulators also have required that insurers waive prior authorization requirements for ongoing treatment needs and expand access to off-formulary prescription medications.<sup>28</sup>

The alterations to prescription drug access are likely not long-lasting and will presumably fade out once the current crisis subsides. This is predominantly due to the risk of overutilization or abuse of prescription drugs. While it is true that protecting at-risk populations during a pandemic is imperative to public health, extended access to certain opioids has been shown to negatively affect populations if there are little to no monitoring tools in place (Gugelmann & Perrone, 2011). Therefore, as the prescription drug changes stand now, it is likely that prescription refills and remote prescription coverage will revert to pre-COVID measures.

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25. Specific federal law for Medicare Part D and Medicare Advantage plans here relaxing any “refill-too-soon” policies.

26. From 2013–2016, the U.S. Centers for Disease Control and Prevention (CDC) noted 48.4% of American adults used a prescription drug at least once in the past 30 days.

27. Executive Order No. 2020-25, State of Michigan (2020).

28. Sabrina Corlette and Madeline O’Brien, *State Action Related to COVID-19 Coverage of Critical Services by Private Insurers*, <https://www.commonwealthfund.org/publications/maps-and-interactives/state-action-related-covid-19-coverage-critical-services-private>.

## IV. Health Insurer Filings

### *Rate and Form Review*

The regulation of insurance rates and forms is a central aspect of the insurance regulation process and constitutes one of the most significant responsibilities of insurance departments in each state. The regulation of insurance prices and products carries significant public policy relevance, as it has a direct impact on the cost of insurance, the supply of insurance and the overall health of the insurance marketplace (e.g., Ippolito, 1979; Grabowski et. al., 1989; Barrese, et. al., 2009; Harrington, 2010; Cole and Karl, 2015 and 2019; Born et. al., 2020). As it relates specifically to health insurance rate/form regulation, the COVID-19 pandemic necessitated a degree of regulatory attention. Alaska was the first state to take an action that addressed COVID-19 and price/product regulation. The NAIC indicates that 26 states have taken at least one action, and a total of 34 actions have been taken across all states. Of these actions pertaining to rate and form review, six were orders, nine were requests, and 18 were notices.<sup>29</sup>

Many of these actions appear to be borne out of the social distancing guidelines brought about by COVID-19 and often direct insurers to some form of electronic filing. For example, Illinois requested that communications with the Department of Insurance (DOI) be sent via email. In a similar vein, other states, such as Tennessee and Virginia, requested all filings be made electronically. However, a smaller number of actions have been more substantive with respect to the rate filing process and outcomes for insurance consumers. For example, some states, such as Colorado, have issued guidelines regarding the filing process for insurance companies seeking to provide premium discounts or relief during the COVID-19 pandemic. Other states, such as Alaska and Nebraska, have provided guidance regarding filing deadlines. Probably the most significant action relates to the small number of states, including Kansas and Wisconsin, that have removed the deemer provision for filings that would have normally be considered approved in the absence of the pandemic.

The move towards online filing is not particularly new, as many insurers were already communicating and completing the rate filing process using electronic means pre-COVID-19 using the System for Electronic Rate and Form Filing (SERFF). SERFF, formed in 2013, is an online system that enables rate and form filings and is commonly used, processing more than 550,000 transactions in 2019.<sup>30</sup>

What appears to be more substantial, however, is that COVID-19 led some states to remove the deemer provision, which will inevitably slow the rate/form filing process down for some insurers. More specifically, deemer provisions apply to states that allow insurers to file rate increases, and if no action is taken by the commissioner in regards to the disposition of the request within a pre-specified time

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29. Kentucky took an action that was not classified as an order, request or notice by the NAIC.

30. Proposal RFP-#2701, *SERFF Modernization – Mobilization and Pilot Phase*, NAIC, November, 2020.

period (e.g., 60 days, etc.), the rate change is deemed as approved.<sup>31</sup> If the deemer provisions are not restored, insurers in affected states will be required to wait for formal approval rather than deeming the requested product/price to be approved and ready for use in the marketplace.

### *Statutory Filings*

The NAIC requires that any insurer authorized to do business in the U.S. prepare statutory financial statements in accordance with Statutory Accounting Principles (SAP) guidelines. Though using a structure similar to that of generally accepted accounting principles (GAAP), SAP guidelines are chiefly devised to help with insurer solvency regulation. In light of COVID-19, the 2020 Statutory Accounting Principles (E) Working Group held a session as part of its annual meeting dedicated to COVID-19-related filing issues.<sup>32</sup> The Working Group noted that many jurisdictions suggested working from home and/or required social distancing in the workplace. Subsequently, the NAIC acknowledged it is in the public interest to provide extensions on statutory filings in order to ease the transition to meet any social distancing and/or telework requirements.

Before the Working Group meeting, however, some states had already offered filing extensions due to limitations related to COVID-19. The changes proposed span the bulk of forms required by the NAIC, as well as many ancillary filing documents (e.g., prior approval forms, rates, file and use, etc.). The state changes to filing forms vary drastically. Many states recommended insurers file electronically (Arkansas, California, Colorado), some states extended review periods for certain filings (Alaska extended review periods for rate, form, and advertisement filings), while some prohibited insurers from cancelling policies due to nonpayment. Currently, there are no reports of insurers struggling to meet states' extended filing guidelines.

## **V. Conclusion**

COVID-19 had an impact on virtually every aspect of the economy, and the health insurance industry is no exception. As a result, the NAIC took a variety of regulatory actions toward health insurers. The majority of these actions focused on consumer cost sharing, telehealth, premiums/cancellations, SEPs, rate and form

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31. According to the International Risk Management Institute (IRMI), a deemer period is “a term used in connection with rate and form approval laws in states that regulate rates and forms via the ‘file and use’ system. Insurers file rates and forms and, if not disapproved within a certain length of time (the “deemer period”), then the rates are ‘deemed approved.’” <https://www.irmi.com/term/insurance-definitions/deemer-period>.

32. Session 4 of the Statutory Accounting Principles (E) Working Group detailed changes regarding filing, debt restructuring and investment income form extensions due to the impact of COVID-19.

reviews, and statutory filings. In this article, we summarize the actions taken by the NAIC in the hopes of easily distilling the information in a manner that informs policymakers, state insurance regulators and insurance consumers. Where applicable, we also comment on the potential influence that various regulations may have on the health insurance marketplace.

Currently, the NAIC remains engaged with federal agencies, such as the federal Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS), to provide a forum for coordination between state and federal policy efforts targeting health insurance. Moreover, the NAIC continues to be directly involved with federal lawmakers to ensure that congressional efforts to stabilize or support health insurance markets are efficiently communicated. Per the NAIC's most recent COVID-19 report, this involvement with federal agencies and U.S. congressional leaders is intended to persist so long as the COVID-19 pandemic continues to be a significant public health concern.<sup>33</sup>

While many of the changes implemented by states are intended to be temporary and focused on consumer advocacy, long-term changes may be needed, and some consideration to the health insurance market may be required. While not currently an issue for health insurers, the effects of extending current COVID-19 orders may result in financial constraints over the long term. For example, if moratoriums on deemer provisions and other rate restrictions remain in place for an extended period of time, insurers will likely experience more difficulty raising prices. Even putting aside the additional price regulatory constraints, other regulatory actions, such as required coverage for telehealth visits or mandated reduction in consumer cost-sharing measures, may affect insurers' underwriting and pricing decisions if these actions remain in effect during an extended period of time. Whether or not the nature of the NAIC and state commissioner orders will provide better quality care and/or result in financial complications for health insurers require more time and data. Such inquiries are beyond the scope of this study but may be a productive research avenue for scholars in the future.

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33. NAIC, *A Report of the NAIC on the State Insurance Regulatory Response to COVID-19*, Update 2, September 2020.



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