HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Draft Pending Adoption

Draft: 12/15/25

Health Insurance and Managed Care (B) Committee
Hollywood, Florida
December 11, 2025

The Health Insurance and Managed Care (B) Committee met in Hollywood, FL, Dec. 11, 2025. The following Committee members participated: Glen Mulready, Chair (OK); Ann Gillespie, Co-Vice Chair, represented by Adam Flores (IL); Grace Arnold, Co-Vice Chair (MN); Trinidad Navarro represented by Susan Jennette (DE); Dean L. Cameron (ID); Marie Grant (MD); Anita G. Fox (MI); D.J. Bettencourt (NH); Alice T. Kane represented by Viara Ianakieva and Alejandro Amparan (NM); Jon Pike (UT); Kaj Samsom represented by Mary Block (VT); Patty Kuderer (WA); and Allan L. McVey and Joylynn Fix (WV). Also participating were: Heather Carpenter (AK); Peter M. Fuimaono (AS); Sterling Gavette (AZ); Martin Sullivan (GA); Doug Ommen (IA); Michael T. Caljouw (MA); Robert L. Carey (ME); Angela L. Nelson (MO); and Cassie Brown (TX).

1. Adopted its Nov. 20 and Summer National Meeting Minutes

The Committee met Nov. 20. During this meeting, the Committee took the following action: 1) adopted its 2026 proposed charges, including the 2026 proposed charges for the Consumer Information (B) Working Group and the Health Innovations (B) Working Group; and 2) adopted the 2026 proposed charges for the Health Actuarial (B) Task Force, the Regulatory Framework (B) Task Force, and the Senior Issues (B) Task Force.

Commissioner Arnold made a motion, seconded by Commissioner Pike, to adopt the Committee's Nov. 20 (Attachment One) and Aug. 13 minutes (*see NAIC Proceedings – Summer 2025, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

2. Adopted the Reports of its Working Groups and Task Forces

Commissioner Arnold made a motion, seconded by Fix, to adopt the following task force and working group reports: 1) Consumer Information (B) Working Group, including its Oct. 31 (Attachment Two), Oct. 23 (Attachment Three), Oct. 3 (Attachment Four), Oct. 3 e-vote (Attachment Five), and Aug. 11 (Attachment Six) minutes; 2) Health Innovations (B) Working Group; 3) Health Actuarial (B) Task Force; 4) Regulatory Framework (B) Task Force; and 5) Senior Issues (B) Task Force. The motion passed unanimously.

3. Adopted the *Prior Authorization White Paper*

Commissioner Arnold said the Regulatory Framework (B) Task Force met Dec. 10. During this meeting, the Task Force adopted the *Prior Authorization White Paper*, which the Committee and NAIC leadership directed the Task Force to develop by the end of this year. She discussed the Task Force's work in developing the white paper.

Commissioner Arnold said that, as discussed at the Task Force's meeting at the Summer National Meeting, the Task Force exposed an initial white paper draft in July for a public comment ending Aug. 29. The Task Force met Sept. 22 to discuss the comments received. She said that following the Sept. 22 meeting, the Prior Authorization (PA) Drafting Group, which developed the initial white paper draft, reviewed the comments to consider which, if any, to incorporate into a revised white paper draft. She said that, in October, the Task Force exposed a revised white paper draft reflecting the Aug. 29 comments received for a public comment period ending Nov. 19. She said the white paper adopted by the Task Force incorporates some of the suggested revisions included in the Nov. 19 comments.

Commissioner Arnold stated that the white paper before the Committee for adoption today provides a comprehensive overview of PA in healthcare, detailing: 1) its purpose; 2) its processes; 3) consumer, provider, and insurer perspectives on PA; 4) state PA reform efforts; and 5) PA regulatory frameworks. She said the Task Force intends for the white paper to guide state insurance regulators in understanding legislative options to reform PA processes and believes the white paper will serve as an informative resource for regulators, policymakers, and industry stakeholders aiming to understand and improve PA systems to balance cost containment, patient safety, and administrative efficiency. Commissioner Arnold explained that the white paper does not extensively cover artificial intelligence (AI) in PA but offers support for future AI-related discussions.

Commissioner Arnold said that since the Task Force adopted the white paper on Dec. 10, she has heard from some states that the section in the white paper highlighting state PA reform efforts does not include information about their state's PA laws. She acknowledged the white paper is a snapshot in time and, as such, will not include state PA reform efforts moving forward. She said she will work with NAIC committee support to develop a way to track and update, as needed, information on state PA reform laws.

Director Fox made a motion, seconded by Jennette, to adopt the *Prior Authorization White Paper* (Attachment Seven). The motion passed unanimously.

4. Heard a Presentation from the CHIR on State-Level Actions to Mitigate Projected Coverage Losses and Premium Impacts from H.R. 1 and Other Federal Changes Impacting the Individual Market

Lucy Culp (Blood Cancer United) said the NAIC consumer representatives are pleased to share a new report titled *Recommendations for States' Efforts to Mitigate Harms Caused by Federal Actions* with the Committee. She said that Blood Cancer United, on behalf of the NAIC consumer representatives, contracted with the Center on Health Insurance Reforms (CHIR) to conduct research and develop the report. Culp said the report examines the impact of federal policy changes on health insurance access and affordability. She said that, as many of the Committee members know, the federal Congressional Budget Office (CBO) is estimating that, between legislative and regulatory changes at the federal level, 10 million people are expected to lose either Medicaid or Affordable Care Act (ACA) Marketplace coverage. Over the next decade, the CBO anticipates that another four million will lose coverage and become uninsured. Culp said the report details how state insurance regulators can mitigate those harms in meaningful ways, protecting consumer access to affordable, high-quality coverage and access to care.

Sabrina Corlette (CHIR) discussed the federal changes that will lead to unprecedented coverage losses for consumers. She said the first change, which will lead to coverage losses, is the loss of enhanced premium tax credits if Congress allows those credits to expire at the end of the year. She said that without these credits, some consumers will not be able to afford coverage. She said other changes, such as new documentation requirements for Special Enrollment Periods (SEPs), shorter open enrollment periods (OEPs), and the end of automatic re-enrollment, will lead to coverage losses because of the increased red tape.

Corlette described the options the states have to mitigate those losses, including: 1) providing state financial help through subsidy wraps, which 11 states and the District of Columbia currently provide; and 2) establishing a Basic Health Program (BHP), which three states and the District of Columbia have established. Corlette said that for states that operate their own ACA Marketplace (i.e., state-based marketplaces [SBMs]), other options they can take are through changes in ACA Marketplace policies, such as establishing facilitated enrollment, flexible enrollment opportunities, and standardized plans. She also discussed other options states can take to mitigate coverage losses through insurance regulation, such as preventing insurers from denying coverage solely because of past-due premiums and continuing to require plans to price for cost-sharing reductions via on-Marketplace silver plans (or silver loading). Corlette discussed other state options involving consumer communications and engagement and market oversight.

5. Heard a Presentation from Wakely on the Emerging 2025 Individual Market Risk Pool

Michelle Anderson (Wakely Consulting Group—Wakely) and Michael Cohen (Wakely) discussed: 1) the 2026 market framework; 2) the 2025 individual market framework morbidity; 3) medical trends in the individual market and commercial market; and 4) key considerations and uncertainties going forward.

Anderson provided a snapshot of the 2026 market and the drivers causing the highest premium rate changes since 2018. Those drivers include: 1) 2025 emerging experience and a sicker population; 2) trend patterns; 3) inflation; 4) rate correction from prior years; 5) regulatory changes, including the enhanced premium tax credit expiration; 5) expensive medications, such as glucagon-like peptide-1s (GLP-1s); and 6) uncertainty.

Anderson next discussed the 2025 changes in morbidity in the individual market. She said Wakely's analysis of the changes supported many health carrier findings. For the 2025 period analyzed (January through July of 2025), Wakely continues to see a dramatic increase in overall relative risk of 6.8% from 2024 to 2025, with the federally facilitated marketplaces (FFMs) having higher increases. She said ACA Marketplace enrollment continued to increase, but morbidity continues to increase, which she said could be due to the impacts from Medicaid redeterminations, which were required when Medicaid continuous enrollment ended in April 2023 due to the end of the public health emergency (PHE) declared for the COVID-19 pandemic. She noted that historically, higher enrollment increases are correlated with lower morbidity. Anderson discussed the change in the percentage of enrollees with claims from July 2024 to July 2025. She noted that this is a distinct change from the trend in the reduction in the number of people with claims that occurred since the introduction of the enhanced premium tax credits.

Cohen discussed the general drivers of trends from 2024 to 2026. He explained that persistent inflationary pressure on provider costs, especially hospital labor and supplies, continues to push the unit cost trend upward across all years. He noted that the pharmacy trend remains highly influenced by specialty drugs and GLP-1s. Cohen discussed the implications of these trends for 2027.

Director Cameron asked Anderson about the differences between the SBMs and FFMs regarding the changes in relative risk and changes in the percentage of enrollees with claims. Anderson said that a possible driver of that difference is the availability of more no-cost gold plans and low-cost silver plans in the FFMs. However, because of the type of data collected, Cohen said Wakely cannot be certain if those are the drivers because it could also be the disproportional impact of Medicaid redetermination on the FFMs, rather than the SBMs. He said there could also be operational differences between FFMs and SBMs that cause this difference, or something else Wakely has not been able to pinpoint at this time. The Committee discussed this issue and decided that it merited follow-up with Wakely in the future, once more data has been collected.

Gavette asked about the trend in overall pharmacy utilization. Cohen said the 2024 data show an overall 9% trend increase, with GLP-1s and specialty drugs driving the trend. He stated that when it obtains the full data for 2026, Wakely plans to re-examine the numbers.

Superintendent Carey asked how much confidence Wakely has in the numbers to date because they only reflect data from the first six months of 2025. Anderson said there are a lot of caveats when looking at partial-year data. She noted, however, that, like what happened in 2025, even the partial year data shows that there were significant shifts and deviations from what carriers nationally had assumed. She stated that, regardless, it is more of an art than a science in making these assumptions. Cohen said that, in addition, the Committee should keep in mind that, when thinking about 2027, there is a two-year lag, and the starting point is 2025.

Commissioner Mulready asked for clarification on rate corrections. Cohen said that when carriers set rates in 2025, they were using 2023 data and assumptions. As such, carriers make corrections later. Superintendent Carey

suggested that with Wakely's assistance, the Committee should consider developing a common data template that the states can use for their individual markets.

Director Fox asked about Wakely's funding sources. Anderson said carriers fund Wakely for its risk adjustment project. She said carriers voluntarily submit their data to Wakely. She discussed the parameters of such data collection to ensure its credibility. Anderson said she believes Wakely's data is representative of national numbers.

6. Heard an Update from the CCIIO on its Recent Activities

Peter Nelson (Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO's recent activities of interest and priorities. He discussed the federal Centers for Medicare & Medicaid Services' (CMS's) recently released enrollment snapshot. He said the 2026 enrollment snapshot, which was released Dec. 5, showed that nearly 950,000 consumers who do not currently have health care coverage through plans in the individual market ACA Marketplace have signed up for coverage in 2026, since the start of the Marketplace OEP on Nov. 1. Existing consumers are also returning to the Marketplace to actively renew their coverage, and anyone who does not actively renew will be automatically re-enrolled for 2026. Over 4.8 million existing consumers have already returned to the Marketplace to select a plan for 2026.

Nelson explained that the proposed federal U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2027 rule has been delayed, but he is hopeful that it will be released soon. Nelson also discussed the CCIIO's work to stabilize the individual market. He urged state insurance regulators to think about using the flexibility and state innovation opportunities provided through ACA waivers, such as the Section 1332 and Section 1333 waivers, to also stabilize their individual markets.

Director Fox asked how the CCIIO identifies individuals to be removed from the Marketplace rolls because they have no claims, under the assumption that they did not know they had coverage. She said there are individuals who have no claims because they are young and healthy, and others who, because of other situations, do not seek care but still want coverage. She also asked how the proposal to provide health savings accounts (HSAs) to individuals would work because HSAs are typically associated with group coverage. Nelson said the CCIIO uses the same processes it has used in the past to identify these individuals, such as through consumer complaints and periodic data matching for Medicaid. He said that with respect to the question about HSAs, it is envisioned that access to HSAs would be coupled with catastrophic plans or bronze plans, which would create a new level of affordability for some consumers.

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

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Draft: 11/25/25

Health Insurance and Managed Care (B) Committee
Virtual Meeting
November 20, 2025

The Health Insurance and Managed Care (B) Committee met Nov. 20, 2025. The following Committee members participated: Glen Mulready, Chair (OK); Ann Gillespie, Co-Vice Chair (IL); Grace Arnold, Co-Vice Chair (MN); Trinidad Navarro represented by Susan Jennette (DE); John F. King represented by Steve Manders (GA); Dean L. Cameron represented by Weston Trexler and Shannon Hohl (ID); Marie Grant (MD); Anita G. Fox (MI); D.J. Bettencourt represented by Brenda Golden Hallisey (NH); Alice T. Kane represented by Brittany O'Dell (NM); TK Keen (OR); Jon Pike (UT); Kaj Samsom represented by Anna Van Fleet and Christine Menard-O'Neil (VT); Patty Kuderer (WA); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its Task Forces' 2026 Proposed Charges

Commissioner Mulready said the Committee's first item of business was to consider adoption of its task forces' 2026 proposed charges. He said that prior to this meeting, committee support distributed the task forces' 2026 proposed charges and posted them on the Committee's web page. He said the Health Actuarial (B) Task Force adopted its 2026 proposed charges Oct. 20; the Regulatory Framework (B) Task Force adopted its 2026 proposed charges Oct. 20; and the Senior Issues (B) Task Force adopted its 2026 proposed charges Oct. 24.

Commissioner Pike made a motion, seconded by Director Fox, to adopt the task forces' 2026 proposed charges. The motion passed unanimously.

2. Adopted its 2026 Proposed Charges

Commissioner Mulready said committee support distributed the Committee's 2026 proposed charges and posted them on the Committee's web page prior to the meeting. He said its 2026 proposed charges are the same as its 2025 charges. Commissioner Mulready said the Committee received one comment letter from the NAIC consumer representatives on the Committee's 2026 proposed charges, suggesting revisions to the proposed charges for the Committee, Consumer Information (B) Working Group, Health Innovations (B) Working Group, and Senior Issues (B) Task Force.

Amy Killelea (Killelea Consulting) said that to continue the work of the Health Workstream under the former Special (EX) Committee on Race and Insurance, the NAIC consumer representatives suggest that the Committee add a charge similar to a charge adopted by the Regulatory Framework (B) Task Force to: "Examine factors contributing to disparities in coverage and affordability and recommend appropriate steps to reduce those disparities." The Committee discussed the suggested language. Although some Committee members expressed support for the suggested charge, others suggested that the charge should be more general, as the Regulatory Framework (B) Task Force has already adopted a similar charge. After additional discussion, the Committee agreed to add a new charge with the following language: "Continue to support efforts to address disparities in coverage and affordability and recommend appropriate steps to reduce those disparities." Killelea said the NAIC consumer representatives also suggest that the Committee expand its charge 1F to examine rising health care costs and cost drivers, as well as factors that contribute to coverage losses. The Committee agreed to accept the suggested revision.

Killelea said the NAIC consumer representatives suggest that the Consumer Information (B) Subgroup add a new charge to: "Identify communication goals, strategies, and tactics to reach communities that experience inequities in health insurance access, including through partnerships with community-based organizations." After discussion, the Committee agreed to add the new charge. Killelea said the NAIC consumer representatives suggest revising the Health Innovations (B) Working Group's charge 3B to include discussing state innovations related to health care that reduce disparities in coverage and affordability. Commissioner Grant, who serves as chair of the Health Innovations (B) Working Group, expressed support for the suggested revisions.

Killelea said the NAIC consumer representatives also suggested revisions to the Senior Issues (B) Task Force's 2026 proposed charges. After discussion, the Committee decided to defer consideration of the suggested revisions because the Task Force has already adopted its 2026 proposed charges, and as such, the Task Force members have not had the opportunity to discuss the suggested revisions. The Committee suggested that after the Task Force is reestablished in 2026, the NAIC consumer representatives reach out to the Task Force's 2026 chair and vice chair for consideration of their suggested revisions.

Commissioner Pike made a motion, seconded by Commissioner Grant, to adopt the Committee's 2026 proposed charges, including the revisions to the Consumer Information (B) Working Group's and the Health Innovations (B) Working Group's 2026 proposed charges (Attachment One-A). The motion passed unanimously.

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

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Adopted by the Executive (EX) Committee and Plenary, Dec. __, 2025
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 20, 2025

2026 Proposed Charges

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

The mission of the Health Insurance and Managed Care (B) Committee is to consider issues relating to all aspects of health insurance.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
   A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC's position through letters and testimony, when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   C. Monitor the activities of the Regulatory Framework (B) Task Force.
   D. Monitor the activities of the Senior Issues (B) Task Force.
   E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
   F. Examine factors that contribute to rising health care costs and insurance premiums as well as coverage losses. Review state initiatives to address cost drivers, consumer affordability, and coverage continuity.
   G. Continue to support efforts to address disparities in coverage and affordability and recommending appropriate steps to reduce those disparities.
   ~~G~~H. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   ~~H~~I. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.

2. The **Consumer Information (B) Working Group** will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.
   C. Identify communication goals, strategies, and tactics to reach communities that experience inequities in health insurance access, including through partnerships with community-based organizations.

3. The **Health Innovations (B) Working Group** will:
   A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE (*continued)*

B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision making, and health care delivery and financing models—to achieve better patient outcomes, reduce disparities in coverage and affordability, and lower spending trends.
C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

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Draft: 11/10/25

Consumer Information (B) Working Group
E-Vote
October 31, 2025

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Oct. 31, 2025. The following Working Group members participated: David Buono, Chair (PA); TJ Patton, Vice Chair (MN); Anthony L. Williams (AL); Debra Judy (CO); Terri Smith (MD); Jeana Thomas (MO); Donna Dorr (OK); Jill Kruger (SD); Vickie Trice (TN); Shelley Wiseman (UT); and Andrew Davis (WA).

1. Adopted Revisions to the *Frequently Asked Questions About Health Care Reform* Document

The Working Group conducted an e-vote to consider adoption of the *Frequently Asked Questions About Health Care Reform* document (Attachment Two-A). The document provides state insurance department staff information about the Affordable Care Act (ACA) and related policies to aid in responding to consumer questions. The Working Group revises the document each year to keep it up to date. The motion passed unanimously.

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

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FREQUENTLY ASKED QUESTIONS ABOUT HEALTH CARE REFORM

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PURPOSE

This document is designed for state insurance departments to use as they give answers to frequently asked questions (FAQ) and guide consumers about their health care choices. This document reflects regulations and guidance received from the federal government as of October 2025 and is subject to change by legislation, regulation, or legal decision.

This document isn't intended to be given directly to consumers. States will need to modify this document to include state-specific information and terminology. Content in [brackets] must be edited to provide state-specific information. Drafting notes indicate where states may choose to add additional clarity on state policies. While some sections may be useful for direct-to-consumer communications, the document's primary purpose is to give insurance department staff accurate and understandable information to use when they respond to consumer questions about health care reform. **For 2026, changes to premiums and tax credits make it especially important to encourage consumers to review their options by visiting the exchange website to view available plans or consulting a producer, navigator, or certified application counselor.**

Note that the federal Affordable Care Act (ACA) and related regulations refer to "exchanges" that operate in the states, while federal guidance documents refer to these exchanges as "marketplaces." This document uses the term "exchanges." However, some states may decide to follow federal guidance and use the term "marketplaces."

Note, also, that states will need to modify the FAQs if the state has combined the exchange for individuals and families with the Small Business Health Options Program (SHOP) exchange.

HEALTH CARE REFORM OVERVIEW

Health care has changed in many ways as a result of the passage and implementation of the Patient Protection and Affordable Care Act, Public Law 111-148 (PPACA), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152). These two laws are collectively known as the ACA**.**

Q 1: When did the ACA take effect?

The ACA was enacted March 23, 2010.

Q 2: What changes have taken place?

Several changes took place before January 1, 2014:

- Lifetime and annual dollar limits on essential health benefits (EHB) were no longer allowed. Annual dollar limits on EHB were also phased out by January 1, 2014.
- Consumers were guaranteed certain appeal rights.
- Nearly all adult children up to age 26 became eligible to remain on a parent's health insurance policy, regardless of the child's marital status, financial dependency, enrollment in school, or place of residence.
- Insurers must cover certain preventive services without cost-sharing. (See Question 24.)
- Medical loss ratio (MLR) standards limited how much of the premium dollars insurers collect they can spend on administrative expenses.
- Many insurers must use a standardized Summary of Benefits and Coverage (SBC), which makes it easier to compare plans.
- Small businesses that provide health care for employees could apply for a tax credit.

- Beginning in 2023, consumers in a Medicare Part D standard plan no longer faced a donut hole, but cost-sharing may vary for other plans.

Several major changes became effective for non-grandfathered individual and small group plans sold or renewed on or after January 1, 2014:

- Plans must include new consumer protections. Health insurers can't deny or refuse to renew coverage because of a pre-existing medical condition. They also can't charge a higher premium due to a person's gender or health condition.
- Insurers must cover routine medical costs if a person participates in a clinical trial for cancer or other life-threatening diseases.
- Many, though not all, insurance plans must cover a minimum set of essential health benefits (EHB) and can't put annual dollar limits on these benefits.
- Individuals and families may qualify for financial assistance when they shop in the health insurance exchanges. The American Rescue Plan Act increased the amount of financial assistance and removed the income limit of 400% of the federal poverty limit to qualify for assistance for 2021 and 2022. The increased amounts of assistance were extended with the Inflation Reduction Act to be available through the end of 2025.
- In the small group market, from the period November 15 to December 15 each year, small employers can purchase coverage for their workers for the following year without having to meet minimum participation or minimum contribution requirements.

Note: Plans sold before March 23, 2010 that have had no significant changes are considered "grandfathered" and aren't required to comply with many of these requirements. (See Questions 31 and 32 on grandfathering.) Additionally, plans sold before January 1, 2014 may—if allowed by the state—continue to be renewed without coming into compliance with certain reforms. (See Question 32 on transitional plans.)

Q 3: Where can a person find more information about the ACA, including detailed timeline information?

For more information about the ACA and its key provisions, visit the federal government's website at *www.healthcare.gov*, or call 1-800-318-2596 (TTY: 1-855-889-4325).

For information about implementation of the ACA in [insert name of state], contact [insert name of state exchange] at [email address] or [xxx-xxx-xxxx].

There are also several other helpful sites and resources for more information about the ACA, including: Kaiser Family Foundation (*https://www.kff.org/affordable-care-act/*); Commonwealth Fund (*https://www.commonwealthfund.org/health-care-coverage-and-access*); the Georgetown Center on Health Insurance Reforms (*https://chir.georgetown.edu/#*); and the Center on Budget and Policy Priorities (*www.healthreformbeyondthebasics.org*).

Q 4: Do the consumer protections of the ACA apply to all health coverage?

No, the ACA consumer protections don't apply to all health coverage. The ACA largely established new protections in the individual and small group markets, which includes policies sold through the exchanges in every state. Health coverage sold outside of the individual or small group markets, or that is not considered insurance, may not be required to comply with some or any of these protections.

Consumers may have questions about several types of coverage other than the qualified health plans sold through exchanges.

- Short-term, limited duration insurance. Several protections applicable in the individual market do not apply to short-term, limited duration insurance. However, state law or regulation may add some protections. Because the ACA does not apply, these plans may do any or all of the things in the list below, unless prohibited by state law or regulation:
    - deny coverage or increase premium due to health status,
    - exclude essential health benefits,
    - refuse renewal,
    - limit coverage of pre-existing conditions,
    - establish annual or lifetime benefit maximums,
    - set a yearly out-of-pocket maximum above $10,600 for an individual, or
    - exceed medical loss ratio standards without rebating premium.

  *[**NOTE:** Beginning September 1, 2024, federal rules prohibit the sale of short-term plans that provide more than three months of coverage, with a maximum one-month extension. However, in August 2025, federal agencies announced they would not prioritize enforcement of these rules.]*
- Association health plans. Depending on the structure of the association and state law, consumer protections in the individual, small group, or large group market plans may apply to association health plans.
- Health care sharing ministries or similar arrangements. These coverage arrangements are **not** considered to be insurance, so the requirements and protections described in this FAQ do not apply.
- Fixed indemnity insurance. The requirements and protections described in this FAQ generally do not apply.

Drafting Note: States may want to add more details about state-level protections that apply to the coverage types mentioned in the bullets above.

EXCHANGE BASICS

Q 5: What is the [insert name of state health insurance exchange]?

The [insert name of state exchange] is the name of [insert name of state]'s health insurance exchange. The ACA created health insurance exchanges as places where individuals, families, and small employers can compare private health insurance plans and shop for coverage. Exchanges also provide access to premium tax credits to help individuals pay for coverage. (See Questions 89-92) Through exchanges, individuals may also qualify for help to lower their out-of-pocket costs (deductibles, coinsurance, or copayments) when they receive health care services. Insurers may sell plans through the exchange, as well as in the market outside the exchange. Premium tax credits and cost-sharing reductions aren't available for plans sold outside the exchange.

For questions about the [insert name of state SHOP exchange], see Questions 43-46, 49-53, and 76-79.

Drafting Note: States that have no market outside the exchange should modify the previous paragraph accordingly. States should note, however, that some individuals such as incarcerated individuals and immigrants not legally present cannot be denied coverage based on health status even though they will not be able to buy coverage through the exchange. (See Questions 126-129.)

To learn more, or to apply for coverage through the [insert name of state exchange], individuals and families should visit the website for the [insert name of state exchange] at [insert *link to state exchange website*]. For more general information about health insurance exchanges, visit the federal government's website at *https://www.healthcare.gov/what-is-the-health-insurance-marketplace*.

Q 6: Are there different types of health insurance exchanges?

While the basic features of exchanges are the same in all states, the ACA allows for differences in *who* operates them. Some exchange options include the federal government operating the exchange, the state operating the exchange, and a partnership between the federal and state governments to operate the exchange. Please contact [insert state consumer affairs contact information] to learn how the exchange in [insert state name] is operated.

Q 7: What is a CO-OP plan?

CO-OP stands for Consumer Operated and Oriented Plan, which is a type of health insurer created under the ACA. The ACA gave low-interest loans to private organizations to create this type of nonprofit insurer designed to increase the number of plan choices available through the state exchanges. Any profits earned by CO-OPs must be applied to either lower premiums or expand benefits for customers. The federal Center for Consumer Information and Insurance Oversight (CCIIO) in the U.S. Department of Health and Human Services (HHS) maintains oversight of the CO-OPs. CO-OPs also must be governed by their members (or customers) and are required to offer plans through their respective states' exchanges.

In [insert name of state], the [insert name of CO-OP] is the CO-OP available through the [insert name of state exchange]. If a CO-OP in the state is no longer available or enrollment has been capped, then consumers can explore other coverage options through the exchange during the open enrollment period. Or they may be eligible for a special enrollment period (SEP) if their CO-OP coverage ends outside of the open enrollment period.

To find out more about the CO-OP program, please visit *http://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html*.

Drafting Note: States should modify or eliminate this question if there aren't any CO-OPs in the state, if the CO-OP is no longer available, or enrollment has been capped.

Q 8: If consumers live in one state but work in another, to which state's exchange should they apply?

Consumers should apply for coverage in the state where they live.

Q 9: Who can buy a plan through the [insert name of state exchange]?

In [insert name of state], any individual or family may buy coverage through the [insert name of state exchange]. The only people who can't are those who are not lawfully present in the U.S. (see Questions 126-128), incarcerated individuals (other than pending disposition of charges) (see Question 129), and generally, people on Medicare (see Question 100). While most individuals and families **can** buy coverage through the exchange, eligibility for premium tax credits and cost-sharing reductions is dependent on not having access to other coverage, e.g., Medicaid/Medicare eligibility, offers of affordable employer-sponsored coverage (see Question 91). When individuals become eligible for Medicare while enrolled in an exchange plan, they will no longer be eligible for any premium tax credits or cost-sharing reductions. (See Question 102.)

Small employers (employers with fewer than [XX] employees) may buy health insurance for their employees through the [insert name of state SHOP exchange]. If a state SHOP exchange is not operative in a state, *healthcare.gov* generally directs small employers to contact producers (agents/brokers) or insurance companies

directly. (For more information about the [insert name of state SHOP exchange], see Questions 43-46, 49-53, and 76-79.)

Drafting Note: States should insert the appropriate number in place of XX above, considering the specific state rules for SHOP participation.

Q 10: When are consumers able to enroll in plans through the [insert name of state exchange]?

Consumers may enroll during the annual open enrollment period or when they qualify for a special enrollment period. In [insert name of state], open enrollment through [insert name of state exchange] for 2025 coverage for individuals and families begins [November 1, 2024] and continues through [January 15, 2025].

Coverage effective dates depend on the date of enrollment and are contingent on consumers paying the first month's premium directly to the insurance company. Enrollment during a special enrollment period will be effective the first day of the following month. Some special enrollment periods allow coverage to begin retroactive to the date of a qualifying event, such as the birth or adoption of a child.

People with incomes at or below 150 percent of the poverty level who are eligible for coverage through [insert name of state exchange] may enroll in coverage at any point during the year and switch plans up to once a month. A chart with various multiples of the federal poverty level in different years is available at https://www.healthreformbeyondthebasics.org/reference-guide-yearly-thresholds/.

During open enrollment, consumers may change plans, change insurance companies, or stay with the plan they have if it's still available. Current enrollees will also receive a new eligibility determination of the amount of financial help they'll receive in the form of premium tax credits or cost-sharing reductions. If a consumer doesn't select a new plan and is eligible for auto-renewal, then they will be automatically re-enrolled into the closest comparable plan for 2026. So, consumers who want to make changes to their coverage effective on January 1 must choose a plan by December 15.

Drafting Note: States should insert the appropriate dates for their Open Enrollment Periods.

Q 11: What if a consumer wants to enroll or change plans outside of the open enrollment period?

Consumers may be eligible to enroll in coverage at times other than during the open enrollment period. There are special enrollment periods (SEPs) for individuals or families if they experience certain events. Some examples of events that trigger a SEP include: 1) loss of minimum essential coverage for an individual or their dependent; 2) gaining or becoming a dependent (such as marriage or the birth/adoption of a baby); and 3) being enrolled in a plan without premium tax credits and then becoming newly eligible for premium tax credits. (See Question 91.) The federal website *https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/* lists possible options for consumers to obtain coverage outside an open enrollment period. Consumers generally have 60 days from the date of the event that triggered a SEP to enroll in coverage. Additional information about SEP rules is available at *https://www.healthreformbeyondthebasics.org/sep-reference-chart/*.

Consumers can apply for coverage through the [insert name of state exchange] any time during the year, regardless of whether it's an enrollment period. The [insert name of state exchange] will process applications and tell consumers whether they can enroll or if they must wait until an enrollment period. The exchange will also provide guidance on whether the applicant may be eligible for other types of coverage. Contact the [insert name of state exchange] at [insert *website*] or [insert phone number] for information about whether a consumer might be eligible to enroll in coverage through the [insert name of state exchange] during a SEP. People who are eligible for Medicaid and the Children's Health Insurance Program (CHIP) can apply and enroll in [insert name of state

Medicaid agency] at any time. People who become eligible for Medicare while enrolled in [insert name of exchange] should immediately notify the exchange and enroll in Medicare. (See Question 102.)

Q 12: How can a consumer prepare to enroll in a plan through the [insert name of state exchange]?

The federal website *https://www.healthcare.gov/apply-and-enroll/get-ready-to-apply/* has suggestions for things consumers should think about to prepare to enroll in a plan through the exchange. The [insert name of state department of insurance] website at [insert *website*] has helpful information for consumers who are thinking about enrolling in a plan through the [insert name of state exchange]. Consumers can also make an appointment with a navigator, certified application counselor, insurance producer (agent/broker), or other assister to help prepare for enrollment and compare plans. To find those who can assist consumers, go to Find Local Help at: *https://localhelp.healthcare.gov/*.

Consumers can start gathering basic information about household income, such as their most recent tax return if they filed one, or other income information. A full list of required documents is available at *https://marketplace.cms.gov/outreach-and-education/marketplace-application-checklist.pdf*. Many people will qualify for financial help to make insurance affordable, and consumers will need income information to find out how much help they are eligible for. Consumers can find more information about how to save money on coverage at *https://www.healthcare.gov/lower-costs/*.

SHOPPING FOR HEALTH INSURANCE: WHAT IS COVERED?

Q 13: What types of plans are available through the [insert name of state exchange]?

Health plans sold through the [insert name of state exchange] must meet comprehensive standards for a broad array of items and services that must be covered. (See Question 16.) To help consumers compare costs, plans available through the [insert name of state exchange] are organized in four tiers/levels that estimate the generosity of the plans' coverage:

- **Bronze level** – The plan must cover about 60% of expected costs across a standard population. This is the lowest level of coverage.
- **Silver level** – The plan must cover about 70% of expected costs across a standard population.
- **Gold level** – The plan must cover about 80% of expected costs across a standard population.
- **Platinum level** – The plan must cover about 90% of expected costs across a standard population. This is the highest level of coverage.

In addition, catastrophic plans cover the same services, but their coverage is less generous than the bronze level plans. Catastrophic plans have very high deductibles, and only preventive care and three primary care visits are covered pre-deductible. A catastrophic plan may have lower premiums, but consumers will pay more out of pocket when they use care. Individuals are eligible to purchase a catastrophic plan if:

1. The individual is under the age 30.
2. The individual is over the age of 30 and qualifies for a "hardship exemption" (*https://www.healthcare.gov/health-coverage-exemptions/hardship-exemptions/*)
3. The individual is over the age of 30 and qualifies for an "affordability exemption." https://www.healthcare.gov/exemption-form-instructions/

Premium tax credits and cost-sharing reductions are not available for catastrophic plans.

Stand-alone dental plans are available through the [insert name of state exchange]. (See Question 25.)

Q 14: What is actuarial value?

Actuarial value is how much of a standard population's medical spending the health insurance plans will pay for in-network, covered benefits. Plans are organized by metal level based upon actuarial value percentages (60% for bronze, 70% for silver, 80% for gold, and 90% for platinum). These metal levels represent the approximate actuarial value of plans at each level. A higher percentage means the plan covers more of a standard population's costs (and the population pays less out of pocket). A lower percentage means the plan covers less (and the people who have the plan pay more out of pocket). The actuarial value calculation focuses on cost-sharing charges so that a bronze plan has higher enrollee cost-sharing amounts compared to a gold plan. There also may be differences in how benefits are covered, such as differences in the prescription drugs that are covered, or how many physical therapy visits the plan covers. The ACA requires all metal level plans and catastrophic plans to cover a comprehensive set of health care benefits and services - the essential health benefits (EHB). (See Question 16)

Actuarial value is calculated for a standard population and does not mean that the plan will pay that percentage of any given person's actual costs. For instance, a silver tier plan will pay more than 70% of covered medical expenses for some people and less than 70% for other people.

Actuarial value does not give other information about a plan that may be important to a particular person or affect their costs. It does not indicate how broad or narrow a plan's provider network is, the quality of the provider network, information about the plan's customer service and support, how broad or narrow the drug formulary is, or what the premium levels are. Lower metal tier plans, like bronze plans, often have lower premiums, but consumers may end up paying more in the form of cost sharing (deductibles, co-pays, and co-insurance). All of this information is important for consumers to consider when they choose a plan.

See *https://www.healthcare.gov/choose-a-plan/* for more consumer information about choosing a plan.

Q 15: How do the tiers (bronze, silver, gold, and platinum) help consumers compare plans?

The tiers are a way to categorize plans based on "actuarial value." Plans within each tier have a similar actuarial value, even if they cover different benefits or have different types of cost-sharing. While all plans in a tier must cover essential health benefits (EHB) (see Question 16), the details of their coverage (such as how many physical therapy visits are covered or which prescription drugs are covered) may be different. Not all plans in the same tier have the same benefits or cost-sharing requirements. Some plans may offer benefits in addition to the EHB.

The metal levels show the amount of cost-sharing required by the plan. Metal levels do not give consumers a signal about the plan's provider network size, quality, or any other aspect of coverage.

Q 16: What services/benefits must plans cover? What are essential health benefits (EHB)?

Many plans sold in the individual and small group market, including all of those sold through the [insert name of state exchange] and [insert name of state SHOP exchange] must cover, at a minimum, a comprehensive set of benefits known as essential health benefits (EHB). These EHB include the following:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs

- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, including chronic disease management
- Pediatric services, including oral and vision care

"Grandfathered," "transitional," and "short-term" plans in the individual and small group markets, as well as other arrangements like health sharing ministries, limited benefit plans, and in some states, Farm Bureau plans, are not required to provide the full array of EHB. For more information about grandfathered plans, see Questions 31-32.

The ACA limits cost sharing (co-pays, co-insurance, deductibles) for EHB, adjusted annually. The 2026 cost sharing limits for EHB services provided in-network are $10,600 for self-only coverage and $21,200 for family coverage. These amounts are lower for those who qualify for cost-sharing reductions. (See Questions 86, 88, 91.)

States define the scope of EHB by selecting a benchmark plan, which they may update periodically.

For more detailed information about essential health benefits in [insert name of state] and other states, visit *https://www.cms.gov/cciio/resources/data-resources/ehb.html#ehb*

[For more information on [name of state]'s EHB benchmarking process, visit here [insert link].]

Q 17: What insurance companies offer coverage through the [insert name of state exchange]? How can consumers get a list of companies and plans available?

There are listings of the health plans available through the [insert name of state exchange] on its website: [Insert *link to state exchange website*]. People without access to the Internet can call the customer service line for the [insert name of state exchange] at [insert phone number] or get help from a qualified agent, broker, or other type of assister. (See Question 66.)

Q 18: How can a consumer find out the details about what a particular plan covers?

All individual and small group plans offered after January 1, 2014, will cover essential health benefits (EHB) (see Question 16), except grandfathered, transitional, short-term plans, and other types of arrangements. (See Questions 31-32 and 97.)

To learn if a specific benefit is covered, and at what level, check a plan's Summary of Benefits and Coverage (SBC). The SBC is a uniform document that includes details about what a plan does and does not cover. It also includes information about what kinds of costs a consumer can expect to pay out of pocket, such as copayments, coinsurance, and deductibles. An insurance company must provide an SBC for all health plans except for the non-ACA compliant plans listed in Q16, which includes short-term and limited benefit plans. An SBC gives information in the same way for every plan to make it easier to compare plans. SBCs are available on the federal government's website at *www.healthcare.gov*, the [insert name of state exchange] website at [insert *link*], the insurance company's website, or from a producer (agent/broker) for plans offered in the market outside the exchange.

It should be noted that the SBC provides only a *summary* of the benefits. More detailed information is available through the insurer or an insurance producer (agent/broker), and each SBC must include a link to a copy of the actual individual coverage policy or group certificate of coverage that will provide more detailed information.

The [insert name of state exchange] website at [insert *link*] includes information about what each plan covers and links to the insurer's plan brochures.

In addition to the SBC, plans offered through [insert name of state exchange] must publish an up-to-date and complete list of prescription drugs covered in the plan's formulary drug list, including information on any drug tiers and any restrictions on the way a drug may be obtained. (See Question 27.) Plans must also publish an up-to-date, complete provider directory, including information on the provider's location, specialty, and whether the provider is accepting new patients. (See Question 29.)

Consumers can read more about the SBC here:
www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html

Q 19: How can consumers compare benefits and understand what a plan covers?

In addition to getting a Summary of Benefits and Coverage (SBC) (see Question 18), consumers can get information about the health plan options available in their state online at the [insert name of state exchange] website at [insert *link*], through the [insert name of state exchange]'s toll-free telephone number, or from agents, brokers, navigators, or certified application counselors. To find those that can help consumers in their area, direct them to [insert link for state exchange or "Find Local Help" at *https://localhelp.healthcare.gov/*]

Q 20: How can consumers see and compare premiums for plans?

The [insert name of state exchange] is set up to let consumers compare policies based on premiums, provider network, actuarial value, and other factors. In addition to premium costs, consumers should look at all the benefits and cost-sharing provisions when choosing a plan because plans with the lowest premium often have the highest out-of-pocket costs.

Consumers can get information to compare premiums from the [insert name of state exchange] website at [insert *link*] or call center at [insert phone number]. Also, navigators and certified application counselors must provide impartial assistance and can receive no payment or commissions from insurance companies. In addition, insurance producers (agents/brokers) or other assisters should be able to help consumers compare plans.

Consumers should visit https://localhelp.healthcare.gov/ to connect with navigators, certified application counselors, and licensed producers (agents/brokers) in their area or go to [link to state exchange website].

Drafting Note: States that allow stand-alone vision plans to be sold through the exchange should change this answer to include stand-alone vision plans.

Q 21: Can a person or a health insurance issuer take benefits out of a plan? What if a consumer doesn't need all of the benefits in a plan?

No. Neither consumers nor health insurance issuers can take benefits out of a plan. At a minimum, every health plan on the [insert name of state exchange] must provide coverage for all the essential health benefits (EHB) the ACA requires. (See Question 16.) Even though a person may not need every benefit in a plan, plans must cover all the essential benefits to share risk across a broad pool of consumers and to be sure all benefits are available to everyone. This also helps to protect people from risks they can't always predict across their lifetimes.

Non-ACA compliant plans listed in Question 16, including short-term plans or limited benefit plans, do not cover all the essential health benefits (EHB), and consumers may be required to pay the full cost of medical care these plans don't cover.

Drafting Note: States with an individual mandate may want to add: Consumers who don't have a plan that provides minimum essential coverage may have to pay a penalty when they file their state income taxes. The federal penalty was reduced to $0 starting with tax year 2019. (See Question 60.)

Q 22: Can consumers' health conditions affect what coverage they are able to get?

No. Under the ACA, health insurance companies can no longer deny someone coverage, or exclude coverage for a specific condition, a practice that used to be known as a "pre-existing condition exclusion." Nor can they charge a higher premium because of a person's health condition. These protections apply whether a person buys an individual market plan through the exchange or outside the exchange. It is important to note that the prohibitions on pre-existing condition exclusions do not apply to non-ACA compliant plans listed in Question 16, including short-term or limited benefit plans.

Q 23: Can an insurance company charge tobacco users more than non-tobacco users?

Under the ACA, health insurance companies in the individual and small group markets can charge consumers who use tobacco products a higher premium. People who use tobacco may be charged up to [insert state-specific tobacco surcharge – no higher than 50%] more than people who do not use tobacco. Consumers in group plans may not have to pay this extra charge if they complete a tobacco cessation program and cannot be charged more if they aren't offered an opportunity to complete a tobacco cessation program. This doesn't apply to coverage that isn't considered comprehensive individual coverage, including short-term plans.

Drafting Note: States that don't allow the tobacco surcharge should replace the previous paragraph with the following one: In [insert name of state], health insurance companies cannot charge consumers a higher premium for being a tobacco user.

Q 24: What are preventive benefits and how are they covered?

Preventive benefits are health screenings and services that provide early detection of medical conditions or can help prevent illness. By preventing and detecting conditions early, preventive benefits help keep people healthy and lead to better health outcomes. The ACA requires that most health plans cover many preventive services with no out-of-pocket costs (meaning no deductibles, copayments, and coinsurance) for all new plans sold after September 23, 2010. Some of these covered preventive services are:

- Colorectal cancer screenings, including polyp removal for individuals 45 or older
- Immunizations and vaccines for adults and children
- Medications and counseling to help adults stop smoking
- PreExposure Prophylaxis (PrEP), medication to protect against HIV infection
- Prediabetes and type-2 diabetes screening
- Well-woman check-ups, as well as mammograms and cervical cancer screenings
- Well-baby and well-child exams for children

Certain ancillary services that are part of preventive services, for example anesthesia provided during a colonoscopy and laboratory services needed for PrEP) must also be provided without cost sharing. Due to coding or other issues, health plans may inappropriately charge cost sharing or deny coverage for a qualified preventive service. (See codes-and-claims.pdf (naic.org).) If this happens, consumers may file an appeal and challenge the

charged amount. For more information on filing an appeal, go to how-to-appeal-a-denied-claim.pdf (naic.org). (See also Question 118.) Plans may only charge for a qualified preventive service if a consumer receives that service from an out-of-network provider when there is an in-network provider available. If there is no in-network provider available to provide a particular preventive service, then the plan cannot charge for the preventive service when an out-of-network provider delivers them.

For more detailed information about covered preventive services, visit the federal government's website at *https://www.healthcare.gov/what-are-my-preventive-care-benefits*

Drafting note: States should note if they have codified preventive services requirements in state law.

Q 25: Are dental or vision benefits for children and adults available through the [insert name of state exchange]?

The ACA requires plans sold through the [insert name of state exchange] to include vision coverage for children, so children's vision benefits are included in plans through the [insert name of state exchange]. Dental benefits are treated differently. The ACA lets insurance companies offer health plans through the [insert name of state exchange] that don't include children's dental benefits as long as the [insert name of state exchange] offers a stand-alone dental plan that includes a children's (pediatric) dental benefit.

Currently, adult vision services are not considered essential health benefits (EHB) for adults, and plans are not required to cover these benefits. (See Question 16.) However, states have the option to require coverage of adult dental care by adding these services to the state's EHB benchmark plan. A plan can choose to include these benefits as part of its coverage. Check a plan's Summary of Benefits and Coverage (SBC) to learn if the plan includes dental or vision coverage for adults.

Some insurance companies may offer stand-alone dental plans through the [insert name of state exchange]. Check the [insert name of state exchange] website at [insert *link*] for more information.

Check the federal website at *www.healthcare.gov* for more information about dental benefits.

Drafting Note: States where consumers may buy dental coverage without buying health coverage should add a sentence to explain, if appropriate.

Drafting Note: States that allow people with Medicare to buy dental plans through the exchange should include this information in this answer.

Drafting Note: States that allow stand-alone vision plans to be sold through the exchange should change the answer to this question as appropriate.

Drafting Note: States may add adult dental to the EHB. If a state does, they should amend this section.

Q 26: Are mental health and substance use disorder benefits available through the [insert name of state exchange]?

Yes. The Affordable Care Act (ACA) requires all individual and small group health plans sold through the [insert name of state exchange] to include coverage for mental health and substance use disorder (MH/SUD) services as part of the essential health benefits (EHB) package. These benefits must be covered at parity with medical and surgical benefits, meaning that financial requirements (such as copayments or deductibles) and treatment

limitations (such as visit limits or prior authorization rules) cannot be more restrictive than those applied to medical/surgical services, consistent with the federal Mental Health Parity and Addiction Equity Act (MHPAEA).

All ACA-compliant plans are still required to meet MHPAEA's core parity requirements and provide access to MH/SUD treatment as an essential benefit. Each state's EHB benchmark plan outlines the specific MH/SUD services covered. Plans must also comply with state law requirements related to mental health and substance use disorder coverage, which may exceed federal standards.

Consumers can review their plan's Summary of Benefits and Coverage (SBC) for information on mental health and substance use disorder services and any applicable cost-sharing. For more information, visit [insert name of state exchange] or www.healthcare.gov.

Drafting Note: States may want to outline and include a link to their state-specific parity requirements.

Drafting Note: States that require broader MH/SUD coverage than the federal standard should note those additional protections here.

Q 27: How does a consumer find out what drugs a plan covers?

Health insurers keep lists of which drugs are covered and which are covered at the lowest cost for each of their plans. These lists are called formularies. Drug cost-sharing is often "tiered"—that is, consumers pay less for a generic drug, more for a brand name drug, and sometimes even more for a "nonpreferred" brand name drug. Consumers should review the formularies in any plan they are considering to be sure the plan meets their prescription drug needs and to know what cost-sharing is required for any given drug. For plans that use formularies, the Summary of Benefits and Coverage (SBC) includes an online link where consumers can find information about the plan's drug coverage. Consumers also can call health insurers for information about formularies.

Formulary information is also available on [insert name of state exchange]'s website [insert *link*]. If a consumer enrolls in coverage and needs access to a drug not on the plan's formulary, then the enrollee may be able to access the drug through an exceptions process. Plans are required to provide a standard and expedited exceptions process to help consumers access needed drugs not included on the plan's formulary.

Drafting Note: States should add language to describe their rules regarding whether the insurance company can change the formulary or tiering after the consumer has bought the plan.

Q 28: What are out-of-network services, and do consumers have any coverage for them?

Services are considered out-of-network if they are from a doctor, hospital, or other provider that does not have a contractual relationship with a particular health plan. Not all plans cover out-of-network services, but when they do, a consumer's share of the cost is usually a lot higher than for an in-network service. (See Question 24 on preventive services and Question 30 on emergency services.) Whenever possible, consumers should find out whether a provider is in-network before they receive services. Consumers also should find out if their regular or desired health care providers are in-network before they buy a plan. Also, different plans offered by the same insurer may have different provider networks, so consumers should be careful to look at the network for their specific plan. When reviewing plans to buy, the specific plan name should be on the Summary of Benefits and Coverage (SBC). After a consumer buys a plan, they can find the specific plan name on the cover page of the policy document or on their health insurance identification card.

Though the ACA limits how much money people must spend each year on their family's health care, health insurers are allowed, although not required by federal law, to count the cost of out-of-network services toward these limits.

A plan's Summary of Benefits and Coverage (SBC) includes information about coverage for out-of-network services and a link to the plan's website and the provider network.

Q 29: How do consumers determine if their doctor or dentist is in the network?

The [insert name of state exchange] website (at [insert *website*]) lets consumers look up whether their doctor or dentist is in the plan network. For plans with a provider network, the Summary of Benefits and Coverage (SBC) includes an online link to a list of network providers. Maintaining accurate health plan provider directories is required by federal law. Because plan networks may change regularly, provider directories may show outdated information temporarily while providers and insurance companies work to update and verify their information. Consumers should check with the doctor or dentist before they schedule an appointment to learn if the provider is still in the plan's network.

Q 30: Do consumers have access to emergency care out-of-network?

Yes. The ACA requires many health plans that provide benefits for emergency services to cover them regardless of whether the provider is in or out of the network. Under the ACA, health plans are not allowed to charge a higher copayment or coinsurance amount for out-of-network services received in an emergency. In addition, [insert name of state] prohibits balance billing for emergency care received out-of-network, meaning only in-network rates apply for all emergency care.

The No Surprises Act provides federal protections against balance bills for most emergency services (ground ambulance services are excluded, unless a state has passed legislation to apply these protections to them) and care provided by out-of-network clinicians at in-network facilities. Most provisions of the No Surprises Act are effective for plan years beginning on or after January 1, 2022. Fully insured plans, self-funded plans, and grandfathered plans are covered by this federal law. *The legislation does not protect those insured by the non-ACA compliant plans listed in Q16, including short-term health plans and limited benefit, dental, and vision plans.*

See link: *https://www.cms.gov/nosurprises*

Drafting Note: States that have their own balance billing laws can add details in their protections and how they interact with federal rules.

Q 31: What is a "grandfathered" health plan?

A grandfathered health plan is a plan that has existed continuously since prior to March 23, 2010, and that has not made certain significant changes in the plan. Grandfathered plans are not subject to many of the ACA requirements, such as the requirement that plans cover essential health benefits (EHB) (see Question 16), but they are considered to provide minimum essential coverage under the ACA. (See Question 60.)

Grandfathered plans may lose their "grandfather" status if a plan makes certain changes, such as a major increase in their cost-sharing (coinsurance, deductibles, copayments) or dropping benefits that cover diagnosis or treatment of a particular condition. Employer-sponsored plans that significantly increase the employee share of the premium also could lose "grandfathered" status. If a plan's "grandfathered" status is forfeited, that plan would have to follow the applicable ACA requirements.

In the individual market, a consumer cannot enroll in a grandfathered plan with a new enrollment.

Consumers who were already enrolled in an individual market plan prior to March 23, 2010, can renew their coverage in that grandfathered plan.

There is no list of grandfathered plans. Although it can be difficult to find, a plan must show in the plan materials if it is a grandfathered plan. Also, consumers can check with their insurance company or employer to figure out if their plan is grandfathered.

Q 32: Can consumers keep an existing plan that isn't grandfathered, but doesn't comply with the ACA reforms (known as transitional plans or grandmothered plans)?

It depends. In November 2013, CMS announced a transitional policy that would let insurers, if the state allows, extend policyholders' 2013 coverage for up to several more years even if the plan didn't follow certain ACA reforms. These transitional plans can no longer be sold to new customers (after January 1, 2014), and individuals who bought them aren't eligible for subsidies. An individual or small business that has one of these plans would be notified by the insurer. If a consumer has a transitional plan, they should check with their insurance carrier to learn if it will renew their plan and what changes, if any, it will be making to the plan.

Drafting Note: States that didn't adopt this policy, applied it only in certain markets (i.e., in the small group market but not the individual market), or that have already phased out transitional plans would need to edit this answer accordingly or delete it entirely.

EMPLOYER-SPONSORED COVERAGE

Q 33: Is employer-based coverage required to cover dependents (spouses and children)?

Under the ACA, if an employer with 50 or more employees doesn't offer coverage that meets minimum standards to employees and their dependents and employees access premium tax credits through the exchange, then the employer may have to pay a tax penalty. (See Questions 56-57.) However, for purposes of this penalty, the IRS has interpreted the phrase "and their dependents" to mean children under age 26 but not spouses. For more information, see *https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions*. Small employers with fewer than 50 employees that don't offer coverage to employees or their dependents are not subject to any tax penalties, but may qualify for a tax credit if they choose to offer coverage. (See Question 55.)

Also, if employer-based coverage includes children, then the ACA requires employers to let children up to age 26 stay on their parents' policy. Adult children up to age 26 can stay on their parents' policy whether or not they live in their parents' home, are married, or the parents no longer claim them as a dependent on their tax return. The employee can be required to pay for this coverage, however.

An employer who offers health benefits to employees must also offer the same health benefits to similarly-situated employees who are eligible for Medicare. This rule applies when an employee is 65 or older and the employer has 20 or more employees and when the employee has a disability and the employer has 100 or more employees. This rule applies to dependents when an employer offers health benefits that include dependents. (See Question 99)

Q 34: What can a consumer do when employer-based health coverage ends?

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal health law since 1986, when employees and their dependents lose employer-based coverage, they're still eligible to stay on their employer's

group health plan, even though that coverage would otherwise end. COBRA doesn't apply to employers with fewer than 20 employees [insert state mini-COBRA law information if applicable].

Employees or their dependents who are eligible for Medicare when employer group health coverage ends may not enroll in an exchange plan, but are eligible to enroll in COBRA. However, COBRA coverage is expensive and will only pay benefits secondary to Medicare benefits, even if the Medicare-eligible individual has not enrolled in Medicare. The most recent Department of Labor model COBRA notice includes more specific information about coordination of benefits between these two programs. This model notice can be found at *https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra*. If an individual is enrolled in COBRA coverage and subsequently becomes eligible for Medicare, then primary COBRA benefits will end. (See Question 99 for further help with Medicare questions.)

Drafting Note: COBRA is secondary to Medicare benefits because Medicare secondary payer rules that apply to employer group health benefits don't apply to COBRA benefits. Most employer group health plans have strong coordination of benefit rules. Medicare-eligible individuals are subject to recovery actions if COBRA mistakenly pays primary benefits even if the Medicare-eligible individual has not actually enrolled for those benefits.

COBRA coverage can be expensive because the former employer isn't required to pay any part of the premium. Those who have lost employer-based health coverage may be eligible to access advance premium tax credits to buy a more affordable individual or family policy through the [insert name of state exchange] (see Questions 86-88), even if the loss of coverage occurs outside of the open enrollment period. Consumers enrolled in COBRA don't qualify for advance premium tax credits. Dropping COBRA coverage outside of an open enrollment period doesn't qualify as a special enrollment opportunity.

Drafting Note: An individual who is eligible but not enrolled in Medicare must act within eight months after losing employer-based health insurance to enroll in Medicare Part B, and 63 days to enroll in a Medicare Part D plan to avoid late enrollment penalties. Some employers pay COBRA premiums for a stipulated number of months as part of a separation agreement. This confuses the matter for employees who have not yet enrolled in Medicare and may wait to do so until free COBRA coverage ends.

Q 35: Must a consumer use all available COBRA coverage before buying coverage through the exchange?

No. COBRA allows group health plan participants and beneficiaries to continue coverage under their group health plan for a limited period of time after certain events cause a loss of coverage, such as voluntary or involuntary job loss, reduction in the number of hours worked, transition between jobs, death, and divorce. Individuals who lose eligibility for minimum essential coverage, including employer-based coverage, will be eligible for a special enrollment period (SEP) when they can buy coverage on the [insert name of state exchange] or in the individual market outside of the exchange. At this time, they also may apply for advance premium tax credits and cost-sharing reductions through [insert name of state exchange] to learn if they are eligible to receive them. However, individuals who have already enrolled in COBRA coverage must wait until the next open enrollment period or until that COBRA coverage has been exhausted before enrolling in an individual market plan.

Medicare-eligible former employees have an 8-month SEP to enroll in Medicare Part B that starts on the day following their last month of employment. If they enroll during this SEP, there is no late enrollment premium penalty or other coverage restrictions. They have 63 days to enroll in Medicare Part D from the last date without prescription drug benefits that are at least equivalent to Medicare's. (See Questions 42 and 99)

Q 36: If a consumer has access to employer-based coverage, can an employer make the consumer wait before becoming eligible for benefits?

Yes. Employers may require a waiting period before individuals become eligible for benefits. Under the ACA, this waiting period can't be longer than 90 days. Employers also may impose an additional one-month orientation period before the waiting period begins. For more information, consumers should contact their employer's human resources department.

Q 37: Can a consumer with access to employer-based coverage get premium tax credits to buy a plan through the [insert name of state exchange]?

A consumer who has access to employer-based coverage is free to buy a plan through the [insert name of state exchange], but premium tax credits to buy the coverage are available only if the employer's plan isn't affordable or doesn't provide minimum value. (See Question 91.) Consumers who have access to employer-based coverage that is affordable and provides minimum value will not be able to get premium tax credits and cost-sharing reductions.

Coverage isn't affordable if the cost of employee-only coverage under the lowest-cost employer plan is more than 9.96% of the employee's annual household income in 2025. The plan doesn't provide minimum value if it pays for less than 60% of medical costs that the plan covers, or if it doesn't provide substantial coverage of inpatient hospital or physician services. The HHS and IRS have developed a minimum value calculator available at *www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm*.

Consumers can learn if an employer plan meets minimum value by looking at the Summary of Benefits and Coverage (SBC) or by asking the employer to fill out an Employer Coverage Tool. This form provides information that will help the consumer answer application questions correctly at the [insert name of state exchange]. The Employer Coverage Tool can be found at https://www.healthcare.gov/downloads/employer-coverage-tool.pdf

There's more information about [insert name of state exchange]'s website at [insert *link*] and on the IRS websites listed below:

www.irs.gov/Affordable-Care-Act/Individuals-and-Families/The-Premium-Tax-Credit

www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Premium-Tax-Credit

Q 38: If a consumer is offered employer-based coverage that would cover a spouse or dependents, can that consumer's spouse or children use premium tax credits to buy coverage through the exchange?

The IRS updated the rules in this area for plan years 2023 and later.

Consumers do not qualify for premium tax credits when an employer offers them coverage that is considered affordable and provides minimum value. The revised rule updates the method to determine when an employer's offer is affordable. Affordability now considers the cost of coverage for the entire family when determining the eligibility for spouses and dependents. Family members qualify for premium tax credits when they are otherwise eligible and the cost of family coverage exceeds 9.96% of household income. The employee's eligibility is determined by the affordability of employee-only coverage. When employee-only coverage costs less than 9.96% of household income and family coverage requires a higher share of income, the employee would not be eligible for premium tax credits, but family members would be eligible.

Before 2023, the entire family was ineligible for premium tax credits when the cost of employee-only coverage was less than the specified share of household income.

Q 39: What is a health reimbursement arrangement?

In a health reimbursement arrangement (HRA), an employer may offer employees tax-free funds they can use to buy health coverage. There are different types of HRAs. In an individual coverage HRA, an employer may offer funds instead of a group health plan to some or all employees. The employees use the funds to buy individual market health plans for themselves and their families. In an excepted benefits HRA, an employer may offer funds and a group health plan. The employees and their families may use the HRA funds to buy health coverage other than comprehensive health coverage, such as dental and vision coverage or short-term, limited duration health insurance.

A Medicare-eligible employee can have an HRA if the employee is enrolled in a health care flexible spending account (HCFSA). The employer can pay Medicare Part B and Part D premiums for active employees only if the employer payment plan is integrated with the group health plan. (See Department of Labor rules.)

Q 40: If a consumer is offered a health reimbursement arrangement (HRA), can that consumer get premium tax credits to buy coverage through the exchange?

The answer depends on the amount of the HRA the employer offers. If the employer offers enough money through an HRA to make an exchange plan affordable for an employee, then neither the employee nor their dependents are eligible for premium tax credits. If the amount of the HRA isn't enough to make an exchange plan affordable, then the employee and their dependents may still receive premium tax credits. If the HRA is a qualified small employer HRA (QSEHRA), then the amount of the tax credit is reduced by the amount of the QSEHRA. More information about HRAs and small businesses can be found at: *https://www.healthcare.gov/small-businesses/learn-more/qsehra/*

The [state exchange name] might not take a consumer's HRA into account when calculating their premium tax credits. In that case, the consumer may want to apply less than the full amount of the credit they are awarded when they pay their premiums each month. With this approach, consumers are less likely to need to pay back some of the premium tax credit when the consumer files their federal income tax return.

Q 41: What are Health Savings Accounts?

A Health Savings Account or HSA is a tax-advantaged account that individuals covered under high-deductible health plans (HDHPs) can use to save for qualified medical expenses. (For more information on HSAs, go to Publication 969 (2024), Health Savings Accounts and Other Tax-Favored Health Plans | Internal Revenue Service (irs.gov.) Individuals may contribute to HSAs when they're enrolled in a health plan that meets certain IRS requirements to be an "HSA-qualified" health insurance plan. All bronze and catastrophic plans purchased through the exchange are HSA-qualified. Other plans must have a minimum deductible (presently $1,700 for self-only coverage and $3,400 for family coverage). The deductible must apply to all covered benefits received from in-network providers. Importantly, "preventive care" benefits, as set forth by the United States Preventive Services Task Force and IRS rules, are the only type of benefits that may be provided before the deductible is met by the enrollee. (List: A and B Recommendations | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org.) The health plan must not be limited to vision, dental, disability, workers' compensation, and other so-called "excepted benefits" or other types of limited coverage.

An individual is not eligible to contribute to an HSA for any month that they: (1) have coverage under any health insurance plan or other arrangement (including employer-sponsored health flexible spending arrangements or health reimbursement arrangements) that does not apply a deductible equal to or exceeding the minimums described above; (2) are enrolled in Medicare; or (3) can be claimed as a dependent on another individual's tax return.

A Medicare beneficiary cannot contribute to an HSA once they are enrolled in Medicare. For individuals that enroll in Medicare after they turn 65, their Medicare effective date could be retroactive up to six months which could impact their eligibility to make HSA contributions. HSA account owners can still use their HSA funds to pay Medicare premiums (all Medicare Parts but not Medicare Supplement insurance), deductibles, co-pays, and coinsurance, as well as other eligible expenses for Medicare doesn't cover (e.g., dental, vision, hearing).

Q 42: When an employee is enrolled in both employer-based coverage and Medicare, is Medicare a primary or secondary payer?

When an employee or a dependent is eligible for Medicare, the size of the employer group determines if the group plan is primary or secondary to Medicare. When an employee or a dependent is age 65 or older and there are 20 or more employees, the employer group health plan is primary. When an employee or their dependent is disabled and there are 100 or more employees, the group health plan is primary. The number of employees includes both full-time and part-time employees. If the employer has fewer than 20 (if the employee or a dependent if age 65 or older) or 100 (if the employee or their dependent is disabled) employees, then Medicare will be primary and the group health plan will be secondary. For more information, consumers can go to: https://www.medicare.gov/health-drug-plans/coordination/who-pays-first. (See Questions 99 and 100)

Q 43: What is the [insert name of state SHOP exchange]?

Under the ACA, states or the federal government may create Small Business Health Options Program (SHOP) exchanges, where small employers who want to offer coverage to their employees can shop for plans. In [insert name of state], the SHOP exchange is called the [insert name of state SHOP exchange]. The SHOP can help a small employer offer a range of small group plans to their workers. Eligible employers can apply for the Small Business Health Care Tax Credit if they offer coverage through the SHOP and meet certain other criteria. The SHOP has no minimum contribution requirements for employers, but some states may impose a contribution requirement in addition to a minimum participation rate. [Add information on your state.] Employers who are interested in applying for the Small Business Health Care Tax Credit must contribute at least 50% of the cost of their employees' premiums to be eligible for the credit. Just as with the regular small group market, employers who sign up for coverage during the small group open enrollment period that runs from November 15 to December 15 will face no minimum participation requirements. Coverage would then be effective for workers beginning January 1.

The ACA calls for "employee choice" in the SHOP exchanges. Under this provision, small employers may choose to give their employees a choice of health plans from multiple insurers across all metal levels (See Question 15) on the SHOP exchange. In some states, employers may also choose to offer coverage from one insurance company. Whether or not they offer employees choice, in most states, employers will work with their SHOP-registered producer (agent/broker) or insurance company (or companies) to obtain application, enrollment, and billing information.

There's more information about the [insert name of state SHOP exchange] at [insert *link to state SHOP exchange website*]. There are resources with information about small employer issues and the ACA on the following websites:

Healthcare.gov Exchange for Small Businesses
http://healthcare.gov/small-businesses

U.S. Department of Labor Patient Protection and Affordable Care Act information
https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families

Affordable Care Act Tax Provisions
https://www.irs.gov/affordable-care-act

Q 44: Is there a cost to participate in [insert name of state SHOP exchange]?

There's no fee for small employers or their employees to enroll in SHOP coverage. Some employers may be eligible for the Small Business Health Care Tax Credit, which can be worth up to 50% of the employer's premium contribution.

Q 45: Can insurers charge more (or less) for policies sold through [insert name of state SHOP exchange]?

No. Insurers must charge the same for similar plans whether they're sold through the [insert name of state SHOP exchange] or in the market outside of the [insert name of state SHOP exchange].

Q 46: What happens if an employer's staff increases to more than [50] employees in the year after the employer bought coverage through the SHOP?

Once enrolled in SHOP exchange, businesses can renew their coverage even if the number of their employees increases to more than [50].

Drafting Note: States should modify the number of employees in accordance with the state definition of small employer.

Q 47: How are small employers defined?

In [state], small employers are eligible for coverage in the small group market or in the SHOP exchange if they have [50] or fewer employees. The definition may be different in other states.

Drafting Note: States should modify the number of employees in accordance with the state definition of small employer.

Q 48: How do employers with full-time and part-time employees know whether they're required to pay a penalty if they don't offer health insurance to their workers?

Small employers are not required to pay a penalty if they don't offer health coverage. Penalties are assessed against employers with at least 50 full-time equivalent employees who 1) do not offer health coverage that meets minimum standards or 2) have an employee who gets coverage through the exchange and gets premium tax credits. (See Questions 56-57.)

The IRS website provides more information: *https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions*

Q 49: Are health insurers required to sell their plans through the federal SHOP exchange?

SHOP plans haven't been offered through the federal SHOP Exchange website since 2018. Instead, there are two options to enroll in a SHOP plan, which are:

1. Work with a SHOP-registered producer (agent/broker).
2. Sign up with an insurance company.

For more SHOP information, including SHOP plans and prices, click on the Healthcare.gov link below.
https://www.healthcare.gov/small-businesses/choose-and-enroll/enroll-in-shop/

Drafting Note: Consumers should not create an account, log in to an existing account, or start an application on HealthCare.gov for SHOP coverage, even if that is how they enrolled in SHOP coverage in the past.

Q 50: Are small employers required to buy a health plan for their employees through [insert name of state SHOP exchange]?

No. Small employers may buy health insurance for employees through the [insert name of state SHOP exchange] or in the market outside the exchange. However, to be eligible for the Small Business Health Care Tax Credit (see Question 58), in most cases a small employer must have bought the coverage through the SHOP exchange. It is important for small employers to understand and compare all options available to them. State-licensed health insurance producers (agents/brokers), including SHOP registered producers (agents/brokers), are available to help small employers compare options and determine which plan best meets their needs.

More information about the Small Business Health Care Tax Credit is available at

https://www.irs.gov/pub/irs-pdf/p4862.pdf

Drafting Note: States that require small employers to buy health insurance for their employees through the exchange should modify this answer as appropriate.

Q 51: Will consumers be better off with individual coverage through the [insert name of state exchange] rather than through the small employer coverage?

Maybe. It depends on many variables, such as the employees' out-of-pocket expenses under the small group plan offered, the consumers' personal circumstances, and the premiums of plans available through the exchange. Employees, their spouses, and dependents offered coverage through an employer are usually not eligible for premium tax credits, so small employer-sponsored coverage could cost less than individual coverage through the federal exchange.

Employers and employees should compare rates for plans offered through the [insert name of state exchange] and for plans in the market outside the [insert name of state exchange].

Q 52: Can insurers require employers to meet participation rates in order to be eligible to buy small group coverage through the [insert name of state SHOP exchange] or in the market outside the [insert name of state SHOP exchange]?

As a result of the ACA, insurers offering coverage in the small group market can't deny coverage to a small employer who doesn't meet minimum participation requirements, if the employer seeks coverage during the small group open enrollment period that runs from November 15 to December 15 each year. Outside of that time period, insurers in the small group market can require small employers to meet participation requirements through the [insert name of state exchange] or outside the [insert name of state exchange] consistent with [insert name of state] law.

[Insert name of state] law doesn't allow a small employer insurer to impose more stringent requirements than the following:

- [insert participation limits consistent with state law]

Drafting Note: States with state-based exchanges may impose minimum participation rates as a condition of participation in a state SHOP exchange. In states with a federally-facilitated exchange, the SHOP has a default minimum participation rate of 70% for qualified health plans (QHPs). The minimum participation rate also will be adjusted higher or lower depending on state law or general insurer practice. For more information, see this link: https://www.agentbrokerfaq.cms.gov/s/article/What-is-the-Minimum-Participation-Rate-MPR-requirement-Can-businesses-sign-up-for-Small-Business-Health-Options-Program-SHOP-coverage-without-meeting-this-requirement

Q 53: Can small employers who are the sole employees of their business buy small group coverage either through the [insert name of state SHOP exchange] or the outside market?

Neither federal nor state law lets insurers sell small group health insurance plans to self-employed individuals with no common law employees through the SHOP.

Contact the [insert name of state exchange] at [insert *link*] or [phone number] or a licensed producer (agent/broker) for help.

Q 54: How does rating work in the small group market?

Under the ACA, there is adjusted community rating in the small group market. This means that the rates each employer pays for health insurance depends on the claims experience of the insurer's entire small group market in [insert name of state], rather than the claims experience of that employer's small group.

The ACA offers states the option to combine the individual and small group markets. By combining the markets, a larger number of policyholders shares the risk. A larger risk pool increases rate stability; however, initially premiums for individuals are likely to be lower on average, while premiums for small employers are likely to be higher.

Q 55: Do small employers who don't offer health care insurance coverage to their employees have to pay a tax penalty?

No. Small employers who want to provide coverage may be eligible for the Small Business Health Care Tax Credit to help make insurance more affordable.

If the employer does offer coverage, then the coverage must meet the ACA's minimum standards for small group insurance plans, as well as specific requirements that apply to the small group market, such as coverage of essential health benefits (EHB) and the prohibition on discrimination based on health status.

Q 56: Do large employers have to offer health care insurance coverage to their employees? What about seasonal employees?

Under the ACA, if an applicable large employer doesn't offer affordable coverage that provides minimum value to full-time employees (and their dependents[1]), and an employee gets premium tax credits, then the employer has to pay a penalty. For employer-based coverage to be considered affordable in 2026, the premiums for the plan's employee-only option must be less than 9.96% of his or her 2026 annual household income.

To offer minimum value, the plan must pay at least 60% of the medical costs for services the plan covers and include substantial coverage of inpatient hospital and physician services. The HHS and IRS have developed a minimum value calculator at *www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm*.

Applicable large employers are employers with 50 or more full-time employees, including full-time equivalent (FTE) employees. Full-time employees are employees with 30 hours or more of service in a week. The number of FTE employees is determined by adding the number of hours of service in a month for all part-time workers and dividing by 120 hours per month. The term "applicable large employer" is used for the employer shared responsibility and information reporting provisions of the ACA.

Penalties were assessed starting January 1, 2016 against employers with 50 or more FTE employees who do not offer health coverage if an employee gets premium tax credits.

Employers with a large seasonal workforce (such as agricultural workers hired for the harvest season or retail clerks hired for the holiday season) are given leeway under the ACA not to count seasonal employees to decide if they meet the definition of a large employer. If the employer has more than 50 full-time or FTE employees during 120 or fewer days per year, then the employer doesn't have to count those employees for those months.

For more information, go to the IRS website at *https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions*. IRS Publication 5208 also has information to determine if an employer is an applicable large employer.

This answer does not take into account all possible situations. Employers should consult a tax professional for help with their particular situation.

Q 57: What are the penalties if large employers don't provide coverage?

Large employers may have to pay a tax penalty if they don't offer affordable coverage that provides minimum value (see Question 56) for at least 95% of their full-time employees and their dependents, or all but five full-time employees, whichever is greater, and at least one of their employees gets premium tax credits through the [insert name of state exchange].

[1] The rules implementing employer shared responsibility provisions have interpreted the phrase "and their dependents" to mean children under age 26, but not spouses. There's more information at *https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions*.

In general, an applicable large employer that ***does not offer*** minimum essential coverage to at least 95% of its full-time employees (and their dependents) will be liable for the first of two types of employer shared responsibility payments if at least one full-time employee receives the premium tax credits for purchasing coverage through the exchange. On an annual basis, this payment is equal to $3,340 in 2026 (indexed for future years) for each full-time employee, with the first 30 employees excluded from the calculation. This calculation is based on ***all*** full-time employees (minus 30), including full-time employees who have minimum essential coverage under the employer's plan or from another source.

In general, an applicable large employer that ***does offer*** minimum essential coverage to at least 95% of its full-time employees (and their dependents) will be liable for the second type of employer shared responsibility payment if at least one full-time employee receives the premium tax credit for purchasing coverage through the exchange. Generally, a full-time employee will receive the premium tax credit because the minimum essential coverage offered was not affordable, did not provide minimum value, or because the employee was not one of the at least 95% of full-time employees offered minimum essential coverage. On an annual basis, this payment is equal to $5,010 in 2026 (indexed for future years) but only for each full-time employee who receives the premium tax credit. The total payment in this instance cannot exceed the amount the employer would have owed had the employer not offered minimum essential coverage to at least 95% of its full-time employees (and their dependents).

More information about employer penalties can be found at *https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions*

Medicaid-eligible employees can't get premium tax credits, so employers will not face penalties for employees who receive Medicaid coverage or for employees' children who receive CHIP coverage.

Q 58: How do small employers find out if they're eligible for the Small Business Health Care Tax Credit?

Employers who buy coverage for their employees through the [insert name of state SHOP exchange] may be eligible for the Small Business Health Care Tax Credit. To qualify, the employer must: 1) have fewer than 25 full-time equivalent employees; 2) pay employees an average annual wage that's less than $50,000; and 3) pay at least half of the insurance premiums for their employees.

The tax credit operates on a sliding scale, with a maximum credit of 50% of the employer's share of the premium costs. It is only available to small employers buying health insurance through [insert name of state SHOP exchange]. The tax credit may be worth up to 50% of an employer's contribution toward employees' premium costs (up to 35% for tax-exempt employers).

Contact the [insert name of state SHOP exchange] at [insert link] or [insert phone number] for more information. A competent tax advisor also should be able to advise a small employer. The IRS provides additional information at *https://www.irs.gov/newsroom/small-business-health-care-tax-credit-questions-and-answers-calculating-the-credit*

Q 59: What ACA requirements apply to large employers?

Several ACA requirements apply to non-grandfathered health plans that large employers offer on either an insured or self-insured basis. The requirements include limits on out-of-pocket expenditures and waiting periods, no annual or lifetime dollar limits on coverage of essential health benefits or cost-sharing for preventive services, the requirement that coverage be offered to adult children up to age 26, and the requirement of access to internal and external appeals. Also, as noted in Question 56, large employers are required to offer affordable and adequate coverage, or they face a tax penalty.

ACA REQUIREMENT TO HAVE BASIC HEALTH CARE COVERAGE (INDIVIDUAL MANDATE)

Q 60: What is the individual responsibility requirement, and does it mean consumers must maintain coverage?

Under the ACA, consumers and their dependent children are required to have "minimum essential coverage," unless they qualify for an exemption. This requirement is known as "individual shared responsibility" or the "individual mandate." However, there hasn't been a federal tax penalty for going without coverage since 2019. While there's no income tax penalty for not having minimum essential coverage, those without it have to pay out of pocket for their health care expenses.

This link to the IRS website has more information: *www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage*

Coverage purchased through an exchange counts as minimum essential coverage, and so do other types of coverage. Employer-sponsored coverage, grandfathered plans, Medicare, Medicaid, and CHIP are all minimum essential coverage. Short-term health plans, fixed indemnity insurance, and coverage through a health care sharing ministry are not minimum essential coverage.

Check the website at *www.healthcare.gov/fees/fee-for-not-being-covered/* for more information.

Q 61: Why is it important to have minimum essential coverage?

Beginning in 2019, there's no longer an income tax penalty for those who don't have minimum essential coverage. There's more information about the penalty at *http://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered./*

But having minimum essential coverage offers consumers more protection against high health costs. Also, individuals enrolled in minimum essential coverage (MEC) that ends are eligible for a Special Enrollment Period (SEP). During that time, they can enroll in individual market coverage, including exchange coverage. Those not enrolled in MEC aren't eligible for a SEP if their coverage ends. They have to wait until the next Open Enrollment Period or until they qualify for another SEP to enroll. Individuals aren't eligible for premium tax credits until they are enrolled in an exchange plan. More information on SEP rules is available at *https://www.healthreformbeyondthebasics.org/sep-reference-chart/*.

Drafting Note: States with their own penalties for not having MEC should include that information.

ENROLLING IN HEALTH CARE COVERAGE: WHERE CAN CONSUMERS GET HELP?

Q 62: How should consumers prepare before choosing and enrolling in a plan?

Consumers should make a list of questions before they shop for a health plan. Consumers should gather information about their household income and set a budget for health insurance. Consumers should find out if they can stay with their current doctors and pharmacy, whether their medications are covered, and understand how insurance works—including understanding deductibles, out-of-pocket maximums, and copayments. For guidance on shopping for a health plan, go to What%20to%20Ask%20When%20Shopping%20for%20Health%20Insurance.pdf (naic.org).

There are several resources from the KFF, *Consumer Reports*, the NAIC, your state's insurance department, HHS, and the U.S. Department of Labor (DOL) to help consumers understand how insurance works, the different insurance options, and what to consider when buying coverage. For questions about Medicare and other health coverage, consumers can contact the state SHIP.

A standard form called the Summary of Benefits and Coverage, or SBC, and the companion set of uniform definitions, also is available for many health insurance plans. This information can help consumers compare different insurance options. (See Question 18.) Consumers can get the form and definitions through the [insert name of state exchange] at [insert *link to state exchange website*], or ask the plan for it. The [insert name of state exchange] also can direct consumers to more information and resources about the options that are available.

Q 63: Where can consumers go for help to choose and enroll in a plan?

Consumers who are eligible to buy coverage through the [insert name of state exchange] can enroll through the [insert name of state exchange] website at [insert *link*], by phone at [insert phone number], or in person through [insert *links* and contact information].

A few types of individuals are trained to help consumers make decisions about health coverage:

A. Insurance producers (agents/brokers)

Health insurance producers (agents/brokers) sell insurance coverage from one or more insurance companies. Health insurance producers (agents/brokers) are licensed by [insert name of state] and receive continuing education related to their job. They can help educate consumers about health insurance policies, help consumers apply for coverage, and advise consumers about the type of health insurance coverage that best suits them and their family. Producers (agents/brokers) can sell consumers insurance plans in the market outside the exchange, as they always have. They may recommend specific plans to clients and are paid by insurers, usually through commissions. (See Question 65.)

Producers (agents/brokers) who want to sell policies through the [insert name of state exchange] have extra training from the HHS or the state-based exchange. They have passed a test at the end of their training to sell insurance policies through the [insert name of state exchange]. [Insert name of state] requires producers (agents/brokers) to have extra state-specific training before they sell through the [insert name of state exchange]. A list of producers (agents/brokers) authorized to sell through the [insert name of state exchange] is available on the [insert name of state exchange] website at [insert *link*]. Consumers may want to talk with more than one producer (agent/broker) before they decide which plan to buy. (See Question 66.)

Drafting Note: If a state doesn't have a list of producers (agents/brokers) on the exchange, then modify the answer accordingly.

B. Navigators

Navigators are individuals trained to help consumers understand the insurance policies available through the [insert name of state exchange] and answer consumer questions about the [insert name of state exchange]. They also can answer questions about insurance assistance programs, including Medicaid and CHIP. Navigators also can help educate consumers about their health insurance policy options and help them apply for coverage. Their services are free to consumers. Unlike agents/brokers who earn commissions from insurers, navigators are paid through grants from the [insert name of state exchange]. They cannot recommend specific health plans and must receive training to help consumers, pass a test, and be certified by [insert name of state exchange]. In [insert name of state], navigators also must have extra state-specific training before they can help consumers. Consumers can contact navigators at [insert state contact information]. (See Questions 67 and 75.)

Drafting Note: States where the HHS will be doing training and certification should modify the preceding paragraph accordingly. The HHS certifies navigators in the federally-facilitated exchanges.

C. In-person assistance personnel

In-person assistance personnel generally do the same things as navigators. In-person assistance personnel have received and successfully completed comprehensive training. They also can help educate consumers about health insurance policies and help them apply for coverage. [Insert name of state] has set up an in-person assistance program. Consumers can contact in-person assistance personnel at [insert contact information].

Drafting Note: States should delete this section if they do not have in-person assistance personnel.

D. Certified application counselors

Certified application counselors (CACs) provide enrollment assistance to consumers. Certified application counselors receive and successfully complete comprehensive training. They can help educate consumers about health insurance plans and help them complete an application for coverage. In [insert name of state], examples of certified application counselors include staff at [insert name of local community health centers or hospitals or consumer nonprofit organizations]. Like navigators, CACs cannot recommend specific plans, and are generally paid via grants as part of nonprofit organizations.

Drafting Note: States will need to customize this section depending on the type of exchange they have and what kinds of individuals will be assisting consumers. More customization may be necessary if the state has any licensure or certification requirements.

Q 64: May consumers directly enroll for coverage through insurers?

Yes. Consumers may buy coverage directly from an insurance company. However, consumers should make sure that the coverage they buy is offered through the [insert state name of state exchange] and that the insurer has a direct enrollment agreement with the [insert name of state exchange] so consumers can get any premium tax credits or cost-sharing reductions to which they are entitled. Consumers can look up whether the insurer has a direct enrollment agreement by visiting https://data.healthcare.gov/issuer-partner-lookup; under "Organization type" select "Enhanced Direct Enrollment (EDE) web-broker" and "Classic Direct Enrollment (DE) web-broker."

Consumers enrolling directly through the insurance company portal may not see all plans available through the [insert name of state exchange]. An insurance company portal may also offer plans that aren't offered through the exchange. An enrollee who buys a plan outside of the exchange isn't eligible for premium tax credits and cost-sharing reductions.

Drafting Note: States that don't allow insurers to enroll consumers directly into plans through the exchange should change this answer accordingly.

Q 65: How are people who help consumers enroll in health coverage paid?

Insurance producers (agents/brokers) may have an agreement that the insurance company will pay them if they enroll consumers in a health insurance policy consistent with state law. The state-based exchange may set rules about paying health insurance producers (agents/brokers) from the exchange or directly from insurance companies. In [insert name of state], the producer (agent/broker) will be paid an amount agreed to by the health insurance producer (agent/broker) and the company.

In [insert name of state], navigators get funding from [insert funding source]. They don't get enrollment-based reimbursement from insurance companies and aren't allowed to charge a fee.

In-person assistance personnel will be paid by [insert funding source]. They don't get enrollment-based reimbursement from insurance companies and aren't allowed to charge a fee.

Certified application counselors are not paid through the [insert name of state exchange]. They don't get enrollment-based reimbursement from insurance companies and aren't allowed to charge a fee. They may, however, receive federal funding through other grant programs, or Medicaid, or from another source.

Q 66: How can consumers find an insurance producer (agent/broker) to help them enroll in a plan?

In [insert state name], the [insert name of state health insurance exchange] website at [insert *link*] lists insurance producers (agents/brokers) authorized to enroll individuals, families, and small businesses in coverage through the [insert name of state exchange]. Consumers can contact the [insert state insurance department] for a list of licensed health insurance producers (agents/brokers) in their area. Some producers (agents/brokers) don't contract with all health plans, so consumers must make sure they know the full list of plans that are available to them before they ask a producer (agent/broker) for help. Also, health insurance producers (agents/brokers) may or may not have training to help individuals complete the enrollment process for Medicaid or CHIP after they get an eligibility decision.

There's also helpful information at healthcare.gov *https://localhelp.healthcare.gov/*

Drafting Note: States should modify this answer consistent with the information available in the state.

Q 67: How can consumers find a navigator or certified application counselor to help them enroll in a plan?

In [insert state name], the [insert name of state health insurance exchange] website at [insert link] lists navigators and certified application counselors authorized to enroll individuals, families, and small businesses in coverage through the [insert name of state exchange].

Drafting Note: In states that use healthcare.gov, a list of navigators and certified application counselors can be found by visiting https://localhelp.healthcare.gov/ and clicking the "Assisters" tab.

Q 68: What are the qualifications required for health insurance producers (agents/brokers) to participate in the [insert name of state exchange]?

In [insert name of state], health insurance producers (agents/brokers) are regulated by the [insert name of state department of insurance]. Producers (agents/brokers) receive training from the [insert name of state exchange or the HHS]. The insurance companies must appoint the insurance producers (agents/brokers) who sell their plans through the [insert name of state exchange]. A producer (agent/broker) selling plans through the [insert name of state exchange] must provide information about all plans that are offered on the [insert name of state exchange], even if the producer (agent/broker) isn't authorized to sell some of those plans.

Drafting Note: States that don't require producers (agents/brokers) to be appointed to all of the insurance companies selling through the exchange or that don't require producers (agents/brokers) to provide information about all plans available through the exchange should modify the previous paragraph accordingly.

Q 69: Where should consumers go if they have a problem enrolling in a plan through the [insert name of state exchange]?

The [insert name of state exchange] should be able to help consumers with any problems. In particular, [insert name of state exchange] operates a call center to help answer consumer questions. The number for the call center is [insert number]. The phone number is available on the [insert name of state exchange] website at [insert *link*].

Insurance producers (agents/brokers), navigators, in-person assistance personnel, and certified application counselors also should be able to help. (See Question 63.) Consumers can also contact the [insert name of state insurance department] at [insert phone number] to file a complaint or report a concern about a negative experience with an insurance company, producer (agent/broker), navigator, in-person assister, or certified application counselor during and after the enrollment process.

Q 70: Do consumers have to re-enroll annually?

Eligibility for premium assistance and enrollment in a health plan will be decided annually using updated income, family size, and tax information (when authorized). Each year, before the open enrollment period, the [insert name of state exchange] will check income data and send a notice to marketplace enrollees who are determined eligible to enroll in a plan through the [insert name of state exchange]. This notice explains the consumer's eligibility for the upcoming year, based on tax information and information from other electronic data sources, and tells the consumer to let the [insert name of state exchange] know of any changes in their situation. During the annual open enrollment period eligible consumers can change plans or insurance companies if they want to.

All consumers are encouraged to go to the exchange to review all of their options and to update income and other information to ensure the correct subsidy is received. Those enrolled in a plan through the exchange in 2025 who are eligible for auto-renewal and choose not to re-enroll or enroll in a different plan by December 15, 2025, will be automatically re-enrolled in their current plan (or similar plan, if their current plan is no longer available). For the 2026 coverage year, the key dates are as follows:

- **November 1, 2025**: Open enrollment starts—the first day a consumer can apply for 2025 coverage.
- **December 15, 2025**: The last date to enroll for coverage that starts January 1, 2026.
- **December 31, 2025**: The date when all 2025 exchange coverage ends, no matter when the consumer enrolled.
- **January 1, 2026**: The date when 2026 coverage can start if consumers applied by December 15, 2025, or consumers were automatically re-enrolled in their 2025 plan or a similar plan.
- **January 15, 2026**: The last date to enroll in 2026 plan year coverage with an effective date of February 1, 2026. Consumers who miss this deadline can't sign up for a comprehensive individual market health plan inside or outside the exchange or change plans unless they qualify for a special enrollment period (SEP). (See Question 11.)

  If a consumer is automatically re-enrolled into a different plan than the one they had the previous year, they qualify for an SEP. They can complete an application and select a new plan starting 60 days before their plan is discontinued and ending 60 days after.

If a consumer is automatically re-enrolled in a different plan with a different issuer than the one they had the previous year, they must pay the first month's premium by January 1 in order to effectuate coverage. If they do not pay the first month's premium on time, their coverage will be automatically terminated. They will not be eligible for a grace period (see Question 94). But they can select a new plan through the end of open enrollment.

During the year, consumers with coverage through the [insert name of state exchange] must report certain life changes to the [insert name of state exchange]. Consumers should report changes as soon as possible, especially changes that qualify a consumer for a SEP. Consumers eligible for a SEP typically have 60 days to enroll in new coverage. (See Question 11.) Life changes include changes in income from a new job and getting married or divorced. See *www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/* [or cite to SBM if appropriate] for information about reporting life changes.

Consumers who have not requested financial assistance don't need to report changes related to financial assistance eligibility.

Drafting Note: Some state-based marketplaces may have different deadlines for automatic re-enrollment and end dates for open enrollment and the timeframes above should be revised accordingly.

Q 71: If a consumer is automatically re-enrolled in a health plan, can they still get financial assistance?

Consumers will be automatically re-enrolled in a health plan with financial assistance if:

- They authorized [insert name of state exchange] to pull tax data related to income and household size;
- They updated their [insert name of state exchange] application in 2024 or 2025;
- They enrolled in 2025 coverage with the premium tax credit and/or cost-sharing reductions;
- They don't fall into one of the special groups that cannot be redetermined; AND,
- The [insert name of state exchange] determines, using available information, that they are eligible for the premium tax credit and/or cost-sharing reductions for the upcoming year.

Not all marketplace enrollees are eligible for automatic redetermination of premium or cost-sharing assistance. Consumers in the following situations will be automatically re-enrolled in marketplace coverage without financial assistance if they fail to act before December 16:

- Consumers who did not authorize the exchange to pull tax data related to income and household size.
- Consumers who auto-renewed for the past two years, did not return to the exchange to update eligibility in those years, and have no IRS information on income available for those years.
- Consumers who are not currently receiving premium or cost-sharing assistance.
- Households where at least one member of the enrollment group has Medicare.
- Consumers who received premium assistance in the previous two tax years (2024 and 2025) but didn't file taxes or filed but didn't reconcile their premium assistance (see Question 73).

Q 72: What should a consumer do if they are automatically re-enrolled in a health plan without premium assistance?

To avoid owing the full premium for January, consumers who are automatically re-enrolled without financial assistance should return to the [insert name of state exchange] website before December 31 to cancel their plan. They can still update their application and get financial assistance for coverage starting February 1 (if eligible), if they act before the end of open enrollment.

Drafting Note: States should change this answer as appropriate to reflect the process in the state.

Q 73: What happens if a person didn't reconcile their premium assistance on a federal income tax return?

The ACA requires people who receive advance premium tax credits to file a tax return and reconcile the credit amount they received against the final credit amount for which they were eligible. The exchange will discontinue premium tax credits for people who fail to do this for two consecutive tax years (tax years 2023 and 2024, for coverage year 2026). People in this situation are not eligible for premium tax credits until they file taxes for these years and attest to reconciling their premium tax credits on their [insert name of state exchange] application.

People who fail to file and reconcile the advance premium tax credits for one year will receive a notice encouraging them to file and reconcile their tax credit, and informing them of the consequences if they do not.

Drafting Note: States should change this answer as appropriate to reflect the process in the state.

Q 74: How do insurance producers (agents/brokers) help consumers with enrollment through the [insert name of state exchange]?

In [insert name of state], health insurance companies appoint producers (agents/brokers). Insurance companies make sure the producer's (agent's/broker's) license is valid and registered with the [insert name of state exchange]. The producers (agent/broker) can help consumers log on to the [insert name of state exchange]. Consumers should log into their own [insert name of state exchange] account. The producer (agent/broker) can help consumers as needed. The producer (agent/broker) then works with consumers to complete the application. Consumers are prompted to enter the insurance professional's [insert name of state exchange] user identification number and national producer number on the application to show that the professional helped them.

Drafting Note: States should change this answer as appropriate to reflect the process in the state.

Q 75: How does a navigator or certified application counselor help consumers with enrollment through the [insert name of state exchange]?

In [insert name of state], navigators and certified application counselors (CACs) can help consumers create an account and log on to the [insert name of state exchange]. Consumers should log into their own [insert name of state exchange] account. The navigator or CAC can help consumers as needed to complete the application. Consumers may be prompted to enter the navigator's or CAC's [insert name of state exchange] user identification number on the application to show that the navigator or CAC helped them.

The navigator or CAC can help consumers to compare health plans and answer questions about health insurance policies in general. The navigator or CAC can answer questions from consumers about the differences in health plans and what they might mean for them, but the navigator or CAC **CANNOT** recommend or suggest which health plan would be best for consumers and their families. Navigators and CACs aren't permitted to collect premium payments on behalf of an insurer or the [insert name of state exchange]. Consumers are asked to enter the navigator's or CAC's [insert name of state exchange] user identification number on the enrollment page to show that the navigator or CAC helped them.

Navigators and CACs **CANNOT** sell, solicit, or negotiate a health plan through the [insert name of state exchange]. They **CANNOT** suggest that one plan would be better for the individual than another.

Drafting Note: States should change this answer as appropriate to reflect the process in the state.

Q 76: Can small employers use licensed insurance producers (agents/brokers) to buy health insurance through [insert name of state SHOP exchange]?

Yes. Licensed insurance producers (agents/brokers) are available to help small employers compare and determine which health plan best meets their needs. This is true whether they're interested in buying coverage in the market outside the [insert name of state SHOP exchange] or through the [insert name of state SHOP exchange].

Licensed insurance producers (agents/brokers) are able to compare plans in the market outside the [insert name of state SHOP exchange] with those offered through the [insert name of state SHOP exchange] to decide where they can buy the plan that is best for them. Employers may wish to talk with more than one producer (agent/broker) before deciding which plan to buy.

Q 77: May small employers use navigators to buy health insurance?

Yes. Navigators can explain the parts of the plans offered through the [insert name of state SHOP exchange] but CANNOT legally offer advice as to which plan is a better fit for the small employer. Only a licensed insurance producer (agent/broker) is qualified and allowed to offer this advice.

Q 78: How can an insurance producer (agent/broker) help a small employer participate in the [insert name of state SHOP exchange]?

An insurance producer (agent/broker) can help any small employer, as has been true in the past. The producer (agent/broker) can help the employer decide which health insurance policy would be best for them, enroll employees in the plan, file health insurance claims, and understand the process of enrollment.

In the [insert name of state SHOP exchange], the HHS expects that insurance producers (agents/brokers) will be in contact with employers both before and after enrollment, as they will be a primary contact for customer service issues.

Q 79: What is the benefit of using an insurance producer (agent/broker) to enroll in the [insert name of state exchange] or the [insert name of state SHOP exchange]?

Whether consumers are individuals or small group businesses, the insurance producer (agent/broker) can work with their needs and requirements. Producers (agents/brokers) have a working knowledge of the qualified health plans and their benefits. However, producers may steer consumers to the plans that pay the highest commission. A producer (agent/broker) may help individual consumers or small employers create an account with the [insert name of state exchange] or [insert name of state SHOP exchange] if needed, but consumers, or a legally authorized representative, must create their own [insert name of state exchange] username and password. Consumers should not share this information with third parties, including insurance producers (agents/brokers).

Q 80: Will an insurance producer (agent/broker) show consumers all of the plan choices available through the [insert name of state exchange]?

In [insert name of state], producers (agents/brokers) aren't required to show consumers all available health plans. If the consumer is using the [insert name of state exchange] website with the help of a producer (agent/broker), then all qualified health plan (QHP) choices will be displayed. If the producer (agent/broker) goes through an insurance company portal, all plans available through the [insert name of state exchange] may not be shown, but other plans available in the market outside the exchange—that aren't eligible for the advance premium tax credits—may be shown. Consumers should ask the insurance producer (agent/broker) if they're being shown all of the plans available through the [insert name of state exchange] and whether premium tax credits or cost-sharing reductions apply to the plans they are looking at.

All producers (agents/brokers) must follow applicable [insert name of state] laws, regulations, and [insert name of state exchange] requirements, including standards related to relationships or appointments with insurance companies.

[Insert name of state] expects that the insurance producer (agent/broker) will tell consumers if they give them information about health plans with which the producer (agent/broker) has a business relationship and that consumers can always directly access the [insert name of state exchange] website where they'll find information about other available qualified health plans. The [insert name of state] expects that insurance producers (agents/brokers) will advise consumers to check with the [insert name of state exchange] about available premium tax credits or cost-sharing reductions.

Drafting Note: States should modify this answer if producers (agents/brokers) are required to show consumers all options available through the exchange.

Q 81: Will consumers have to share their personal information, including their tax returns, with a producer (agent/broker), navigator, in-person assistance personnel, or certified application counselor?

No. A consumer shouldn't share personal information, including tax returns, with a producer (agent/broker), navigator, in-person assistance personnel, or certified application counselor. When consumers complete the application on the [insert name of state exchange] website with the help of a producer (agent/broker), navigator, assister, or counselor, they should be able to fill out and submit their eligibility application without the producer (agent/broker), navigator, assister, or counselor in direct view of the application. While consumers applying for financial assistance are asked to enter their income, income figures from the IRS won't be shown during the application process, whether the consumer gets help filling out the application or does it independently. In [insert name of state], after completing the registration and training, producers (agents/brokers), navigators, in-person assistance personnel, and certified application counselors must complete and comply with a privacy and security agreement and get a user ID to use with the [insert name of state exchange].

Q 82: Will consumers have to share their account username and password with an insurance producer (agent/broker), navigator, in-person assister, or certified application counselor?

No. A producer (agent/broker), navigator, in-person assistance personnel, or certified application counselor should never ask for a consumer's account username and password. If a consumer is asked to share a username or password, then they should immediately contact the [insert name of state insurance department] at [insert phone number] and discuss this with the consumer assistance representatives.

Q 83: What should a consumer do if they believe an unauthorized entity has changed or obtained their insurance information?

Producers (agents/brokers) and lead generators are prohibited from submitting or modifying a consumer's application without documented consent.

If the consumer believes their coverage has been modified or personal information accessed by an unauthorized entity, they should contact [name and info for appropriate state department of insurance contact] and the Exchange [include State Exchange or Federal Exchange contact].

Q 84: What help should an insurance producer (agent/broker), navigator, in-person assister, or certified application counselor give consumers if they or their dependents are eligible for Medicaid or CHIP?

Producers (agents/brokers), navigators, in-person assisters, and certified application counselors will work with all consumers who ask for help with [insert name of state exchange] enrollment, including those eligible for Medicaid or CHIP. The [insert name of state exchange] will send a notice to consumers who are eligible for Medicaid or CHIP. A producer (agent/broker), navigator, in-person assister, or certified application counselor working with these consumers is expected to refer consumers to the [insert name of state Medicaid and CHIP agency]. Producer (agents/brokers), navigator, in-person assister, and certified application counselor training will include information about where to direct Medicaid- or CHIP-eligible consumers.

Producers (agents/brokers) should be able to give consumers a referral to a navigator, in-person assister, certified application counselor, or the [insert name of state Medicaid agency]. Navigators, in-person assisters, and certified application counselors should help all consumers seeking help to complete an application through the [insert name

of state exchange]. If the [insert name of state exchange] assesses the consumer as Medicaid- or CHIP-eligible, then the navigator, in-person assister, or certified application counselor may refer the consumer to the state Medicaid agency for more information. Navigators, in-person assisters, and certified application counselors often are not required to help consumers fill out a state Medicaid application if it is different from the application used by the [insert name of state exchange], but they can refer consumers to appropriate resources in those cases.

Q 85: May an insurance producer (agent/broker), navigator, or certified application counselor continue to work with consumers after they enroll in a plan through the [insert name of state exchange]?

Insurance producers (agents/brokers), navigators, and certified application counselors may continue to communicate with consumers after they've enrolled in a plan through the [insert name of state exchange], as long as the communications follow any laws and regulations that apply.

The communications also must follow the privacy and security standards the [insert name of state exchange] has adopted (pursuant to 45 C.F.R. §155.260). These standards limit how a producer (agent/broker) may use any information gained to provide help and services to consumers shopping for qualified health plans.

COSTS AND ASSISTANCE WITH COSTS

Q 86: Is there cost-sharing for contraceptives?

Except for health plans sponsored by certain employers that have religious or moral objections to contraception, all plans, including those offered through the [insert state name of state exchange], must cover in-network doctor-prescribed FDA-approved methods of contraception without cost-sharing.

For specific information about a plan's contraceptive coverage, consumers should check the plan's Summary of Benefits and Coverage (see Question 18) or ask their employer or benefits administrator. More information about contraceptive coverage is available on the federal website at *www.healthcare.gov/coverage/birth-control-benefits/* and *www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf*

Q 87: How much do health plans offered through the [insert name of state exchange] cost?

There are many plans designed to fit different budgets, both through the [insert name of state exchange] and in the market outside the exchange. Many consumers buying a health plan through [insert name of state exchange] could qualify for premium tax credits (see Questions 89-92), which help lower the cost of premiums. Consumers may also benefit from additional savings and discounts based on their income levels. Check with the [insert name of state exchange] at [insert *link*] or direct the consumer to an online calculator to estimate whether they may qualify for subsidies: *https://www.kff.org/interactive/subsidy-calculator/*

To see specific costs of plans offered through the [insert name of state exchange], go to [insert *state exchange website*], call [insert state exchange telephone number], or talk to a navigator, certified application counselor, in-person assister, insurance producer (agent/broker), or other assister. (See Question 63.)

Q 88: Do health plans offered through the [insert name of state exchange] have large out-of-pocket costs?

The health plans available through the [insert name of state exchange] have different out-of-pocket costs. The ACA requires that many health plans (including most plans that people get from an employer) limit consumers' annual out-of-pocket costs for in-network essential health benefits (EHB) services to no more than $10,600 for individuals and $21,200 for families in 2026. These maximum out-of-pocket amounts will go up in future years. Please note out-of-network services do not count toward these limits on the health plan's annual out-of-pocket costs. (See Question 28.) There are also separate out-of-pocket maximums for stand-alone dental plans.

Health plans are required to cover certain preventive services without cost-sharing (copays, co-insurance, deductibles). (See Question 24.) Income levels can also affect eligibility for different savings through the premium tax credit or a health plan that has lower cost-sharing and lower out-of-pocket costs (copayments, coinsurance and deductibles). Check with the [insert name of state exchange] at [insert *link*] or direct the consumer to an online calculator to estimate whether they may qualify for subsidies: *https://www.kff.org/interactive/subsidy-calculator/*

Navigators, certified application counselors, in-person assisters, producers (agents/brokers), or other assisters are available to help consumers learn if they qualify. The exchange application can also tell consumers whether they might be eligible for Medicaid or CHIP programs, which have little to no out-of-pocket costs.

Q 89: Where can consumers find out if they're eligible for help to pay premiums or for Medicaid?

Consumers may apply with the [insert name of state exchange] or the [insert name of state Medicaid agency].

The [insert name of state exchange] determines eligibility for advance payments of premium tax credits and cost-sharing reductions. The [insert name of state exchange] will review Medicaid and CHIP eligibility and can make a referral to the [insert name of state Medicaid agency] for a final determination.

Consumers wanting to check eligibility for Medicaid can apply directly with the [insert name of state Medicaid agency]. The [insert name of state Medicaid agency] will enroll eligible consumers in Medicaid or CHIP or send their information to the [insert name of state exchange] to determine their eligibility for advance payments of the premium tax credit and cost-sharing reductions if they aren't eligible for Medicaid or CHIP.

Drafting Note: States with a different process will need to modify this answer accordingly.

Q 90: Is there help for consumers who can't afford coverage?

Yes, consumers with low or moderate incomes could qualify for reduced costs through Medicaid, CHIP, or exchange coverage but eligibility rules apply. Most states use federal government funds to expand Medicaid so that it covers adults with an income at or lower than 138% of the federal poverty level. In 2025, that is roughly $21,600 for a family of one and $44,360 for a family of four, with higher amounts applicable in Alaska and Hawaii. Consumers should contact the [insert name of state exchange] or the [insert name of state Medicaid agency] directly if they think they might be eligible for Medicaid.

In [insert name of state], children may be able to get coverage through Medicaid or CHIP programs for which their parents aren't eligible. Some families may find it more affordable to enroll their children in Medicaid or CHIP and buy coverage for the parents through the exchange.

Drafting Note: States may need to modify the answer to this question depending on the state's decisions regarding Medicaid expansion.

Q 91: Who's eligible for premium tax credits and cost-sharing reductions?

The ACA created premium tax credits and cost-sharing reductions to help cut costs for eligible consumers who buy a plan through the [insert name of state exchange]. (See Question 89.) The amount of the tax credit or cost-sharing reduction depends on family size and income and varies on a sliding scale: Larger families and families with lower incomes get the most help. Premium tax credits and cost-sharing reductions aren't available for individuals who are eligible for Medicaid, CHIP, Medicare, or qualifying employer-sponsored coverage. Consumers who forget to update the [insert name of state exchange] about changes in their eligibility for other

coverage might owe money at tax time. More information about premium tax credits and cost-sharing reductions is available at *www.healthcare.gov*

This link allows consumers to estimate how much financial help is available for them: *www.healthcare.gov/lower-costs/qualifying-for-lower-costs/*

Q 92: How do premium tax credits to buy coverage through the [insert name of state exchange] work?

Consumers who qualify for premium tax credits can either receive them in advance, or they can wait until they file their taxes. The advance payment is sent to the insurance company that offers the plan the consumer has chosen and is used to reduce the monthly insurance premium. Consumers also have the choice to wait to receive their tax credits when they file their federal income tax return. They also can use just part of their estimated tax credits in advance.

Consumers who want to use their premium tax credits in advance need to be as accurate as possible to estimate how much income they expect to have in the year they get coverage. To avoid owing money at tax time, consumers need to update the [insert name of exchange] during the year with any changes in income, family size, employment, or becoming eligible for Medicare. (See Question 99.)

Consumers who don't use the premium tax credits in advance don't have to tell the [insert name of state exchange] about any changes to their income or employment during the year. They can claim the tax credits on their tax returns.

Consumers may go to the [insert name of state exchange] website at [insert *link*] or call the [insert name of the state exchange] at [insert telephone number] for more information about premium tax credits. Navigators, certified application counselors, in-person assisters, producers (agents/brokers), or other assisters also are able to give consumers information about the tax credit. There's more information about premium tax credits on the federal website *www.healthcare.gov*

Q 93: Is an individual who is a victim of domestic abuse and separated (but not divorced) from his or her spouse eligible for subsidies on the exchange?

Yes. In general, married couples must file a joint tax return in order to be eligible for premium tax credits and cost-sharing reductions. For victims of domestic abuse, however, contacting their spouse to file a joint return may present a risk and may be legally prohibited if a restraining order is in place. As a result, married individuals who are victims of domestic abuse may still be eligible for subsidies if they are living separately from their spouse. Consumers in this situation should list "unmarried" on their exchange application and can do that without fear of penalty for misstating their marital status. For more information, see *www.healthcare.gov/income-and-household-information/household-size* or *www.irs.gov*.

Q 94: If a consumer is eligible for premium tax credits, is there a grace period before an insurer can terminate the consumer for non-payment of premiums?

Yes. The ACA requires insurance companies to give enrollees who receive premium tax credits a 90-day grace period for non-payment of premiums before the policy can be terminated, provided the enrollee has paid at least one month's premium. Claims must be paid during the first 30 days of the grace period, but the insurer may suspend payments to providers during the remainder of the grace period. In order to keep coverage at the end of the grace period, a consumer's account must be fully paid within 90 days of missing a premium payment.

Drafting Note: States should review their laws for other grace periods that might apply.

Q 95: What should consumers do if they find themselves enrolled in both exchange coverage with premium tax credits and Medicaid, CHIP, or Medicare?

The [insert name of exchange] conducts periodic data matching to identify individuals enrolled in both private insurance with premium tax credits and Medicare or private insurance with premium tax credits and Medicaid/CHIP and sends notices to those consumers. Upon receiving the notice, consumers may contact the exchange to end their exchange coverage with premium tax credits.

When individuals become eligible for Medicaid, CHIP, or Medicare while enrolled in an exchange plan, they will no longer be eligible for any premium tax credits or cost-sharing reductions. If a consumer wants to maintain exchange coverage while enrolled in Medicaid or CHIP, they will have to pay the full premium. Private plans generally may not cover an individual for the same benefits covered by Medicare, so people who become eligible for Medicare while enrolled in [insert name of exchange] should immediately notify the exchange to end their coverage and enroll in Medicare. Consumers can also contact the State Health Insurance Assistance Program (SHIP) [insert name of SHIP] at [insert contact information].

A consumer who wants to maintain exchange coverage while enrolled in Medicaid/CHIP may apply for coverage without financial assistance during the annual open enrollment period or a special enrollment period (SEP). When a consumer is enrolled in exchange coverage with premium tax credits or cost-sharing reductions and simultaneously covered by Medicaid, CHIP, or Medicare, the consumer likely will have to pay back all or some of the tax credits received for the months after they were determined to be eligible for Medicare or Medicaid/CHIP. Consumers who receive the notice but have more recently been denied eligibility for Medicaid or CHIP do not need to take any further action with [insert name of state exchange], but they may want to contact their state Medicaid or CHIP agency to confirm that they're not enrolled.

A consumer who finds they are enrolled in a health plan without his/her knowledge should contact the State Department of Insurance at [insert link].

QUESTIONS ABOUT OTHER TYPES OF COVERAGE

Q 96: What is available in the market outside the [insert name of state exchange]?

In [insert state name], health insurance coverage is also available in the market outside the [insert name of state exchange]. However, if consumers want to take advantage of premium tax credits to help pay for part of their premiums or for cost-sharing assistance, then they must buy coverage through the [insert name of state exchange]. (See Questions 90 and 91.)

Consumers may buy plans in the market outside the exchange that aren't required to cover the essential health benefits (EHB), such as fixed indemnity plans, short-term policies, or insurance coverage and discount plans that include only specialty or ancillary services (for example, hearing, chiropractic, etc.), as well as other arrangements like health sharing ministries or Farm Bureau plans. Note, though, that these policies don't have to comply with ACA reforms such as the requirement that plans cover pre-existing conditions. In the case of health sharing ministries and plans sold in some states through the Farm Bureau, they are not insurance products but may look similar, leading to consumer confusion. (See Question 4.) The NAIC has some resources discussing these types of plans:
https://www.naic.org/documents/health_insurance_what_to_ask.pdf
https://content.naic.org/article/not-all-products-are-health-insurance-health-care-sharing-ministries-discount-plans-and-risk-sharing

Contact [insert state Department of Insurance contact] or an insurance producer (agent/broker) for help.

Q 97: What are short-term plans?

Short-term plans sold or renewed after September 1, 2024, may only provide coverage for up to three months, with a maximum one-month extension. Plans sold before September 1, 2024, may be renewed under their initial terms. In 2025, the federal government issued non-enforcement guidance of this current short-term plan rule, but has yet to issue revised regulations as of this document's 2026 update.

Short-term plans are not required to comply with many of the consumer protections of the ACA. For instance, they may charge different premiums based on an applicant's health conditions, exclude essential health benefits, and exclude coverage for pre-existing conditions.

Drafting note: States with their own regulations on short-term plans should add a statement that describes allowable short-term plans, including duration restrictions, rating requirements, or benefit mandates.

Q 98: If consumers already have health insurance coverage, may they buy separate policies for their children?

Consumers who already have coverage for themselves are eligible to buy a policy for a child through the [insert name of state exchange]. The ACA requires that any health plan offered through the exchange also must be offered as a child-only plan at the same tier of coverage. Consumers also may be eligible for tax credits for child-only plans they buy through the [insert name of state exchange]. Visit the [insert name of state exchange] website at [insert *website for the state exchange*] for more information about child-only plans available through the [insert name of state exchange].

However, children who aren't legal residents of the United States aren't eligible for child-only plans through the [insert name of state exchange]. Consumers may be able to buy a child-only policy in the market outside the [insert name of state exchange], either directly from an insurer or through a producer (agent/broker). For a list of licensed insurers in [insert name of state], visit the [name of state department of insurance] website at [insert *link*]. A child also may be eligible for Medicaid (contact [insert name of state Medicaid agency] at [insert contact information]) or coverage through [insert state Children's Health Insurance Program (CHIP)]. To learn more about CHIP plans, visit *www.insurekidsnow.gov*

ACA MEDICARE-RELATED QUESTIONS

Q 99: Who should consumers contact with questions about Medicare, Medicare Supplement insurance, or Medicare Advantage Plans?

Medicare coverage, Medicare Supplement insurance (Medigap), and Medicare Advantage plans aren't available through the [insert name of state exchange]. Consumers who are currently enrolled in Medicare may not buy coverage through the exchange. Enrollees who are enrolled in Medicare because of end stage renal disease (ESRD) can enroll in a Medicare Advantage plan beginning in 2021. Questions involving the ACA and Medicare, Medicare Supplement insurance, or Medicare Advantage Plans can be referred to [insert name of State Health Insurance Program (SHIP)] at [insert contact information]. The federal government's Medicare website, *www.medicare.gov*, also has more information about health reform and Medicare changes.

Q 100: Are people who pay premiums for Medicare Part A able to enroll through the [insert name of exchange]?

Individuals who aren't entitled to premium-free Medicare Part A may buy coverage through [insert name of exchange] instead of paying the Part A premium and being enrolled in Part A. They may also be eligible for

premium tax credits. This includes those beneficiaries who only enrolled in Medicare Part B because they couldn't afford the Part A premium. In both cases, these beneficiaries must disenroll from Medicare Part A, if they have it, and from Medicare Part B, if they have it. Consumers who substitute a qualified health plan (QHP) for Medicare may pay higher premiums for Medicare if they decide to enroll in Medicare in the future and may have a gap in benefits. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about their choices.

Q 101: Can a person with ESRD (End Stage Renal Disease) enroll in or stay in an Exchange plan *instead* of enrolling in Medicare?

If a consumer with ESRD has not applied for Medicare, then they can stay in or apply for coverage through the [insert name of exchange]. However, delaying Medicare benefits has consequences. Individuals with ESRD who don't apply for Medicare may not be eligible for certain Medicare benefits if they enroll in Medicare in the future, may pay a higher premium for late enrollment, or may have a delay in benefits when they begin Medicare coverage. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about these complex choices.

Drafting Note: Medicare beneficiaries with ESRD can enroll in Medicare Advantage Plans.

Q 102: If individuals become eligible for Medicare and are already in a QHP, can they stay in their plan?

Yes. A person who is enrolled in a QHP* can enroll in Medicare and stay in the QHP. However, that person will no longer be eligible to receive any premium tax credits. If the consumer has been receiving an advanced premium tax credit, then the consumer must report eligibility for Medicare to the [insert name of state exchange] to end the tax credit. A consumer who does not do this will be liable to repay the premium tax credits for which they were not eligible.

Without the enrollee's authorization, a QHP may not terminate coverage from a policy in which the individual was enrolled after becoming eligible for Medicare. However, a QHP is not designed to coordinate its benefits with Medicare. Both the premium and the benefits of a QHP are designed to provide primary coverage, not supplemental coverage. Depending on state law, a QHP may reduce its benefits to pay covered expenses that remain after Medicare pays, but the premium will stay the same. This may happen even if the individual does not sign up for Medicare Part B. Consumers who are eligible to enroll in Medicare Part A at no cost (zero premium) are encouraged to enroll in Medicare when they are eligible to avoid premium penalties and delayed benefits later. Those who must pay to enroll in Medicare Part A should compare the costs and benefits of remaining in a QHP with the costs and benefits of moving entirely to Medicare Parts A and B with options to enroll in a Medicare supplement, Medicare Part D drug plan, or Medicare Advantage plan. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about how and when to enroll in Medicare and any penalties that can apply.

**Note that this information (except for the premium tax credits) applies to individual coverage inside and outside an exchange.*

Q 103: Is there anything consumers and their dependents who are already on Medicare and have employer-based health insurance coverage need to do because of the ACA?

Generally, there's nothing consumers need to do because of the ACA if they're already on Medicare and have employer-based coverage. If consumers have coverage through an employer, they may also have coverage through Medicare if they are eligible. To find out which plan would pay first and which would pay second, visit

https://www.medicare.gov/health-drug-plans/coordination/who-pays-first. The ACA made no changes to these rules.

If the employer changes the benefits that cover consumers or their dependents, then they will send consumers a notice about those changes. Consumers can ask their employer's human resources department how those changes work with Medicare.

The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about how their existing employer-based coverage works with Medicare.

Q 104: Is there anything consumers and their dependents who are already on Medicare and have retiree coverage from an employer need to do because of the ACA?

The ACA didn't change retiree benefits. Consumers should contact their employer's human resources department for help. Consumers who need more information about how Medicare and retiree benefits work together can contact the SHIP at [insert contact information].

Q 105: Will consumers with Medicare Supplement insurance be affected by the ACA?

No. The ACA doesn't change the cost-sharing for Medicare supplement policies.

Q 106: How will consumers' Medicare prescription drug "donut hole" be affected?

The ACA began closing the "donut hole" in 2011, and it was closed entirely effective for 2019. For 2025, not only is there no donut hole, but the maximum out-of-pocket expense will be $2,100 for drugs covered by Medicare Part D drug plans and Medicare Advantage plans with drug coverage.

For more information, contact Medicare at *www.medicare.gov* or 1-800-MEDICARE or the [insert name of SHIP] at [insert contact information].

Q 107: What about long term care (LTC) insurance policies?

The [insert name of state exchange] doesn't include long term care (LTC) insurance policies, and policies sold on the [insert name of state exchange] don't typically cover LTC services. Insurance producers (agents/brokers) still sell LTC insurance outside the exchange. The HHS website https://acl.gov/ltc has information about LTC insurance and the NAIC has produced a Shopper's Guide available at https://content.naic.org/sites/default/files/publication-ltc-lp-shoppers-guide-long-term.pdf

ACA MEDICAID-RELATED QUESTIONS

Q 108: Where can consumers find more information about Medicaid?

Contact the [insert name of state Medicaid agency] at [insert contact information] with any questions or concerns about Medicaid and the ACA. Also, the HHS website has basic information about Medicaid posted at *https://www.healthcare.gov/medicaid-chip/*.

Q 109: Did consumers' eligibility for Medicaid change under the ACA?

The ACA provides funds for states to expand their eligibility for Medicaid. Adults with incomes less than 138% of the federal poverty level generally were not eligible for Medicaid prior to the ACA. Most states have used ACA funds to open eligibility to this group. The pre-ACA Medicaid eligibility categories continue to be eligible

for Medicaid, although the financial method to decide eligibility has changed. Medicaid-eligible consumers include children, pregnant women, parents (or other caretaker relatives), blind, disabled, and elderly, but all must meet the financial eligibility test set by [insert name of state]. Contact the [insert state Medicaid agency] at [insert contact information] for more information.

Drafting Note: States that have not expanded Medicaid should modify this answer as appropriate.

There is more information about who is eligible for Medicaid and the Children's Health Insurance Program at this link: *https://www.healthcare.gov/medicaid-chip/*

Q 110: What is the expanded Medicaid eligibility category under the ACA?

Adults who weren't eligible for Medicaid in the past may be eligible under the ACA. [Insert name of state] has decided to expand Medicaid coverage to new groups, now covering low-income adults with household incomes less than 138% of the federal poverty level who do not qualify through another Medicaid eligibility pathway. Beginning in January 2027, individuals in this category will need to work (or perform other qualifying activities) for at least 80 hours a month to qualify for Medicaid. Certain populations are exempt from this requirement, including pregnant women, those with serious medical conditions, parents/caregivers of a dependent child 13 years and younger or with a disability, and others. Contact the [insert name of state Medicaid agency] at [insert contact information] for more information.

Drafting Note: States that have not expanded Medicaid will need to revise this answer accordingly. Some states may get CMS permission to implement work requirements early, through waiver authority, or to delay implementation of the work requirement until January 2029.

There is more information about who is eligible for Medicaid and the Children's Health Insurance Program at this link: *https://www.healthcare.gov/medicaid-chip/*

Q 111: What is the federal poverty level (FPL), and why is it important in the context of health care coverage?

The FPL is how the federal government defines poverty, and it's used to decide who's eligible for federal subsidies and entitlement programs. In states that have expanded Medicaid, low-income adults under 65 with incomes up to 138% of the FPL (or about $45,000 for a family of four) generally can get Medicaid coverage. Children, parents, pregnant women, seniors, and people with disabilities have different income limits. People with incomes above these levels may be eligible for premium tax credits to help them buy a plan through the [insert name of state exchange]. Cost-sharing reductions are available until a family's income reaches 250% of the FPL. Individuals who are eligible for both Medicare and Medicaid, or whose incomes don't exceed certain amounts, may be eligible for one of several low-income programs to supplement their Medicare benefits. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about their eligibility for these low-income programs.

Drafting Note: States that didn't expand Medicaid will need to revise the previous paragraph accordingly.

This link has general information about income levels at which financial help or coverage is available, as well as what counts as income: *www.healthcare.gov/lower-costs/qualifying-for-lower-costs/*

Q 112: What benefits are available for expansion-eligible adults enrolled in Medicaid?

Each state that expanded Medicaid has defined the benefit package for this eligibility group. The benchmark benefit package must include at a minimum the essential health benefits (EHB) available through the [insert name

of state exchange]. (See Question 16.) Contact the [insert name of state Medicaid agency] at [insert contact information] for more information.

Drafting Note: States that didn't expand Medicaid will need to revise the previous paragraph accordingly.

Q 113: Are undocumented immigrants eligible for Medicaid?

Undocumented immigrants are not eligible for full Medicaid coverage. Health care providers can be paid through Medicaid for treating an emergency medical condition when a patient's health is in serious jeopardy.

Drafting Note: States that have Medicaid-like coverage or Marketplace coverage for undocumented or otherwise ineligible immigrants will need to revise accordingly.

Drafting Note: States can use state-only funds to provide health coverage (beyond emergency services) to otherwise eligible individuals regardless of immigration status.

Q 114: How do consumers apply for Medicaid?

Consumers can apply online through the [insert name of state exchange]. They also can apply by mail, phone, or in person. If a consumer applies through the [insert name of state exchange], then his or her eligibility for Medicaid also will be assessed, and the consumer's application will be transferred to the [insert name of state Medicaid agency] for final determination of eligibility. Under the law, there's "no wrong door" to apply for health coverage, whether it's through [insert name of state Medicaid agency], CHIP, or the [insert name of state exchange]. If a consumer isn't eligible for Medicaid, then the consumer's eligibility for coverage through the [insert name of state exchange] and for premium tax credits or cost-sharing reductions will be evaluated. Also, the HHS website has basic information about Medicaid posted at *https://www.healthcare.gov/medicaid-chip/*

Q 115: Do consumers who apply for Medicaid, CHIP, premium tax credits, and cost-sharing reductions need to submit documents to prove their income?

As much as possible, the [insert name of state exchange] uses existing data sources or gets information from various federal and state agencies, such as the IRS, to verify income. The rules are designed to ensure a high degree of program integrity and reduce the amount of paperwork that consumers need to provide.

Some consumers will be asked to provide documents to prove their income. The processes to verify income to qualify for Medicaid and CHIP are separate from those to verify income for premium tax credits and cost-sharing reductions. To verify income for Medicaid, CHIP, premium tax credits, and cost-sharing reductions, [insert name of state exchange] will use data from the IRS, the Social Security Administration (SSA), and other income data sources.

Effective October 2024, the federal exchange does not accept applications without a Social Security Number. Additional guidance will be provided for those eligible persons who do not have a Social Security Number.

For Medicaid and CHIP, issues that come up about verifying income will be resolved through a process of explanations and documentation for each consumer. For premium tax credits and cost-sharing reductions, most verification issues will be resolved through a process of explanations and documentation for each consumer. But, to limit the administrative burden, the [insert name of state exchange] may sample only some cases to verify eligibility for premium tax credits and cost-sharing reductions.

COMMON CONCERNS ABOUT HOW THE ACA AFFECTS CONSUMERS

Q 116: Does the ACA eliminate private health insurance?

No. The ACA created health insurance exchanges (see Questions 5-6) where consumers can compare and shop for private insurance plans. The ACA also set many new federal rules and protections that apply to people who buy private health insurance in each state. Consumers can purchase private health insurance through the exchanges or outside of them. Outside of the exchange, a variety of private plan types are available, including both ACA-regulated plans and plans not regulated by the ACA. (See Questions 2 and 4.)

Q 117: Does the ACA include rules about insurance premiums?

Yes. In individual and small group health insurance market plans covered by the ACA's rating rules, premiums may only vary based on an individual's age, the area of the state in which the policy is sold, tobacco use, and family size. For covered plans, these are the only factors that an insurance company can use when it sets premiums. ACA plans can't refuse to insure or charge higher premiums to consumers with medical problems. These rating rules cover individual and small group health plans offered through the exchanges or outside of them, but do not apply to short-term, limited duration plans.

To help make coverage affordable, many consumers who buy qualified health plans through individual market exchanges are eligible for premium tax credits. Also, consumers under age 30 or those who obtain a hardship exemption may be eligible to buy catastrophic plans, which cost less.

Drafting Note: States may want to link to rate submissions and final approvals. States that don't allow the tobacco surcharge or use a different ratio than 1.5:1 should note that health insurance companies are prevented from charging consumers a higher premium for being a tobacco user or are limited in the amount of tobacco surcharge they can apply.

Q 118: Does the ACA address discrimination?

In addition to the ACA's market reforms, the ACA includes a separate nondiscrimination provision that prohibits health insurance companies that receive federal funding from discriminating on the basis of race, color, national origin, sex, age, or disability.

Section 1557 of the ACA prohibits discrimination by health programs or activities receiving funds from HHS and by exchanges established under the ACA. The scope of this prohibition was first outlined via final rule in 2016, which broadly defined the areas of prohibited discrimination. Gender identity was a controversial inclusion in the rule. On June 12, 2020, a final rule was published that changed the 2016 regulations to limit the applicability. One of the changes in the 2020 rule was to remove the prohibition on discrimination based on gender identity. On June 15, 2020, the U.S. Supreme Court held that discrimination on the basis of sex included discrimination based on sexual orientation and gender identity. HHS announced that effective May 10, 2021, it would interpret and enforce Section 1557's prohibition on discrimination to include discrimination based on sexual orientation and gender identity. HHS has finalized an updated nondiscrimination rule that would codify protections against discrimination based on sexual orientation and gender identity and require broad applicability of Section 1557.

In addition, health insurers must follow any state laws and regulations that apply to marketing and can't use marketing practices or benefit designs that will discourage individuals with significant health needs from enrolling. Health insurers must also provide meaningful access for individuals with limited English proficiency and post taglines in the languages spoken by persons with limited English proficiency.

Q 119: Where else can consumers find answers to health insurance questions?

[Insert links to State DOI, Exchange, Medicaid, navigator organizations, etc.]

Q 120: What does the health plan "accreditation status" information on the exchange website mean?

Accreditation is a comprehensive process that private, nonprofit organizations use to review how well health plans deliver care and how they work to improve the delivery of care over time. Health plans offered through the [insert name of state exchange] must be certified by a recognized accrediting body, such as URAQ and/or the National Committee for Quality Assurance (NCQA), within a time frame set by the [insert name of state exchange]. Accreditation ensures that the plans sold on the [insert name of state exchange] meet the minimum quality, access, nondiscrimination, and marketing standards in the ACA.

Q 121: What does the health plan "consumer experience" information on the [insert name of state exchange] website mean?

Consumer experience ratings come from surveys that ask individuals who have coverage through a health insurance plan how they like the plan. These individuals also rate the quality of the medical care they receive and the accessibility of the medical care that they need.

Q 122: What appeal rights and other dispute resolutions actions are available to consumers?

Several actions are available to consumers to address disputes with health insurers.

Insurance companies won't pay for services a plan doesn't cover, such as care that isn't medically necessary. Consumers have the right to ask their insurance company to reconsider a decision to deny coverage and, after that, consumers have the right to an independent external review of the decision. When care is denied as "not medically necessary," consumers or their clinicians may submit additional documentation – such as a letter of medical necessity – to support the appeal.

Consumers have a right to appeal their health insurance company's unfavorable coverage decision. Insurance companies must give consumers a first-level internal appeal, administered by the company. If the company upholds its initial unfavorable coverage decision, then it must offer an external review administered by an independent third party. Consumers may also be able to request a second-level internal appeal. Such initial and second-level internal appeals must be completed withing the legal time limits specified by law. Expedited review for emergency situations is available.

The insurance company may require two levels of internal appeals before the external review option for claims denied as not medically necessary or medically appropriate. For more information about how to appeal a health insurance company's unfavorable decision, the consumer can refer to the notice of the insurance company's unfavorable coverage decision (often referred to an Explanation of Benefits, or EOB), plan or policy documents, or contact [insert state insurance department] at [insert telephone number].

Consumers can also file a formal insurer complaint directly with the insurer if they believe a claim or coverage decision was handled improperly. Consumers may also file regulator complaints with [insert name of state insurance department] when claims are denied, or when they believe that their health insurance company isn't properly following the legal appeals process. Consumers can contact the state insurance department at [insert contact information]. Please note this does not delay or extend the 4-month filing deadline that starts with receipt of the final coverage decision.

If consumers are unable to access in-network care from a provider with appropriate expertise, within a reasonable distance, or in a timely manner, they may contact the insurer or the state insurance department for assistance or to file a complaint.

Note that there is a separate appeals process if a consumer is dissatisfied with an eligibility decision made by [insert name of state exchange]. The consumer can contact [insert name of state exchange] for more information.

Drafting Note: States that have additional consumer protection laws or appeal timelines that differ from federal standards should include that information here.

Drafting Note: If the state has specific procedures for network adequacy complaints or access-to-care issues, that information may also be included.

Drafting Note: States may wish to add a reference or link to their consumer assistance program or ombudsman office that helps individuals file appeals or complaints.

Q 123: Where do consumers file a complaint for a product sold through the [insert name of state exchange]? What about plans sold in the market outside the [insert name of state exchange]?

Consumers should first contact the insurance company with any complaint about benefits or services they're not receiving. If consumers aren't satisfied, they should contact the [insert name of state exchange] for help with questions or complaints.

The [insert state department of insurance] investigates complaints about insurance companies and can either look up consumers' complaints or direct consumers to the right place to file a [insert name of state exchange] related complaint. The [insert state insurance department] is ready to help consumers with any questions or complaints they may have about their coverage. To find out more about filing complaints, consumers can contact the [insert state department of insurance] at [insert contact information].

Q 124: If consumers apply for coverage directly from the company instead of the [insert name of state exchange], what are the rules regarding open and special enrollment?

In [insert name of state], insurance companies sell policies outside the exchange. Enrollment periods for coverage outside the [insert name of state exchange] generally are the same as enrollment periods through the exchange. (See Question 11.) Contact the [insert name of state department of insurance] at [insert contact information], or an insurance producer (agent/broker) for more information about enrollment.

If someone did not enroll in the [insert name of state exchange] during this enrollment period or experienced certain life events during the year, they may be able to newly enroll in a plan or switch plans outside of open enrollment through a special enrollment period (SEP). If you qualify for a SEP, you usually have up to 60 days following the event to enroll in a plan. If you miss that window, you have to wait until the next Open Enrollment Period to apply. Job-based plans must provide a special enrollment period of at least 30 days.

For more information about special enrollment periods (SEPs), see this link:
https://www.healthreformbeyondthebasics.org/sep-reference-chart/

QUESTIONS INVOLVING SPECIAL CIRCUMSTANCES AND POPULATIONS

Q 125: What is available for consumers with chronic conditions? Does the ACA help them get better coverage?

Yes. All plans subject to the ACA must insure consumers with a chronic or pre-existing medical condition, must cover pre-existing conditions, and can't charge higher premiums because of a health or medical condition. They are also required to offer comprehensive coverage. Discrimination on the basis of age, health, disability, or expected length of life is prohibited. Coverage for these benefits is available from the beginning of the policy coverage period, without a waiting period, even if there was no prior coverage. Many plans include wellness programs to help consumers manage chronic conditions.

Q 126: What options are there for consumers with children who aren't citizens or legal residents?

Consumers with children who are not citizens, legal residents, or lawfully present, won't be able to buy a policy through the [insert name of state exchange], but they may be able to buy a policy directly from an insurance company or through an agent. Insurers that sell policies through the exchange must make those policies available to individuals, including children, who are not eligible for enrollment in a health insurance policy through [insert name of state exchange]. Depending on their status, children also may be eligible for [insert name of state Medicaid and CHIP]. For more information, go to *www.insurekidsnow.gov*

Q 127: What are the options for consumers with Deferred Action for Childhood Arrivals (DACA) Status?

People with Deferred Action for Childhood Arrivals (DACA) Status are no longer eligible for enrollment in a health insurance policy through [insert the name of state exchange] or financial assistance to help make that coverage affordable. People with DACA status may buy a policy directly from an insurance company or through an agent.

Q 128: Are immigrants not lawfully present in the U.S. eligible for coverage through the [insert name of state exchange] or for premium tax credits?

No. Immigrants not lawfully present in the U.S. aren't eligible for coverage through the [insert name of state exchange]. They also aren't eligible for advance payment of premium tax credits. Insurers that sell policies through the exchange, however, must make those policies available upon request to individuals, including children, who aren't eligible to participate in the [insert name of state exchange].

Q 129: Are incarcerated people eligible for coverage through the [insert name of state exchange] or for premium tax credits?

No. Incarcerated people generally aren't eligible for coverage through the [insert name of state exchange]. They also aren't eligible for advance payments of the premium tax credits. Upon release from incarceration, consumers qualify for a 60-day Special Enrollment Period to apply for and select a plan. Consumers who are incarcerated pending the disposition of charges are eligible.

Q 130: Are tribal members eligible for coverage through the [insert name of state exchange] or for premium tax credits?

Yes. Tribal members may buy coverage through the [insert name of state exchange]. Tribal members have access to enrollment all year. They're also eligible for premium tax credits. And, because of the federal government's special trust responsibility, members of federally-recognized Indian tribes are eligible to receive benefits not

available to others, such as plans with no cost-sharing, under certain circumstances. For more information, go to *www.healthcare.gov* or the website for the Indian Health Service (IHS) agency within the HHS at *www.ihs.gov/*

QUESTIONS ABOUT MLR

Q 131: What is the Medical Loss Ratio (MLR) requirement?

The ACA's MLR requirement is that health insurers must spend at least a certain percentage of consumers' premium dollars on direct medical care and health care quality improvement. The MLR limits the amount of premium dollars spent on administrative expenses, such as overhead, marketing, salaries, and profit.

The ACA requires that health insurance companies providing coverage in the large employer market (usually 50 or more employees) must spend at least 85% of premiums on direct medical care and quality improvement activities. Health insurers who provide coverage in the small employer market (usually fewer than 50 employees) and individual market must spend at least 80% of premiums on direct medical care and quality improvement activities, or they must rebate (refund) the extra premium.

Q 132: What is an MLR Rebate?

Under federal law, if a health insurer doesn't meet the MLR target (described in Question 131), then that health insurer must give consumers or employers a rebate for the premiums it collected that were greater than the target.

Q 133: How can consumers learn if their insurer paid rebates?

Companies that pay rebates must send notices to enrollees. The list of the rebates paid can be found at *www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html*

QUESTIONS ABOUT WHETHER A PLAN IS LEGITIMATE

Q 134: Why is it especially important to be aware of possible scams or insurance fraud now?

Health insurance rules and regulations are constantly changing. Con artists posing as representatives of the federal government or posing as legitimate insurance agents, brokers, or navigators might try to steal consumers' money, identity, or health information through various health insurance schemes. Open enrollment periods are especially appealing times for criminals to try to blend in with legitimate marketing efforts or take advantage of consumers who may feel pressure to find coverage.

Q 135: What do the scams or fraudulent activities look like?

Scammers often use sophisticated tools and fast-talking scripts to entice potential victims. For instance, criminals might try to convince consumers to reveal personal information to receive a "national health insurance card" or a new or "updated" Medicare card under the ACA. Or they may also try to sell consumers health insurance policies that are fake, worthless, or not what they claim to be. Scammers often use automated telephone calls, text messages, e-mails, or websites that mimic legitimate sites.

Q 136: Can consumers get help from their current insurance producer (agent/broker) or insurance company to buy health insurance coverage through the [insert name of state exchange]?

Yes. Working with individuals known personally or known to be working for a licensed agency or insurer is a dependable way to avoid fraud. Consumers can contact [insert jurisdiction's licensing department URL] to verify an agent's license status.

Q 137: If consumers don't have a relationship with an insurance producer (agent/broker) or company, where should they go for help?

Consumers can contact the [insert name of state exchange] for assistance. They'll get help reaching a registered or licensed navigator specifically trained to help them choose the best health insurance product for their needs.

Drafting Note: States without navigators should update this response to provide alternates sources for consumer assistance.

Q 138: If someone comes to consumers' homes, calls consumers out of the blue, or sends emails to offer consumers health insurance coverage for a terrific premium, how will consumers know whether the person and the health insurance coverage are legitimate?

Remember this simple formula: **STOP – CALL – CONFIRM**

STOP – Consumers should ask the person for identification, such as their full name and license number, and a phone number where they can reach them later. If the person refuses to give this information for any reason, or tries to pressure them or rush them into signing any document or making a spoken agreement, or if the person requires the consumer to provide a credit card number before revealing specific details of the insurance product, consumers should immediately hang up, close their door, or walk away.

Consumers should NEVER provide their Social Security number (SSN) or a credit/debit card number to anyone unless they personally know the individual. Likewise, they should NOT sign any paperwork or write a check.

CALL – Consumers should contact the [insert name of state department of insurance] or the [insert name of state exchange]. The insurance company, agent, or broker, as well as the navigator, must be registered or licensed with the [insert state department of insurance] before they can sell insurance or counsel consumers through the [insert name of state exchange].

Drafting Note: States should modify the previous paragraph as necessary to reference the entity charged with registering or licensing navigators.

CONFIRM – Consumers should always confirm that the company or producer (agent/broker) offering insurance coverage, or the navigator providing assistance, is authorized to provide information or coverage before signing any documents or giving any personal information.

Remember that if something seems too good to be true, it usually is.

Draft: 11/5/25

Consumer Information (B) Working Group
Virtual Meeting
October 23, 2025

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met Oct. 23, 2025. The following Working Group members participated: David Buono, Chair (PA); T.J. Patton, Vice Chair (MN); Randy Pipal (ID); Michelle Baldock (IL); Alex Peck (IN); Jeana Thomas (MO); Elouisa Macias (NM); Donna Dorr (OK); Jill Kruger (SD); and Christina Keeley (WI).

1. Discussed Revisions to the *Frequently Asked Questions About Health Care Reform* Document

Buono thanked regulators and interested parties who reviewed and made updates to portions of the *Frequently Asked Questions about Health Care Reform*.

He said the revised document had been circulated earlier in the week and asked reviewers whether they had any questions for the Working Group on their sections. Lucy Culp (Blood Cancer United) discussed changes she made to how non-major medical plans are described in several questions. Her changes highlighted that short-term, limited benefit plans are not the only non-major medical plans consumers may consider. The Working Group agreed to retain her changes.

J.P. Wieske (Monument Advocacy) suggested adding language across several questions encouraging consumers to shop and compare their options for 2026 due to the expected changes in premiums. The Working Group decided to add a statement on this topic to the Purpose section at the beginning of the document, rather than in individual questions and answers.

The Working Group discussed the proposed addition of several questions by consumer representatives. The added questions and answers cover mental health and substance use services, finding navigators, and re-enrollment. The Working Group agreed to add these questions and answers and to delete a question on navigators that was made redundant by the addition of another question.

The Working Group discussed whether to include a statement on Medicaid eligibility changes that take effect in January 2027, despite the document being updated to reflect changes for 2026. The Working Group decided to retain the suggested addition because the language clarifies when the Medicaid change takes effect.

Brenda J. Cude (University of Georgia) said she made additional edits and added questions to the version circulated on Oct. 21. Because her changes had not been reviewed by others, the Working Group decided to review the document again, send any final edits to Joe Touschner (NAIC), and conduct an e-vote on approval of the document in the week of Oct. 27.

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

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Draft: 11/10/25

Consumer Information (B) Working Group
Virtual Meeting
October 3, 2025

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met Oct. 3, 2025. The following Working Group members participated: TJ Patton, Vice Chair (MN); Tara Smith (CO); Michelle Baldock (IL); Alex Peck (IN); Jeana Thomas (MO); Jennifer Ramcharan and Vickie Trice (TN); Shelley Wiseman (UT); and Coral Manning (WI).

1. Confirmed State Votes to Approve a Template Media Release on Shopping for Health Plans in 2026

Patton reminded the group of an ongoing e-vote to approve a template media release to encourage consumers to review their plan choices for 2026. Patton described the document and mentioned that several states had already submitted electronic votes in favor of approving the template. Colorado and Indiana added their votes to approve the template.

2. Discussed its Plan for Revising the *Frequently Asked Questions About Health Care Reform* Document

Patton described the purpose of the *Frequently Asked Questions About Health Care Reform* document as a reference document for state insurance department staff. He said it can be used by states to help respond to consumer questions about health care reform topics, although the document is not intended to be shared directly with consumers.

Patton asked about the Working Group's past process for making updates. Joe Touschner (NAIC) said that Working Group members, interested regulators, and interested parties can volunteer to review sections of the document and make any necessary updates. Touschner reviewed the 14 sections of the document.

Regulators and interested parties selected sections of the FAQ to review. Brenda J. Cude (University of Georgia) offered to help other reviewers with wording for their sections. The Working Group agreed to provide updates to the document by Oct. 20 to meet the goal of distributing the final document to states before Nov. 1.

3. Discussed Changes in the Medicare Advantage Market

Patton asked for feedback from the Working Group on changes occurring in the Medicare Advantage market. He said plans in Minnesota have left the state entirely or reduced their service areas. He said remaining carriers have eliminated commissions for selling their plans for 2026. He said this could result in Medicare beneficiaries having difficulty understanding their options and selecting the right plans. Patton said he would support the Working Group taking up this issue and developing a template document that helps consumers understand their Medicare choices. He said the Working Group could potentially work with the Senior Issues (B) Task Force on such a document.

Harry Ting (Consumer Representative) reported observations from a Medicare broker he spoke with. He said drug plans are dropping out or offering minimal commissions. He said Medicare Advantage plans are dropping preferred provider organization (PPO) plans.

Bonnie Burns (California Health Advocates—CHA) said health care providers are also leaving the Medicare Advantage market. She said that Medicare supplement guaranteed issue opportunities only occur when providers leave a network, provided the federal Centers for Medicare & Medicaid Services (CMS) grants the opportunity. She said that both the Senior Issues (B) Task Force and the Improper Marketing of Health Insurance (D) Working Group should examine these issues.

Patton said states should consider providing broad overviews for consumers of Medicare, Medicaid Advantage, and Medicare supplement plans. He said states should also do outreach with the broker communities in their states. Burns encouraged state insurance regulators to work with State Health Insurance Assistance Programs (SHIPs) in their states. Ting said it is difficult for consumers to compare prices for Medicare supplement plans, but SHIPs can help them make such comparisons.

Patton said the Working Group would continue conversations on this topic with the Senior Issues (B) Task Force.

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

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Draft: 11/10/25

Consumer Information (B) Working Group
E-Vote
October 3, 2025

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Oct. 3, 2025. The following Working Group members participated: David Buono, Chair (PA); TJ Patton, Vice Chair (MN); Tara Smith (CO); Michelle Baldock (IL); Alex Peck (IN); Terri Smith (MD); Jeana Thomas (MO); Maryann Arriola (MP); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keely (WI).

1. Adopted a Template Media Release on Health Insurance Changes for 2026

The Working Group conducted an e-vote to consider adoption of the *Template Media Release on 2026 Health Coverage* document (Attachment Five-A) The template encourages consumers to explore all their health coverage options for 2026 considering potential changes to premium costs for plans purchased through Affordable Care Act (ACA) marketplaces. The motion passed unanimously.

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

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NAIC Consumer Information (B) Working Group

Template Media Release on 2026 Health Coverage

Consumers Have Options For Health Insurance Coverage

It's time to think about your health insurance coverage for 2026. Changes are coming and premiums may be higher if you're enrolled in a Marketplace plan. The [Department of Insurance] encourages everyone to look at **all** their health plan options – a plan through [state-based exchange or the Health Insurance Marketplace], an employer, or directly from an insurer. Start early to find the coverage that best fits your needs.

What are my options?

- **Enroll in a [state-based exchange or Health Insurance Marketplace] plan.** The Marketplace is a service that helps people shop for and enroll in affordable health insurance. Under the Affordable Care Act (ACA), [state operates the state-based exchange or the federal government operates the Health Insurance Marketplace]. In [state], you can apply at [state-based exchange's website or **HealthCare.gov**]. Use the Find Local Help tool to find an agent, broker, or assister who can help you understand and compare your options, free of charge.

  Most people who use the Marketplace can get help to pay for a plan. The amount depends on your income. But less help is expected in 2026. Enhanced subsidies, which helped to make coverage more affordable for everyone, are scheduled to end. Losing the enhanced subsidies could greatly increase your monthly cost for coverage compared to 2025.

- You might be eligible for a catastrophic plan through the Marketplace. These plans usually have lower monthly premiums. They protect you from very high medical costs if you have serious illness or injury, but typically come with high deductibles and limited coverage before the deductible.

- **Enroll in job-based coverage**. If you're employed and your employer offers health benefits, you may qualify for health insurance at work, even if you haven't had this coverage in the past. You may also be able to enroll in coverage through your spouse's employer or, if you're younger than 26 years old, through your parent's employer.

- **Enroll in a plan through a private insurer.** You may also buy coverage through an agent or broker or directly from a health insurance company. You may find plans that cost less than a Marketplace plan, but be sure they meet your health care needs.

- **Enroll in a student health plan**. If you're younger than 30 and enrolled in school, you may be eligible for a student health plan. Contact your school to explore this option. Be sure the plan meets your coverage needs.

[Drafting Note: Include if applicable to your state.

What if my insurer leaves the ACA Marketplace?

If your insurer leaves the Marketplace, you should carefully review your options, including plans inside and outside the Marketplace.

If you don't choose and enroll in a new plan, you may be automatically enrolled in a different Marketplace plan. However, this plan may not meet your health care needs. That's why it's important to review your options and select a plan that works for you. You can start to review plans on November 1.**]**

What should I think about when I choose a plan?

If you need help understanding health insurance, contact the [state] Department of Insurance. We can help you find licensed agents or other assisters who can review your options.

To choose a plan, it's important to carefully think about your family's health care needs. Calculate your costs from recent years and try to estimate what they might be for the coming year. You should also consider health changes that are possible in the coming year, such as starting a family or needing durable medical equipment for worsening sleep apnea, mobility impairments, or hearing impairments. Don't forget to include copays for doctor's visits, prescription medications, and any procedures you might need.

Next, compare the premiums, out-of-pocket expenses, and benefits under each plan. If you're buying a policy from the Marketplace, you can compare the plans offered side by side. Finally, decide how much you can afford to pay.

The **NAIC's Health Insurance Shopping Tool** can help you determine which plan is right for you. The Marketplace also has helpful information about **choosing a plan**.

Know that some products aren't health insurance and don't have the same consumer protections as health insurance. **Health care sharing ministries (HCSMs), discount plans, and risk-sharing plans** are not insurance products and the Department of Insurance may not be able to help you if a problem occurs.

Draft: 11/10/25

Consumer Information (B) Subgroup
E-Vote
August 11, 2025

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Aug. 11, 2025. The following Subgroup members participated: David Buono, Chair (PA); TJ Patton, Vice Chair (MN); Anthony L. Williams (AL); Terri Smith (MD); Jeana Thomas (MO); Jill Kruger (SD); Vickie Trice (TN); Shelley Wiseman (UT); Andrew Davis (WA); and Christina Keely (WI).

1. Adopted a Consumer Guide on Shopping for Health Insurance

The Working Group conducted an e-vote to consider adoption of the *A Consumer's Guide to Buying Your Own Health Insurance* document (Attachment Six-A). The guide helps consumers understand health insurance, providing key definitions, explanations of plan types, questions to ask, and tips to follow. The motion passed unanimously.

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

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A CONSUMER'S GUIDE TO BUYING YOUR OWN HEALTH INSURANCE

Buying health insurance can feel overwhelming if you have many choices. The tips in this guide will help you understand how to move forward on your own or with the help of an insurance agent, broker, or producer.

Government-Sponsored and Employer-Based Coverage

Before you buy health insurance, it's worth it to check if you're eligible for coverage through a government program or an employer.

- Medicare: If you're 65 or older, have received Social Security Disability Insurance benefits for at least 24 months, or have End Stage Renal Disease or Lou Gehrig's Disease (ALS), then you likely qualify for Medicare. To find out more, contact [the name of your state's SHIP program] at [your state's SHIP program phone number] or an insurance agent, broker, or producer approved to sell Medicare-related plans.
- Medicaid: Medicaid serves people who qualify based on their income. It pays for comprehensive health care at little or no cost. If you think you might qualify for Medicaid, call [name of state Medicaid agency] at [state Medicaid phone number] to learn more. People who qualify for both Medicaid and Medicare can receive benefits from both programs.
- Employer-Sponsored Coverage: Many employers offer health insurance as a benefit to employees, their spouses, and dependents. Check with your or your spouse's employer to find out about eligibility, coverage, and costs.

1. Know Key Terms Before You Shop

- **Premium:** What you pay each month for your health plan's coverage.
- **Deductible:** The amount you pay out-of-pocket before insurance starts paying.
- **Copayment (Copay):** Fixed fee per doctor visit, hospital day or stay, or prescription. For example, $20 for a doctor's visit or $30 to see a specialist.
- **Coinsurance:** The percentage of costs you pay. For example, 30% of hospital charges.
- **Out-of-pocket maximum:** The most you'll pay each year before insurance covers 100%. Not all plans have an out-of-pocket maximum.
- **Annual or lifetime limit:** The most a health plan will pay each year (annual) or in total over the time you have the plan (lifetime) toward your covered health costs. After you reach that amount, the plan won't pay any more of your health costs. Health plans subject to the Affordable Care Act don't have these limits.

- **Provider:** An individual or facility that provides health care services.
- **Network:** The facilities, providers, and suppliers (such as pharmacies) your health insurer has contracted with to provide health care services. If your health plan uses a provider network, then you pay less if you see a provider in the network.
- **Pre-existing condition:** A health problem like asthma, diabetes, or cancer you had before your health insurance went into effect. Some health plans don't cover services to treat pre-existing conditions.
- **Health insurance navigator:** A trained professional who provides free unbiased help to understand and enroll in Marketplace plans **[If applicable, replace with name of Marketplace plans in your state].**

2. Find Which Type of Health Plan Is Right for You

- **Marketplace Plans [If applicable, replace with name of Marketplace plans in your state]:** If you're younger than 65, you should look into these plans. You may qualify for financial help to reduce your monthly premium or your out-of-pocket costs. Law requires Marketplace plans to cover a comprehensive range of services, also called the 10 "essential health benefits." **[link to https://www.healthcare.gov/coverage/what-marketplace-plans-cover/]** The 10 essential health benefits are:
  - Outpatient care
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services
  - Pediatric oral and vision care

  Marketplace plans must cover services to treat pre-existing conditions. To find out more, contact [phone number for Marketplace plans in your state], an insurance agent, broker, producer, or a health insurance navigator. **[Add link to Marketplace or navigator resources.]**

- **Short-Term, Limited Duration Plans:** These plans offer coverage for up to 3 months. They don't have to cover all of the essential health benefits or services to treat pre-existing conditions.
  [Drafting Note: Adjust the definition according to state law or changes in federal policy.]
- **Other Types of Health Insurance:** You can buy other types of health insurance plans but they may not cover the essential health benefits. You also can't get financial help to

pay premiums or out-of-pocket costs with these plans. Some insurance plans only cover a few services or specific conditions. Some pay you directly a fixed amount that's not related to your health care costs. For more information about other types of coverage, click here. **[Link to Types of Health Coverage Table]**

Other Types of Coverage That Are NOT Insurance

- **Health Care Sharing Ministry Plans:** Faith-based organizations sponsor these plans. They are not insurance plans. These plans use part of plan members' contributions to pay benefits. They do not guarantee how much they'll pay for the services they cover.
- **[Include if applicable] Farm Bureau Plans:** Individuals and families may qualify for coverage through the Farm Bureau, a private company. This coverage is not insurance. These plans may not cover the 10 essential health benefits or pre-existing conditions.
- **Discount Plans:** With a discount plan, you pay upfront for a discount on services from participating providers. These plans are not insurance. They do not cap the amount you may owe for health care services.

Compare Types of Health Coverage **[Link to Types of Health Coverage Table]**

3. Watch Out for Red Flags

- **Don't rely on verbal promises.** Ask the health plan representative to give you the following information in writing:
  - What's covered
  - What's not covered
  - Costs (including premiums, deductibles, copays)
  - Keep a copy of any information you get.
- **Be cautious about unsolicited information or marketing.** Think twice before you respond to unsolicited calls, texts, or emails from unknown sources. Ask your state insurance department to confirm that insurance agents, brokers, and producers are licensed.
- **If something sounds too good to be true, it probably is.** Ads that offer comprehensive coverage for a really low price (such as $50 per month) are often misleading.
- **Approach offers of upfront payments to you with caution.** Some health plan ads or salespersons offer a gift or a government subsidy card you can use for groceries, bills, or medical needs if you sign up. These offers may be deceptive or even illegal.
- **Ask about added fees.** Fees other than the health plan premium could mean you're signing up to join an association. Know what you're paying for.
- **Avoid pushy sales tactics.** If someone pressures you to sign today or says, "this offer is expiring now," be cautious.

- **Clarify vague plan details.** Be sure to get a Summary of Benefits and Coverage or another official plan document that describes the costs and coverage in writing.

4. Tips to Follow

- **Carefully review documents before you sign.** Use the documents to check provider networks and what the plan does and doesn't cover. Carefully read anything asking you to verify your own information. Be sure you also aren't agreeing to something that limits your benefits or increases your costs.
- **Be sure you will have access to the documents after you sign.** If you sign online, be sure you can access your documents later.
- **Take your time.** Don't rush your decision. If there's a deadline, such as the limited enrollment periods for Marketplace plans, start before the deadline to give yourself more time.
- **Compare multiple plans.** Ask a trusted friend, family member, or local health navigator to review plans with you if you're not sure.

5. Ask the Right Questions

- **Is the plan an insurance plan?** If not, you may not have government protections that require the plan to pay its stated benefits.
- **Is the plan a comprehensive health plan?** Comprehensive health plans (sometimes called major medical) cover a wide range of health care services and may protect you from high costs. Other types of plans have more limited benefits.
- **Which services are and aren't covered?** Does the plan cover hospital services, primary care and specialty physician services, other medical services like lab and imaging, prescriptions, and mental health services?
- **Are your preferred providers in the network?** Check whether physicians, hospitals, or other providers you want to continue to use are in the network. Ask if there are any limits on your ability to use these providers.
- **Does the plan cover treatment for pre-existing conditions?**
- **Does the plan have an annual or lifetime limit on the amount it will pay for your care?**
- **Is there an out-of-pocket maximum that limits your total cost for deductibles, co-insurance, and copayments?**
- **Does the plan cover preventive services at no cost to you?**
- **Does the plan cover your prescription drugs? How much will you pay for those drugs under the plan?**

- **If you're dealing with an insurance agent, broker, or producer, are they licensed in your state?** States require insurance agents, brokers, and producers to meet state-specific qualifications to be licensed. If they are licensed, they have a state insurance license number. Ask for that number. With the number, you can check that person's credentials at **[state DOI webpage for licensed producers].** Later, if you have a complaint or suspect fraud, you can report that person to **[relevant state insurance department's phone number].**

Follow this guide to be in a stronger position to get the coverage you need — and avoid falling for scams or misleading sales pitches.

Types of Health Coverage

Plan Type	What is Covered?	What is NOT Covered?	Does the Plan Pay You Or the Provider?	Is This a Marketplace Plan?
Hospital Indemnity Policy: Pays a set dollar amount for each hospital stay	Any covered hospital visit	Any services other than hospitalization	Usually pays you a set amount regardless of the amount of your hospital bill	No
Other Fixed Indemnity Policy: Pays a set dollar amount per service	Any covered service	Services for pre-existing conditions, maternity, ambulance	Usually pays you a set amount regardless of the amount your provider bills	No
Critical Illness Policy: Pays a set dollar amount per diagnosis	Any covered specific diagnosis, such as cancer	Services for pre-existing conditions, maternity, ambulance	Usually pays you a set amount regardless of the amount your provider bills	No
Disability Income Protection: Pays a set dollar amount per period if you become disabled	Any covered disability	Services for pre-existing conditions, maternity, routine physicals	Pays you a set amount depending on the policy benefits	No
Accident Only Policy: Pays a set dollar amount for covered accidents	Any covered accident	Services for pre-existing conditions, maternity, routine physicals	Usually pays you a set amount regardless of the amount your provider bills	No
Limited Benefit Policy: Pays a set dollar amount for each service	Often doctor visits, lab services, some hospital services	Services for pre-existing conditions, maternity, infertility, mental health conditions	May pay you or your provider, but the amount may not depend on the amount your provider bills	No
Vision or Dental (Limited Scope) Policy: Pays for a specific set of services within the scope of the policy	Limited services for coverage type	Services outside the scope of coverage and for pre-existing conditions, maternity, ambulance	Usually pays your provider	No
Short Term, Limited Duration Insurance: May	Limited medical services	Usually services for pre-existing conditions, maternity, infertility, mental health conditions, ambulance	Usually pays your provider	No

only be available for 3 months **[Drafting Note: Adjust the definition according to state law or changes in federal policy.]**				

Plans that aren't Marketplace plans may not cover pre-existing conditions or cover all of the essential health benefits. Unless you have a Marketplace plan, you aren't eligible for financial help to pay premiums or out-of-pocket costs.

Adopted by the Health Insurance and Managed Care (B) Committee, Dec. 11, 2025
Adopted by the Regulatory Framework (B) Task Force, Dec. 10, 2025
Draft: 12/4/25

Prior Authorization White Paper

Contents

What is prior authorization?

Prior authorization (PA) is a mechanism used to check that a service, treatment, or medication is covered by the health plan and is appropriate, medically necessary, safe, and cost effective. It is intended to ensure safety (e.g., prevent negative drug interactions), reduce utilization of medically unnecessary or ineffective treatments or services, and contain health care costs. PA is used for a broad range of services, treatments, and medications. By formalizing in advance, in writing, the insurer's commitment to covering a health care service, PA can achieve a favorable balance between costs and benefits for both insurers and their members. It can also provide needed assurance for consumers and providers prior to the provision of services. While PA can benefit insurers, providers, and consumers, the process has been criticized for burdening providers and delaying care for consumers.

How this document can help regulators

In recent years, state legislatures have enacted and updated PA statutes to streamline PA processes to reduce administrative burdens, support improved patient outcomes, and promote greater transparency in the PA process. Most proposed legislation focuses on the method by which PA must be requested (e.g., by phone, fax, or electronic means, such as through an electronic health record (EHR) or an online portal), timeframes for plan responses, and "provider gold-carding," which is a system in which providers can bypass the PA process given their previous record of consistently providing evidence-based medical care. This white paper is meant to be a source of information and a roadmap of legislative options related to PA.

This white paper will not elaborate on the growing use of artificial intelligence (AI) in the PA process. The Innovation, Cybersecurity, and Technology (H) Committee (H Committee) is the more appropriate forum for a detailed discussion of this topic. The Regulatory Framework (B) Task Force, however, would be comfortable assisting the H Committee in any of its work to better understand the use of AI in the PA process in any forthcoming materials.

The prior authorization process

The PA process typically involves several steps, requiring coordination among health care providers, the patient, and the insurance company.[1] Those steps typically are:

- ***Submission:*** The health care provider submits a PA request to the insurer, detailing the medication, treatment, or service recommended for the patient.
- ***Review:*** The insurer reviews the request, verifies the patient is currently covered with the insurer, determines if PA applies to the requested medication, treatment, or service, and then evaluates it against its clinical guidelines and policies.
- ***Decision:*** Based on its review, the insurer either approves or partially approves the coverage request or makes an adverse determination by denying the coverage request, often providing an explanation.
- ***Appeals:*** If the request is not approved, the patient or provider may appeal the adverse determination through the insurer's appeal process and provide additional information to support the necessity of the treatment. Two levels of appeals processes are typically available—internal and external review.

[1] https://www.health.harvard.edu/staying-healthy/prior-authorization-what-is-it-when-might-you-need-it-and-how-do-you-get-it.

Common treatments and medical services subject to prior authorization

Services and treatments more likely subject to PA are those that are high-risk, high-cost, or subject to clinical variation. Examples include:

- ***High-Cost and Specialty Drugs:*** Medications that are expensive or require careful monitoring, such as biologics or oncology drugs.
- ***Advanced Imaging:*** Services such as magnetic resonance imaging (MRI), computed tomography (CT) scans, or positron emission tomography (PET) scans.
- ***Surgical Procedures:*** Surgeries that are elective or involve the use of experimental techniques.
- ***Durable Medical Equipment:*** Items like wheelchairs or hospital beds.
- ***Mental Health and Substance Use Disorder Services:*** More intensive services and some medications for treating these conditions.

Prior authorization issue perspectives

To completely understand the PA process, one must contemplate three perspectives: the provider, the consumer, and the insurer. The three perspectives presented in this section reflect the information the Task Force heard in presentations, documents, and surveys as it was drafting this white paper. The Task Force's intent in including these perspectives is to capture the conversations state regulators may be called upon to engage in as they work to reform the PA process.

The provider perspective

Administrative burden and expense

Prior authorization seemingly imposes substantial administrative burdens, costs, and inefficiencies on providers. According to a recent American Medical Association (AMA) online survey of one thousand (1,000) physicians[2], physicians or their staff spend 13 hours per week requesting PAs. Health care providers must employ and maintain knowledgeable staff who can help monitor the PA process. According to the same AMA survey[3], 40% of participating physicians have staff who work exclusively on PAs. Providers' EHRs do not always integrate with insurer systems, requiring provider staff to manually enter data into these systems or use antiquated technology, such as fax machines, and phones to transmit sensitive information. Furthermore, incorrect or missing patient demographic and insurance information can delay PA or result in unexplained denials.

In some cases, health insurers require PA to be completed at defined intervals during a course of treatment. This may take the form of step therapy, which is the process by which an insurer requires the use

[2] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[3] Id.

of a particular treatment first, and only upon failure will a preferred or prescribed treatment be approved, or requirements for regular authorizations to monitor treatment progress and efficacy. Navigating these PA requirements during ongoing treatment of a patient burdens a provider with additional administrative tasks.

Some pharmacists have expressed concern over the added burden and processing time that can result when the PA determination is not completed by the prescriber or their staff before the prescription order is transmitted to the pharmacy (prospective) but is instead completed after it has been received at the pharmacy from the provider, submitted to the carrier for coverage and then returned to the provider for the authorization process to be completed (retrospective). The acceleration in the availability and use of electronic PA systems by prescribers could result in more prospective and fewer retrospective prior authorization determinations.

Additionally, treating physicians sometimes encounter health plan reviewers who have no experience treating the patient's condition, who are not in the same specialty, or who are not physicians at all. This results in significant and unnecessary time spent attempting to justify a course of treatment to an inexperienced health plan representative and the potential for an inappropriate denial due to reviewer's lack of experience.

Lack of consistency and transparency

Definitions of medical necessity for a particular service differ among insurers, and some insurers define medical necessity without providing the clinical criteria necessary for a provider to determine if the health care service being requested meets the medical necessity threshold. Providers may need to work more closely with insurers to determine what will be approved for each patient's plan and potentially researching alternative treatments that may not be as effective as the provider's preferred treatment. Furthermore, requiring a provider to navigate differences in medical necessity criteria during an ongoing course of treatment highlights the disruption that can be caused due to PA processes.

Some providers report that denial letters do not always include detailed clinical reasoning or guidance on how to successfully submit an appeal. This can create confusion for providers who are trying to understand the rationale behind the determination and decide on next steps. Some health care providers completely avoid the PA process by not accepting insurance.

Technology and communication limitations

Health care providers sometimes find the technologies (including software, web portals, fax machines, and phone) used to facilitate the PA process between the insurer and the provider are cumbersome and costly to implement.

Moreover, some providers report significant delays or denials resulting from an insurer not updating its utilization management processes or communicating changes to processes or codes. Though some insurer portals make it easy to look up required PA information by simply inputting a procedure's current procedural terminology code, other insurers use manual processes that create inefficiencies when a provider is required to contact them. Many provider organizations, particularly smaller or independent

practices, face challenges in adopting or maintaining EHR systems that are fully interoperable with insurer platforms. As a result, even where modern digital PA tools are available, provider staff may still need to manually enter information, make phone calls, or document communications via fax to complete the PA process.

Health care providers report that when they are required to contact a health benefit plan by phone, staff experience long hold times and need to create documentation of their communications by phone or fax in case such information is later needed to prove contact was made.

Clinical variation and alignment with coverage criteria

In addition to determining whether a requested service is recommended according to research-based evidence, insurers also consider whether the service is the most cost-effective way to treat a patient. Clinical standards used by providers focus on delivering efficient and effective care depending on a patient's particular needs but may not always align with plan coverages or account for cost considerations. As a result, there may be times that a provider's preferred treatment differs from what is initially approved for coverage. Rather than treating a patient with what the health care provider considers to be the most appropriate treatment using their knowledge of clinical standards of care, a health care provider that receives an adverse determination for a PA request must choose whether to appeal and possibly further delay treatment or prescribe a different therapy that is covered by the patient's insurer.

The consumer perspective

While PA processes are well-meaning for the health care system and are intended to help control costs and avoid unnecessary utilization of health care services, the consumer experience can be affected by inefficiency, care disruption, and adverse outcomes.

Disruptions in care

According to a KFF survey, approximately six in 10 insured adults are not able to use their insurance without experiencing a problem.[4] Of those insured adults that report having an issue with using their insurance, 16% reported experiencing problems specifically with PA processes.[5] Additionally, a KFF analysis of CMS' 2023 Transparency in Coverage data demonstrated that lack of prior authorization or appropriate referral accounted for 9% – more than six million - of in-network claim denials. Separately, a self-reporting physician survey conducted by the AMA in 2024, found that 93% of participating physicians reported that PA leads to patients experiencing delays in care that they would not have otherwise experienced.[6] Moreover, 82% of the physicians in the same survey reported that PA processes can lead patients to abandon treatment.[7]

[4] https://www.kff.org/affordable-care-act/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/
[5] Id.
[6] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.
[7] Id.

Beyond driving individuals away from engaging with their providers, PA processes may also discourage individuals from seeking long-term treatment that may require multiple interactions with PA processes with different health care providers, different health insurers, or both. When health insurers require PA to be completed at defined intervals during ongoing treatment, patients can experience undue stress and disruptions to their treatment and recovery.

Effect on Costs

Studies have shown that commercial premiums could significantly increase if PA were to be eliminated.[8] However, PA processes may lead to delays or disruptions in care, which can lead patients to seek more expensive forms of care or forego treatment. Both options may lead to increased overall costs. For example, rather than scheduled treatment, there may be an increase in emergency room visits and otherwise preventable healthcare utilization.

For those consumers who do seek care in an emergency room setting, they will incur significant out-of-pocket costs that may otherwise be avoided by seeking care in non-emergency room settings.[9] For example, one study found that an insured spends $646 out-of-pocket on average for an emergency room visit.[10]

Adverse and inequitable outcomes

Within the overall insured population, certain groups of people experience a disproportionate share of PA problems. For example, 31% of adults who use more health care services (defined as having more than 10 doctor visits a year) experience difficulties navigating PA processes.[11] About a quarter (26%) of individuals with mental health conditions who sought treatment or a prescription experienced problems or delays as a result of their difficulties navigating PA processes.[12] Seeking medical care can be stressful, complicated, and expensive, and adding the burden of PA processes can be harmful. Among individuals who reported problems with PA processes, they were twice as likely (than individuals who did not report experiencing issues with PA processes) to report that their health declined as a result (26% v. 11%, respectively).[13]

[8] For example: https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/8-18-23_BCBSA-Prior-Authorization-Impact.pdf.
[9] https://www.healthsystemtracker.org/brief/emergency-department-visits-exceed-affordability-thresholds-for-many-consumers-with-private-insurance/#Total%20and%20Out-Of-Pocket%20Costs%20for%20Emergency%20Department%20Visits,%202019
[10] Id.
[11] https://www.kff.org/affordable-care-act/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/
[12] Id.
[13] Id.

The appeals process

It is important to note that most PA requests are approved. Additionally, AHIP's survey of their members reported similar numbers in the commercial market with approval rates for prescription medications at 90% and medical services at 97%.[14]

Despite the large percentage of coverage authorizations, many requests are still denied. In the event of a PA denial, there are mechanisms to appeal. The appeal process allows for the exchange of additional clinical information and further evaluation of the appropriateness of the requested treatment. These processes are often complicated, burdensome, difficult to access, and may discourage consumers who receive a denial from appealing.

The following statistics are not specific to coverage denials related to prior authorization, but they illustrate the relatively low number of appeals in relation to denied claims. In Pennsylvania, for example, of the 2,135,041 claims denied by qualified health plans (QHPs) in the state's individual health insurance market, just 3,156 internal appeals were filed. Of those internal appeals, nearly half (48%) were overturned in favor of providing coverage for the requested service.[15] The pattern is repeated at the national level. QHPs offering individual health insurance coverage through the Federally Facilitated Exchange (FFE) in 2022 denied 69,315,868 claims. While the total number of denied claims does not account for claims that were, for example, ultimately paid before an appeal was filed, the numbers still demonstrate that a very small percentage of denials are appealed, and 42% of the appeals filed were overturned.[16] Increased transparency and streamlined functionality of the appeals process will help ensure fair and comprehensive claim adjudication.

The insurer perspective

From the insurer perspective, the primary goals of PA include:

- Directing patients toward medically necessary and appropriate treatments for patients to improve the quality of care;
- Preventing excessive, unnecessary, harmful or fraudulent health care utilization; and
- Containing costs and ensuring health care dollars are used effectively.

Patient Safety

Prior authorization can support patient safety by helping ensure that care decisions are based on clinical evidence and tailored to individual needs. PA can prevent harmful activity by providers in some instances,

[14] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf
[15] https://www.pa.gov/content/dam/copapwp-pagov/en/insurance/documents/posted-filings-reports-orders/posted-reports/aca-plan-transparency-reports/transparency-coverage-report-aca-health-plans-2024.pdf
[16] Id.

such as providing inappropriate cancer treatments to patients who may not even suffer from cancer.[17] Other examples cited may include overuse of opioids, antipsychotic medications in children, and high-risk medications for elderly patients.

PA can also help ensure patients receive a safe and appropriate level of care. For example, performing unnecessary imaging tests can have negative impacts, including false positives,[18] exposure to unnecessary radiation, and higher out-of-pocket costs. [19]

Additionally, PA can help ensure that patients get care that is aligned with the latest evidence. For example, one study suggests that nearly 4 in 10 patients do not receive care that meets the latest medical evidence, which can negatively impact outcomes and may endanger patient safety.[20]

It is difficult to determine how frequently these forms of consumer harm are prevented by PA, but there is no reason to doubt that such harms are a legitimate concern.

Cost containment

One purpose of PA is to prevent the use of low-value health care services, generating savings for insurers, plan sponsors and members without compromising quality of care.[21] While the research on the value proposition of health care services may be clear in some cases, it may be evolving or disputed in others, especially for newer modes of treatment that may lack a large evidence base. This can lead to disputes, appeals and complaints to regulators.

On behalf of the Blue Cross Blue Shield Association (BCBSA), the actuarial firm Milliman conducted an analysis of claims data to determine the impact to commercial premiums nationally if prior authorization was eliminated across all medical and pharmacy services.[22] The study determined that eliminating PA for all services would result in a premium increase of almost $30 PMPM; even eliminating PA for a narrow scope of services would lead to a premium increase of over $20 PMPM. Across the entire commercial market, Milliman calculates that premium increases could total between $43B and $63B annually. Milliman also notes cost-sharing would increase with the elimination of PA.

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[17] Examples: https://www.propublica.org/article/anthony-olson-thomas-weiner-montana-st-peters-hospital-leukemia; https://www.thelundreport.org/content/tenth-lawsuit-claims-oregon-labs-testing-caused-women-harm-unneeded-chemotherapy

[18] Ganguli I, Simpkin AL, Lupo C, et al. Cascades of care after incidental findings in a US national survey of physicians. JAMA Netw Open. 2019;2(10):e1913325. doi:10.1001/jamanetworkopen.2019.13325

[19] Rosenkrantz AB, Sadigh G, Carlos RC, Silva E 3rd, Duszak R Jr. Out-of-Pocket Costs for Advanced Imaging Across the US Private Insurance Marketplace. J Am Coll Radiol. 2018 Apr;15(4):607-614.e1. doi: 10.1016/j.jacr.2017.12.010. Epub 2018 Feb 22. PMID: 29477290.

[20] Duff, J., Cullen, L., Hanrahan, K. et al. Determinants of an evidence-based practice environment: an interpretive description. Implement Sci Commun 1, 85 (2020). https://implementationsciencecomms.biomedcentral.com/articles/10.1186/s43058-020-00070-0

[21] One often-cited source is the Low-Value Care Task Force at VBID Health: https://vbidhealth.com/low-value-care-task-force/

[22] "Potential Impacts on Commercial Costs and Premiums Related to the Elimination of Prior Authorization Requirements," March 30, 2023. Available at https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/8-18-23_BCBSA-Prior-Authorization-Impact.pdf

The same Milliman study found that PA encourages performance improvement, because providers in a program know they are being evaluated against evidence-based clinical criteria. In an independent study, Milliman estimated that eliminating this effect by restricting the use of PA may result in premium increases of 5.6% - 16.7% for plans in Massachusetts.[23]

Suggestive evidence of the cost containment impact of PA is also available through a variety of public sector programs.

When South Carolina's Medicaid program eliminated PA for rehabilitative behavioral health services in 2014, costs for those services reportedly jumped from $300,000 to $2 million per week, leading to a $54 million budget shortfall and an eventual reinstatement of PA requirements.[24] Similarly, researchers have found that in Medicare Part D, PA restrictions reduced spending on drugs by $96 per beneficiary-year (3.6% of drug spending), while only generating about $10 in paperwork costs.[25]

The Centers for Medicare & Medicaid Services (CMS) recently announced an Innovation Center model, the Wasteful and Inappropriate Service Reduction (WISeR) Model, for patients and providers in Original Medicare.[26] The model will test technology-enabled PA and pre-payment review to expedite and improve the review process for a pre-selected set of services that are vulnerable to fraud, waste and abuse. CMS describes the goals as helping patients avoid unnecessary or inappropriate care, lowering costs and easing administrative burden on providers.

The potential cost containment benefits of PA may be particularly important for health insurers in the context of the Affordable Care Act's (ACA) insurance reforms. Core ACA provisions such as guaranteed issue, community rating and prohibitions on pre-existing condition exclusions provide important consumer protections but also leave insurers on the hook for higher health care costs. In this context, PA represents one of the few tools remaining for insurers to contain costs, which in turn can help keep premiums and out-of-pocket costs in check.

For context, however, it is important to note that an industry survey reported that insurers across all lines of business do not base their PA programs on cost alone[27].

Friction with providers and members

For insurers, the benefits of PA must be weighed against the administrative costs and burdens of administering a PA program and the friction and conflict that can arise with health care providers and members. This friction results from issues including administrative burden on providers and members, potential reductions in provider time available for patient care, provider resentment at being second-

[23] "Potential impacts on costs and premiums related to the elimination of prior authorization requirements in Massachusetts," October 10, 2023. Available at https://www.milliman.com/en/insight/potential-impacts-costs-premiums-elimination-prior-authorization-massachusetts
[24] https://kffhealthnews.org/news/article/prior-authorization-insurer-denials-patients-run-out-of-options/
[25] Zarek C. Brot-Goldberg, Samantha Burn, Timothy Layton & Boris Vabson, "Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare," January 2023. Available at https://www.nber.org/papers/w30878
[26] https://www.cms.gov/priorities/innovation/innovation-models/wiser
[27] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf

guessed, patient frustration with delays, and poorer quality outcomes due to delayed or abandoned care. These frictions are explored in detail in other sections of the white paper, but it is important to note that they may generate costs and burdens for insurers as well as other PA stakeholders.

Electronic prior authorization (ePA)

Health insurers have been broadly supportive of moving away from manual and "paper" processes for PA and toward more uniform electronic submission standards. For example, insurers supported federal adoption of the CMS Interoperability and PA final rule in 2024, which is discussed in more detail in the Federal Government section.[28] This rule was followed by a complementary health information technology certification rule published on Aug. 4, 2025. Insurer advocates have typically recommended that state activity in this area should focus on aligning state requirements for insurers with these federal rules, and that states should consider proactively implementing requirements for health care providers to use electronic processes.[29] An initiative by insurers covering more than 50 million Americans found that implementing ePA led to faster time to patient care, faster times to decisions, and improved information for providers.[30] Despite this, an AHIP survey of member plans reports that manually submitted PA requests still account for nearly half of all PA requests.[31]

In June 2025, nearly 60 national and regional health plans, representing 257 million lives, announced a series of new voluntary commitments aimed at simplifying and improving the PA process.[32] Through these commitments, participating health plans support increasing the use of ePA through the development of standardized data and submission requirements that will support faster turn-around times. Participating health plans committed that as of Jan. 1, 2027, 80% of medical ePA approvals with complete information will be processed in near real-time.

Many health plans are already moving towards a one-system solution across all product lines both public and private because it is expected to be easier to update their systems simultaneously and use for all product lines instead of managing multiple integrations and processes.

Several states are moving forward with implementation of a unified approach across both public and private commercial health insurance markets by extending the federal electronic PA requirements and standards for medical items and services to the private commercial market. Examples include Virginia, Alaska[33], California, Tennessee, Utah, and Washington[34].

[28] https://www.ahip.org/news/press-releases/ahip-statement-on-the-cms-interoperability-and-prior-authorization-final-rule
[29] https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states
[30] https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states
[31] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf
[32] https://www.bcbs.com/news-and-insights/article/right-care-right-place-right-time
[33] Alaska Statute 21.07.150 Prior authorization programming interface.
[34] https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.830.

Given the immense use of resources consumed by the PA process, some entrepreneurs have created businesses that exist solely to facilitate PA electronic communication between health care providers and health benefit plans.

Selective use, gold carding, and other streamlining initiatives

Health plans have implemented a number of modifications to streamline the PA process and reduce the burden of PA for certain subsets of providers and patients. Gold carding is one such initiative that involves a process by which a high performing health care provider may qualify for an exemption from an insurer's PA requirements.[35] Other approaches to streamlining the PA process include removing some services and drugs from PA requirements, reducing or waiving PA for patients undergoing active treatment, and reducing or waiving PA requirements for providers in value-based contracts.[36]

Some health insurers have opposed statutory or regulatory mandates in this area, preferring to be permitted the flexibility to explore a range of options to strike a favorable balance between administrative simplification, patient protection and cost containment.

Evidence base

One of the key purposes of PA is to ensure that covered services are evidence-based and effective. In light of concerns from some physicians, advocates and policymakers about the evidence base used in PA,[37] it is important to clarify the current practices and requirements in this area.

Health plans collect and assess medical evidence for the specific populations they serve. PA programs are typically based on guidelines from medical societies like the American College of Cardiology and the American College of Radiology, as well as scientific evidence from recently published, peer-reviewed medical literature. Practicing community physicians and subject matter experts at leading academic institutions may also contribute to the development of clinical guidelines.

Health plans subject to accreditation typically undergo rigorous reviews of insurers' clinical guidelines. In addition, guidelines must also meet state and federal laws and Center for Medicare & Medicaid Services (CMS) requirements where applicable. Many state laws require guidelines to be evidence-based and updated annually. In addition, PA denials are typically subject to appeal and external review requirements that provide the opportunity for an independent check on practices not aligned with clinical evidence.

It is also important to note that questions about the value proposition of particular health care services may not be entirely resolvable by clinical evidence. For example, there may be cases where two therapies

[35] See e.g., https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf
[36] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf
[37] For example, Congress has considered legislation that would push Medicare Advantage issuers to consult with health care providers on evidence-based best practices for prior authorization: https://delbene.house.gov/news/documentsingle.aspx?DocumentID=3221

offer comparable clinical outcomes but differ significantly in cost or other factors relevant to patient experience, such as comfort, convenience or aesthetic considerations.[38]

Accreditation Standards for PA

The majority of states utilize accreditation entities such as the National Committee on Quality Assurance (NCQA) or URAC to ascertain that insurers are meeting a state's regulatory requirements. These accreditation bodies review an insurer's utilization management program, including prior authorization requirements. Accreditation standards typically address areas such as the clinical criteria used for decisions, regular review and availability of the criteria, practitioner involvement, qualifications of health professionals making PA decisions, and timeframes for decisions, among other areas. Accreditation standards are updated regularly. For example, many of these standards are in the process of being updated to align with the new federal requirements mentioned in this white paper.

Reform examples

States

Gold carding

There are several ways state laws have sought to reduce the level of PA, including limitations or exemptions for PA for certain services and gold carding.

"Gold carding" describes a process by which a health care provider may qualify for an exemption from some or all a health insurer's PA requirements. A provider who has qualified for a gold card for a particular health care service will not be required to obtain PA before performing that service. Once implemented, these programs are intended to simplify health care for consumers, providers, and insurers.

Under state-mandated gold carding programs, a health insurer is required to evaluate a health care provider's history of requesting PA for a particular health care service to determine whether the provider qualifies for an exemption from PA for that particular service. The insurer examines plan data to determine the number of times the provider's request for a particular service was approved. If the percentage of approved requests meets the threshold rate mandated by the state, the insurer will be required to issue the provider a gold card exemption for that service. State-level gold carding laws are relatively new, and their long-term impacts remain uncertain. While these laws are intended to reduce administrative burden by exempting providers from certain PA requirements, research has shown that they may also increase service utilization and place upward pressure on health care costs.[39] In some cases, the thresholds for exemption are set low, which can pose risks to patient safety. Additionally, some laws limit an insurer's ability to review or revoke a provider's gold card status except on an infrequent basis, such as once every 12 months.

[38] Potential examples could include proton beam therapy for cancer treatment or autologous breast reconstruction following mastectomy.
[39] https://legislature.vermont.gov/assets/Legislative-Reports/Blue-Cross-VT-Provider-Passport-Program-Report-01-15-2023.pdf.

This restricted oversight can delay timely intervention when concerns arise. At the same time, some insurers have begun developing their own gold carding initiatives, which may allow for more flexibility, service-specific targeting, and closer monitoring.

A gold card is insurer-specific such that a health care provider may meet the standard for obtaining a gold card from some insurers but not others, except in instances where a state has mandated broad-based gold-carding requirements. Even if a provider has been granted a gold card for a particular service, if an insurer determines that a service provided by the provider holding a gold card exemption for that service was not medically necessary or otherwise fails to meet plan eligibility standards, the insurer may still decline to cover the service.

Arkansas

Arkansas includes PA for prescription drugs its gold card program requirement. Insurers in Arkansas examine a health care provider's history of all PAs requested for all health care services, which Arkansas defines to include prescription drugs.[40] A health care provider's gold card exemption privilege extends to any health care service for which they received approval of the PA request at least 90% of the time within a six-month evaluation period.[41] An insurer may rescind a health care provider's exemption if the provider performs five or fewer of the health care service for which they obtained an exemption.[42]

Arkansas has also established a process that allows an insurer to continue requiring PA for a particular drug if the insurer obtains approval from the state's boards of pharmacy and medicine to continue requiring PA.[43] When an insurer receives approval to continue requiring PA for a particular drug, the approval is good for two years, and the insurer may continue requiring PAs for that drug from all health care providers, regardless of any gold card exemption privilege a health care provider would have otherwise had.

Texas

In 2022, Texas enacted House Bill 3459, known as the Texas Gold Act[44]. This Act was amended in 2025 with the passage of House Bill 3812.[45] House Bill 3812: 1) extended the length of gold cards from six months to one year; 2) included claims from products not regulated by the Texas Department of Insurance (TDI) in gold card evaluations; and 3) placed restrictions on administrative licenses only for the physician in charge of all utilization management for a health plan and physicians making recissions. The law became effective on Sept. 1, 2025.

Under these laws, physicians and providers can be exempted from PA requirements for certain health care services if they maintain an approval rate of at least 90% over a recent one-year period – for those services. When evaluating a physician or provider for this exemption, an insurer must consider all PA requests

[40] Ark. Code Ann. § 23-99-1103(10)(A).
[41] Ark. Code Ann. § 23-99-1120(a).
[42] Ark. Code Ann. § 23-99-1122(a)(3).
[43] Ark. Code Ann. § 23-99-1128(b).
[44] https://legiscan.com/TX/text/HB3459/2021.
[45] Texas House Bill 3812 https://legiscan.com/TX/text/HB3812/id/3247239

submitted by that physician or provider across all health insurance policies and health benefit plans issued by the insurer, not just those that allow for gold carding.

It is important to note that these laws do not apply to patients insured by Medicaid or Children's Health Insurance Program (CHIP). The TDI oversees the implementation of this law.

A provider or physician in Texas qualifies for an exemption once they have: 1) submitted five or more eligible PA requests for the particular health care service in the most recent evaluation period; and 2) at least 90% of the eligible PA requests for a particular service were approved. [46]

The physician or provider is not required to request an exemption. It is the responsibility of the insurer to notify physicians and providers that they have been granted or denied a PA exemption for those health care services for which the minimum threshold has been satisfied.

Under the law, the notice granting exemptions must contain a plain language explanation of the effect of the PA exemption and any claim coding guidance to properly document the exemption. Exemptions must remain in place for at least 12 months before being rescinded.

West Virginia

An updated West Virginia statute lowered the requirements to qualify for a gold card program[47]. This allows a health care provider to earn exemption from PA requirements based on the provider's track record of previous PA approvals and the frequency with which the provider performs the procedure. If a health care provider has performed an average of 30 procedures per year and has received a 90% final prior approval rating in a six-month period, the health insurer may not require a PA for at least the next six-month period, or longer if the insurer allows. The state legislature clarified in 2025 that prescription drugs and related authorizations are exempted from the gold card program.

Wyoming

The Wyoming legislature passed legislation regarding provider exemptions from PA requirements (gold carding).[48] The law will go into effect January 2026. The legislation establishes guidelines for a provider to be exempted from completing PAs for health care services that have been authorized 90% of the time in the preceding 12 months. The provider must have submitted no fewer than five PAs for the procedure during that time. The insurer can review the exemption every twelve months, but they may establish a longer exemption period. In addition, an exemption cannot be revoked before twelve months have passed.

Providers are not required to apply for an exemption. The insurer or contacted utilization review entity shall provide a health care provider with: 1) a statement that notifies the health care provider that the provider qualifies for the exemption; 2) a list of services for which the exemption applies; and 3) a statement of the

[46] Texas Administrative Code https://texas-sos.appianportalsgov.com/rules-and-meetings?$locale=en_US&interface=VIEW_TAC_SUMMARY&recordId=209986 and Texas Insurance Code Title 14, Ch. 4201 https://statutes.capitol.texas.gov/Docs/IN/htm/IN.4201.htm#4201.653

[47] https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/IB%2021-08%20Electronic%20PA%20(1).pdf.

[48] Wyo. Stat. Ann. § 26-55-112

12-month duration. A health care provider may appeal a health insurer's or contract utilization review entity's decision to deny an exemption.

Addressing continuity concerns

District of Columbia

The District of Columbia[49] requires a PA to be valid for at least one year or for the course of the treatment, including any dosage changes.[50]

Illinois

Illinois also requires health insurers to honor an approved PA for the first 90 days of a health insurance consumer's coverage under a new health insurance policy. Illinois also prohibits concurrent review and post-service utilization review for certain services for which PA has been prohibited, which is important to ensure PA is not shifted to another manner of utilization management or cost-shifting to patients.[51]

New Hampshire

Starting Jan. 1, 2025, under New Hampshire's PA law, an approved PA cannot be revoked, limited, conditioned, or restricted for 60 business days.[52]

New Mexico

In New Mexico, health insurers are prohibited from rescinding or modifying prior authorizations for mental health or substance use disorder services once care has been rendered in good faith based on a medical necessity determination, except in cases of fraud or violations of the provider's contract. NMSA 1978, Section 59A-22B-6. Insurers also may not require prior authorization or referrals for urgent behavioral health services, including acute care, acute episodes of chronic conditions, or initial in-network treatment. NMSA 1978, 59A-22B-7(A). For ongoing or additional services, prior authorization decisions must be made in consultation with the patient's provider. NMSA 1978, 59A-22B-7(B).

Additionally, New Mexico law prohibits prior authorization and step therapy requirements for FDA-approved medications prescribed to treat autoimmune disorders, cancer, substance use disorders, or rare diseases, provided a medical necessity determination is made by a healthcare professional in the same or similar specialty. NMSA 1978, Section 59A-22B-8(A). A "rare disease or condition" is defined as one affecting fewer than 200,000 individuals in the United States. NMSA 1978, Section 59A-22B-2(Q).

[49] https://code.dccouncil.gov/us/dc/council/laws/25-100.
[50] https://www.ama-assn.org/practice-management/prior-authorization/fixing-prior-auth-we-must-ensure-continuity-care#:~:text=Georgia%2C%20Kentucky%2C%20Louisiana%2C%20Michigan,hemophilia%20or%20Von%20Willebrand%20disease.
[51] https://www.ilga.gov/documents/legislation/103/HB/10300HB5395enr.htm
[52] RSA 420-J:6.

Oklahoma

House Bill 3190[53] specifies that PAs are valid for at least 45 days, or for six months in the case of chronic conditions, creating a more predictable and less disruptive process for patients. A health plan cannot revoke, limit, condition, or restrict PA if care is provided within 45 business days from when the health care provider received the PA, unless the enrollee was no longer eligible for care on that day.

Tennessee

Tennessee passed a law[54] that took effect in 2025 that requires health insurers to honor an approved PA for the first 90 days of a health insurance consumer's coverage under a new health insurance policy.

Texas

In Texas, a health insurer is not permitted to require more than one annual PA for a prescription drug for certain conditions.

Wyoming

The Wyoming Insurance Code, titled *Ensuring Transparency in PA Act* was passed in 2024[55] and addresses continuity of care and step therapy. If an individual changes health care coverage and has an approved PA with their prior insurer, and the health care service is a covered benefit under the new plan, the new insurer must honor the PA for at least 90 days.

In addition, insurers cannot require a consumer to repeat a step therapy protocol if that enrollee, while under their current or previous health benefit plan, used the prescription drug required by the step therapy protocol, or another prescription drug in the same pharmacologic class.

Reducing response times

Michigan

Michigan's PA law[56] requires a review period of 72 hours for urgent PA requests, or within 72 hours of receiving additional information, if necessary. For non-urgent requests, insurers must act within 7 calendar days of submission or within 7 calendar days of receiving additional information. If an insurer fails to act within these timeframes, the prior authorization is automatically granted. Approved prior authorizations are valid for a minimum of 60 days or for the clinically appropriate duration, whichever is longer.

New Hampshire

Beginning Jan. 1, 2025, New Hampshire's PA law requires all PA requests to be processed within 7 calendar days if submitted electronically and 14 calendar days if submitted non-electronically. Urgent requests must be processed within 72 hours. If the health insurer does not notify the covered person and their provider within these time limits, the PA request will be considered approved.[57]

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[53] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400.
[54] https://legiscan.com/TN/text/HB0885/2023.
[55] Wyo. Stat. Ann. §§ 26-55-101 through -113
[56] Michigan PA 60 of 2022 (MCL 500.2212e)
[57] NH RSA 420-J:6.

Oklahoma

House Bill 3190[58], which took effect on Jan. 1, 2025, requires utilization review entities to respond more promptly to PA requests. After a utilization review entity has obtained all necessary information to make a decision, the entity must respond within 72 hours for urgent requests and within seven days for non-urgent requests.

Texas

According to TDI, commercial insurers have two business days to approve a PA request after receiving all necessary information. Life-threatening conditions require a response within one hour and concurrent care within 24 hours.

Washington

Washington has implemented shorter turnaround times for PA approvals[59], ranging from one to five calendar days, aiming for timely patient access to care. The required turnaround times differ depending on how the request is submitted to the carrier (non-electronic versus electronic) and whether the request is urgent. For ePA requests, carriers must make a decision and notify the provider and facility of the decision within three calendar days for a standard request and within one calendar day for an urgent request. Turnaround times are a little longer for non-electronic requests - within five calendar days for a standard request and two calendar days for an urgent request.

West Virginia

West Virginia statute allows for a bundled request per episode of care[60]. An episode of care is defined as a medical condition or specific illness. For non-life threatening or routine medical conditions, the health insurer must respond within five business days from the date the PA was received. For life threatening or non-routine medical conditions, the insurer must respond within two business days. Incomplete PAs must be corrected within two business days by the provider from the date of receipt of the insurer. The health care provider shall provide the requested information within three business days from the date of the returned request, and the health insurer shall render a determination within two business days after the receipt of the requested information.

Wyoming

Wyoming's *Ensuring Transparency in PA Act* relied heavily on the American Medical Association (AMA) model legislation and established response times for PA requests.[61] PA response times for non-emergent responses are to be within five calendar days of obtaining all necessary information to complete the review. Urgent authorizations must be completed within 72 hours of obtaining all necessary information. Health insurers and contracted utilization review entities shall not require PA for medications used for opioid use disorder. In addition, a health insurer or contracted utilization review entity shall not require PA for

[58] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400
[59] Washington RCW 48.43.830 https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.830
[60] https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/IB%2021-08%20Electronic%20PA%20(1).pdf
[61] Wyo. Stat. Ann. §§ 26-55-101 through -113

rehabilitative or habilitative services including, but not limited to, physical therapy service or occupations therapy services for the first 12 visits for each new episode of care.

Updating technology and systems

New Hampshire

Starting Jan. 1, 2025, New Hampshire's PA laws incentivize electronic submissions by applying shorter processing timeframes for requests submitted electronically. Additionally, it permits providers to initiate peer-to-peer review before a determination is made.[62]

Texas

In 2014, Texas mandated standardized PA request forms for health care services and prescription drug benefits.[63] The regulation, which took effect on Sept. 1, 2015, established an advisory committee tasked with updating the forms every two years. Its primary goal was to streamline the PA process, making it more efficient and transparent for both providers and patients. The forms must be provided in both paper and electronic formats and made accessible on health plan websites. Medicaid and CHIP are required to accept these forms.

Washington

Washington state's PA legislation differs from other states by prioritizing the use of EHR and interoperable systems, requiring automatic decisioning of some requests, and setting faster turnaround times for PA approvals. It also requires insurers to include PA data in their annual report to the Office of the Insurance Commissioner (OIC).

With the passage of Engrossed Second Substitute House Bill (ESSHB)1357[64] in 2023, each carrier is required to build and maintain a PA application programming interface (API) that automates the process for in-network providers to determine whether a PA is required for health care services, identify PA information and documentation requirements, and facilitate the exchange of PA requests and determinations from its EHR or practice management system by January 1, 2025. Carriers would also be required to automate the process to determine whether a PA is required for durable medical equipment or a health care service, streamlining the process. The API requirements were modified by Substitute House Bill (SHB) 1706[65] in 2025 to align the API requirements codified in Washington's RCW with the guidance and timelines in the CMS Interoperability and PA Final Rule[66].

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[62] RSA 420-J:6.
[63] see 28 Tex. Admin. Code § 19.1810
[64] Washington ESSHB 1357 https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/1357-S2.SL.pdf?cite=2023%20c%20382%20s%201
[65] Washington SHB 1706 https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Session%20Laws/House/1706-S.SL.pdf
[66] CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) https://www.cms.gov/priorities/burden-reduction/overview/interoperability/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

West Virginia

During the 2024 Legislative Session, West Virginia updated its PA laws[67] to require a health insurer to submit requests with any related communication via an electronic portal.

Ensuring qualifications of health benefit plan reviewers

Oklahoma

Oklahoma's House Bill 3190[68] requires all adverse determinations and appeal decisions to be made by a physician or licensed mental health professional to ensure that qualified professionals are involved in medical decisions. For adverse determinations, the physician or licensed mental health professional must:

- Possess a current and valid unrestricted license in the United States;
- Have the appropriate training, knowledge, or expertise to apply relevant clinical guidelines to the requested health care service; and
- Make the determination under the clinical direction of a licensed physician who serves as a medical director for the utilization review entity.

For appeals, the requirements are more stringent. The physician or licensed mental health professional must share the same or a similar specialty as the health care professional who typically manages the medical condition in question. This means they should either maintain board certification in the same specialty or have training and experience relevant to treating the condition and any related complications. All appeal decisions must consider all known clinical aspects of the health care service under review, including any pertinent medical records provided by the enrollee's health care provider.

Texas

Texas' regulations require PA determinations to be made by an individual licensed to practice medicine in Texas who has the same or similar specialty as that physician. The physician or provider has the right to a review regarding a PA exemption to be conducted by an independent review organization.[69]

Improving transparency

New Hampshire

Beginning March 31, 2026, New Hampshire's PA law requires health insurers to report PA as specified in 45 CFR 156.223 to the commissioner and requires the New Hampshire DOI to post insurer-specific data online.[70]

Oklahoma

House Bill 3190[71] requires health insurers to publish their PA requirements online, ensuring they are accessible to patients and providers. If a utilization review entity—defined as an individual or organization

[67] W. Va. Code Ann. §33-15-4s *et.seq*.
[68] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400.
[69] see 28 Tex. Admin. Code §19.1732(b)
[70] RSA 420-J:6.
[71] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400.

that performs PA for a health benefit plan—plans to implement a new requirement or change an existing one, they cannot do so until their website reflects the updated information.

Furthermore, utilization review entities are required to enhance communication opportunities during the PA process. They must have staff available for phone calls regarding PA issues at least eight hours a day during normal business hours. In addition, they must allow staff to address communications about PA concerns after regular business hours and provide treating providers with the opportunity to discuss a PA denial with an appropriate reviewer.

Pennsylvania

Pennsylvania passed Act 146 in 2022 to overhaul its PA rules. Specifically, under the revised rules, health insurers now must post their medical policies and the medical services that are subject to PA on public-facing websites. Additionally, health care providers and health insurers now must use electronic portals to streamline document and information exchange.

Texas

If a PA exemption is denied, the insurer is required to provide a notice to the provider describing why the exemption was denied, directions on how to appeal the denial and information on how to file a complaint with TDI.[72]

Virginia

Virginia requires each health insurer to make available by posting on its website no later than March 31 of each year the PA data for health care services for the previous calendar year for all metrics required for compliance with federal law and CMS regulations.[73] These specifically include those promulgated under 42 C.F.R. §§ 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c).[74] It also requires carriers to make available through one central location on the carrier's publicly accessible website or other electronic application, the list of services and codes for which prior authorization is required."[75]

Washington

Starting Oct. 1, 2020, and annually thereafter, carriers in Washington must include in their annual report to the OIC aggregated and deidentified data related to their PA practices and experience for the prior plan

[72] see 28 Tex. Admin. Code §19.1732(b)

[73] Subsection F of § 38.2-3407.15:8 of the Code of Virginia.

[74] These include a list of all items and services that require prior authorization; the percentage of standard and expedited prior authorization requests that were approved, aggregated for all items and services; the percentage of standard and expedited prior authorization requests that were denied, aggregated for all items and services; the percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services; the percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services; the average and median time that elapsed between the submission of a request and a determination by the ... plan, for standard prior authorizations, aggregated for all items and services; the average and median time that elapsed between the submission of a request and a decision by the ... plan for expedited prior authorizations, aggregated for all items and services.

[75] Subsection C of § 38.2-3407.15:8 of the Code of Virginia.

year.[76] For each category (inpatient medical or surgical, outpatient medical or surgical, mental health and substance use disorder, durable medical equipment, diabetes, and prescription), insurers must list the ten codes with the:

- Highest total number of PA requests during the previous plan year, including the total number of PA requests for each code and the percentage of approved requests for each code;
- Highest percentage of approved PA requests during the previous plan year, including the total number of prior requests for each code and the percentage of approved requests for each code; and
- Highest percentage of PA requests that were initially denied and then subsequently approved on appeal, including the total number of PA requests for each code and the percentage of requests that were initially denied and then subsequently approved.

West Virginia

In West Virginia, if a PA request is rejected by the health insurer and the health care provider asks for an appeal by peer review, the peer review shall be with a health care provider similar in specialty, education, and background. The time frame for a peer-to-peer appeal process shall take no longer than five days from the date of request of the peer-to-peer consultation. The time frame regarding an appeal of the decision on a PA shall take no longer than 10 business days from the date of the appeal submission.

Wyoming

Wyoming's *Ensuring Transparency in PA Act* establishes guidelines for review of adverse determinations.[77] Individuals qualified to make adverse determinations need sufficient knowledge in the applicable practice area or specialty, knowledge of coverage criteria, have an unrestricted license to practice within the scope of their profession recognized in the United States or District of Columbia, and knowledge of the person's medical history and diagnosis. The health insurer or contracted utilization review entity shall provide the opportunity for the provider to discuss the medical necessity of the service. An attempt to schedule the discussion should take place within five days of the provider's request.

Finally, under the Act, the insurer or contracted utilization review entity shall make any PA requirements and restrictions easily accessible to enrollees, health providers, and the public on their website. If a provider requests the PA requirements or restrictions from an insurer, the insurer must provide the list to the requesting party within 24 hours.[78] Furthermore, any changes to the requirements must be posted 60 days in advance of the change's enactment.[79] These deadlines relate to the disclosure and review of PA requirements, not a specific patient PA request.

[76] Washington RCW 48.43.0161 https://app.leg.wa.gov/RCW/default.aspx?cite=48.43.0161
[77] Wyo. Stat. Ann. § 26-55-101 through -106
[78] Wyo. Stat. Ann. § 26-55-103
[79] Wyo. Stat. Ann. § 26-55-103

The Federal Government

In addition to state legislative action, the CMS issued the CMS Interoperability and PA Final Rule[80] in 2024 to set uniform national PA standards for the federal health coverage programs under its jurisdiction, as well as for QHPs offering ACA compliant coverage through FFEs. The rule created uniform timeframes for PA decisions, data exchange requirements, transparency requirements, and other digitization efforts.

Specifically, the rule sets federal standards for PA response timeframes, generally requiring impacted payers to send a PA decision within 72 hours for expedited or urgent requests and 7 calendar days for standard or non-urgent requests. The rule also requires impacted payers to specify a reason when they deny a PA request, regardless of the method used to send the PA request. The reason for denial must be of sufficient detail to enable the provider to know what action to take as follow-up – that is, whether to appeal, submit additional documentation, or identify alternative treatment options.

The federal rule includes an extensive list of PA-related information that impacted payers must publicly report, including: 1) a list of all items and services that require PA; 2) the percentage of standard PA requests approved, aggregated for all items and services; 3) the percentage of standard PA requests denied, aggregated for all items and services; 4) the percentage of standard PA requests approved after appeal, aggregated for all items and services; 5) the percentage of PA requests for which the timeframe for review was extended and the request was approved, aggregated for all items and services; 6) the percentage of expedited PA requests approved, aggregated for all items and services; 7) the percentage of expedited PA requests denied, aggregated for all items and services; 8) the average and median timeframe between submission of a standard PA request and a decision, aggregated for all items and services; and 9) the average and median timeframe between submission of an expedited PA request and a decision, aggregated for all items and services.

In addition to these requirements, the rule requires impacted payers to build ePA systems to communicate PA information and to efficiently and transparently process PA requests. Under the rule, these new ePA systems will enable:

- Electronic access to information for patients on PA requests and decisions;
- Electronic access to information for providers on when PA is required and what information is required to accompany a PA request;
- Electronic exchange of PA requests and decisions between providers and payers; and
- Electronic exchange of PA information across payers.

Although this rule does not reach health insurers operating in states with State-Based Exchanges (SBEs), having federal standards may help encourage national uniformity as states continue to grapple with the issue. Additionally, as discussed in the Industry Trade Associations section, an industry PA initiative includes a voluntary commitment across more than 45 plans to support the new technical standards for ePA beyond the federal programs impacted by the rule to all lines of business.

[80] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

The CMS Interoperability and PA Final Rule does not apply to prescription drugs. The rule explicitly excludes drugs from its requirements for PA, including the new API standards and process changes, because the CMS determined that the standards and timeframes for drugs differ significantly from those for medical items and services. While the rule excludes drugs, the CMS has noted comments regarding this exclusion and has indicated that specific rulemaking for drug PA may be forthcoming.

Provider Trade Associations

American Medical Association (AMA)

AMA PA and Utilization Management Reform Principles

To address its concerns with utilization management programs, such as PA, in 2014, the AMA published its Prior Authorization and Utilization Management Reform Principles.[81] This proposal received endorsement from over 100 medical and physician associations. The goal was to ensure that patients have timely access to necessary treatments while also reducing administrative costs for the healthcare system.

The AMA strongly urged health plans, benefit managers, and any other party conducting utilization management, to apply the 21 principles outlined in its proposal. The principles included the following:

- Any utilization management program applied to a service, device or drug should be based on accurate and up-to-date clinical criteria and never cost alone. The referenced clinical information should be readily available to the prescribing/ordering provider and the public.
- Utilization review entities should offer an appeals system for their utilization management programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/subspecialty for discussion of medical necessity issues.
- A drug or medical service that is removed from a plan's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year.
- A PA approval should be valid for the duration of the prescribed/ordered course of treatment.
- Utilization review entitles should publicly disclose, in a searchable electronic format, patient-specific utilization management requirements, including PA, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effective date in order to be relied upon by providers and patients, including prospective patients engaged in the enrollment process. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers what supporting documentation is needed to complete every PA and step therapy override request.
- Utilization review entities should provide, and vendors should display, accurate, patient-specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for purposes that include e-prescribing.

[81] Prior Authorization and Utilization Management Reform Principles https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf

- Eligibility and all other medical policy coverage determinations should be performed as part of the PA process. Patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim.
- If a utilization review entity requires PA for non-urgent care, the entity should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information.
- PA should never be required for emergency care.
- Health plans should offer providers/practices at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to "gold-card" or "preferred provider" programs or attestation of use of appropriate use criteria, clinical decision support systems or clinical pathways.

Consensus Statement on Improving the PA Process

In 2018, the AMA collaborated with healthcare providers - including physicians, pharmacists, various medical groups, and hospitals - as well as health benefit plans to identify ways to enhance the PA process. The goals of this collaboration were to ensure safe, timely, and affordable access to evidence-based care for patients, improve efficiency, and reduce administrative burdens. Together, they published the "Consensus Statement on Improving the Prior Authorization Process." [82]

In the statement, five areas were identified that could improve PA programs:

- **Selective Application of PA.** Differentiate the application of PA based on provider performance regarding quality measures, adherence to evidence-based medicine, or other contractual agreements. This approach can help target PA requirements where they are most needed and reduce the administrative burden on healthcare providers. Criteria for selective application may include ordering or prescribing patterns that align with evidence-based guidelines and historically high approval rates for PA.
- **PA Program Review and Volume Adjustment.** Regularly reviewing the list of medical services and prescription drugs subject to PA can help identify therapies that no longer require it due to low variability in utilization or low denial rates. This review can also uncover services, especially new and emerging therapies, where PA may be necessary due to insufficient evidence regarding their effectiveness or safety concerns.
- **Transparency and Communication Regarding PA.** Effective two-way communication channels between health plans, healthcare providers, and patients are essential for timely resolution of PA requests. This can help minimize delays in care and clearly convey PA requirements, criteria, rationale, and any program changes.
- **Continuity of Patient Care.** Maintaining continuity of care is crucial for patients undergoing active treatment, especially when there are changes in formulary or treatment coverage and/or when switching health benefit plans. Access to prescription medications for patients on established

[82] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf

chronic therapies can also be impacted by PA requirements. Although many standards are in place regarding timeliness, continuity of care, and appeals—enforced by state and federal laws as well as private accreditation standards—additional efforts should be made to reduce the burdens and disruptions in patient care associated with PA.

- **Automation to Improve Transparency and Efficiency.** Moving towards industry-wide adoption of ePA transactions based on established national standards can streamline and enhance the process for all stakeholders. Additionally, providing electronic access to PA requirements and formulary information directly within EHRs and pharmacy systems can improve efficiency, reduce time to treatment, and potentially decrease the number of PA requests, as healthcare providers will have the necessary coverage information when making treatment decisions. The adoption of technology by all involved stakeholders, including healthcare providers, health benefit plans, and their partners or vendors, is essential for achieving widespread utilization of standardized ePA processes.

AMA Model Legislation

The AMA has released model legislation multiple times, with the most recent publication in 2025. The goal of the model legislation[83] is to enhance transparency and minimize interruptions to patient care. The following states have adopted language directly from the model legislation: Delaware, Georgia, Illinois, Mississippi, New Jersey, Oklahoma, and Wyoming.

The model legislation recommends the following measures:

- Establishing quick response times: 24 hours for urgent care and 48 hours for non-urgent care.
- Requiring that adverse determinations be made solely by a physician who is licensed in the state and is in the same specialty that typically manages the patient's condition and with experience treating the patient's condition.
- Prohibiting retroactive denials for care that has been preauthorized.
- Requiring that authorizations remain valid for at least one year, irrespective of dose changes, and for those with chronic conditions, they should be valid for the duration of treatment.
- Requiring the public release of insurers' PA data by drug and service as it relates to approvals, denials, appeals, wait times and more.
- Prohibiting PA for the provision of medications for opioid use disorder (MOUD).
- Ensuring that new plans honor a patient's PA for at least 90 days.
- Reducing the volume of PA requests through exemptions or gold-carding programs.

[83] American Medical Association's Ensuring Transparency in Prior Authorization Act: https://fixpriorauth.org/sites/default/files/2025-04/Health%20Plans%2C%20Ensuring%20Transparency%20in%20Prior%20Auth%20Act%202025.pdf

- Improving transparency during adverse determinations and denials by requiring the utilization review entity to provide the enrollee and requesting health care provider with specific details about the determination and the enrollee's right to appeal.

The model legislation also defines several terms including clinical criteria, medically necessary health care services, PA, urgent health care service, and utilization review entity.

A utilization review entity is any individual or entity that performs PA on behalf of certain other entities, including but not limited to, insurers that write health insurance policies, a preferred provider organization (PPO), or health maintenance organization (HMO), or an employer with employees who are covered under a health benefit plan or health insurance policy. Under the model legislation, a utilization review entity is required to make PA requirements and restrictions readily accessible on its website in detailed but easily understandable language. This should also include written clinical criteria.

Utilization review entities are also required to submit an annual report to the state's Department of Insurance (DOI) that contains specific information about PA requests from the previous calendar year. The DOI is required to submit a report to the legislature that includes a summary of the reports provided by the utilization review entities and recommendations for the removal of PA requirements on services that are regularly approved (80% of the time) for PA.

The model legislation defines medically necessary health services as those that a prudent physician would provide to diagnose or treat an illness, are clinically appropriate, in accordance with generally accepted standards of medical practice, and not primarily for economic benefit. If a utilization review entity is questioning whether a health care service is medically necessary, it must notify the enrollee's physician. Before issuing an adverse determination, the enrollee's physician must be given the opportunity to discuss the medical necessity of the service with the physician determining authorization of the service under review.

Furthermore, a utilization review entity issuing an adverse determination must explain its reasoning using its own PA requirements as a basis, provide the clinical criteria used, inform the enrollee of their right to appeal and the process to file an appeal, and provide all information necessary to support a successful appeal. A notification of an adverse determination and a denial of an appeal must include the National Provider Identifier (NPI) of the physician who reviewed the PA request and is responsible for the determination, as well as the physician's credentials, board certifications, and specialty areas, expertise, and training.

When issuing a denial of an appeal, the utilization review entity must provide the enrollee and requesting health care provider with the reasons for denying the appeal, the clinical criteria used in determining the denial of the appeal, the process for challenging the determination, and all information necessary to support a successful second level appeal (when the next level is not an external review process).

The model legislation also outlines a gold-card system. A utilization review entity may not require a health care provider to complete a PA for a health care service if in the most recent 12-month period, the

utilization review entity has approved or would have approved not less than 80% of the PA requests submitted by the health care provider for that service, including any approval granted after an appeal.

Finally, the model legislation establishes PA exemptions for emergency services and medications for opioid use disorder (MOUD) and outlines electronic standards for PA. By a given date, an insurer must accept and respond to PA requests under the pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions. Any technology not directly integrated with a physician's EHR/electronic prescribing system must not be considered secure electronic transmission.

American Psychiatric Association Model Legislation

In 2022, the American Psychiatric Association (APA) developed model legislation[84] aimed at reforming the PA process to reduce unnecessary administrative burdens and improve patient access to care. This legislation focuses on streamlining the authorization process, increasing transparency, and ensuring timely decision-making.

The proposal identifies specific scenarios that would be exempt from PA, including:

1) Generic prescription drugs that are not classified as controlled substances under 21 CFR 1308.11 through 21 CFR 1308.15 or under any state criminal law.

2) Any prescription drug, whether generic or brand-name, that is not classified as a controlled substance in federal or state law, after the insured or enrollee has been prescribed the drug without interruption for six months.

3) Any prescription drug, whether generic or brand-name, where the insured or enrollee has already undergone PA for the same dosage and received approval for coverage, on the grounds of therapeutic duplication.

4) Any prescription drug, whether generic or brand-name, when the dosage has been adjusted by the prescriber.

5) Any long-acting injectable prescription drug.

The model legislation also aims to eliminate unnecessary paperwork and ensure that any denial of coverage is made by a physician with the appropriate expertise. Denials during the PA process must be made by a physician who specializes in the same field as the prescriber or who focuses on the diagnosis and treatment of the condition for which the drug was prescribed.

The model legislation outlines expedited internal appeal processes with quick response times for denials. It requires decisions to be made within 48 hours for expedited appeals. If the prescriber believes that the insured or enrollee will suffer serious harm without access to the prescribed drug, the denial becomes eligible for an expedited internal appeal. Once the expedited appeal process is initiated, the insurance

[84] APA Prior Authorization Model Legislation
https://votervoice.s3.amazonaws.com/groups/americanpsych/attachments/SAC/2022%20APA%20Prior%20Authorization%20Reform%20Model%20Legislation.pdf

carrier must render a decision within 48 hours and provide written notice. If a decision is not made within this timeframe, the initial denial is automatically overturned, and the insured or enrollee receives immediate coverage approval for the prescription drug.

Additionally, the model legislation proposes eliminating PA requirements through the implementation of gold-carding programs. Under these programs, a physician or provider would not need PA for a specific health benefit if, during the most recent six-month evaluation period, the carrier approved or would have approved at least 90% of the PA requests submitted by that physician or provider for that health benefit. Physicians or providers will be reevaluated every six months to determine their eligibility for this exemption.

Legislative Organizations

National Council of Insurance Legislators (NCOIL)

Prior Authorization Reform Model Act

In March 2025, the National Council of Insurance Legislators (NCOIL) introduced a draft of the Prior Authorization Reform Model Act.[85] The primary purpose of the model act is to protect the patient-provider relationship from unreasonable third-party interference and to ensure that PA programs do not impede the independent medical judgment of physicians and other healthcare providers. The model act aims to improve timely access to care and increase transparency by establishing new requirements for health insurance companies. NCOIL adopted the model act on Nov. 15, 2025.[86]

Key provisions of the model act include:

- **Transparency and accessibility:** Insurers are required to publicly disclose which services necessitate prior authorization and to provide a transparent approval and denial process. They must also post statistics regarding PA approvals and denials on their websites in an easily accessible format.
- **Evidence-based criteria:** The clinical criteria used for PA decisions must be evidence-based, align with nationally accepted standards, and be made available online.
- **Physician review:** Denials must be reviewed by a physician, and appeals must also be examined by a physician or their representative.
- **Continuity of care:** Insurers must honor PAs from a previous insurer for a specified period (e.g., 90 days) during a patient's transition between health benefit plans.
- **Prohibition of retroactive denials:** Health plans are prohibited from retroactively denying claims for care that was preauthorized.
- **Time limits:** The model act establishes specific time limits for review processes.
- **Chronic conditions:** PAs for chronic or long-term conditions must remain valid for 12 months or the duration of the treatment, whichever is shorter.
- **Reporting:** Insurers must report PA data annually to the relevant state insurance department.

[85] https://ncoil.org/wp-content/uploads/2025/03/NCOIL-Prior-Auth-Reform-Model-Draft-3-26-25.pdf
[86] https://ncoil.org/wp-content/uploads/2025/11/NCOIL-Prior-Auth-Model-November-2025.pdf

The model act applies to all health insurance insurers, plans, private review agents, and utilization review plans, with exceptions for self-insured health benefit plans under the federal Employee Retirement Income Security Act (ERISA) of 1974 and healthcare provided under the Workers' Compensation Act.

Industry Trade Associations

In June 2025, AHIP and the BCBSA announced a voluntary initiative by health insurers to simplify PA, with a focus on "connecting patients more quickly to the care they need while minimizing administrative burdens on providers."[87] The initiative applies to insurance markets including commercial coverage, Medicare Advantage, and Medicaid managed care. The participating member health plans voluntarily commit to:

- **Standardize electronic PA** by Jan. 1, 2027. Participating health plans will work toward implementing common, transparent submissions for ePA.
- **Reduce the scope of medical claims subject to prior authorization**, with demonstrated reductions by Jan. 1, 2026. Individual plans will commit to specific reductions to medical PA as appropriate for their particular market.
- **Ensuring continuity of care when patients change plans**, beginning Jan. 1, 2026. When a patient changes insurance companies during a course of treatment, the new plan will honor existing PAs for benefit-equivalent in-network services as part of a 90-day transition period.
- **Enhance communication and transparency on determinations,** operational for fully insured and commercial coverage by Jan. 1, 2026, with a focus on supporting regulatory changes for expansion to additional coverage types.
- **Expand real-time responses.** In 2027, at least 80% of approvals of electronically submitted complete medical PA requests will be answered in real-time and health insurers will support federally required technical standards for ePA requirements beyond federal programs across all insurance markets.
- **Ensure medical review of denied requests based on medical necessary/clinical factors**, a standard that is already in place

These commitments build upon ongoing health plan efforts to make PA a more seamless and transparent process and reflect insurers' goal to ensure patients receive the most effective care, at a more affordable cost.

Takeaways

State regulators should work within the broader NAIC to develop PA standards or best practices. In addition, the following best practices should be helpful to states considering PA reforms.

[87] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization

Take advantage of data calls

Make use of targeted data calls while in the legislative process to understand the state-specific market conditions. This data will prove invaluable to mold future legislation that will benefit the entire healthcare ecosphere.

Incorporating flexibility in legislation

Any new processes in legislation, while well-intentioned, may cause unintended consequences to consumers. insurers, and providers. New processes, such as ePA, can cause unneeded delays if systems crash unless there are alternate methods permitted.

Build relationships with state partners

In all conversations with providers, regulators, insurers, and consumer organizations, stay patient focused. The ultimate goal is to get patients the necessary care they need in the shortest amount of time.

Implementation processes

As with any health care legislation, prior authorization changes to law can require significant effort to implement. It is important for state agencies to understand their roles with any changes, and to have mechanisms in law or processes in place to communicate how actions or decisions by one agency may impact the work of other agencies. In addition, many of the changes to facilitate faster processing time require IT updates at both the insurer and provider levels, taking both time and a financial commitment to achieve.

Develop provider and consumer education

States may pursue public awareness campaigns so that health insurance consumers and their physicians become familiar with PA processes and the attendant appeal rights. States may also highlight rules currently in effect designed to significantly increase transparency of health insurer processes. Bringing more focus to the health insurance consumer experience with PA will greatly benefit those depending on the coverage they purchased to help navigate and address complex health concerns.

Create structure for enforcement

New PA requirements can have complicated enforcement mechanisms, and some may require additional staff expertise or investment in training. The Regulatory Framework (B) Task Force will evaluate the need for an ad hoc or other group to support regulators newly embarking on PA enforcement.

APPENDIX—CHART ON STATE PA LAWS AND TYPE PRIOR AUTHORIZATION LAW

Observations of State Insurance Laws Regarding Prior Authorization

- 49 states have some form of PA law as well as the District of Columbia and Puerto Rico.
- 22 states and Puerto Rico have gold carding laws with some being enacted as early as 1998 with most having adopted gold carding laws between 2018 and 2024. There has been an increase in state adoptions in the last two years.
- Some states have PA statutes limited to emergency procedures, while others touch on most or all medical procedures that require prior authorization.

Common Provisions in Prior Authorization Laws

- Response Times: Most jurisdictions have provisions relating to response times. Generally, these require a response in 24-72 hours for urgent requests and 5-7 business days for non-urgent requests. A few jurisdictions allow for automatic approval if no response is received within the required timeframe.
- Retrospective Denials: Half of the jurisdictions have provisions relating to retrospective denials. Most commonly these are prohibitions against pre-approved/authorized services except in cases of fraud, misrepresentation, ineligibility, or coverage lapses.
- Clinical Criteria and Medical Necessity: Just over half of jurisdictions have provisions related to clinical criteria and medical necessity. Common provisions include requirements for evidence-based and/or peer-reviewed standards and transparency requirements (clinical criteria available publicly or upon request) with a few requiring annual review/update of clinical criteria to include new or updated practice and guidelines.
- Qualifications of reviewer: 33 of 56 jurisdictions have requirements related to the qualifications of the reviewer. Most of these require adverse determinations to be made by a licensed physician or healthcare professional and some specify licensure in that state or a same or similar specialty as the treating provider. Other common requirements include board-certification and conflict-of-interest protections.
- Gold carding: 23 jurisdictions have provisions relating to gold carding. Trends in gold carding provisions include PA exemptions for providers with a greater than 90% approval rate and exemptions for certain procedures or services. Gold carding eligibility is typically granted for a specific time period and subject to renewal.
- Peer-to-peer/appeal process: 26 jurisdictions have provisions for peer-to-peer appeal processes. Most commonly these provisions require that providers have the opportunity to engage in a discussion with a clinician of the same or similar specialty as the requesting provider before a denial is considered final.

Many also require expedited appeals for urgent conditions, external reviews from independent review organizations, or appeal reviewers to be different from the original reviewer.

State	Citation (s)	Response Times	Retrospective Denials	Clinical Criteria & Medical Necessity	Qualifications of Reviewer	Gold Carding	Peer-to-Peer/Appeal Process
AL	27-3A-5	(a)(4)(c)(6) Response in 2 working days and no later than 30 days from appeal.			(a)(4)(a) by physician in same or similar specialty.		(a)(4)(c) 48 hours expedited appeal.
AK	Alaska Statute 21.07.250(14); 21.07.020; 300gg-19a; 3 AAC 28.908 – 3 AAC 28.914, 3 AAC 28.989.	PA for a covered medical procedure on the basis of medical necessity may not be retroactively denied unless PA is based on materially incomplete or inaccurate information.	(21.07.020) for materially incomplete or inaccurate info on behalf of provider.			(b)(1)(300gg-19a)For emergency services.	
AZ	ARS 20-2803	None for initial med. Screening, otherwise 24 hours by phone or fax.			(E)Access to a physician when necessary for determinations.		
AR	23-99-1105	(a)Two days for nonurgent; expedited one day; (e)(1) Emergency service requiring post evaluation or stabilization shall make an auth within sixty minutes of receiving request.	(23-99-1109)(b)(1) cannot rescind PA based on med. Necessity at least three days before scheduled admission or service.	(23-99-1103)(B) "Medical necessity" includes the terms "medical appropriateness", "primary coverage criteria", and any other terminology used by a utilization review entity	(23-99-1111)(c)(1) An adverse determination regarding a request for prior authorization shall be made by a physician who possesses a current and unrestricted Arkansas license to practice medicine .	(23-99-1120)(a)(2) If a provider's PA requests are approved 90% or more in a six month period.	(23-99-1111)(c)(3)(A) The requesting provider may contact reviewing physician within one business day of adverse determination for an urgent svc or two days for a nonurgent service.
CA	HSC s 1367.01 to 016 T.28 s 1300.67.2.41	5 business Days, urgent 72 hrs. 24 hrs exigent.		Requires reasonably necessary info.	Licensed physician or health care professional .		Plan must cover 1 therapeutically equivalent drug, device or product for prevention of AIDS/HIV w/o PA or step therapy.

CO	C.R.S. 10- 16-124.5 C.R.S. 10- 16-113	Electronic: 2 business days Nonurgent facsimile or email: 3 business days		PA process should consider national standards for electronic PA, whether to require carriers and PBM firms to use clinical criteria based on medical necessity, and ensure that carriers and PBM firms use evidence-based guidelines in determinations.	Licensed physician familiar with Colorado standards of care. First-level appeals should include consultation of appropriate clinical peer(s) and should not involve any physicians or peers involved in the initial adverse determination.		Carrier shall give the medical facility or health care professional an opportunity to request, orally or in writing, a peer-to-peer conversation about an adverse determination by the reviewer. The conversation shall occur within 5 calendar days of receipt of the request and shall be between the entity rendering the health care service and the reviewer who made the determination or a clinical peer designated by said reviewer if they are not available within those 5 days. If the P2P conversation does not resolve the matter, the determination may be appealed by the covered person. A P2P conversation is not a prerequisite to request a review.
CT	CT Gen Stat § 38a-472g		No retrospective denial if insurer failed to notify the insured's provider at least 3 business days before the date of the procedure whose PA was revoked.				
DE	HB 381 (2016) 18 Del.C.§§ 3373 and 72	Pharmaceuticals: 2 business days Other health care services: 5 business days		Criteria shall be described in language easily understandable by a health care provider in the same clinical area.			

DC	L25-0100 DC Code §§31-3875.03; 31-3875.02; 31-3875.06	Urgent: 24 hours Long-term services: 30 days All others: 3 business days for electronic portal requests and 5 business days for requests submitted via a different medium.	For emergency health care services: only if the utilization review entity shows clear and convincing evidence that the service was not medically necessary.	PA may only be required for a covered service based on determination of medical necessity for different care or that the care is experimental or investigational.	Adverse determination: Current and non-restricted license to practice in D.C., Maryland, or Virginia, and same or similar specialty as a physician who typically manages the relevant service or condition. Reviewing physician: Under direction of one if the entity's directors responsible for providing services to D.C. enrollees and has no financial incentive. Utilization entity appeals: Current and non-restricted license to practice in D.C., Maryland, or Virginia; same or similar specialty as a physician who typically manages the relevant service or condition, knowledgeable in and experienced with the service. Shall not receive any financial incentive and shall not have been involved in making the adverse determination or subordinate of the physician who was.		Enrollee has 15 calendar days to appeal an adverse determination. The utilization review entity shall notify the enrollee's provider before issuing the determination that the medical necessity of the health care service is under question and request additional information on the necessity of the service.
FL	F.S.A. § 627.42392 Ch. 2016- 224 (627.4239 2) and Ch. 16 – 222	Health plans shall provide treatment authorization 24/7 and establish written procedures for requesting and granting authorizations. Medicaid requires expedited PA requests to be processed within 3 business days and standard requests to be processed within 14 days with an average turnaround time within 7 days.					

GA	GA Code Ann. §§33-46-1 to 16; §§ 33-46-20 to 32	Non-urgent: 7 calendar days Urgent: 72 hours		Criteria are based on sound clinical evidence and are evaluated periodically to ensure efficacy. "Medically necessary" means healthcare services that a healthcare provider would provide to a patient for the purpose of treating an illness, injury, or disease or its symptoms in a manner that is in accordance with generally accepted medical standards, clinically appropriate, not primarily for the economic benefit of the insurer or convenience of the patient or provider, and not primarily custodial care.	Healthcare provider with a current and valid nonrestricted license or other appropriate authorization, is currently in active practice in the same or similar specialty, is knowledgeable in and experienced with the service under appeal, is not directly involved in making the adverse determination, and considers all clinical aspects of the service under review.	For unanticipated emergency and urgent services, covered services that are incidental to the primary covered service and medically necessary, and ambulance transportation.	
HI	HB 954	Non-urgent: 5 calendar days before provision of the service. Request is deemed approved after 48 hours if the utilization review entity fails to make a decision, request more information, or notify the provider that PA is being questioned for medical necessity. 24 more hours are given after additional information is given. Provider who fails to submit requested information within 24 hours shall submit a new PA request.	No retrospective denial if care is provided within 45 business days from the date the provider received the PA. A utilization review entity shall pay a provider the contracted rate for a PA unless: the provider intentionally misrepresented the health care service with intent to deceive and obtain an unlawful payment; the provider failed to meet timely filing requirements; the review entity is not liable for the claim; or on the day the service was provided, the service was no longer a covered benefit, the provider was no longer contracted with the patient's insurance plan, or the patient was no longer eligible for coverage.	Any current PA requirements shall be readily available in detailed and easily understandable language on the utilization review entity's website. New PA requirements or amendments must not be implemented until the website is updated to reflect it and until providers have been given written notice within 60 days before the requirement's implementation.	Physician who has a current and valid non-restricted license, is and has been in active practice for at least 5 consecutive years in the same or similar specialty, has knowledge of and experience with the services under appeal, has no financial interest in the appeal's outcome, and was not directly involved in making the determination.	For prehospital transportation or the provision of emergency health care services.	Any utilization review entity questioning a health care service's medical necessity shall notify the enrollee's physician of said questioning. The physician shall have the opportunity to discuss the medical necessity with the physician responsible for determining authorization of said service via telephone.
ID	Title 41, Ch. 39 (41-3930)	Nonemergency: 2 business days No PA for emergencies	In cases of fraud, misrepresentation, nonpayment of premium, exhaustion of benefits, or if covered person is not enrolled at the time of service.				

IL	Public Act 102-0409 215 ILCS 134/10	Urgent care: Within 48 hours of receiving all required information Non-urgent PA: 5 calendar days of receiving info Appeal: 15 business days of receiving info	No retrospective denial for routine services when an associated health care service has received PA or when PA is not required for said service.	Criteria must be based on national standards except where State law provides its own, be developed in accordance with current national medical accreditation standards, ensure quality of care and access to services, be evidence-based, flexible to allow deviations, and be evaluated and updated at least annually. "Medically necessary" means that a service addresses the needs of a patient for screening, preventing, diagnosing, or treating a condition or its symptoms and comorbidities, in a way that is: in accordance with generally accepted standards of care; clinically appropriate; and not primarily for the economic benefit of the health care plan, purchaser, or utilization review org., or for the convenience of the patient or provider.	Physician with a current and valid nonrestricted license to practice medicine in the U.S., in the same or similar specialty as a physician who manages the condition, have knowledge of and experience providing the health care services under appeal, not directly involved in the adverse determination, and that considers all known clinical aspects of the service.	A health insurance issuer shall periodically review and consider removal of PA requirements where a medication or procedure is customary and properly indicated with support from peer-reviewed medical publications, or for patients currently with an established treatment regimen.	
IN	SB 400 (2023) HR 1143 (2018) SB 73 (2017) 27-1-37.5-1 to 17	Urgent: 48 hours Nonurgent: 5 business days	Health plan shall not deny a claim based solely on lack of PA for the unanticipated health care service. It shall not deny payment for a service rendered in accordance with a PA and all terms and conditions of the provider's agreement with the health plan.			No PA on list of CPT codes for state employees through June '26	The health plan's clinical peer and the covered person's provider or designee shall provide a peer-to-peer review within 7 business days, given that all needed information has been received.
IA	191 IAC 79 IA HF2399 (2022)	Urgent: 72 hours Nonurgent: 5 calendar days When additional needed information is submitted, the applicable time period for a decision starts again. QHP drugs: 24 hours	If fraud, waste, or abuse occurred, or if inaccurate information was provided; If, on the date that the health care service was provided, the service was no longer a covered benefit under the covered person's health plan, or the provider was no longer contracted with the carrier providing the health plan, or the covered person was no longer a participant in the health benefit plan; If the provider failed to meet the carrier's requirements for timely filing of claims; or If the carrier does not have liability for the service due to coordination of benefits.			PA shall be valid for the specific health care service for not less than 90 days from the date of PA receipt, provided that the covered person has the same health benefit plan for those 90 days.	

KS	40-4603	24/7 access to a representative for services provided immediately after treatment of an emergency health condition.				For emergency services if symptoms presented show that an emergency medical condition exists, or for emergency examination and stabilizing services.	
KY	KY Rev Stat § 217.211 SB 54 2019	Urgent review: 24 hours Nonurgent review: 5 days	If the approval was based on fraudulent, materially inaccurate, or misrepresented information.	"Medically necessary health care services" means health care services that a provider would render to a patient to prevent, diagnose, or treat an illness, injury, disease, or its symptoms in a way that is in accordance with generally accepted medical standards and is clinically appropriate.	Licensed physician of the same or similar specialty as the ordering provider		
LA	HB 468 (2023) SB 188 (2023) LSA-RS 22:1006.1 LSA-RS 46:460.33 ASB 348 (2022) LSA-R.S. 22:1139 SB 112 (2022)	Urgent: 2 business days Non-expedited: 5 business days Concurrent: 24 hours of obtaining needed information Retrospective review: 30 business days of obtaining needed info. Insurance issuer has 1 calendar day to inform the provider what additional info. is needed. Provider has 2 business days to provide it.	Denied if: benefit limitations are reached, documentation fails to support the claim, the service is no longer medically necessary, the service would require disapproval in accordance with the enrollee's plan, another payor is responsible for the payment, the provider was already paid for the services, the claim is fraudulent, and/or the recipient of the service was not eligible to receive said service.	Criteria are evidence-based and updated and reviewed by an insurance issuer.	Licensed healthcare practitioner similar in education and background as the requesting provider, or a same or similar specialist who treats the condition and any complications resulting from the health care service.	For invasive procedures for which PA was received from the insurance issuer before the procedure was finished or PA was not required by the issuer.	The health insurance issuer shall appoint a physician to conduct a peer review and shall notify the requesting physician of the determination within 2 business days of the peer review date.
ME	Chapter 273 PL S.P. 218- L.D. 705 2019	Nonemergency: 72 hours or 2 business days, whichever is shorter With outside consultation: 72 hours or 2 business days after initial response, whichever is shorter.	If fraudulent or incorrect information was provided.	Criteria are based on published sound clinical evidence and are evaluated periodically to ensure efficacy.	Clinical peer who may not have been involved in making the initial adverse health care treatment decision unless additional information is provided on appeal.	No PA for first 12 visits of a new episode of care, including for rehabilitative or habilitative services.	
MD	MD Code Ann. 19-108.2 MD Ins Code § 15-851 (2019)	Real time approval for requests that need no additional information and meet the payor's criteria for approval. Otherwise: Nonurgent pharmaceuticals: 1 business day Nonurgent other: 2 business days					

MA	MGL C. 1760, 25	If a payer does not respond within 2 business days, the request is deemed to have been granted.		Guidelines should be developed with input from practicing physicians and participating providers in the carrier's service area, developed in accordance with national accreditation standards, updated at least biennially, evidence based, considerate of individual health care needs of the insured, assessed by the carrier to show compliance with state and federal parity requirements, and compliant with state and federal law.			
MI	Section 500.2212c SB 247 (2022)	Non-urgent: Granted if not decided upon or replied to within 7 calendar days of the request. Urgent: Granted if not decided upon or replied to within 72 hours.		Criteria must be developed by either an entity that works directly with clinicians and does not receive direct payments based on the outcome of the clinical care decision, or a professional medical specialty society. The criteria must take into account the needs of atypical patient populations, ensure quality of care and access to needed services, be evidence-based, be flexible to allow deviations, and be evaluated and updated at least annually.	Licensed physician who is board certified or eligible in the same specialty as a provider who typically manages the condition or service under review. If no such physician can be identified within the applicable time limits, the insurer may use a licensed physician in a similar and appropriate specialty.	An insurer shall adopt a program that promotes the modification of PA requirements based on: The performance of health care providers, involvement of contracted providers to participate in a financial risk-sharing payment plan, and health provider specialty, experience, or other factors.	
MN	M.S.A. § 62M.01 to 19	Standard: 5 business days Expedited: 48 hours, including at least one business day after the initial request Appeal: 15 days + 4 additional days if needed due to circumstances outside the control of the review organization.	If there is evidence that the PA was based on fraud or misinformation, or if a previously approved PA conflicts with state or federal law.	If no independently developed evidence-based standards exist for a particular procedure, an insurer or utilization review organization shall not deny coverage solely based on the ground that the procedure does not meet an evidence-based standard. Clinical criteria must be established with appropriate involvement from actively practicing physicians and must be evaluated and updated annually based on sound clinical principles.	Physician in the same or a similar specialty as typically manages the condition or treatment under discussion who is reasonably available to review the case. Reviewer may not receive any financial incentive based on the number of adverse determinations they make.		
MS	MS Code 2015 83- 9-63	Within 2 business days					

MO	Mo. Rev. Stat.§§ 376.1350-376.1389; SB 982	24 hours electronically or telephonically, plus confirmation within 2 work days Concurrent: 1 work day	The grievance decision is finalized, binding, and subject to judicial review if: review is filed within 30 days of the final decision, judicial review is limited to the record before the director, the enrollee and carrier are real parties in interest, and the scope of judicial review extends only to whether the action is unlawful or in excess of the director's statutory authority.	Based on sound clinical evidence and evaluated periodically. When conducting utilization review, carrier shall only collect necessary information.	Qualified health care professional licensed in Missouri. Compensation for those conducting utilization reviews shall not contain incentives to make medically inappropriate decisions.		Review by the grievance advisory panel follows the same time frames as a first level review. Any grievance decision shall include notice of the right to file an appeal with the director's office.
MT	MT ST. §§ 33-32-101 to 419	Request for ext. review: 120 days of receipt of adverse determination Preliminary review of ext. review request: 5 business days of receipt of request		"Medical necessity" means health care services that a provider would provide to a patient to prevent, diagnose, treat, cure, or relieve a health condition, which are: in accordance with generally accepted standards, clinically appropriate and effective, not primarily for the convenience of the patient or provider, and not more costly than alternative service(s) likely to produce equivalent results.	Physician whose specialty focuses on the diagnosis and treatment of the condition that the Rx drug was prescribed to treat, provided that PA does not require a physician's involvement on the part of a health insurance issuer.	For any generic Rx drug that is not a controlled substance after a person has been continuously prescribed said drug at the same quantity for 6 months, Any generic or brand name Rx drug(s) for therapeutic duplication if the covered person already has PA for therapeutic duplication for the same dosage of the Rx drugs, Any Rx drug with a dosage adjusted within FDA or clinical standards, and Any long-acting injectable antipsychotic Rx drug.	A covered person may request external review when a health insurance issuer fails to adhere to state law involving the resolution of grievances. They are entitled to any available remedies on the basis that the issuer failed to provide a reasonable appeals process.

ND	2280 2025 Session Eff. 8/1/205	**26.1 - 36.12 - 05**. **Prior authorization - Nonurgent circumstances**. Nonurgent - 7 Days **26.1 - 36.12 - 06. Prior Authorization. Urgent Health Care Services**. Urgent - 72 hours **26.1 - 36.12 - 07. Prior Authorization. Emergency Medical Condition.** Emergency - 2 days following admission	**26.1 - 36.12 - 09. Retrospective denial.** May not revoke authorization for 45 days unless there is evidence the prior authorization was based on fraud.	**26.1-36.12-02. Disclosure and review of prior authorization requirements.** A prior authorization review organization shall make any prior authorization requirements and restrictions readily accessible on the organization's website to enrollees, health care professionals, and the general public. Requirements include the written clinical criteria and be described in detail using plain and ordinary language comprehensible by a layperson	**26.1 - 36.12 - 04. Personnel qualified to review appeals.** A prior authorization review organization shall ensure all appeals are reviewed by a physician. The reviewing individual: a. Shall possess a valid nonrestricted license to practice medicine. b. Must be in active practice in the same or similar specialty as the physician who typically manages the medical condition or disease for at least five consecutive years. c. Must be knowledgeable of, and have experience providing, the health care services under appeal. d. May not receive any financial incentive based on the number of adverse determinations made. This subdivision does not apply to financial incentives established between health plan companies and health care providers. e. May not have been directly involved in making the adverse determination. f. Shall consider all known clinical aspects of the health care service under review, including a review of all pertinent medical records provided to the prior authorization review organization by the enrollee's health care provider, any relevant records provided to the prior authorization review organization by a health care facility, and any medical literature provided to the prior authorization review organization by the health care provider.		**26.1-36.12-03. Personnel qualified to make adverse determinations.** A prior authorization review organization shall ensure all adverse determinations are made b y a licensed physician or licensed pharmacist. The reviewing individual: 1. Must have experience treating patients with the condition or illness for which the health care service is being requested; and 2. Shall make the adverse determination under the clinical direction of one of the prior authorization review organization's medical directors who is responsible for the health care services provided to enrollees.
NE	NE ST. §§ 44-5401 to 5431; LB77	Urgent: 12 hours Nonurgent: 3 days		Criteria shall be based on sound clinical evidence and evaluated periodically to ensure efficacy.	A physician that is reasonably available to review the case, unless the health care services were provided or authorized by a provider other than a physician. In this case, the appeal may be reviewed by a nonphysician provider whose scope of practice includes the services under review.		A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

NV	NV ST.§§ 687B.225; 616C.157; 683A.372	Treatment, diagnostic tests, consultation: 5 working days The PA shall be deemed to be given if the insurer fails to respond on time. They may subsequently deny authorization. Other requests: 20 days		Procedures shall include a quality assurance mechanism that ensures that an external review is conducted within the specified time frames, the selection of qualified and impartial clinical reviewers for external reviews, suitable matching of reviewers to specific cases, the independent review organization employs an adequate number of reviewers, the confidentiality of records and review criteria, and that a person employed by the organization adheres to external review requirements.	Physician or other appropriate health care provider who must: be an expert in the treatment of the covered person's medical condition under review; be knowledgeable about the recommended service through recent or current clinical experience treating similar patients with the same or similar medical condition; hold a nonrestricted license in the U.S. and, if a physician, hold a current certification byt a specialty board of the American Board of Medical Specialties in the area(s) appropriate to the subject of review; and have no history of disciplinary actions or sanctions that question the reviewer's physical, mental, or professional competence or moral character.		
NH	NHRSA §§ 420-J: 5, 420-J:6, I (c) 420-J:6, III 420-J:6, X 420-7-b; 415-A:4-a; 415-A:4-b	Urgent care appeals: 72 hours Confirmation of expedited decision: 2 business days Non-urgent: 14 calendar days Request for more info: 7 calendar days		Criteria shall be developed with input from practitioners with relevant knowledge, updated at least biennially, compliant with national accreditation entity standards, based on current and nationally accepted standards, and evidence-based.	Has appropriate medical and pro. expertise and credentials to apply clinical criteria. Med. necessity determination is made by one of the carrier's or UR entity's medical directors who is responsible for reviewing health care services provided to covered NH residents.	For interfacility transports related to treatment of certain mental illnesses. For at least one medication-based treatment option for substance use disorders without renewal more frequently than every 12 months.	Urgent determinations in 72 hours, additional information given at least 48 hours. The determination shall be made within 48 hours after the add'l information is received or the claimant misses the deadline to provide it. Peer-to-peer reviews can be requested before PA determination or after denial and before grievance, and shall be available within 2 days.

NJ	NJ Uncodified AB 1255	Urgent req: 24 hours Non-urgent req: 72 hours Current inpatient or emergency care services: 24 hours Urgent care: 72 hours Emergency care: 150 min.; services approved if determination is not made within this time	Payer shall honor a PA granted by a previous payer for at least the first 60 days of coverage under a new health plan. Payer shall reimburse a hospital or provider for all medically necessary emergency and urgent health care services covered under the health benefits plan.	"Medical necessity" means or describes a health care service that a health care provider would provide to a covered person to evaluate, diagnose, or treat a condition or its symptoms, that is: in accordance with generally accepted standards, clinically appropriate, not primarily for the convenience of the covered person or provider, and not more costly than alternative service(s) likely to produce equivalent results.	PA denials or limitations shall be made by a physician who shall: make the adverse determination under the clinical direction of a medical director be licensed in NJ, not be paid based on their approval or denial rate, and not be provided preferential treatment by a payer in requests for PA of the reviewing physician if that physician is also a network provider for the payer. Adverse determinations of appeals shall be made by a physician with the same requirements as reviewing physicians for PA denials, and additionally shall: be board certified in a same or similar specialty relevant to the condition or service under review, or has experience with said condition within the last 5 years; not have been directly involved in initial adverse determinations for the same claim; consider all clinical aspects of the service under review; and engages in telephone communication with the treating provider when requested.		Payer found to be in violation of those sections shall be liable for a civil penalty up to $10,000 per day that the payer is in violation if reasonable notice is given to levy the penalty. At the discretion of the commissioner, the payer has 30 days to remedy the condition that caused the violation.
NM	59A-22B-5	PA is granted for determinations not made within 7 days. When a health care professional requests an expedited PA and submits a statement that delay in treatment could cause permanent harm, an adjudication shall be made within 24 hours or deemed granted if no determination is made.	No retrospective denial for mental health or substance use disorder services after the provider renders the services, except in cases of fraud or violation of the provider's contract with the insurer.	"Medical necessity" means health care services determined by a health care provider, in consultation with the insurer, to be necessary according to: generally accepted principles of good medical care; practice guidelines from the federal government or professional associations; or applicable clinical protocols developed by the insurer consistent with federal, national, and professional practice guidelines.	"Medical peer review" means review by a health care professional from the same or similar specialty that typically manages the condition or procedure under review for PA.		An auto-adjudicated PA request based on medical necessity that is pended or denied shall be reviewed by a health care professional who: has knowledge of the medical condition of the covered person for whom the auth is requested, or consults with a specialist who has said knowledge. The health care professional shall make a final determination of the request; if denied, notice of the denial shall be provided to the covered person and their provider with: the grounds for denial, a notice of the right to appeal, and a description of how to file an appeal.

NY	N.Y. Ins. Law §§ 4902; 4903;4904	Appeal of initial UR determination: 30 days Expedited appeals: 2 business days Expedited appeal for substance abuse treatment: 24 hours Step therapy protocol override: 72 hours Step therapy protocol override for urgently needed Rx drug: 24 hours Allow at least 40 hours a week during normal business hours to discuss care and allow telephone requests		Utilization review agent shall use an evidence-based and peer reviewed review tool to determine coverage for substance use disorder treatment, which is designated by the office of alcoholism and substance abuse services. Agent shall use evidence-based and peer reviewed criteria to determine coverage for a mental health condition, which is approved by the commissioner of the office of mental health.	Both standard and expedited appeals shall only be conducted by clinical peer reviewers other than those who rendered the adverse determination.		Expedited appeals: 2 business days of receipt of necessary information, except those for substance use disorder treatment, which shall be determined within 24 hours. Notice of the appeal determination shall include rationale for the determination.
NC	N.C Gen. Stat.§§ 58-50-61; 58-3-200	"Necessary information" includes the results of any patient exam, evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the provider within 3 business days of obtaining all necessary information.	If an insurer determines that items are covered under its health benefit plan, the insurer shall not subsequently retract its determination after the items have been provided or reduce payments unless the determination was based on an intentional misrepresentation about the insured's health condition.	Criteria are based on sound clinical evidence and are periodically evaluated to ensure efficacy. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall either be: the diagnostic criteria in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, or criteria adopted by the insurer or its URO.	Medical doctor licensed to practice in NC with no incentives to make a particular decision.		Insurer shall clearly and comprehensively describe its UR procedures, and include availability of assistance and contact information for Health Insurance Smart NC, in the certificate of coverage and member handbook that it provides to covered persons. UR procedure information should also be included in materials for prospective covered persons.
OH	Ohio Rev. Code § 1751.72	Urgent: 48 hours Non-urgent: 10 calendar days (Both for PA requests and appeals)	If the service is related to another service that has already received PA approval and been performed, the new service was not known to be needed when the original service was performed, and the need for the new service was revealed when the original service was performed.		Appeal shall be between the health care practitioner requesting the service and a clinical peer.		Committing a series of violations that constitute a pattern shall be considered an unfair and deceptive practice. If the appeal does not resolve the disagreement, covered person or a representative may request external review. If the health care practitioner submits a claim including an unintentional error which results in a claim that does not match the information in the originally submitted approved PA request, the practitioner may resubmit the claim upon receiving a denial of services.

OK	Okla. Stat. Tit. 36, § 6907			Procedures shall ensure that health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of practice, and shall include mechanisms to assure availability, accessibility, and continuity of care.			
OR	O.R.S. §§ 743B.001; 743B.256; 743B.420; 743B.423	Nonemergency: within 2 business days If more information is requested, by the later of: 2 business days after receipt of a response or 15 days after the request	Determinations related to benefit coverage are binding on the insurer if obtained within 60 days before date of service Determinations related to eligibility are binding on the insurer if obtained within 5 business days before date of service	Must be evidence-based and continuously updated based on new research, and take into account new treatment developments.	Physician licensed under ORS 677.100–677.228 for all final recommendations regarding treatments subject to UR. Independent review org. shall appoint reviewer(s) with at least one clinician in the same or similar specialty as the provider who prescribed the treatment.	"Managed health insurance" means any health benefit plan that requires enrollee to use specified network(s) of providers managed by the insurer to receive benefits, except for emergency service.	Insurer must give any provider who requested treatment or payment of services but was denied on the basis of being medically unnecessary or experimental the opportunity for a timely appeal with a medical consultant or peer review committee.
PA	Statutes 40 P.S.§§991.2154; 991.2155-2156; 991.2161	Urgent: Within 72 hours if not yet initiated, otherwise 24 hours MA or CHIP: 2 business days All others: 15 days	No denial for closely related services if the provider notifies the insurer within 3 business days of completion and before submitting a claim for payment, including all clinical information to evaluate medical necessity.	Criteria must be based on national medical standards, be applicable with govt. guidelines, provide for appropriate health care service and reflect current medical and scientific evidence.	Licensed provider with appropriate training and knowledge of the same or similar specialty related to the service, OR a licensed provider in consultation with a third-party provider with said qualifications.		For denied PA requests, insurer shall make a licensed professional available for a peer-to-peer review to the requesting provider. The peer-to-peer review procedure shall be available on the insurer's public website and portal. An MA or CHIP plan shall maintain an external grievance process, that includes expedited grievances, to appeal internal grievance denials.
PR	PR St T. 26 § 9005					For emergency services when such services are included in the health plan, and for obstetrical and gynecological care.	
RI	27-18.9 et seq.; 42-14.5-3	Urgent: 72 hours Non-urgent: 15 days (non-administrative)	Only if the initial approval was based on inaccurate information or the healthcare services provided did not follow the provider's care plan and/or prior approval restrictions.	ABD determinations must be made, documented, and signed by a licensed practitioner with the same licensure status as the ordering provider.	Licensed practitioner with the same licensure status as the ordering provider.	The insurance commissioner shall establish and assist an advisory council subcommittee made up of healthcare providers and RI licensed health plans.	A non-administrative ABD reconsideration decision shall not be made until the UR agent's provider has engaged in two-way, direct communication with the provider who is responsible for providing the treatment.

SC	§§ 38-71-144; 44-6-1050					Rx PA extends to all refills allowed by the o.g. prescription and subsequent prescriptions for the same drug at the same dose.	If a benefit plan that covers treatment of stage 4 advanced, metastatic breast cancer denies a PA request or claim for diagnostic imaging based on an adverse medical necessity determination, the covered person shall have a right to expedited external review. A Medicaid recipient who has been denied PA for a Rx drug is entitled to an appeal.
SD	SDCL § 58-17H et seq.	Determinations shall be issued in a timely manner in compliance with SD code. Carriers shall ensure utilization reviewers apply review criteria consistently.	Carrier shall make the determination within a reasonable time period not exceeding 30 days, but can be extended once for up to 15.	Criteria are based on clinical evidence and are evaluated periodically to ensure efficacy.	Reviewer must be a clinically qualified and appropriately licensed health care professional.		
TN	Tenn. Code Sections 56-7-3701-22; (56-61-102)	Urgent: 72 hours + 1 business day if applicable Nonurgent: 7 calendar days		Criteria must be: based on national standards except where state law provides its own, non-arbitrary and cited by the UR org., evidence-based, flexible to allow deviations, and evaluated and updated in accordance with state law.	Licensed healthcare pro. with the same or similar specialty as the physician requesting the PA. For appeals, same or similar specialty as the physician who requested initial PA, and is also currently licensed in the U.S. without restrictions and is knowledgeable and experienced with the services under appeal.	PA requirements shall be reviewed at least annually, during which PA for prescriptions & medical service checks is considered for removal.	Non-urgent requests are approved within 7 calendar days if the provider is not notified that PA is being questioned for med. necessity (except Rx drugs). If notice is provided, it must include a phone # to the UR org., hours of business operation of the physician reviewing the PA, and a statement that there is an opportunity to discuss the medical necessity of the service with the healthcare pro. who will approve or deny the PA. Must request PA at least 5 calendar days before providing service for non-urgent PAs.

TX	Ins. Section 843.3483; Ins. Section 4201.151; Ins. Section 4201.356; Ins. Section 4201.357; 28 TAC Section 19.1730;	A health maintenance org. that uses a PA process that violates TX law, including failing to comply with applicable deadlines, must provide an expedited appeal for any health care service affected by the violation.			Physician licensed to practice medicine in TX and must follow standards developed and approved by health care providers.	At least 90% approval for a particular service during the most recent 6 mo. eval period. No more than one PA annually for Rx drugs for autoimmune diseases, hemophilia, or Von Willebrand disease.	If a provider requests within 10 days that a specialty provider reviews the claim, a provider with the same or similar applicable specialty shall complete a review within 15 days. Appeal process must include procedures for expedited appeals for denials of: emergency care, continued hospitalization, or another service with documentation from the requesting provider proving that the service is needed to prevent death or serious harm to the patient.
UT	Utah Code Annotated § 31A-22- 650; §§ 31A-22-613(4), 31A-22-613.5(2)(d), 31A-22-625(4), 31A-22-627, 31A-22-639		No retrospective denial if the enrollee is eligible for coverage under their insurance policy, their circumstances related to care haven't changed, the provider submits an accurate claim, and no fraudulent or incorrect information was given by the provider.		Currently licensed as a physician and surgeon in a U.S. state, district, or territory.		
VT	18 V.S.A. § 9418, 18 V.S.A. § 9418b, DFR Rule H-2009-03	Urgent: 24 hours Nonurgent: 2 business days with acknowledgement given within 24 hours	Only if the health plan has provided at least 30 days' notice, including the proposed adjustment and explanation of the adjustment. Must be within 12 months of payment of the previously paid claim unless fraud occurred, provider was already paid, services were not provided, or the claim is the subject of legal action.	Based on medical and scientific evidence, and should be updated periodically. "Medically necessary" means appropriate in type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. It must be informed by medical and scientific evidence.	Physician under a medical director responsible for treating the MCO's members except when denial is based on eligibility for coverage.	For treatments ordered by a primary care provider.	The grievance process must allow members at least 180 calendar days following receipt of an ABD notification to request a first level appeal and at least 90 calendar days for a second level appeal. Members can submit and view copies of information related to the grievance. Reviewers must not have any prior involvement with the grievance and shall include at least 1 clinical peer of the treating provider in deciding on an ABD that is based on a medical judgement.
VI	No Provision						

VA	VA Code § 38.2-3407.15 VA Code § 38.2-3407.15:2 14VAC 5-216-40 A, C,E 14VAC5-216-50	Urgent requests via telephone within 24 hours, including weekends. Otherwise, within 2 business days.	In an invasive procedure, if the provider discovers the need to perform a less or more extensive procedure than was authorized, which is medically necessary and not investigative in nature, the carrier will pay the claim.	Carrier shall designate a clinical peer reviewer for the appeal of any adverse benefit determination. The reviewer shall not have been involved in any previous determination with regard to the claim.	An appropriate person designated by the carrier. They shall not have made any previous ABD of the subject under appeal nor shall they defer to any prior ABD.	No PA for at least one drug prescribed for substance abuse treatment.	Each covered person is entitled to a full review of an ABD and may file an appeal orally or in writing within 180 days. Pre-service claims: 30 days Post-service claims: 60 days Urgent appeals/requests to extend: 72 hours (any needed add'l info should be requested within 24 hr) Notification of an urgent care ABD shall describe the appeal process. Carrier shall provide coverage pending the appeal of a review decision. Reductions or terminations of an approved course of treatment shall constitute an ABD.

WA	Wash. Rev. Code § 48.43.830; § 48.43.537; § 48.165.050 Wash. Admin. Code § 284-43-2050	Electronic Standard PA request: 3 calendar days Expedited request: 1 day Request for more info: 1 day Nonelectronic Standard request: 5 days Expedited request: 2 days Request for more info: 5 days		Detailed, easily understandable, based on evidence-based clinical review criteria, and accommodating to underserved populations. Criteria should be updated at least annually.	Licensed in Washington or a state with comparable standards and should have substantial, recent clinical experience with the same or similar health conditions.	No automatic denial when it is impossible for the provider to obtain PA before performing services or notify payor within 24 hours.	Carrier or its representative must allow specialists to request PA for diagnostic or lab service in advance.
WV	W. Va. Code Ann. §33-15-4s et.seq.	Initial Review in 2 days, Additional Information given 3 days, with a follow up of 2 days for final decision.		Inpatient prescriptions written at time of discharge no PA if not over $5000 per day. After three days a PA may be required.	If PA is rejected, the physician can then request for an appeal by a physician with same specialty, background, and education.	If a health care practitioner has performed 30 procedures in 6 mos w/90% approval received Gold Card for 6 mos.	Appeals shall take no longer than 5 business days. Appeal on a PA shall take no more than 10 days.
WI	Wis. Admin. Code § 632.855	For PA requests of experimental procedures, within 5 work. days.					
WY	W.S. 1977 § 26-55-101 et seq.	PA requirements and restrictions must be easily accessible and in detailed yet simple language within 24 hours of being requested by a provider.	Only at the end of a 12 mo. period if the provider would not have met the 90% authorization criteria.	After issuing an adverse determination, insurer must determine authorization of the service and schedule a discussion about its medical necessity within 5 business days of the provider's request.	Provider with knowledge in an applicable specialty, knowledge in the coverage criteria, a current and unrestricted license, and the patient's med history and diagnosis.	For opioid abuse medications or for the first 12 visits of rehab or habilitative services for a new condition or treatment.	Appealing provider must have sufficient knowledge in an applicable specialty, knowledge in the coverage criteria, and a current and unrestricted license; must not have been employed or contracted by the insurer or otherwise have a financial interest in the appeal's outcome; must not have been involved in the initial determination; and must have considered all clinical aspects of the service.