NAIC/Consumer Liaison Committee

November 14, 2026

NOVEMBER 14–17

NAIC®

2026 FALL NATIONAL MEETING

DALLAS, TX

1. Presentation of Consumer Representatives' Excellence in Consumer Advocacy Awards

Amy Bach (United Policyholders) and Harold Ting (Individual Consumer Advocate)

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

2. Consider Adoption of Summer National Meeting Minutes

Attachment One

Commissioner D.J. Bettencourt (NH)

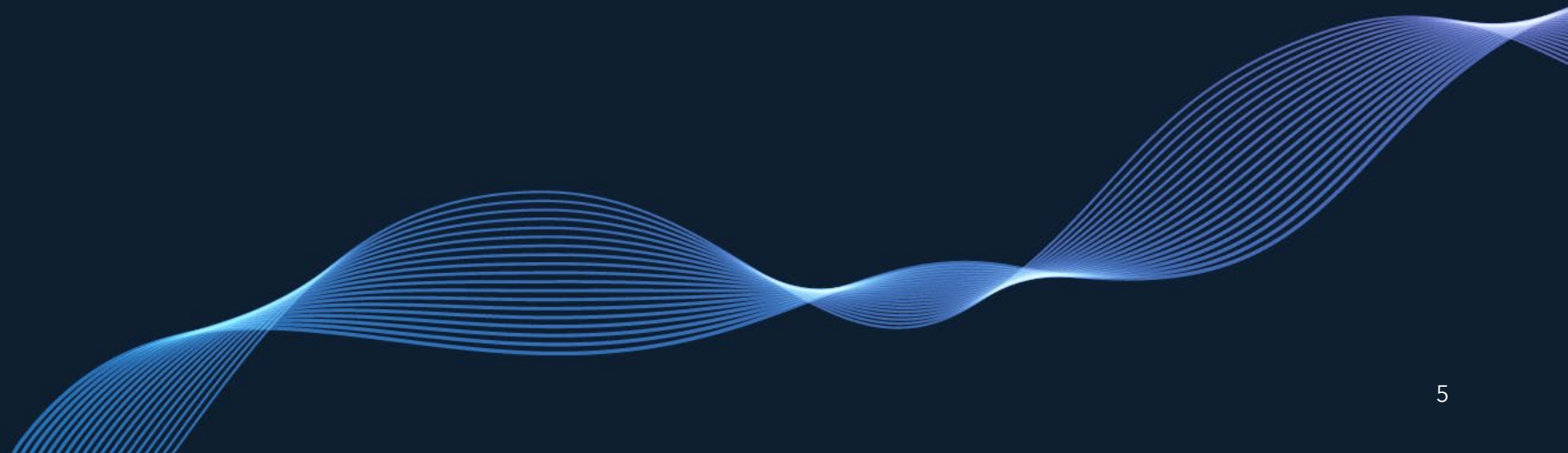
NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

3. Receive a Report from the NAIC/Consumer Participation Board of Trustees

Commissioner Scott A. White (VA)

4. Hear a Presentation on a Life Insurance Consumer Survey

Richard Weber (Life Insurance Consumer Advocacy Center)



NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS



Life Insurance Quantitative Research Study

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Study Background:

This nationwide study was commissioned by the **Life Insurance Consumer Advocacy Center** (LICAC) to investigate consumer experiences, understanding, satisfaction, and the role agents play in shaping informed decisions.

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Research Objectives:

- Identify opportunities to improve consumer awareness, strengthen transparency and inform future consumer advocacy efforts.

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Research Objectives:

- Identify opportunities to improve consumer awareness, strengthen transparency and inform future consumer advocacy efforts.
- Explore the role agents play in helping consumers make informed decisions.

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Research Objectives:

- Identify opportunities to improve consumer awareness, strengthen transparency and inform future consumer advocacy efforts.
- Explore the role agents play in helping consumers make informed decisions.
- Identify opportunities to improve consumer education, transparency and confidence for purchasing and ownership process.

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Methodology:

A 10-12 minute online survey was conducted between March and April 2026 among nationally representative purchasers of life insurance policies within the last 10 years.

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Key Findings

Key Finding: Best Interest Obligations

As you understood things when you bought the policy, did your agent have a legal obligation to act in your best interest?

- **Most policy owners incorrectly believed their agent had a legal obligation to act in their best interest.**

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Key Finding: Best Interest Obligations

As you understood things when you bought the policy, did your agent have a legal obligation to act in your best interest?

- Most policy owners incorrectly believed their agent had a legal obligation to act in their best interest.

- **Only 7% knew that no such obligation existed. The remaining 27% had no understanding one way or the other.**

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Key Finding: Agent Priority

At the time of purchase, who did you feel your agent was primarily looking out for?

- **41% incorrectly believed that the agent represented the policy owner.**

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Key Finding: Agent Priority

At the time of purchase, who did you feel your agent was primarily looking out for?

- 41% incorrectly believed that the agent represented the policy owner.
- **Another 36% incorrectly believed that the agent represented them and the insurance company equally.**

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Key Finding: Agent Priority

At the time of purchase, who did you feel your agent was primarily looking out for?

- 41% incorrectly believed that the agent represented the policy owner.
- Another 36% incorrectly believed that the agent represented them and the insurance company equally.
- **3% believed the agent represented only the agent, and the remainder were unsure.**

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Key Finding: Agent Compensation

Which of the following best describes how you think life insurance agents are paid?

- **Most consumers do not know how their agent is compensated, with only 35% understanding that the agent's compensation is commission determined as a percentage of the premium paid by the policyholder.**

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Key Finding: Agent Commission

What do you think was the approximate commission rate your agent earned on the first-year premium when you purchased your policy?

- **Agent commission rates can often exceed 100% of the first-year premiums paid. Most consumers either had no idea about what the commission rate could be, or believed the rate was 50% or less.**

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Additional Findings

Additional Finding: Consumer Understanding

How well did your agent initially explain the benefits and costs of the policy you purchased?

“Not well” to “Somewhat well”	40%
Very well	40%XX
Extremely well	20%XX

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Additional Finding: Overall Experience With An Agent

How would you rate your insurance agent …

- **Consumers rated their overall experiences with an agent as primarily ”good,” “very good,” or “excellent.”**
- **However, most consumers incorrectly believed their agent was primarily looking out for the consumer’s best interest.**

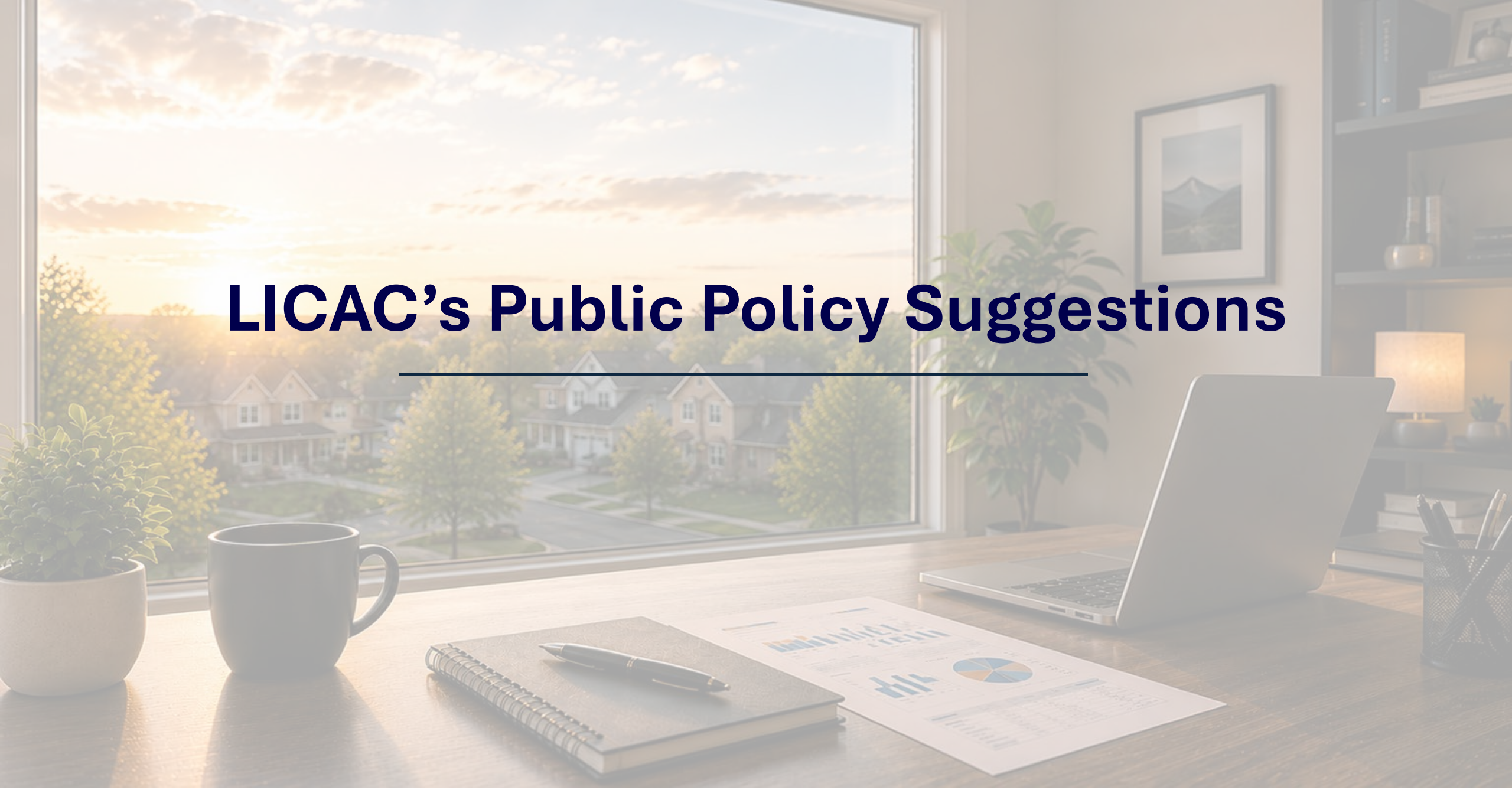
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Additional Finding: Agent Trustworthiness

How would you rate your insurance agent …

- **In general, consumers believed their agents were trustworthy.**
- **However, this perception may be affected by consumers' incorrect understanding of their agent's obligations. Consumers incorrectly believed the agent had an obligation to act in the consumer's best interest.**

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LICAC’s Public Policy Suggestions

LICAC's Suggestions

The survey demonstrates a significant gap between what consumers believe about their relationship with their life insurance agent and the legal obligations that actually exist.

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LICAC's Suggestions

The survey demonstrates a significant gap between what consumers believe about their relationship with their life insurance agent and the legal obligations that actually exist.

Closing that gap through stronger consumer protections and clearer disclosure requirements should be a priority for policymakers and the insurance industry.

To this end, we make the following suggestions …

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LICAC's Suggestions

1. **Establish a best interest obligation for agents or, at a minimum, require disclosures explicitly informing consumers that the agent represents the insurance company and has no obligation to act in the best interest of the policy owner. Establish that insurance companies have an obligation to supervise appointed agents regardless of their employment status.**

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LICAC's Suggestions

1. Establish a best interest obligation for agents or, at a minimum, require disclosures explicitly informing consumers that the agent represents the insurance company and has no obligation to act in the best interest of the policy owner. Establish that insurance companies have an obligation to supervise appointed agents regardless of their employment status.

2. **Expand consumer education on agent compensation and require disclosure explaining agent compensation as part of the policy purchase process.**

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Survey details available in the PDF handout

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Life Insurance
Quantitative Research Study





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About the Life Insurance Consumer Advocacy Center

The Life Insurance Consumer Advocacy Center (LICAC) is a non-profit, social welfare organization formed under Section 501(c)(4) of the Internal Revenue Code.

Mission Statement

The mission of the Life Insurance Consumer Advocacy Center (the Center) is:

- to alert the public, including consumers and policymakers, about the potential risks of certain types of life insurance policies, particularly life insurance investment schemes falling within the category of universal life, and about unfair practices in how such policies are sold; and
- to advocate for reasonable and essential consumer protections for these types of products.

LICAC's Work

LICAC Achieves this mission by:

- Collecting and sharing consumer stories about failed policies and unfair practices
- Advocating for consumer protections through legislative and regulatory action
- Working with the National Association of Insurance Commissioners to promote consumer interests
- Raising public awareness of current legislation
- Partnering with other advocacy groups
- Acting as an industry authority in legal cases, legislative hearings, and more.

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Background and Methodology

Study Background: This study was commissioned by the Life Insurance Consumer Advocacy Center (LICAC) to investigate consumer experiences, understanding, satisfaction, and the role agents play in shaping informed decisions.

Research Objectives: This research was designed to…

- Identify opportunities to improve consumer awareness, strengthen transparency and inform future consumer advocacy efforts.
- Explore the role agents play in helping consumers make informed decisions.
- Identify opportunities to improve consumer education, transparency and confidence for the purchasing and ownership process.

Key Finding: The survey found that most consumers do not understand that the life insurance agent represents the insurance company and mistakenly believe that agents are legally required to act in the best interest of the consumer. Consumers have little understanding of how their agents are compensated.

Methodology: A 10-12 minute online survey was conducted between March and April 2026 among nationally representative purchasers of life insurance policies within the last 10 years. The study has a margin of error of ±6.8% at the 95% confidence level, meaning the results provide a reliable directional view of consumer perspectives. The study includes 203 nationally representative consumers who were sourced from Research America's online research panel. Recruitment was conducted via email invitation to panel members, and data quality was ensured through screening, attention checks and ongoing monitoring.

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Key Findings

Data percentages have been rounded for clarity; combined totals may not equal 100%

Key Finding: Best Interest Obligations

At the time they bought their policy, most policy owners incorrectly believed their agent had a legal obligation to act in their best interest. Only 7% knew that no such obligation existed. The remaining 27% had no understanding one way or the other.

Consumers Were Asked: As you understood things when you bought the policy, did your agent have a legal obligation to act in your best interest?

Consumer Responses:

Yes	65.5%
No	7.3%
Don’t Know/Not Sure	27.1%

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Key Finding: Agent Priority

Very few policy owners understood that the agent represented the insurance company. 41% incorrectly believed that the agent represented the policy owner, and another 36% incorrectly believed that the agent represented them and the insurance company equally. 3% believed the agent represented only the agent, and the remainder were unsure.

Consumers Were Asked: At the time of purchase, who did you feel your agent was primarily looking out for?

Consumer Responses:

Themselves	3.4%
Both me and the insurance company equally	36%
The insurance company	10.3%
Me, the customer	41%
Don’t Know/Not Sure	9.4%

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Key Finding: Agent Compensation

Most consumers do not know how their agent is compensated, with only 35% understanding that the agent's compensation is commission determined as a percentage of the premium paid by the policyholder.

Consumers Were Asked: Which of the following best describes how you think life insurance agents are paid?

Consumer Responses:

Salary (paid by insurance company)	13.3%
Commission (a percentage of the premium paid by the policy holder)	35%
A combination of both salary and commission	37.4%
Compensation comes directly out of my policy's value	3.4%
Other	0.5%
Don't Know/Not Sure	10.3%

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Key Finding: Agent Commission

Agent commission rates can often exceed 100% of the first-year premiums paid. Most consumers either had no idea about what the commission rate could be, or believed the rate was 50% or less.

Consumers Were Asked: What do you think was the approximate commission rate your agent earned on the first-year premium when you purchased your policy?

Consumer Responses:

Less than 50%	34%
50%	23.1%
Approximately 100%	5.9%
More than 100%	0.5%
Don’t Know/Not Sure	36.5%

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Additional Findings

Data percentages have been rounded for clarity; combined totals may not equal 100%

Additional Finding: Consumer Understanding

Most consumers felt their agents explained the benefits and costs of their policies at least somewhat well, showing an information gap between consumer understandings of their specific policies and consumer understanding of their agent's roles and responsibilities.

Consumers Were Asked: How well did your agent initially explain the benefits and costs of the policy you purchased?

Consumer Responses:

Not well at all	2.5%
Not very well	7.4%
Somewhat well	29.6%
Very well	39.9%
Extremely well	20.7%

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Additional Finding: Overall Experience With An Agent

Consumers rated their overall experiences with an agent as primarily ”good”, “very good”, or “excellent”. However, most consumers incorrectly believed their agent was primarily looking out for the consumer’s best interest.

Consumers Were Asked: How would you rate your insurance agent for each of the following attributes? – Overall experience.

Consumer Responses:

Poor	0.5%
Fair	7.9%
Good	25.6%
Very Good	31%
Excellent	31.5%
Don’t Know/Not Sure/Can’t Rate	3.4%

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Additional Finding: Agent Trustworthiness

In general, consumers believed their agents were trustworthy. However, this perception may be affected by consumers' incorrect understanding of their agent's obligations. Consumers incorrectly believed the agent had an obligation to act in the consumer's best interest.

Consumers Were Asked: How would you rate your insurance agent for each of the following attributes? – My agent is trustworthy.

Consumer Responses:

Poor	1%
Fair	6.4%
Good	24.1%
Very Good	31.5%
Excellent	30.5%
Don't Know/Not Sure/Can't Rate	6.4%

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LICAC's Public Policy Suggestions

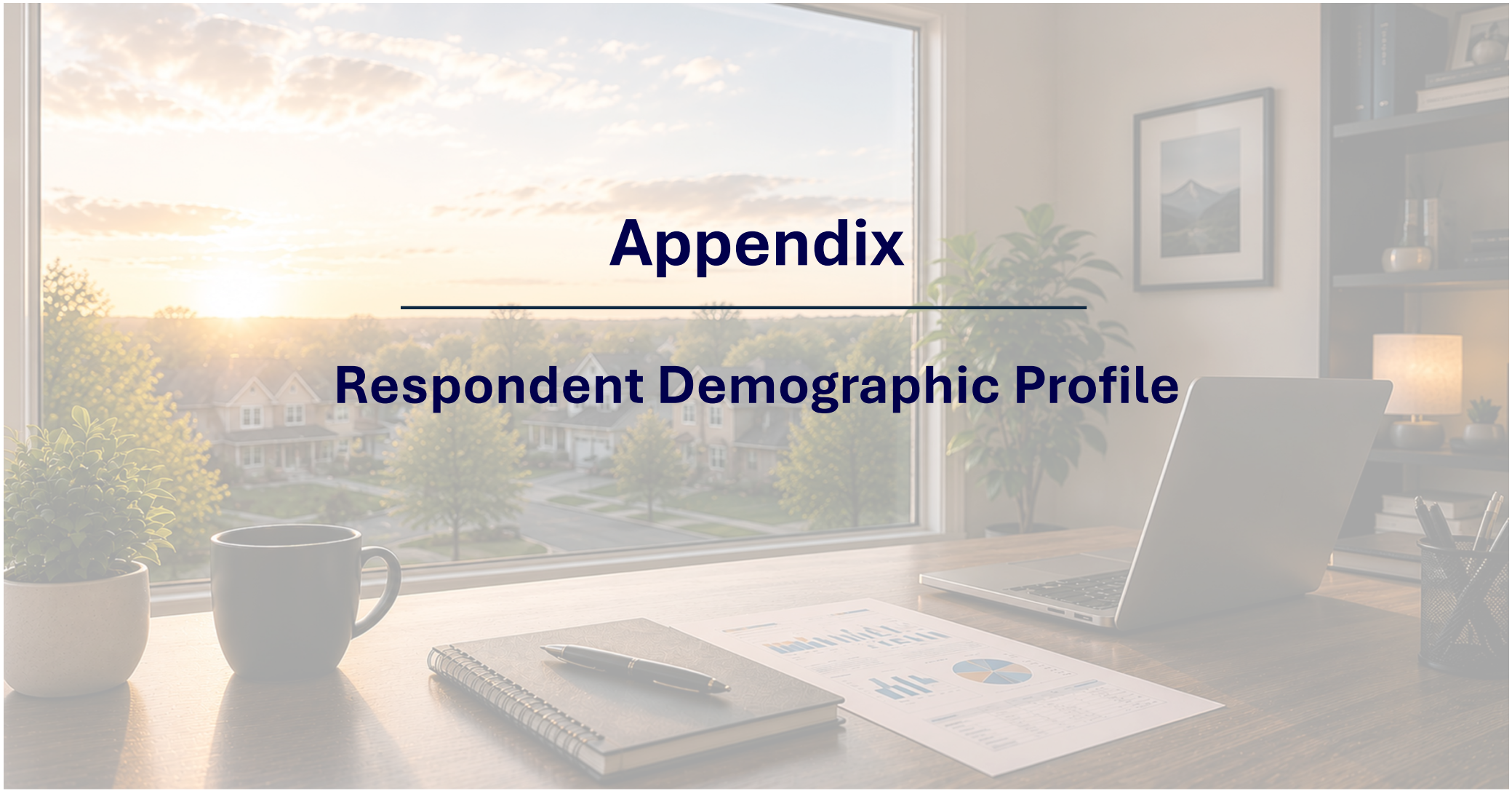
LICAC's Suggestions

The survey demonstrates a significant gap between what consumers believe about their relationship with their life insurance agent and the legal obligations that actually exist. Closing that gap, through stronger consumer protections and clearer disclosure requirements, should be a priority for policymakers and the insurance industry.

1. **Establish a best interest obligation for agents or, at a minimum, require disclosures explicitly informing consumers that the agent represents the insurance company and has no obligation to act in the best interest of the policy owner. Establish that insurance companies have an obligation to supervise appointed agents regardless of their employment status.**
2. **Expand consumer education on agent compensation and require disclosure explaining agent compensation as part of the policy purchase process.**

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Appendix

Respondent Demographic Profile

Respondent Demographic Profile

Gender	n=203	%
Male	99	49%
Female	104	51%
Non-Binary	0	0%

Ethnicity	n=203	%
Latino/a or Hispanic	17	8%
White or Caucasian	143	70%
Black or African American	40	20%
Asian/Pacific Islander	13	6%
Native American	3	1%
Some other ethnic or racial background	0	0%

Education	n=203	%
Less than high school	2	1%
High school diploma or equivalent	31	15%
Some college	44	22%
Vocational/technical school	14	7%
Associate's Degree	22	11%
Bachelor's Degree	66	33%
Master's Degree	15	7%
Post-Graduate Degree	9	4%

Household Income	n=203	%
Less than $50,000	68	33%
$50,001 to $100,000	73	36%
$100,001 to $200,000	50	25%
More than $200,000	8	4%
Prefer not to say	4	2%

Age	n=203	%
Silent Generation (1928–1945)	21	10%
Baby Boomers (1946–1964)	57	28%
Gen X (1965–1980)	45	22%
Millennials (1981–1996)	56	28%
Gen Z (1997–2012)	22	11%

Employment	n=203	%
Full time	100	49%
Part time	14	7%
Not employed/seeking employment	4	2%
Full-time student	2	1%
Part-time student	1	0%
Homemaker/stay-at-home parent	11	5%
Retired	69	34%
Prefer not to say	2	1%



Thank You

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5. Hear a Presentation Recapping Wildfire/Smoke Damage

Amy Bach (United Policyholders)

United Policyholders
www.uphelp.org

Clearing the air: New standards and protocols related to wildfire smoke damage and insurance claim handling

NAIC Meeting
Consumer Liaison Committee
Saturday, November 14th, 2026
Dallas, TX

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United Policyholders (UP)

A 501(c) 3 national not-for-profit with a 35-year track record of problem-solving, informing and advocating for insurance consumers with a focus on property insurance, disaster resilience and recovery.

Through 3 programs UP educates and helps consumers be properly insured and treated fairly by insurers. We coordinate with state insurance regulators and a wide range of stakeholders to effectuate loss indemnification and dispute resolution.

Roadmap to Recovery® *Educating, and helping households navigate insurance, repairs and rebuilding and avoid problems after disasters.*

Roadmap to Preparedness *Educating and helping consumers be resilient to disasters, insure assets to value, shop smart, and proactively reduce risk.*

Advocacy and Action *Advancing policyholder priorities and perspectives in legislative, regulatory, legal and public policy forums.*

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What we know

- Smoke plumes from urban conflagrations (WUI megafires) carry contaminants into structures, damage property and leave particulates that are hazardous to human health and can accumulate in HVAC ducts, soft goods and porous surfaces

- Over the past decade, research and evidence has confirmed that insurers' standard approach to cleaning or replacing damaged personal property and restoring structures to safe and habitable pre-loss condition needs to be much more thorough and based on testing, not just visual inspections and "sniff" tests

- Testing before and after remediation and restoration should be standard protocol but hasn't been. Health and safety can't be sacrificed for cost savings

- In the aftermath of wildfires, a significant number of "standing home" property owners are mired in disputes and litigation with insurers

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What else we know

- The (“New York”) Standard Form home insurance policy (codified in @28 states) insures “all loss by fire” and does not recognize smoke damage as a distinguishable peril.

- State regulators in CA, WA and CO have issued guidance to insurers that they cannot parse smoke from fire damage yet language is surfacing that purports to limit coverage for smoke damage

- Insured renters and homeowners reasonably expect that their insurer will arrange and pay for the removal of hazardous substances and to restore their residence to pre-loss condition, subject to policy limits

- No official standards for wildfire byproducts other than lead and asbestos

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Regulatory Actions

- Colorado:
  - Legislatively mandated study on Remediation of Property Damaged by Fire (pending)
  - Bulletin No. B-5.53 Division Position Concerning Wildfire Smoke, Soot, Ash, Odor, and Char Damage Sublimits
- California:
  - Bulletin 2025-7 Insurance Coverage for Smoke Damage and Guidance for Proper Handling of Smoke Damage Claims for Properties Located in or near California Wildfire Areas
  - Commissioner's Wildfire Smoke and Insurance Task Force
  - Recently enacted legislation

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Regulatory Actions

- New Mexico:

The Office of the Superintendent of Insurance (OSI) is requesting the following with respect to property and casualty claims:

1. For smoke, soot and ash claims:
   a. Inspect the home when smoke, soot and ash are visible. Authorize repairs/cleaning/replacement as necessary of hard surfaces, HVAC systems, attic insulation and soft goods; and
   b. If there is a question of habitability after cleaning, insurance company should offer independent testing at the insurer's cost. Additional Living Expenses should be continued until testing and remediation is complete.

- Washington State: https://www.insurance.wa.gov/insurance-resources/natural-disasters/disaster-recovery/smoke-damage-and-your-homeowner-or-renter-insurance

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CA AB 1642 — Wildfire Environmental Safety and Testing Act

- Directs the Dept. of Toxic Substances Control (DTSC), a division of the state's EPA, to develop health-based standards for investigation, testing and clearance to guide the adequate removal of lead and TEM-identified asbestos inside and outside of homes, schools, workplaces, and other structures in residential areas after a wildfire by 12-31-28

- Directs DTSC to develop health-based standards for investigation, testing and clearance related to CAM 17 heavy metals, Cyanide, Lithium, Dioxins, Manganese and Furans, Polycyclic aromatic hydrocarbons and procedures, for sampling indoor floors, windowsills, contents, and other hard surfaces by 12-31-29

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CA AB 1642 — Wildfire Environmental Safety and Testing Act

- Directs the state's Air Resources Board to develop and publish guidance on levels for indoor air contaminants following residential smoke damage from a wildfire, implications for health or health outcomes, and possible protective measures to reduce health impacts by 12-31-2028

- Directs DTSC in coordination w/Dept. of Ed to develop and publish post-wildfire guidance for schools

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CA AB 1795 — Smoke Damage Recovery Act

- Establishes a wildfire impact zone tied to zip codes located wholly or partially within a CAL FIRE-mapped wildfire perimeter
- Expressly requires insurers to pay for necessary sampling and testing properties within a wildfire impact zone
- Establishes a rebuttable presumption that combustion byproducts in surviving homes in a wildfire impact zone resulted from the wildfire
- Has a savings clause that confirms it doesn’t change existing law related to insurers’ claim handling duties outside the impact zone

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CA AB 1795 — Smoke Damage Recovery Act

- Expressly prevents insurers from cutting off temporary rent benefits before restoration to safe and habitable pre-loss condition has been confirmed
- Requires insurers to share documents that support their claim settlement offer with property owners and affirms general duties related to adjusting wildfire smoke damage claims
- DOI to develop company adjuster and public adjuster training and certification requirements for inspecting, evaluating, sampling, and testing wildfire smoke damaged homes based on the residential property being restored to pre loss condition and cleared for human occupancy

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Common disputes

- Testing methods, destructive testing (drywall removed or not)
- Extent of needed restoration/constructive total loss
- Encapsulation versus removal
- Integrity and credibility of experts
- Who is qualified and willing to declare “clearance” for human occupancy?
- Insurer asserts remediation is complete and terminates temporary rent benefit payments before homeowner feels secure it’s safe to move back in
- Insured runs out of temporary rent coverage due to disputes over testing, remediation, restoration, health and safety

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The ideal order

- Pre-cleaning inspection and testing
  - A qualified professional tests for soot ash, char, asbestos, lead and VOCs
  - Samples should be analyzed by an independent lab
  - Homeowner should get a copy of the results
- A qualified expert prepares a remediation and restoration protocol/plan
- The work gets done by an independent, qualified expert
- Clearance testing
  - If toxins remain, additional remediation is needed

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Thank you!

Consumer Liaison Committee members and meeting attendees for your time and attention

info@uphelp.org

United Policyholders

6. Hear a Presentation Titled *"Unpacking Claim Denials: What Regulators Can Do to Improve Consumer Experience Around Healthcare Billing"*

Eric Ellsworth (Consumers' Checkbook)

CONSUMERS' CHECKBOOK

Unpacking Claims Denials

What Regulators Can Do to Improve Consumer Experience Around Healthcare Billing

Eric Ellsworth

Consumers' Checkbook / Center for the Study of Services

November 14, 2026

CHECKBOOK HEALTH

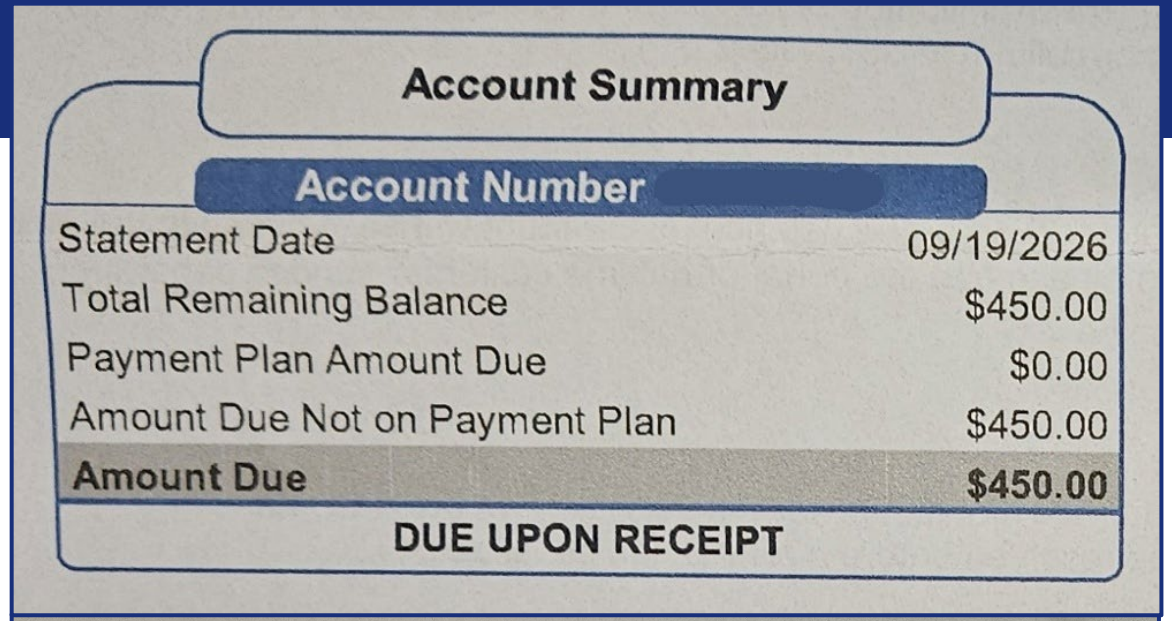
Claims Handling and Consumer Health Costs

- Insurer and provider communications confuse consumers about what is happening with payment for their healthcare
- Upon receiving healthcare bills/EOBs, common questions include:
  - ***Why do I owe the amount listed?***
  - ***Why didn't insurance cover this?***
  - ***Is this correct? Did my healthcare get billed or processed correctly?***
  - ***Should I pay this? What else can I do?***
- Extremely difficult to understand what was/was not paid or why
  - *Increases distrust of health insurance and healthcare*
  - *Undermines the utility of healthcare shopping*
- To empower consumers, much more transparency and oversight of the healthcare billing process is needed

CHECKBOOK HEALTH

Personal Example: *My Daughter*

- I received a bill for the full cost of an office visit
  - Thought I'd paid the copay at the time of visit
  - Didn't receive an EOB
  - We'd met deductible
- Why do I owe $450?!?!
- What the heck is happening?



Account Summary

Account Number

Statement Date	09/19/2026
Total Remaining Balance	$450.00
Payment Plan Amount Due	$0.00
Amount Due Not on Payment Plan	$450.00
Amount Due	**$450.00**

DUE UPON RECEIPT

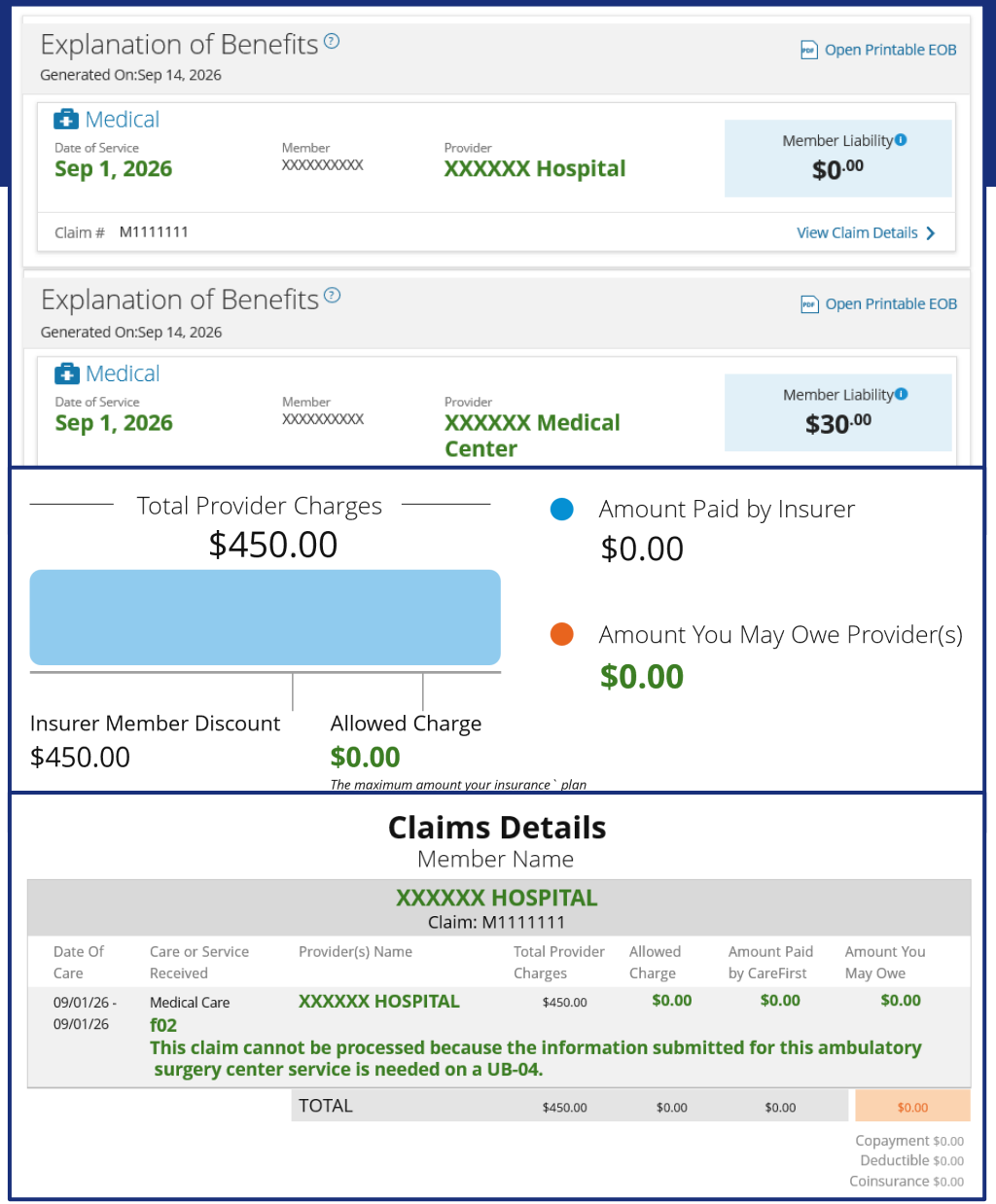
Accounts Not On Payment Plan

	Description	Charges	Insurance Pmt/Adj	Patient Pmt/Adj	Patient Responsibility
Facility Charges					
Encounter:	Patient Name:	Location:			
09/01/2026	Clinical Laboratory	$4,566.00			
	Pediatric Clinic	$196.00			
	Insurance Payments & Adjustments		-$4,732.00		
	Account Subtotals	**$4,762.00**	**-$4,732.00**	**$0.00**	**$30.00**
Physician Charges					
Encounter:	Patient Name:	Location:		Provider:	
09/01/2026	OFFICE O/P EST HI 40 MIN	$450.00			
	Patient Payments & Adjustments			-$30.00	
	Account Subtotals	**$450.00**	**$0.00**	**-$30.00**	**$420.00**
	Account (Not on a Pay Plan) Totals	**$5,212.00**	**-$4,732.00**	**-$30.00**	**$450.00**

CHECKBOOK HEALTH

Personal Example: *Finding the Problem*

- Checked my insurer's website
- Found and deciphered EOBs
  - Matched physician/group & date of service
  - Ignored page of EOB that said I owe $0
  - Identified coding error
  - Knew that provider should not bill for a claim denial related coding problem
- Emailed the provider
  - They acknowledged the error and canceled the bill
- Oversight needs
  - How often do consumers receive bills like this?
  - What actions can regulators take to reduce erroneous bills?



Explanation of Benefits
Generated On:Sep 14, 2026
Open Printable EOB

Medical
Date of Service: Sep 1, 2026
Member: XXXXXXXXXX
Provider: XXXXXX Hospital
Member Liability: $0.00
Claim # M1111111
View Claim Details

Explanation of Benefits
Generated On:Sep 14, 2026
Open Printable EOB

Medical
Date of Service: Sep 1, 2026
Member: XXXXXXXXXX
Provider: XXXXXX Medical Center
Member Liability: $30.00

Total Provider Charges
$450.00

Amount Paid by Insurer
$0.00

Amount You May Owe Provider(s)
$0.00

Insurer Member Discount
$450.00

Allowed Charge
$0.00
The maximum amount your insurance ` plan

Claims Details
Member Name

XXXXXX HOSPITAL
Claim: M1111111

Date Of Care	Care or Service Received	Provider(s) Name	Total Provider Charges	Allowed Charge	Amount Paid by CareFirst	Amount You May Owe
09/01/26 - 09/01/26	Medical Care	XXXXXX HOSPITAL	$450.00	$0.00	$0.00	$0.00
	f02 This claim cannot be processed because the information submitted for this ambulatory surgery center service is needed on a UB-04.					
		TOTAL	$450.00	$0.00	$0.00	$0.00

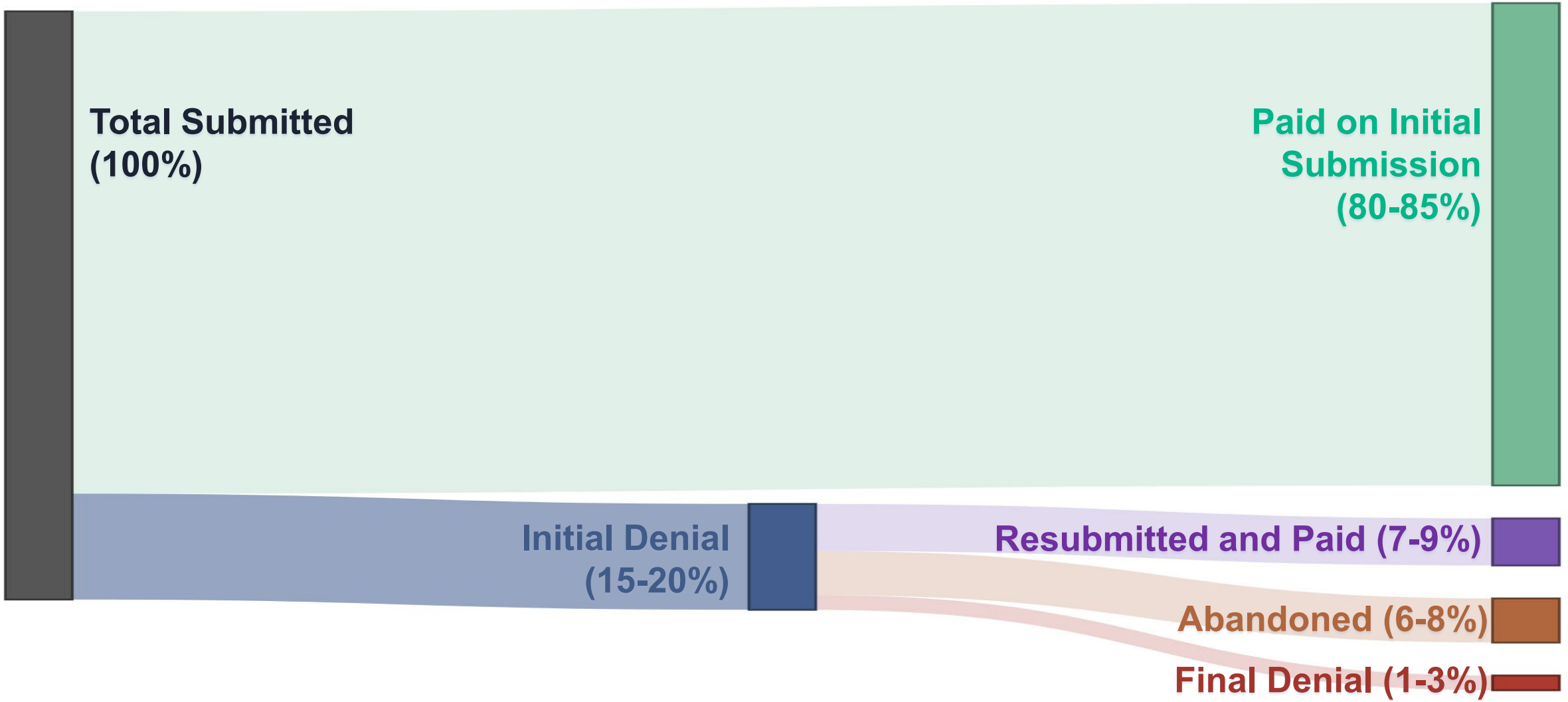
Copayment $0.00
Deductible $0.00
Coinsurance $0.00

CHECKBOOK HEALTH

How Consumers Learn About Claims/Billing Problems

Denial	Scenario	Problem	How Consumers Learn About It
Initial	Registration/ Eligibility	Provider's data about the patient doesn't match insurer's	• Provider says insurance is invalid, patient must pay cash (potentially incorrect) • EOB indicating "non-payment" (unclear if final) • Bill from provider (potentially premature)
	Coding/ Documentation Problems	Claim didn't meet insurer's coding/documentation requirements	
	Duplicate Claims	Multiple claims for same service	
Final	Final Denial	Service not covered or deemed not medically necessary	• Bill from provider • EOB indicating "non-payment" • Denial letter by insurance company
None	Unexpected Bill but No Denial	Consumer didn't/couldn't understand some part of plan design	• Letter or EOB indicating deductible was applied

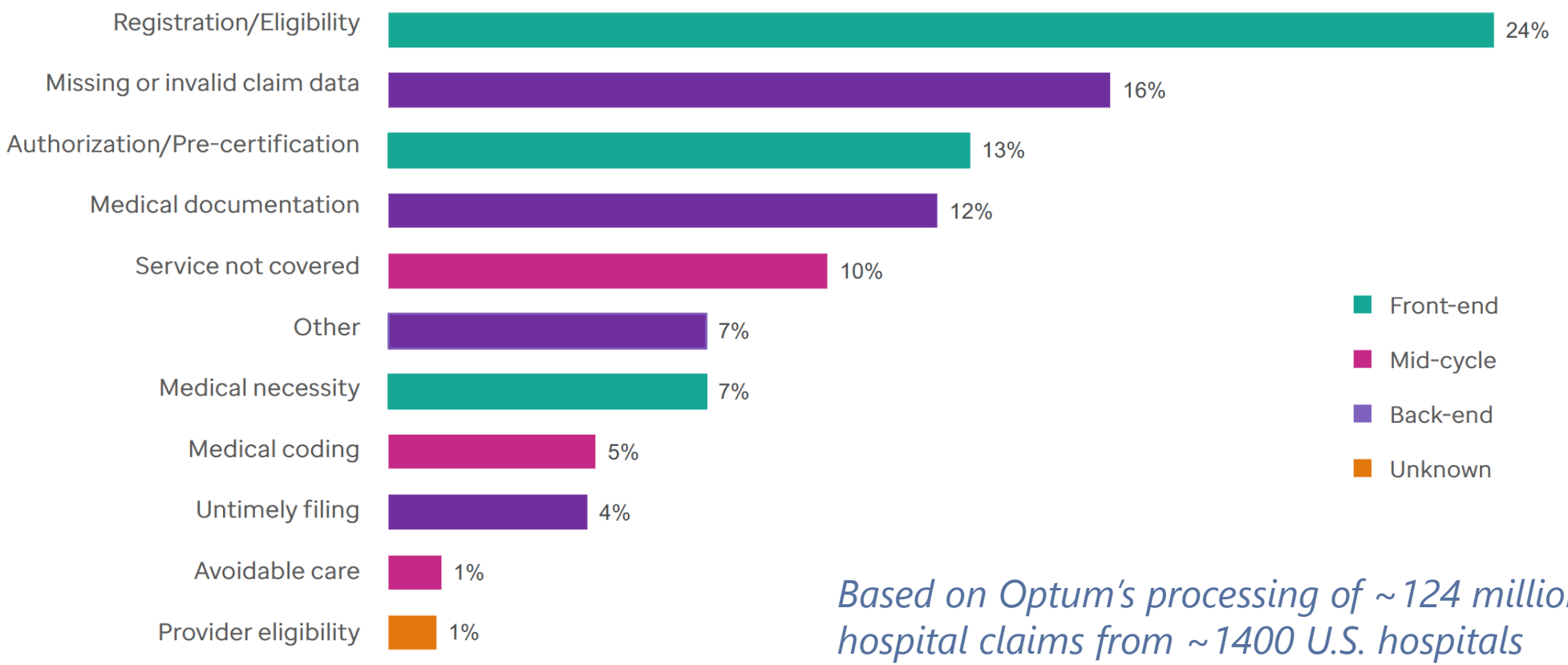
Claims Payment/Rejection Rates



Source: KFF Analysis of Claims Denials

Sources: See extra slides

Reasons for Claim Denials (Hospital)



Based on Optum's processing of ~124 million hospital claims from ~1400 U.S. hospitals

Source: Optum Denial Index 2024

CHECKBOOK HEALTH

Consumers and Regulators Need Better Data

- Consumers can't figure out source of the problem from EOBs and bills
  - Proper path for redress depends on the nature of the denial
  - Wrong path will be time-consuming and fruitless
- EOBs give both too much and too little information
  - One for each often claim saying "you owe X$", don't reflect copay amounts already paid
  - Hard to relate to consumer's real-world experience with providers
  - Unclear timing
- Reported data on claim denials doesn't help regulators distinguish scenarios
  - Different actions are needed to fix different scenarios
- More granular data is available and could provide clarity
  - Details of claims processing are already stored as X12 codes
  - Reason for denials are stored in X12 CARC, RARC codes
  - Analyses can leverage these details to more closely target consumer problems

CHECKBOOK HEALTH

Principles for a Pro-Consumer Revenue Cycle

- **Accurate bills**
  Consumers bills reflect accurate and final amounts due, in line with balance/billing hold-harmless contractual provisions and state laws.
- **Bills are itemized and reconciled, and actionable**
  All healthcare bills sent to consumers are fully reconciled, itemizing and clearly listing what was billed, consumer copays, what insurance did/didn't pay, and what a consumer can do about it.
- **Apps/AI can simplify tracking down what happened**
  Both providers and insurers expose data needed for consumer apps or AI can reconcile payments (insurance, copays, balance bills) and take action to address problems.
- **Regulation and oversight help reduce denials**
  Granular reporting helps identify root causes of denials;
  laws and regulation reduce the causes of denials.

CHECKBOOK HEALTH

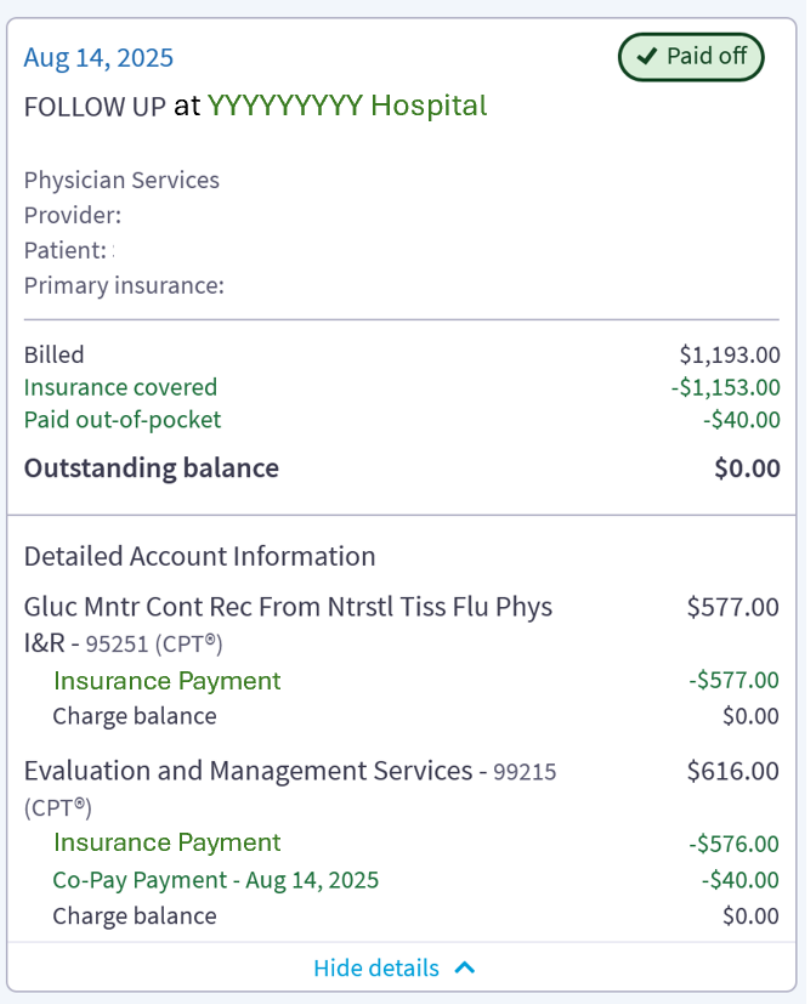
Consumer-Friendly Healthcare Bills

Currently Feasible

- Itemized and reconciled bills are **feasible and in use now**
- Currently only available when EHR integrates with claims processor

Most Consumer-Friendly

- Bills can and should provide detailed reasons for insurance denial/non-payment
- Bills should provide adequate detail to help consumer understand what to do
- All services from an encounter on one bill
- Accessible by AI and apps that can help consumers



Aug 14, 2025 — Paid off

FOLLOW UP at YYYYYYYYY Hospital

Physician Services
Provider:
Patient:
Primary insurance:

Billed	$1,193.00
Insurance covered	-$1,153.00
Paid out-of-pocket	-$40.00
Outstanding balance	**$0.00**

Detailed Account Information

Gluc Mntr Cont Rec From Ntrstl Tiss Flu Phys I&R - 95251 (CPT®)	$577.00
Insurance Payment	-$577.00
Charge balance	$0.00
Evaluation and Management Services - 99215 (CPT®)	$616.00
Insurance Payment	-$576.00
Co-Pay Payment - Aug 14, 2025	-$40.00
Charge balance	$0.00

Hide details

CHECKBOOK HEALTH

General Statutory/Regulatory Options

- Require itemized and reconciled bills
  - E.g. TX SB490 for hospitals
  - Consider mandates for non-hospital bills
- Ensure robust enforcement of balance billing rules
  - Review balance billing/"hold harmless" laws and contractual provisions
  - Identify which agency has responsibility for oversight under different scenarios
  - Track how often providers send bills that are out sync with these laws and contractual terms
- Require standardized coding rules as much possible
  - NCCI, CO Clean Medical Claims Initiative, VT 18 V.S.A. § 9418a
- Require greater transparency of coverage and coding requirements
  - Rules are often buried in provider manuals, fragmented across multiple documents, and not plan-specific
  - Insurers should publish coverage and coding requirements information through search tools and/or APIs
  - Example: Medicare Coverage Database, Coverage API

Insurance Regulation Options

- Reform how insurers report denials so we get more granular and actionable data
  - X12 CARC, RARC codes are already captured in claims handling and contain the information needed
  - Define denial reporting instructions using a X12-based crosswalk
- Help consumers determine whether to contact insurers or providers
  - Find and cultivate a point of outreach for consumers to reach the agencies with authority over billing by providers
- Improve utility of EOBs for identifying and tracking down what insurance did and didn't pay and why
  - Require insurers to publish providers' NPIs and encounter numbers on EOBs
  - Require reporting of claim-line charges, payments/denials, and reasons

Technology Options

- Digital insurance cards
  - Named in CMS Health Tech Ecosystem Pledge
  - No specific requirements yet
- Digital EOBs
  - Patient Access API allows apps and AI to access EOBs on behalf of patients
  - CMS-0057/CMS-9115 requires insurers to post rejected claims
- Standardized provider billing APIs
  - Would enable third party apps/AI to reconcile bills/EOBs/copays
  - Some EHRs offer propriety APIs
  - No standard yet, could be developed

- Real Time Benefit Checks, Pricing and Billing
  - Pharmacies already bill in real time
  - Consumer-Facing Rx Real Time Benefit Check
  - Advanced Explanation of Benefit standard required under No Surprises Act
  - CMS has postponed implementation
  - AEOB infrastructure could be used at many visits

DISCUSSION

Questions?

APPENDIX

Extra Slides

The remaining slides are extra content in case questions are asked

References Claims Payment/Rejection Rates

- **1-** Schwartz et al 2022 Med. Adv claims
  - 85% paid on original submission
  - 1.4% services denied
  - 0.68% of spending denied
- **2 –** Checkbook analysis of Medicaid claims
  - ~85% paid upon submission
  - ~15% Has indicators for denial reasons
- **3-** Rates of reworking of claims
  - Optum Index 2024
  - Zelis Whitepaper: "A Tale of Two Payment Integrity Worlds"
    >60% of rejected claims not reworked
- **4-** Checkbook analysis of ACA claims
  - 8% edited, ultimately paid
- **5**- KFF ACA Denials Report/
  - Transparency in Coverage PUF
  - 17 % overall rejection rate
  - 0.5%-1.5% denial for medical necessity or non-covered svc
- **6 –** 2018 HHS OIG Report on Med Adv
  - 8% initial rejection rate (2016: 8M initial denials / 448M payment requests)
- **7 –** 2023 HHS OIG Report on Med Adv
  - Impossible to properly monitor denial rates and patterns because of lack of clear indicators (better in Medicaid)

CHECKBOOK HEALTH

Revenue Cycle from Provider Point of View

Front End

Pre-Visit

- Scheduling
- Patient Registration
- Insurance Verification
- Prior Authorization
- Appointment Reminders

Mid-Cycle

Visit

- Patient Check-In
- Co-pay and Deductible Collection
- Patient Payment Arrangements
- Clinical Documentation

Claim Submission

- Coding and Charge Capture
- Claim Scrubbing
- Pre-Adjudication
- Claim Submission

Back End

Accounts Receivable Management

- Claim Status
- Denials Management
- Patient Statements/ Patient Notices
- Write-Offs /Refunds Debt Collection

Use of X12 Codes for Reporting of Denials

- HIPAA requires the use of standardized identifiers in healthcare transactions (42 USC 1230d-2; 45CFR Part 162)
  - X12 standard codesets are the designed identifiers meeting this requirement
  - CMS oversee a how they are used in Medicare and Medicaid, which also affects commercial markets
- Insurers and claims processors use X12 codes providing reasons for denial or adjustment of payment
  - Claims Adjustment Reason Codes
  - Remittance Advice Remark Codes
- These codes are already stored with every claim an insurer processes
  - Insurers and claims processors have separate remittance databases tracking back and forth of claims rejections and resubmission
- Reporting denials using a direct cross-walk of X12 codes to denial categories/scenarios would:
  - Enable much more granular analysis and understanding of consumer problems
  - Standardize data across issuers
  - Simplify compliance, since issuers would not need to translate text requirements to database queries

CHECKBOOK HEALTH

Example X12 Codes by Scenario

Scenario 1: Mismatched Data

- CARC 14: date of birth follows the date of service
- CARC 26,27: Expenses incurred prior to coverage/after coverage
- CARC 31: Patient cannot be identified as our insured
- CARC 32,33: Patient is not an eligible dependent/insured has no dependent coverage

Scenario 2: Coding Problems

- CARC 5: The procedure code/type of bill is inconsistent with the place of service
- CARC 11: The diagnosis is inconsistent with the procedure.
- CARC 16: Claim/service lacks information or has submission/billing error(s).
- CARC 4: The procedure code is inconsistent with the modifier used

7. Hear a Presentation Titled *"Federal Policy Updates and Impact on Consumer Access and Affordability"*

Ben Anderson (Families USA), Lindsey Murtagh (Individual Consumer Advocate), and Adam Fox (Colorado Consumer Health Initiative)

Federal policy updates and impact on consumer access and affordability

- Ben Anderson, Families USA
- Lindsey Murtagh, Brown University School of Public Health
- Adam Fox, Colorado Consumer Health Initiative

Coverage cancellations

760,000+ cancellations

What states can do:

- Specify required plan outreach to consumers
- Provide notice and guidance to consumers
- Request data from plans and CMS

Vaccine and preventive services recommendations

ACIP Changes:

Universal recommendations ⇒
Shared clinical decision-making (SCDM)

What states can do:

- Clarify that SCDM recommendations must be covered
- Reference alternative vaccine recommending bodies (e.g. AAP, AAFP, ACOG)
- Conduct oversight of vaccine coverage requirements

The No Surprises Act (NSA)

- Successfully protecting privately covered individuals from surprise medical bills.
- CBO anticipated these protections could be achieved while lowering premiums.
- But, this assumed that most NSA claims that are arbitrated would be paid close to the median in-network rate.

Independent Dispute Resolution (IDR) Process

- Over 2 million disputes were filed in 2025, nearly 10 times the number in 2023.
- Providers, often with private equity backing, file almost all.
- Roughly 85% decided in favor of providers.
- In 2025, annual median prevailing offer was nearly 4x the qualifying payment amount.
- Use of arbitration varies significantly by state.

Consumers will absorb these costs through higher premiums.

Specified State Laws (SSLs) – aka, States' Safety Valve

- IDR only applies if a state law does not.
- For a state law to apply it must apply to:
  - The item or service
  - The provider or facility
  - The payer (including by opt-in for self-funded plans)
- Because federal agencies largely defer to states to identify specified state laws, states have significant leeway in how these laws are shaped.

Best Practices for Specified State Laws

- **Mirror the NSA's Scope:** Cover all NSA items and service
- **Expand beyond the fully-insured market**: Apply to non-fed gov plans. Allow for self-funded opt-in.
- **Prioritize affordability:** Not all payment determinations are equally effective. Benchmarks v. arbitration. Design of arbitration.
- **Close loopholes:** Amend existing SSLs to minimize gaps
- **Cap offers in IDR:** Use licensing authority to regulate providers' engagement in IDR.

Upcoming Federal Policies & Potential Changes

Policy changes post election

Rulemaking

- Provider Fee Rule
- Pre-Verification Rule
- NBPP Rule
- 1332/1333 Waiver Rule
- EHB Changes
- STLDI
- ICHRAs
- Mental Health Parity

8. Hear a Presentation Titled *"Alternative Health Coverage and Emerging Challenges for Consumers"*

Silvia Yee (Disability Rights Education and Defense Fund), Shamus Durac (Rhode Island Parent Information Network), and Deborah Darcy (American Kidney Fund)

‘Alternative health coverage’ and emerging challenges for consumers

Deborah Darcy, American Kidney Fund (AKF), Shamus Durac, RIPIN, Silvia Yee, Disability Rights Education and Defense Fund (DREDF).

November 14, 2026

Consumers Are Facing Affordability Issues

- Exploding premiums and lack of options for consumers.
- Consumers are looking for affordable care.
- Consumers need to have access to health care and coverage in case of a medical issue.
- Consumers need education and protections.
- Risk pool issues.
- Requests from State Insurance Commissioners for guardrails for alternative plans.

Alternative Plans

- Direct Primary Care.
- Short-Term Plans.
- Health Care Sharing Ministries.
- Fixed Indemnity Policies.
- Farm Bureau.
- Limited Partnership Plans.[1]

Statistics - Americans with Health Issues

- 40 million people or 12% of people living in the U.S. have diabetes.[2]
- 48% of adult Americans have a cardiovascular disease. [3]
- 42% of Americans are morbidly obese.[4]

- Americans with chronic diseases or chronic conditions need major medical health insurance plans.

Issues with Consumer Protections and Education

- Consumers Researching on the Internet
  - Websites that generate leads for brokers/salespeople
  - Lack of written materials with disclaimers
  - Misleading marketing

- In many cases it is “Buyer Beware,” but even educated consumers are sometimes not provided needed information.[5]

RIPIN Health Insurance Consumer Assistance

- Operated in contract with RI Office of the Health Insurance Commissioner
- Assists any Rhode Islander with:
  - Finding, enrolling in, and using health insurance coverage
  - Insurance coverage denials and medical billing disputes
  - Administrative issues, system navigation, bureaucratic obstacles to care
- All-payer assistance – fully insured commercial plans (in all markets), but also self-funded plans, Medicaid, Medicare, non-major medical, etc.
- Saved Rhode Islanders $10M in healthcare costs since 2017 (on a $3.1M budget)

Ross and Rachel

- Ross tried to enroll in coverage through HealthSourceRI – Rhode Island's individual marketplace – during 2024 Open Enrollment, but ended up on a lead generator website
- The broker told them the plan was an "Aetna" plan – but was actually through a different TPA using the FirstHealth network, an Aetna product
- This "plan" was a partnership plan – Ross and Rachel were made limited partners (without their knowledge) in a company and were sold "employment-related" coverage

Ross and Rachel

- This plan denied coverage for routine services, but did not communicate how to appeal or even the reason for denial
- Despite multiple requests, Ross and Rachel were refused access to their plan contracts or clinical or coverage criteria
- Ultimately, Ross and Rachel were granted a special enrollment period to enroll into a marketplace plan

Monica

- Monica lost her employment-related coverage after losing her job. She had a long-standing relationship with doctors outside RI
- Monica was already enrolled in Medicaid. However, a broker told her (incorrectly) that she needed to buy a plan to see those doctors
- The plan Monica enrolled in did not provide any documentation when she signed up for it, but she was told her doctors were in-network.

Monica

- Monica's out-of-state doctors were *not* in the new plan's network and claims for all of her appointments were denied
- Monica was never able to receive her plan contract or information about the plan's network
- However, Medicaid ultimately paid for her appointments

Phoebe

- Phoebe was contacted by a broker and was told she was signing up for a plan through HealthSourceRI

- However, she was actually enrolled in a limited benefits plan

- Phoebe was able to obtain documentation showing that the plan was not an ACA-compliant major medical plan. However, she remained enrolled because it was cheaper and because it promised comprehensive preventive service coverage

Phoebe

- While her plan advertised preventive service coverage, it required her to obtain a Cologuard test before a preventive colonoscopy could be performed

- However, Cologuard was contraindicated for Phoebe. Although her colonoscopy fortunately came back typical, it was still not covered by her plan

- Phoebe ultimately was charged $1,850 for the preventive colonoscopy and paid over $1,100

Themes from consumer cases:

- Consumers frequently aren't consciously (and informedly) choosing limited benefit products, they're looking for deals
- Brokers or plan employees often mislead consumers about the extent of their coverage
- Consumers are unable to obtain plan summaries, contracts, or other materials in advance, or often at all
- Consumers only discover their plans are not comprehensive/major medical after services are denied

Recommendations

Threefold goal for DOI Regulation and Policies:

- Access to Knowledge
- Level up Alternative Plans to the new “normal” of consumers who are now accustomed to major medical health insurance, have low health insurance literacy, and who have priority healthcare needs but do not consider themselves as someone with a pre-existing health condition
- Preserve major medical market

Recommendations - Knowledge

- Practical tools that help consumers compare, make an individualized assessment, and understand areas for caution
- Ensure that alternative plans provide critical information to consumers and providers *before and after* enrollment
- Exact penalties and practice consequences for false promises, misleading materials, and failures to provide stated coverage
- Establish and enforce disclosure standards for alternative plans in your state that include how much coverage the plan provides in the context of what the average expense is for the coverage specified

Recommendations – Level Up

- Require alternative plans to show their established current provider network, and give a realistic percentage sense of how many providers in any given area take their insurance and were reimbursed by the plan
- Require alternative plans to provide their in-network healthcare providers with clear information on what procedures are covered, reimbursement rates, and dispute/appeal procedures
- Require plans to provide verifiable information about how and when consumers can get coverage information from plan representatives, file complaints & appeals, and get updates
- Adopt and enforce NAIC Model 880 (unfair trade practices act) or a state equivalent at least with respect to lead generators

Recommendations - Preserve

- Enable state-based exchanges to have a retroactive open enrollment period for consumers who were misled by alternative plans, and enable the state-based insurer to subrogate the misled consumer’s claim after covering the consumer’s retroactive bill
- Investigate, go after, and publicize alternative plans that offer illusory products and follow egregious coverage practices that leaves consumers with no care and large amounts of debt. The penalties obtained can help develop a fund for keeping state exchange products sustainable

Sources

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[2]Centers for Disease Control and Prevention. National Diabetes Statistics Report. Updated September 16, 2026. Accessed October 29, 2026. https://www.cdc.gov/diabetes/php/data-research/index.html. [cdc.gov]

[3]American Heart Association News, “Cardiovascular Diseases Affect Nearly Half of American Adults, Statistics Show,” January 31, 2019, https://www.heart.org/en/news/2019/01/31/cardiovascular-diseases-affect-nearly-half-of-american-adults-statistics-show.

[4] DeCleene NK, Kahn E, Yuan C, et al. US State-Level Prevalence of Adult Obesity by Race and Ethnicity From 1990 to 2022 and Forecasted to 2035. JAMA. 2026;335(11):975–985. doi:10.1001/jama.2025.26817

[5]Amy Killelea, Madison Harden-Stein, and JoAnn Volk, “No Good Options: In the Wake of Marketplace Affordability Woes, Consumers Face Onslaught of Misleading Marketing of Limited Benefits Products,” Center on Health Insurance Reforms, Georgetown University, August 13, 2026, https://chir.georgetown.edu/no-good-options-in-the-wake-of-marketplace-affordability-woes-consumers-face-onslaught-of-misleading-marketing-of-limited-benefits-products/.

9. Discuss Any Other Matters Brought Before the Committee

Commissioner D.J. Bettencourt (NH)