

Draft date: 7/31/23

*2023 Summer National Meeting
Seattle, Washington*

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Monday, August 14, 2023

2:30 – 4:00 p.m.

Seattle Convention Center—Ballroom 1—Level 5

ROLL CALL

Anita G. Fox, Chair	Michigan	Mike Chaney	Mississippi
Jon Pike, Co-Vice Chair	Utah	D.J. Bettencourt	New Hampshire
Mike Kreidler, Co-Vice Chair	Washington	Glen Mulready	Oklahoma
Trinidad Navarro	Delaware	Andrew R. Stolfi	Oregon
John F. King	Georgia	Michael Humphreys	Pennsylvania
Dean L. Cameron	Idaho	Alexander S. Adams Vega	Puerto Rico
Kathleen A. Birrane	Maryland	Allan L. McVey	West Virginia
Grace Arnold	Minnesota		

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

AGENDA

1. Consider Adoption of its June 29 and Spring National Meeting Minutes Attachment One
—*Director Anita G. Fox (MI)*
2. Consider Adoption of its Subgroup, Working Group, and Task Force Reports
—*Director Anita G. Fox (MI)*
 - A. Consumer Information (B) Subgroup—*LeAnn Crow (KS)*
 - B. Health Innovations (B) Working Group
—*Commissioner Nathan Houdek (WI)*
 - C. Health Actuarial (B) Task Force
—*Commissioner Andrew N. Mais (CT) and Paul Lombardo (CT)*
 - D. Regulatory Framework (B) Task Force
—*Commissioner Sharon P. Clark (KY)*
 - E. Senior Issues (B) Task Force—*Director Barbara D. Richardson (AZ)*
3. Discuss Referrals to the Health Actuarial (B) Task Force—*Director Anita G. Fox (MI)*
4. Hear an Update on Market Regulation and Consumer Affairs (D) Committee Work of Interest to the Committee—*Commissioner Jon Pike (UT)*
5. Receive Update from the Consumer Information (B) Subgroup on Work Related



to Consumer Education on Claim Appeal Rights—*LeAnn Crow (KS)*

6. Hear a Panel Discussion on Preventive Services—*Anna Schwamlein Howard (American Cancer Society Cancer Action Network—ACS CAN); Carl Schmid (HIV + Hepatitis Policy Institute), and Amy Killelea (Killelea Consulting)*
7. Hear an Update on Medicaid Redeterminations
—*Miranda Motter (America’s Health Insurance Plans—AHIP)*
8. Hear an Update on the Special (EX) Committee on Race and Insurance Health Workstream Work
—*Commissioner Kathleen A. Birrane (MD) and Commissioner Grace Arnold (MN)*
9. Discuss Any Other Matters Brought Before the Committee
—*Director Anita G. Fox (MI)*
10. Adjournment

Agenda Item #1

**Consider Adoption of its June 29 and Spring National Meeting Minutes
—*Director Anita G. Fox (MI)***

Draft: 8/1/23

Health Insurance and Managed Care (B) Committee
Virtual Meeting
June 29, 2023

The Health Insurance and Managed Care (B) Committee met June 29, 2023. The following Committee members participated: Anita G. Fox, Chair, and Laura Hall (MI); Jon Pike, Co-Vice Chair (UT); Mike Kreidler, Co-Vice Chair, represented by Jane Beyer and Ned Gaines (WA); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron represented by Shannon Hohl (ID); Kathleen A. Birrane and Louis Butler (MD); Grace Arnold represented by Julia Dreier (MN); Chris Nicolopoulos represented by Jason Dexter (NH); Glen Mulready (OK); Michael Humphreys (PA); and Allan L. McVey (WV). Also participating were: LeAnn Crow (KS); Troy Downing (MT); Maggie Reinert (NE); and Larry D. Deiter (SD).

1. Heard Presentations on State Appeals Programs

Director Fox said that during the Committee's meeting at the Spring National Meeting, it heard a presentation from the Kaiser Family Foundation (KFF) on findings from its issue brief "Claims Denials and Appeals in ACA Marketplace Plans in 2021." She said one piece of data from the presentation raising the Committee members' attention was that consumers rarely appeal claim denials. She said that because of that, the Committee wanted to have a broader discussion on: 1) what support the states offer to consumers in this area and how they are raising awareness to consumers of their options to appeal; and 2) what more the Committee and the groups reporting to it can do as well to raise consumer awareness. She said that during today's meeting, the Committee would hear from Maryland, Nebraska, and Michigan on their work to raise consumer awareness of their claim appeal rights.

Butler discussed Maryland's work, including statistics supporting the KFF's findings about the low percentage of consumer claim appeals. He said the Maryland Insurance Administration (MIA) has a dedicated unit, the Consumer Education and Advocacy Unit (Unit), whose mission is to educate Maryland residents about various insurance products and explain to consumers their rights and obligations under the terms of their insurance policies. The Unit travels to fairs, trade shows, and other events across the state to provide educational materials to consumers. It answers questions on various insurance issues, including health insurance and the right of consumers to appeal claim denials. Butler noted that based on questions during these events, it is shocking the low number of consumers who are aware of the MIA and their right to appeal claim denials. He said many consumers, who may know of their claim appeal rights, do not file internal appeals with their insurer because of a fear of retaliation. Butler explained how the Unit will walk a consumer through the process of filing an internal appeal with their insurer. He also discussed Maryland's external independent review process.

Reinert discussed Nebraska's work to educate and assist consumers in appeals of claim denials focusing on its external review program. She provided a history of the program and its steps toward implementation, including developing denial letter templates and working with major medical carriers on the language that the carriers must include in the appeals and grievances sections in their policies and certificates to ensure consumers have notice of their internal and external appeal rights. This information is also posted on the Nebraska Department of Insurance's (DOI's) website. She also discussed the Nebraska DOI's best practices with respect to external appeals, including recommending that consumers assign their doctor to be their authorized representative because provider participation is a vital part of the appeal process.

Reinert provided an overview of the Nebraska DOI's Health Division's efforts to raise consumer awareness of their appeal rights, including highlighting information on its website detailing the steps consumers can take to appeal

claim denials first internally through their insurer and then, if necessary, externally through an independent reviewer. She said that in addition, the Nebraska DOI Health Division conducts an annual “road show” during which it holds community meetings and makes presentations throughout the state to educate consumers on an array of insurance issues, including a consumer’s right to appeal claim denials. Reinert also discussed the Nebraska DOI Health Division’s use of social media—Facebook and LinkedIn—to educate consumers and increase awareness. Reinert highlighted the Nebraska external review program’s successes. She said that since 2014, 786 internal claim denials were overturned. She said that in the past five years, Nebraska has consistently averaged about 250 external appeal cases per year. From that number, approximately 47% of eligible cases were overturned, and about 23% of those cases were not eligible for external review.

Hall discussed Michigan’s efforts to educate and increase consumer awareness of their right to appeal claim denials beginning with changes to the Michigan DOI’s website to make it more consumer-friendly. She said it was hard for consumers to find information on the old website, and the information on it was highly technical and hard for the average consumer to understand. She said the new website resolves these challenges. It has a modern look and feel and is mobile-friendly. She said the new website includes a step-by-step guide at a 7th-grade reading level with links for consumers to use and follow to appeal claim denials.

Hall also discussed the Michigan DOI’s proactive outreach efforts. She said the Michigan DOI plans to continue these efforts and access other means to educate consumers, such as leveraging social media, public service announcements, and sharing information with stakeholders.

Director Fox asked the presenters about their consumer outreach efforts, including how it evaluates the success of those efforts and keeps track of what works. Butler said the MIA’s Unit travels around the state to various events, which in many cases, it does not create, but it piggybacks on already planned events. He said the MIA recently did a podcast on medical necessity. He said that following that podcast, the MIA saw an increase in the number of appeals filed, which he believes is a direct correlation to the podcast’s airing. He said that in addition, the MIA saw an increase in telephone calls from consumers asking for more information about their claim denial appeal rights and the internal and external appeal processes. He also noted that the MIA is on all the social media platforms, including Nextdoor. Reinert said that to increase awareness of planned events during its annual roadshow, the Nebraska DOI places advertisements in local newspapers and on the radio, and it posts information on social media. She said the Nebraska DOI has found that posting on Facebook produces the most engagement from the public, particularly if it does paid pushes that target certain areas in the state where it plans to host an event. She said the Nebraska DOI also reaches out to industry, such as the Independent Insurance Agents & Brokers of America (IIABA) and the National Association of Health Underwriters (NAHU). In addition, it sends out an email blast to insurers.

Hall discussed how Michigan evaluates its success in reaching out to consumers. She said Michigan tracks the number of attendees at its in-person events and has great participation in its virtual events. She noted that because of the COVID-19 pandemic, in-person events were eliminated for a few years, but in-person attendance is beginning to increase since it has recently restarted those events. She said that Michigan has experienced the most success in reaching consumers by using air media—local news station reporters and radio stations—interviews with Director Fox during which she discusses various insurance issues, including consumer appeal rights.

Commissioner Birrane discussed additional approaches the MIA uses to reach consumers. She described the MIA’s LinkedIn platform profile. She also discussed the MIA’s creation of an emoji character called MIA that it uses to interact with the public on Facebook and, as appropriate, other social medial platforms. Commissioner Birrane also noted that the MIA gives more than 600 presentations a year and specifically emphasizes to the public that the MIA is available 24 hours a day, seven days a week to assist consumers, providers, and other stakeholders.

She also noted the MIA's high reversal rate related to medical necessity determinations due to its involvement in assisting the consumer in navigating the appeals process.

2. Received an Update from the Consumer Information (B) Subgroup on its Work Related to Consumer Education on Claim Appeal Rights

Crow discussed the Consumer Information (B) Subgroup's work related to educating consumers on their appeal rights. She said that after the Committee's discussion of the issue at the Spring National Meeting, the Subgroup accelerated its work in this area. She said the Subgroup's most recent meetings have been devoted to this topic. Based on the discussions during these meetings, the Subgroup formed a small drafting subgroup to review the Subgroup's previous work related to this issue to determine whether the Subgroup needs to develop additional resources on the issue. She said that in 2021, the Subgroup developed a series of consumer guides on claims. The five guides were: 1) codes and claims; 2) explanation of benefits; 3) filing health insurance claims; 4) how to appeal a denied claim; and 5) understanding medical necessity.

Crow said the small drafting subgroup has met three times since the Spring National Meeting. During these meetings, the small drafting subgroup started reviewing the guides to see if additional content should be added. She said the small drafting subgroup is also interested in changing the format of the guides from a PDF document to a format that is more interactive for consumers. Crow explained that one example of such interactive content is the Subgroup's "How to Understand Your Insurance Card" document. She said that because of its interactive format, the document has been well received. Crow said the Subgroup has also been working with the NAIC Communications Division as it develops ideas for making the content of the guides more user-friendly. She said as Maryland, Michigan, and Nebraska discussed during their presentations, the Subgroup is exploring ways to leverage social media to let the public know about these resources.

Crow noted that the Subgroup's charge from the Committee is to develop information or resources that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance. She said it might be useful for the Committee to consider additional strategies for engaging consumers on claims and appeals and possibly other health topics. She said she would be happy to provide an update to the Committee on the Subgroup work during the Committee's meeting at the Summer National Meeting. Director Fox said that with respect to letting the public know about the guides and other resources the Subgroup has developed, the Subgroup could consider developing a tool kit with this information and making it available to NAIC members for them to use in their states because many NAIC members do not know this information exists.

Carl Schmid (HIV+Hepatitis Policy Institute) said the NAIC consumer representatives suggested that the Committee invite the KFF to present its findings to the Committee at the Spring National Meeting because they felt it was important for the Committee hear those findings. He said the NAIC consumer representatives believe this issue is of the utmost importance. Reflecting its importance, he said the NAIC consumer representatives have established a subgroup of NAIC consumer representatives focusing on prior authorization, medical necessity, and appeals and denials. The subgroup is developing recommendations for the Committee to consider addressing the low number of consumer appeals of claim denials and other issues related to prior authorization and medical necessity.

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

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Draft: 4/4/23

Health Insurance and Managed Care (B) Committee
Louisville, Kentucky
March 23, 2023

The Health Insurance and Managed Care (B) Committee met in Louisville, KY, March 23, 2023. The following Committee members participated: Anita G. Fox (MI); Jon Pike, Co-Vice Chair (UT); Mike Kreidler, Co-Vice Chair (WA); John F. King (GA); Dean L. Cameron (ID); Kathleen A. Birrane (MD); Grace Arnold (MN); Chris Nicolopoulos (NH); Glen Mulready (OK); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Alexander S. Adams Vega (PR); and Allan L. McVey represented by Ellen Potter (WV). Also participating were: Lori K. Wing-Heier (AK); Michael Conway (CO); Paul Lombardo (CT); Andria Seip (IA); LeAnn Crow (KS); Cynthia Amann (MO); and Troy Downing (MT).

1. Discussed its 2023 Activities

Director Fox outlined the Committee's activities and focus for 2023. She said that in accordance with its charges, the Committee will continue to monitor the activities of its task forces and be responsive to any health insurance-related federal initiatives. She also noted that the Committee's charges include coordinating with the Market Regulation and Consumer Affairs (D) Committee, chaired by the Health Insurance and Managed Care (B) Committee's co-vice chair, Commissioner Pike. She said such coordination provides an opportunity for the Committee to work, as necessary, with the Market Regulation and Consumer Affairs (D) Committee on health benefit plan and producer enforcement issues and to monitor market conduct trends on non-federal Affordable Care Act (ACA) plans.

Director Fox said she anticipates the Committee working closely with the Special (EX) Committee on Race and Insurance's Health Workstream as that Workstream continues its work this year on health equity issues involving underserved and traditionally underrepresented populations. She noted that Committee members Commissioner Birrane and Commissioner Arnold are co-chairs of the Health Workstream. As such, this is a great opportunity for the Committee to collaborate and work with the Health Workstream as it completes its work this year.

Director Fox explained that she would like the Committee to work together this year to focus on several topics raised by Committee members that have been ranked in order of importance based on a recent survey of the Committee membership. Those topics, in order of importance, are: 1) network adequacy; 2) Medicaid unwinding due to the pending end of the COVID-19 public health emergency (PHE); 3) state-based marketplaces (SBMs); 4) pharmacy benefit manager (PBM) regulation; and 5) essential health benefits (EHBs).

Director Fox said that prior to the Spring National Meeting, the Committee met with the NAIC consumer representatives focused on health. She said this meeting provided an opportunity for the Committee and the NAIC consumer representatives to discuss priorities and focus for 2023. She said she plans to continue such outreach to enable the Committee to hear a consumer point of view, which can often be difficult to obtain without such meetings. Director Fox noted that one result of this interaction was the invitation to the Kaiser Family Foundation (KFF) to discuss one of its recently published issue briefs on claims denials and appeals for ACA marketplace plans in 2021 during today's Committee meeting.

Director Fox said that to ensure Committee members remain current on Committee meetings and other activities, she asked each Committee member to designate staff to act as a point of contact. She said she plans to use this group to preview Committee meeting agendas and other items. This group met prior to the Spring National Meeting and will continue to meet on an as-needed basis throughout the year. Lastly, Director Fox said she is instituting interim regulator-to-regulator meetings to allow Committee members and interested state insurance

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regulators to have more in-depth discussions about topics of interest particularly related to presentations the Committee hears during its open meetings. She said the first of these meetings is March 24. During this meeting, KFF representatives will be available to listen and answer questions on claim denials and appeals from an individual state perspective. The Committee will also discuss in more depth its focus for the year.

Director Fox also discussed a meeting with the Center for Insurance Policy and Research (CIPR). She said that during this meeting, she discussed what the CIPR can do to support the Committee's work this year and learned what research the CIPR has already done or plans to do in the areas Committee members have identified as important topics to focus on this year.

2. Adopted 2022 Fall National Meeting Minutes

Commissioner King made a motion, seconded by Commissioner Mulready, to adopt the Committee's Dec. 14, 2022, minutes (see *NAIC Proceedings – Fall 2022, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

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

Commissioner Pike made a motion, seconded by Commissioner King, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its March 2 minutes (Attachment One); 2) the Health Innovations (B) Working Group, including its March 22 minutes (Attachment Two); 3) the Health Actuarial (B) Task Force; 4) the Regulatory Framework (B) Task Force; and 5) the Senior Issues (B) Task Force. The motion passed unanimously.

4. Heard a Discussion on the KFF Issue Brief

Karen Pollitz (KFF) and Kaye Pestaina (KFF) discussed findings from the recently published KFF issue brief "Claims Denials and Appeals in ACA Marketplace Plans in 2021." Pestaina explained that Section 2715A of the ACA requires ACA-compliant plans, including employer-sponsored plans and health insurance marketplace plans, to report certain ACA transparency in coverage data—including data on the number of claims denied—to health insurance marketplace plans, the Secretary of the U.S. Department of Health and Human Services (HHS), and state insurance commissioners, as applicable, and to also make it available to the public. She explained that although the data reporting requirement applies more broadly, to date, the HHS is only requiring federally facilitated marketplace (FFM) plans to submit this data. She said that since 2016, the federal Centers for Medicare & Medicaid Services (CMS) has specifically required only FFM plans to submit a subset of the claims transparency data—claim denials and appeals data—to it. In addition, the data is limited to in-network claims, which combine both medical and pharmaceutical claims. The CMS takes the data submitted and makes it available to the public in public use files (PUFs), which is what the KFF has been examining since 2016.

Pestaina discussed the potential uses of the data, such as using it as a tool for enforcement and oversight. She said that the KFF is not sure if the CMS is using the data for such a purpose. She said some states are using transparency data as part of their oversight responsibilities related to mental health parity plan compliance. Pestaina highlighted other state uses of other non-CMS transparency data, such as the data collected and reported by the NAIC through its Market Conduct Annual Statement (MCAS). She also said that some SBM plans, such as those in California and possibly Minnesota, are collecting claims denial and appeals data.

Pollitz discussed the KFF's findings from its review of the data reported by insurers for the plan year 2021 and posted in the PUF. She said that across HealthCare.gov insurers, approximately 230 major medical issuers, with complete data, nearly 17% of in-network claims were denied in 2021. Insurer denials rates varied widely around this average, ranging from 2% to 49%. She explained that the CMS requires insurers to report reasons for claims

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denials at the plan level. Of in-network claims, about 14% were denied because the claim was for an excluded service, 9% due to lack of preauthorization or referral, and only about 2% based on medical necessity. She highlighted that insurers classified most plan-reported denials (about 82%) as “all other reasons.” She explained that this “all other reasons” category could include claim denials due to billing or coding errors, duplicate claims, or coverage eligibility. Pollitz said that in analyzing the 2021 plan data, as in its previous analyses, the KFF found that consumers rarely appealed their denied claims. In 2021, HealthCare.gov consumers appealed less than two-tenths of 1% of denied in-network claims, which is about only 1 in 500 denied in-network claims. Insurers upheld most denials (around 59%) on appeal.

Director Fox asked Pollitz if she had any thoughts about what the states can do to increase consumer awareness of their rights to appeal claims denials. Pollitz said it is perplexing as to why consumers do not appeal claim denials. She said the KFF recently completed work on a survey targeted at obtaining information from consumers on their experiences with health insurance. One of the questions to be asked is whether consumers understand their appeal rights, how the process works, and/or who or what agency to contact for assistance. She said the KFF plans to release the results of the survey at some point later this year.

Pollitz said she believes there could be other factors beyond consumers being simply overwhelmed and confused about health insurance, such as the fact that because there is a claim, the consumer or a family member is sick and, as such, may not have the wherewithal to investigate next steps and navigate the appeals process. She said that, in addition, the explanation of benefits (EOB) document consumers receive includes information on appeal rights, but it is typically presented in insurance-related jargon and/or found on the last page of a multi-page EOB document. Pollitz said there are consumer assistance programs in many states that could possibly assist consumers in understanding their appeal rights, but the federal government no longer funds these programs. Those programs in existence since 2010, for the most part, still exist due to state funding. She said that state insurance regulators in states that have these programs might want to reach out to them and work together to figure out how to better educate consumers in this area.

Director Fox asked Pollitz if she knew if there ever has been any engagement or ways to engage the provider community to assist consumers in filing appeals of claim denials. Pollitz said she is not aware of any such engagement. However, she believes that the CMS may be engaging with providers as part of implementing the federal No Surprises Act (NSA). Pollitz said that potential insurer engagement with providers could be beneficial in addressing possible issues in the way claims are submitted to insurers for payment, which could be a reason for certain types of denials, and engaging and educating providers on insurer claim submission requirements could resolve some of those issues.

Commissioner Kreidler asked if the KFF knew if SBMs who tracked claim denials and appeals had findings similar to those of the HealthCare.gov insurers. Pollitz said that among the SBMs KFF knows have similar data reporting, Covered California, the findings look roughly the same. She reiterated that she believes the Minnesota SBM may have similar data reporting requirements, but the KFF has not had the opportunity yet to review its data to determine if there are any similarities. Commissioner Kreidler suggested that of those states that have an SBM, the state department of insurance (DOI) may want to reach out to see if the SBM collects this data in order to understand better what is happening in the state as far as the number of claims denials and appeals and whether there is a need to find ways to educate consumers on their appeal rights.

Carl Schmid (HIV+Hepatitis Policy Institute) expressed appreciation for the Committee inviting the KFF to present its findings. He said the KFF findings highlight a number of troubling issues, such as the high percentage of claim denials and how few consumers appeal such denials. He said he hopes state insurance regulators try to address this issue. He offered a few recommendations to address this, such as the NAIC reviewing its appeal models to see if any revisions need to be made or looking at definitions of “medical necessity.”

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5. Heard a Discussion on a State Checklist of Actions Related to the Medicaid Unwinding Process

Sabrina Corlette (Georgetown University, Center on Health Insurance Reforms—CHIR) discussed a recently published issue brief from the State Health and Value Strategies (SHVS) titled “Secrets to a Successful Unwinding: Actions State-Based Marketplaces and Insurance Departments Can Take to Improve Coverage Transitions.” She highlighted the extraordinary work state Medicaid agencies will have to undertake over the next year to reassess the eligibility of approximately 95 million people to retake Medicaid coverage because of the impending end of the COVID-19 PHE. She estimated that approximately 15 million to 18 million of these individuals will be terminated from Medicaid coverage, with many of them being eligible for coverage either through ACA marketplace plans or employer-sponsored insurance (ESI). She discussed the steps state DOIs—along with other partners, such as SBMs and carriers—can take to reduce gaps in coverage and avoid disruptions in care.

Corlette provided a timeline for the Medicaid unwinding process, including the dates certain states plan to begin redeterminations of Medicaid coverage eligibility and terminations of coverage for those deemed ineligible for coverage. Also shown was the decrease in the percentage of the enhanced federal Medical Assistance Percentage (eFMAP) during the time of the Medicaid unwinding process. She discussed temporary and/or short-term actions state DOIs can take to ease transitions, including monitoring the cadence of Medicaid renewals, monitoring qualified health plan (QHP) issuers’ financials and network capacity, and guarding against deceptive marketing of unregulated products. Corlette stressed that it is important that state DOIs communicate early and often with their state and federal partners. She also discussed temporary and/or short-term actions SBMs can take.

Corlette discussed actions state DOIs can take to mitigate the ill effects of churn long-term. Those actions include: 1) expanding continuity of care requirements; 2) requiring QHPs to honor prior authorizations and step-therapy/prescription drug formulary exception decisions; 3) considering the pro-ration of deductibles and maximum out-of-pocket (MOOP) for mid-year transitions; and 4) supporting auto or EZ Enroll initiatives. She discussed similar actions that SBMs can take.

Commissioner Kreidler expressed appreciation for the presentation. He asked Corlette if she has any additional recommendations for the states, particularly those that are actively engaged in the process and are already working with their SBM to smooth the transition process. Corlette said she did not, but she urged state insurance regulators to expect that the process will not go smoothly and to be flexible and maintain lines of communication with their sister agencies, such as the state Medicaid agency.

Director Fox asked about any Special Enrollment Periods (SEPs) for Medicaid recipients that became eligible for Medicare. Corlette said the CMS has instituted such an SEP. She also noted that the CMS has established an SEP for “exceptional circumstances” for FFMs from April 2, 2023, to July 31, 2024. Commissioner Mulready noted that each state will have to decide whether to establish an SEP for enrollment into Medicare supplement (Medigap) plans. He said some states might be able to establish an SEP by rule, which is what Oklahoma did.

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

Jeff Wu (federal Center for Consumer Information and Insurance Oversight—CCIIO) and Jeff Grant (CCIIO) provided an update on activities of interest to the Committee. Grant focused his remarks on the pending released Notice of Benefit and Payment Parameters 2024 proposed rule, which the CCIIO hopes will be finalized soon. He discussed a few of the proposed changes included in the proposed rule, including proposals that expand access to affordable coverage, but in a way designed to improve consumers’ experiences throughout the process of determining eligibility, choosing a plan, and completing enrollment. The goal is to simplify the enrollment process for consumers and improve the quality of care available. A key rationale for many of these proposed policy and operational changes is to enhance health equity and reduce disparities in health coverage and access.

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One proposal central to this goal is enhancing network adequacy and essential community provider (ECP) requirements for individual market QHPs, stand-alone dental plans, and small business health options programs (SHOPs) to ensure consumers have access to a sufficient choice of providers. With the goal of expanding access to services for low-income and medically underserved consumers, CMS proposes to add mental health facilities, substance use disorder (SUD) treatment centers, and rural emergency hospitals to the list of current ECPs.

Grant said that as part of this shift, the CMS is proposing to limit the number of non-standardized plan options to streamline consumer plan choices. He said the CMS is proposing two alternative policies to reduce the number of duplicative or very similar plans currently being displayed to marketplace consumers. SBMs are not impacted. One alternative the CMS proposes is to limit the number of plans insurers can offer at each metal level, product type, and service area to two. Alternatively, the CMS proposes to reinstate a requirement that there be a “meaningful difference” between plans offered on the FFM and the state-based marketplace-federal platform (SBM-FP). Grant reiterated that the proposed rule is not final yet, but explained that these proposed changes reflect CMS’ concern with the proliferation of plans consumers are not able to choose from as opposed to the limited number of plan choices when the health insurance marketplaces first became operational.

Grant said this rule proposes to give health insurance marketplaces the option to implement a special rule giving people who lose Medicaid or the federal Children’s Health Insurance Program (CHIP) 90 days, instead of the typical 60 days, to enroll in a QHP. He also referred to the implementation of the network adequacy wait time requirements, noting the concerns expressed by some commenters about the ability and challenges of the states to have the appropriate tools and resources to assess compliance with the requirements and the burden on providers to get information to insurers in a timely manner, along with other operational challenges.

Grant also touched on: 1) the CMS’ work to modernize the QHP certification process; 2) the independent dispute process under the NSA and the impact of the Feb. 6 Texas court ruling on the ability of the CMS to make payment determinations; and 3) the CMS’ work related to Medicaid unwinding, including improving the transition process for consumers and closing the information gap among the federal and state agencies involved. He closed his remarks by discussing the CCIIO’s work related to health equity.

Commissioner Pike asked about the proposal to limit the number of non-standard plan options. He asked whether there is any consideration to provide flexibility for those states that may have only one or two insurers to permit, if the insurer wishes to do so, more than two plan options. Wu noted the issue’s complexity, explaining that the CMS is carefully weighing all the comments it has received. He pointed out that the proposed rule does not limit the number of standardized plans. An insurer can offer an unlimited number of standardized plans. As such, there are multiple ways for insurers to provide robust competition and choice for consumers in the marketplaces through this mechanism.

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

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Agenda Item #2

**Consider Adoption of its Subgroup, Working Group and Task Force Reports
—*Director Anita G. Fox (MI)***

Virtual Meetings

CONSUMER INFORMATION (B) SUBGROUP

May 25, 2023 / April 25, 2023 / April 17, 2023

Summary Report

The Consumer Information (B) Subgroup met May 25, April 25 and April 17, 2023. During these meetings, the Subgroup:

1. Adopted its April 25 and April 17 minutes, which included the following action:
 - A. Discussed and adopted the document titled *Resuming Medicaid Redeterminations: State Insurance Regulator Guide* as resource for state insurance regulators.
2. Adopted its March 2 minutes, which included the following action:
 - A. Discussed ideas for Subgroup future work, including developing a resource document on using social media, developing a guide to forming partnerships with other agencies, creating alternate versions of existing documents, and developing an education piece for consumers who may lose Medicaid.
3. Discussed other potential Subgroup work related to educating consumers on their claim appeal rights.

Draft: 6/14/23

Consumer Information (B) Subgroup
Virtual Meeting
May 25, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met May 25, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony L. Williams (AL); Debra Judy (CO); Randy Pipal (ID); Alex Peck (IN); Judith Watters (ME); Joy Hatchette (MD); Carrie Couch (MO); Susan Brown (MT); Rebecca Ross (OK); Jill Kruger (SD); Scott McAnally (TN); and Christina Keeley (WI). Also participating was: Cynthia Cisneros (NM).

1. Adopted its April 25 and April 17 Minutes

The Subgroup met April 17 to discuss a guide on Medicaid redeterminations, titled *Resuming Medicaid Redeterminations: State Insurance Regulator Guide*, and it adopted the guide during an e-vote that concluded April 25.

Couch made a motion, seconded by Keeley, to adopt the Subgroup's April 25 and April 17 minutes (Attachment xx and Attachment xx). The motion passed unanimously.

2. Discussed Consumer Assistance on Claim Denials and Appeals

Crow said the Health Insurance and Managed Care (B) Committee had asked the Subgroup to look into claim denials and appeals in response to a recent KFF report on the subject. She said the Subgroup had last addressed appeals in 2021 when it developed a guide for consumers on appealing denied claims.

Crow asked Subgroup members how departments of insurance (DOIs) assist consumers with appeals, how consumers find out about the assistance available, and what barriers prevent consumers from appealing. She also asked about the 2021 guide and whether states use it, including the template letter to request an appeal. Crow said that in Kansas, consumers must first appeal internally. She said most insurers include contact information for the DOI in denial letters. She said many consumers do not believe it is worth it to appeal. She said working with providers and asking them to encourage patients to appeal is one route Kansas has used. Couch said Missouri does not require exhaustion of internal appeals before external review and does not have time limits. She said Missouri also faces obstacles in making consumers aware that assistance is available from the Missouri Department of Commerce and Insurance. She said information in denial letters is one way they find out. Watters said Maine has a similar process to Missouri. She said a consumer advocacy group (Maine Consumers for Affordable Health Care) also provides information and assistance to consumers in filing appeals.

Harry Ting (Health Consumer Advocate) questioned whether all states require explanations of benefits to include contact information for DOIs. He said the 2021 guide is written with medical necessity denials in mind, but denials occur for many other reasons, including missed premium payments and late billing by providers. He suggested that the guide include language to address other denial reasons.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) said consumers should also be directed to their employers when they have employer-sponsored coverage. She said consumer representatives had originally requested that the Health Insurance and Managed Care (B) Committee consider the KFF report. They have formed their own ad hoc group to examine denial and appeals issues. She said the consumer group would be willing to partner with the Subgroup on any work in this area.

Crow said consumers need assistance navigating complicated processes, so it is important to develop a document that is usable and easy to understand. She said the 2021 guide is a good start. She said consumers often do not understand what type of plan they are enrolled in or whether they are eligible for state-based external review.

Crow said the guide could be revised into two separate documents, one shorter and one longer. Bonnie Burns (California Health Advocates—CHA) said many consumers struggle with written communications and do not know how to respond to a denial letter. She said shorter and longer versions would be helpful. She said help should be provided in a very simple way, and when possible, consumers should be connected with an organization like the one in Maine to assist.

Eric Ellsworth (Consumers' Checkbook) said consumers may not know anything about their medical bills. He said the Subgroup should consider the first communication consumers receive that tells them about denials or other forms of nonpayment. He said there is a need for better billing information earlier in the process, including explanations of benefits.

Brenda J. Cude (University of Georgia) said the existing guide makes assumptions, such as that consumers know what denial means. She said a more basic piece could help consumers understand what to look for to know that a claim is denied. She said one basic question for the Subgroup is whether it will develop a formatted guide or content that states can take and use to develop their own materials. Crow said she liked the idea of taking it back to the basics.

Keeley said having two versions would allow more examples and images. She said the term "grievance" should be included, as well as a link to the NAIC glossary. Brown said Montana performs a triage before a consumer files an appeal to ensure an appeal is appropriate or whether a coding issue means the consumer should go back to the biller. She said there are things consumers can do before an appeal to get things corrected.

Culp said her organization assists consumers in navigating care and coverage, and it often takes significant work to uncover the problem, which could be a denial or something else. She said there is high engagement with denial questions on social media and suggested that in addition to shorter and longer guides, bite-sized pieces geared toward social media may be helpful.

Crow said the Subgroup should consider a series of documents that starts pre-denial and walks consumers through the process.

Ellsworth said about 15% of claims face some kind of rejection, including denials and other types. He said over half of rejected claims are eligible for additional work but are not reworked. He asked whether states have authority over contracts that influence billing practices. Brown said it is beyond the insurance department's scope of authority, but they can refer consumers out for consumer protection from the attorney general's office.

Crow said the Subgroup should include something on prior authorization requests, as well as denials. She said the Subgroup may want to update all the documents in its series on claims from 2021. She asked for volunteers to identify gaps in the series and develop revised versions. Brown said the appeals guide may not need to be updated significantly, but all the documents should be reviewed at once.

Hatchette said the Subgroup should not think only about a written document. She said departments should meet consumers where they are with videos and social media. She said the key point to make is that there is somewhere to go for help and that consumers have a right to appeal. Dr. Cude said the first step should remain considering

what consumers need to know. Crow said the Subgroup should figure out its message first and potentially work with the NAIC's communications department to develop videos or other materials like snippets for social media.

Dr. Ting said no document will be as useful as assistance from the staff of an insurance department or State Health Insurance Assistance Program (SHIP). He said increasing the awareness of insurance departments, in general, should also be pursued.

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

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Draft: 5/8/23

Consumer Information (B) Subgroup
E-Vote
April 25, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Apr. 25, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony L. Williams (AL); Randy Pipal (ID); Judith Watters (ME); Carrie Couch (MO); Nichole Faulkner (NC); David Buono (PA); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keely (WI).

1. Adopted a Guide on Medicaid Redeterminations

The Subgroup conducted an e-vote to consider adoption of the document titled *Resuming Medicaid Redeterminations: State Insurance Regulator Guide* (Attachment A). The guide is a resource for department of insurance (DOI) staff in understanding the return of eligibility redeterminations in Medicaid. The motion passed unanimously.

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

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Resuming Medicaid Redeterminations State Insurance Regulator Guide

Background

In March of 2020, and as part of the Families First Coronavirus Response Act, Congress created an incentive for state Medicaid programs to keep consumers continuously enrolled during the COVID-19 pandemic. As a result, states suspended redeterminations of eligibility and Medicaid now covers over 20 million more people than it did in 2019. On December 29, 2022, President Biden signed into law the Consolidated Appropriations Act, 2023 (CAA), which put an end to the Medicaid continuous enrollment provision on March 31, 2023. The CAA allows for states to resume redetermining the eligibility of Medicaid enrollees and to take up to 14 months to complete redeterminations. It also provides for a phased down approach for enhanced Medicaid funding for the States. When redeterminations resume, many Medicaid enrollees will remain eligible, but some will be disenrolled and need to find other coverage from an employer, a Marketplace plan, Medicare, or another source. Many will be eligible for other state or federal assistance with costs, such as premium tax credits or a Medicare Savings Program.

The NAIC's Consumer Information (B) Subgroup developed this resource to help state insurance regulators and their Departments plan for the impact of resumed Medicaid redeterminations. The information and answers below may also be helpful in responding to questions and concerns consumers may have, particularly those who have recently lost Medicaid coverage and are shopping for health insurance for themselves and their family.

State-specific Information on Medicaid Redeterminations

What is happening in my state and when?

- [Unwinding Medicaid Continuous Coverage](#) (Georgetown University)
 - Use this page to find information and resources, including a [50-State Unwinding Tracker](#) with [links to state plans, FAQs, and communications toolkits](#).
- [State Approaches to the Unwinding Period, January 2023](#) (KFF & Georgetown University)
 - KFF lists the timeframe for each state to begin and complete redeterminations.
- [Anticipated 2023 State Timelines for Initiating Unwinding-Related Renewals As of February 24, 2023](#) (CMS)

How many people may be impacted in my state?

- [The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage](#)
 - This Urban Institute report provides national estimates and state tables in Appendix B.
- [Coverage Transition Modeling Dashboard](#) (.xlsx file)

- With funding from AHIP, NORC at the University of Chicago developed estimates for each state of the number of people expected to transition to other coverage sources. Methodology is discussed in [a companion report](#).

Messages and Advice for Consumers

How can my department assist consumers if they receive notice they are losing Medicaid coverage?

- Many individuals who leave Medicaid or CHIP will be eligible for employer coverage. Deadlines for electing employer coverage have been extended. Those who lose Medicaid coverage before July 10, 2023, will have a special enrollment right to elect employer plans until September 8, 2023. After that, the standard special enrollment period of 60 days from the loss of other coverage will apply.
- Shopping for coverage
 - Marketplace. Some consumers may already be aware of the Marketplace; however, there may be some consumers who will need guidance on how to access the Marketplace. Marketplace plans or ACA plans on healthcare.gov are guaranteed issued. Some plans will have \$0 premium after tax credits. Most will have either copays or deductibles.
 - A number of special enrollment periods (SEPs) for Marketplace coverage may be relevant for consumers leaving Medicaid.
 - The SEP for loss of minimum essential coverage (including Medicaid and CHIP) has been extended from 60 days before through 90 days after the coverage loss.
 - A separate SEP is available for those who lose Medicaid or CHIP through July 31, 2024.
 - Individuals with income less than 150% of the federal poverty level may enroll in Marketplace plans in any month.
 - <https://www.healthcare.gov/medicaid-to-marketplace/>
 - Agents, brokers, navigators, and assisters are available to assist consumers.
 - Confirm that the agent is licensed to sell the product.
 - Use [Find Local Help](#) for help with Marketplace plans.
 - NAIC [Health Insurance Shopping Tool](#)
- Tips to offer to consumers (taken from the 2019 “[What to ask when Shopping for Health Insurance](#)” document)
 - Is it a Short-Term, Limited Duration plan, a Sharing Ministry plan, or other limited-coverage plan? Is it sold through an association that requires a membership fee? If so, it could cover less than Marketplace plans.
 - Is the person selling the plan licensed in [STATE]? If so, ask for his/her state license number and contact [STATE DOI] at [phone number] to confirm.
 - What is the insurance company and is it licensed in [STATE]?
 - Does the plan require enrollment in an association or as a limited partner?
 - Does the plan cover your pre-existing conditions? Does it cover your medications?
 - What are the deductibles? There may be different deductibles for different services.
 - Does the plan set a limit on how much I have to pay out of pocket in a year (maximum out of pocket or MOOP)?

- What services DOESN'T the plan cover? Always ask about Exclusions and Limitations on non-ACA policies and whether a claim can be denied or not paid after the fact.
- For services that ARE covered, how much will the plan actually pay? Is there a limit on the total amount the plan will pay per person, per service, or per year?
- How long will the coverage last? Will you be able to keep or renew your coverage if you get sick?
- Does the plan have a provider network? If yes, how do you access the directory of providers and can you review the directory before signing up? Is your doctor or hospital in the network? If not, will doctors and providers agree not to bill for amounts above what the plan pays?

What messages are federal agencies using and recommending related to Medicaid redeterminations?

- [Medicaid and CHIP Continuous Enrollment Unwinding – Toolkit](#)
 - This toolkit includes key messages, drop-in articles, social media and outreach products, call center scripts, and more. A .zip file contains [supporting materials and graphics](#). Materials are available in languages in addition to English on the [CMS Unwinding page](#).

Medicare Issues

Where can I find a review of Medicare enrollment considerations for those losing Medicaid?

- ADvancing States published [a brief guide](#) for counseling Medicare-eligible individuals whose Medicaid benefits changed due to the end of the continuous coverage requirement.

Can states assist individuals who missed a period of guaranteed issue for Medicare supplement coverage while they were enrolled in Medicaid?

- A number of states (including [Alaska](#), [Delaware](#), [Idaho](#), [Kentucky](#), [Maryland](#), [New Hampshire](#), and [Oklahoma](#)) have issued bulletins to direct issuers to offer guaranteed issue of Medicare supplement plans for those who exhausted their open enrollment period as a result of their continued enrollment in Medicaid and who experience a change in Medicaid eligibility.

Additional Resources

- [Connecting to Coverage Coalition](#) has issued a set of resources.
 - The Coalition has compiled resources on redeterminations, including information on [fraud prevention](#), [guidance on texting consumers](#) from the Federal Communications Commission, and [How Health Insurance Providers Are Supporting Americans Through Medicaid Unwinding](#)
- [Unwinding and Returning to Regular Operations after COVID-19](#) (CMS)
 - CMS guidance and resources
- [Unwinding resources for American Indians and Alaska Natives](#) (CMS)

Draft: 5/8/23

Consumer Information (B) Subgroup
Virtual Meeting
April 17, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met April 17, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony L. Williams (AL); Randy Pipal (ID); Alex Peck (IN); Mary Kwei (MD); Carrie Couch (MO); Cuc Nguyen (OK); David Buono (PA); Jill Kruger (SD); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating were: Susan Brown (MT); and Cynthia Cisneros (NM).

1. Adopted its March 2 Minutes

The Subgroup met March 2 to discuss potential Subgroup activities for the year.

Couch made a motion, seconded by Pipal, to adopt the Subgroup's March 2 minutes (*see NAIC Proceedings – Spring 2023, Health Insurance and Managed Care (B) Committee, Attachment One*). The motion passed unanimously.

2. Discussed a Regulator Guide on Medicaid Redeterminations

Crow said the Subgroup identified a guide on Medicaid redeterminations as a top priority during its March 2 meeting. She said millions of people will leave Medicaid in 2023 and need to find new coverage. She said a small group met to draft a guide for state insurance regulators to aid in understanding the resumption of redeterminations. She said many other groups have developed materials aimed at consumers.

Crow said the guide focuses on providing links to existing useful tools. Couch said the guide is a good resource for those who take calls from consumers. She said the draft guide lacks information on navigators and assisters.

Bonnie Burns (California Health Advocates—CHA) said she applauds the group for developing the document. She said people dropped from Medicaid may not know they remain eligible for Medicare Savings Programs or other state-based assistance with health costs. She recommended that the guide refer readers to State Health Insurance Assistance Programs (SHIPs) to check into other programs that may offer benefits. Harry Ting (Health Care Consumer Advocate) agreed that SHIPs should be referenced and provided a suggested resource for assisting Medicare-eligible individuals.

Crow said other emailed suggestions included adding references to enrolling in employer-sponsored plans. Kris Hathaway (AHIP) also recommended adding information on employer coverage. Burns said individuals who lose Medicaid after a redetermination may not have a total loss of assistance due to eligibility for other benefits. She added that not all insurance departments have SHIPs within their departments, so it would be useful to link to them.

Crow asked whether the guide should mention coverage of preexisting conditions since it is not an issue under plans under the federal Affordable Care Act (ACA), but it is for other plans. Subgroup members agreed that there should be information on preexisting condition exclusions.

3. Discussed Other Matters

Crow said the Health Insurance and Managed Care (B) Committee had discussed statistics on claim denials and appeals. She said they showed that consumers appeal very few denials. She said the Subgroup may wish to consider how to assist consumers in understanding denials and making appeals. She reminded the Subgroup that it has already produced a guide for consumers on how to appeal denied claims.

Dr. Ting said it would be a good idea to refresh the denials guide and also to encourage consumers to appeal denials because there is a good chance that a denial would be overturned. He said communications outreach around the value of appealing would be useful in addition to updating the guide. Couch said social media can be a good avenue for reaching consumers.

Cisneros said overall health insurance literacy is also important and that the appeals guide could be part of a larger set of resources. Crow said the Subgroup had put out a more comprehensive guide to using insurance in the past. Buono said Pennsylvania uses a similar comprehensive guide.

Katie Dzurec (Regulatory Insurance Advisors) said information on coverage for preventive services may be useful for state insurance regulators and consumers after the recent *Braidwood* decision.

Crow asked Subgroup members and interested parties to suggest over email other topics for the Subgroup to take up.

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

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*2023 Summer National Meeting
Seattle, Washington*

HEALTH ACTUARIAL (B) TASK FORCE

Saturday, August 12, 2023
2:00 – 3:30 p.m.

Meeting Summary Report

The Health Actuarial (B) Task Force met Aug. 12, 2023. During this meeting, the Task Force:

- A. Adopted its Spring National Meeting minutes.
- B. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met Aug. 12 and took the following action:
 - i. Adopted its July 19, June 7, and May 1 minutes, which included the following action, discussing comments received on a request for comments on various long-term care insurance (LTCI) rate increase review methodologies.
 - ii. Discussed comments received on exposures of ideas for a single LTCI rate increase review methodology for use in multistate actuarial (MSA) filing reviews.
 - iii. Discussed comments received on proposals to revise the Nationally Coordinated LTCI Rate Increase Review Checklist and comments received on an exposure of the Minnesota and Texas LTCI rate increase review methodologies.
 - iv. Discussed drafting changes to VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the *Valuation Manual* to add tables from the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute's final *Long-Term Care Insurance Mortality and Lapse Study*.
 - v. Discussed a referral from the Health-Risk Based Capital (E) Working Group regarding *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51)*.
 - vi. Heard a presentation on public/private long-term care (LTC) funding solutions.
 - vii. Heard an update on a single LTCI multistate rate review approach.
- C. Heard an update on Society of Actuaries (SOA) Research Institute activities.
- D. Heard a presentation on SOA education redesign.
- E. Heard an update from the American Academy of Actuaries (Academy) Health Practice Council.
- F. Heard an update on Academy professionalism.

*2023 Summer National Meeting
Seattle, Washington*

HEALTH INNOVATIONS (B) WORKING GROUP

Sunday, August 13, 2023

9:30 – 11:00 a.m.

Meeting Summary Report

The Health Innovations (B) Working Group met Aug. 13, 2023. During this meeting, the Working Group:

1. Adopted its Spring National Meeting minutes.
2. Heard presentations from Texas, West Virginia, and AHIP on prior authorization and gold card programs.
3. Heard a presentation from ArrayRx on multistate prescription drug purchasing.
4. Heard a presentation from Pharmaceutical Research and Manufacturers of America (PhRMA) on health equity and diversity in clinical trials.

2023 Summer National Meeting

Seattle, Washington

REGULATORY FRAMEWORK (B) TASK FORCE

Sunday, August 13, 2023

12:15 – 1:00 p.m.

Meeting Summary Report

The Regulatory Framework (B) Task Force met Aug. 13, 2023. During this meeting, the Task Force:

1. Adopted its Spring National Meeting minutes.
2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Aug. 7, July 24, July 10, June 29, May 15, April 24, April 17, and March 27 minutes. During these meetings, the Subgroup took the following action:
 - A. Completed its discussions of the comments received on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), specifically Section 8A—General Rules.
 - B. Completed its discussions of: i) the remainder of Section 8, including revisiting the proposed new subsection on short-term, limited-duration (STLD) plans and the discussion of the Feb. 24 comments received on that section; and ii) Section 7—Prohibited Policy Provisions.
 - C. Discussed the comments received on Section 9—Required Disclosure Revisions, including how the recently proposed federal rules on consumer disclosures for STLD plans and hospital indemnity and other fixed indemnity plans could affect proposed revisions to the section.
 - D. Discussed its upcoming work to continue its discussions of the Model #171 revisions and complete those revisions by the end of the year.
3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group, which met Aug. 13 and took the following action:
 - A. Heard an update from the U.S. Department of Labor (DOL).
 - B. Discussed level-funded plans.
 - C. Received an update on the revisions to the NAIC chart on multiple employer welfare arrangements (MEWAs)/multiple employer trusts (METs) and association plans.
 - D. Met in regulator-to-regulator session, pursuant to paragraph 2 (pending investigations), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.
4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its March 23 minutes. The Working Group will meet Aug. 14. During this meeting, the Working Group plans to take the following action:
 - A. Hear presentations on autism treatment standards.
 - B. Meet in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.



5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its July 27 minutes. During this meeting the Subgroup took the following action:
 - A. Adopted its April 17 minutes. During this meeting, the Subgroup exposed the pharmacy benefit manager (PBM) white paper for a 45-day public comment period ending June 1.
 - B. Adopted its Spring National Meeting minutes.
 - C. Adopted the PBM white paper and forwarded it to the Task Force for its consideration, which the Task Force received during the meeting.

6. Heard a panel presentation on prior authorization from representatives of the Leukemia & Lymphoma Society (LLS), the American Medical Association (AMA), and the Washington Office of the Insurance Commissioner. During the presentation, the panelists discussed patient and consumer experiences with prior authorization and how prior authorization requirements can create a barrier to care and be burdensome to physician practices. The panelists discussed opportunities and solutions for state insurance regulators to reform the prior authorization process and provided examples of how certain states, including Washington, are acting on those solutions to reform the prior authorization process. The panelists also discussed federal actions complementing state actions to reform the prior authorization process.

*2023 Summer National Meeting
Seattle, Washington*

SENIOR ISSUES (B) TASK FORCE

Sunday, August 13, 2023
3:00 – 4:30 p.m.

Meeting Summary Report

The Senior Issues (B) Task Force met Aug. 13, 2023. During this meeting, the Task Force:

1. Adopted its April 14 and Spring National Meeting minutes.
2. Heard a presentation from the federal Centers for Medicare & Medicaid Services (CMS) on its new Medicare Advantage marketing rules and regulations.
3. Heard a presentation from eHealth about lead generators and its work.
4. Heard a presentation from the New Mexico Cancer Center (NMCC) on concerns about adverse risk selection in Medicare Advantage plans.
5. Heard an update on the status of Minnesota’s “Own Your Future” initiative and Washington’s WA Cares Fund.
6. Heard a request to open the *Coordination of Benefits Model Regulation* (#120) and make the necessary correction to alleviate the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)/Medicare conflict.

Agenda Item #3

Discuss Referrals to the Health Actuarial (B) Task Force
—*Director Anita G. Fox (MI)*

TO: Director Anita G. Fox, Chair of the Health Insurance and Managed Care (B) Committee

FROM: Judy Weaver, Chair of the Financial Analysis (E) Working Group (FAWG)

DATE: May 24, 2023

RE: Risk Adjustment Receivable (Payable)

As you may be aware, the Financial Analysis (E) Working Group (FAWG) meets annually in Kansas City to discuss among other things, potentially troubled insurers and insurance groups. During this meeting, FAWG also discusses issues and industry trends, including identifying any that are potentially adverse or might warrant communication and coordination with other NAIC groups. As a result of the issues and trends discussed, FAWG would like to refer the following item to the attention of the Committee.

Risk Adjustment Receivable (Payable) – FAWG discussed issues contributing to recent troubled health insurers, some of which had only been in operation a few years. The FAWG has observed that some insurers’ claims experiences resulted in high losses while at the same time the insurer is impacted negatively by high risk adjustment payables. The FAWG has also observed that there may be concerns with a new insurer’s ability to properly identify/code member health status necessary for the risk adjustment formula or, concerns with the insurer’s planned market/growth strategy where no caps or limits are set which may result in higher than anticipate claims experience.

Based on these observations, it is recommended that the Committee consider if it would be beneficial for the NAIC to engage in a discussion with the Centers for Medicare and Medicaid Services (CMS) about state insurance regulators’ concerns with the how the calculation of the risk adjustment receivable (payable) impacts the current or prospective financial solvency position of new health insurer’s entering the exchanges and experiencing significant growth; and whether state insurance regulators identify a need for changes to the calculation.

It should be noted that the FAWG has made referrals to the National Treatment and Coordination (E) Working Group to develop additional guidance for use in the review of licensing applications for new health insurers in the NAIC’s *Company Licensing Best Practices Handbook* and to the Financial Condition Examiners Handbook (E) Technical Group to develop additional guidance on strategic/operational risks faced by health insurers for the NAIC’s *Financial Condition Examiners Handbook* to encourage review of these risks during an onsite examination.

If there are any questions regarding this response, please feel free to contact me or NAIC staff (Jane Koenigsman at jkoenigsman@naic.org) for clarification. Thank you.

Agenda Item #4

Hear an Update on Market Regulation and Consumer Affairs (D) Committee Work of Interest to the Committee—*Commissioner Jon Pike (UT)*

Agenda Item #5

Receive Update from the Consumer Information (B) Subgroup on Work Related to Consumer Education on Claim Appeal Rights—*LeAnn Crow (KS)*

Agenda Item #6

Hear a Panel Discussion on Preventive Services—*Anna Schwamlein Howard (American Cancer Society Cancer Action Network—ACS CAN), Carl Schmid (HIV+Hepatitis Policy Institute), and Amy Killelea (Killelea Consulting)*

**IMPROVING ACCESS TO PREVENTIVE
SERVICES CONSUMER PROTECTIONS**

NAIC National Meeting

August 14, 2023

Presenters

- Carl Schmid, HIV+Hepatitis Policy Institute (Consumer Representative)
- Amy Killelea, Consultant to the Consumer Representatives
- Anna Schwamlein Howard, American Cancer Society Cancer Action Network (Consumer Representative)

NAIC CONSUMER REPRESENTATIVES PREVENTIVE
SERVICES REPORT: BACKGROUND AND
CONTEXT

ACA PREVENTIVE SERVICES OVERVIEW

- The ACA requires non-grandfathered individual, group, and self-funded plans to cover the following preventive services without cost sharing :
 - USPSTF Grade A or B rated services
 - Routine vaccines for adults and children recommended by Advisory Committee on Immunization Practices (ACIP) and approved by CDC Director
 - Preventive services in guidelines supported by Health Resources and Services Administration (HRSA) via the Bright Futures for Children Program
 - Preventive services for women and supported in guidelines by HRSA via the Women's Preventive Services Initiative
- *Braidwood v. Becerra* is a legal challenge to all of the ACA preventive services requirements that regulators should monitor
 - BUT, ACA preventive services are still the law of the land
 - Many states have adopted state laws and regulations that include preventive services coverage ~~sharing~~ protections

INCREASING ACCESS TO PREVENTIVE SERVICES HAS SIGNIFICANT HEALTH EQUITY IMPLICATIONS

Preventive Service	Communities Most Impacted	Benefits of the Intervention
Smoking cessation	Tobacco use is concentrated among low-income communities, including Native American and LGBTQ	Tobacco cessation interventions double the rate at which people who smoke quit smoking
Pre-exposure prophylaxis (PrEP) for the prevention of HIV	Black and African-American and Latino and Hispanic individuals comprise 40% and 29% of new HIV diagnoses, respectively	PrEP is 99% effective at preventing HIV from sex and 74% effective at preventing HIV from injection drug use
Colorectal cancer screening	Rates of late colorectal diagnosis are higher among rural populations, people with lower education and lower incomes, and people who are Black and African American, Latino and Hispanic, or Native American	When detected early, colorectal cancer can be treated with surgery, chemotherapy, radiation, and/or immunotherapy
Postpartum depression screening	Postpartum depression rates are higher based on low income, poor access to education/healthcare, adolescent age, Black and African-American race, and recent immigrant status	Depression treatment for parents with postpartum depression has health and economic benefits for the parent and children

COMPLIANCE WITH THESE COVERAGE AND COST SHARING REQUIREMENTS HAS BEEN A CHALLENGE

Many Americans still paying high costs months after insurers were ordered to cover HIV preventive care

By Sarah Varney, Kaiser Health News
Published 6:19 AM EST, Mon February 28, 2022

The Boston Globe

Despite federal rules, HIV prevention drug still comes with costs

The billing errors have forced some to stop taking the medicine, putting them at heightened risk of contracting the virus.

By [Jessica Bartlett](#) Globe Staff. Updated January 8, 2023, 4:58 p.m.



The New York Times

Preventing Sickness, With Plenty of Red Tape

NAIC CONSUMER REPRESENTATIVE REPORT:
FINDINGS

THE REPORT METHODOLOGY

- Research included:
 - Review of policy analyses and studies on utilization, cost, and health outcomes
 - Informant interviews with patient groups representing constituents impacted by each service or condition; plan and issuer representatives; providers and provider associations; state regulators; and consumers impacted by access challenges

THE REPORT METHODOLOGY (CTD)

- Analysis of a representative sample of Marketplace plan preventive services and payer guidance documents, including:
 - Consumer-facing preventive services coverage descriptions (i.e., preventive services brochures or fact sheets) on publicly available plan websites
 - 2023 plan formulary
 - Most recent payer guidance for each of the four focus preventive services

1) CONSUMER FACING DOCUMENTS LACK COMPREHENSIVE PREVENTIVE SERVICES DESCRIPTIONS



- Most plans assessed did not describe every component of the intervention, especially for services that involved both a medical and pharmacy benefit

1) CONSUMER FACING DOCUMENTS LACK COMPREHENSIVE PREVENTIVE SERVICES DESCRIPTIONS (CTD)

- **Example**: smoking cessation services often described the smoking cessation medications that were covered, but did not describe the counseling components of the intervention

2) PLAN FORMULARIES DID NOT ALWAYS DESCRIBE \$0 COST SHARING PREVENTIVE MEDICATIONS CLEARLY AND ACCURATELY



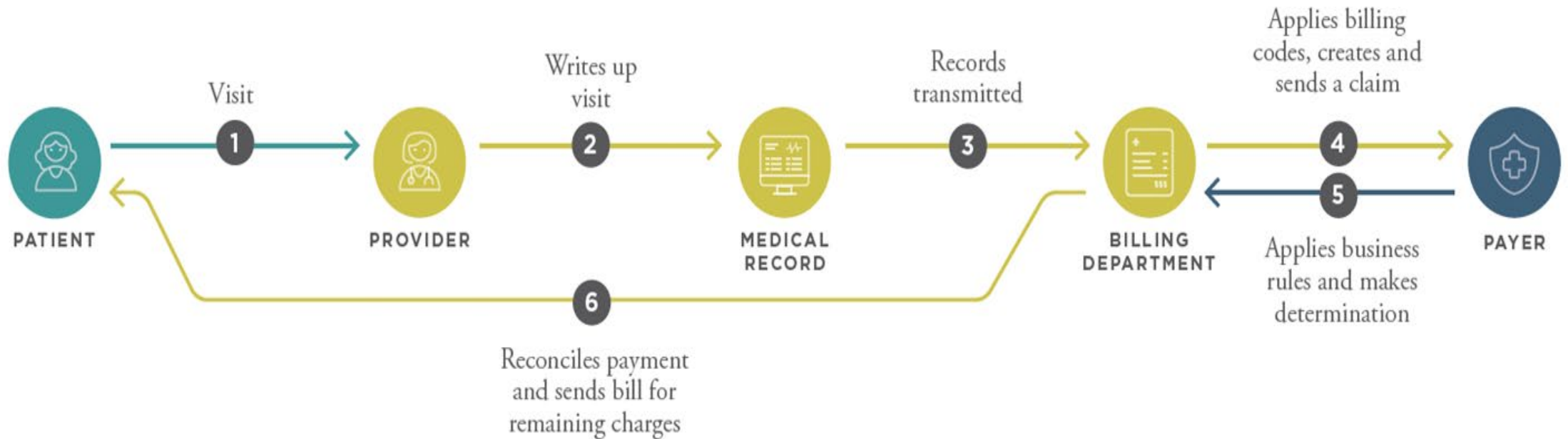
- Plans that were easiest to navigate included separate preventive services formularies, with medications listed by intervention
- It was more difficult to assess \$0 coverage of preventive services medications when the medications were listed in the main formulary by therapeutic class

2) PLAN FORMULARIES DID NOT ALWAYS DESCRIBE \$0 COST SHARING PREVENTIVE MEDICATIONS CLEARLY AND ACCURATELY

- **Example**: there are multiple FDA-approved PrEP medications, but plans did not clearly specify which ones were covered without cost sharing and how consumers who needed access to one regimen over another could access that regimen without cost sharing

3) PAYER GUIDANCE DOCUMENTS THAT INFORM CLAIMS ADJUDICATION POLICIES WERE OFTEN INCOMPLETE

The Role of Claims Adjudication in \$0 Preventive Services



3) PAYER GUIDANCE DOCUMENTS THAT INFORM CLAIMS ADJUDICATION POLICIES WERE OFTEN INCOMPLETE (CTD)



- Most plans did not have publicly available comprehensive payer guidance for each of the four services reviewed
- Common gaps in the payer guidance reviewed included:
 - lack of reference to nationally recognized clinical standards
 - lack of specificity with regard to medical management, including intervals for the service
 - missing core components of the intervention, especially when the intervention included both a medical and pharmacy benefit

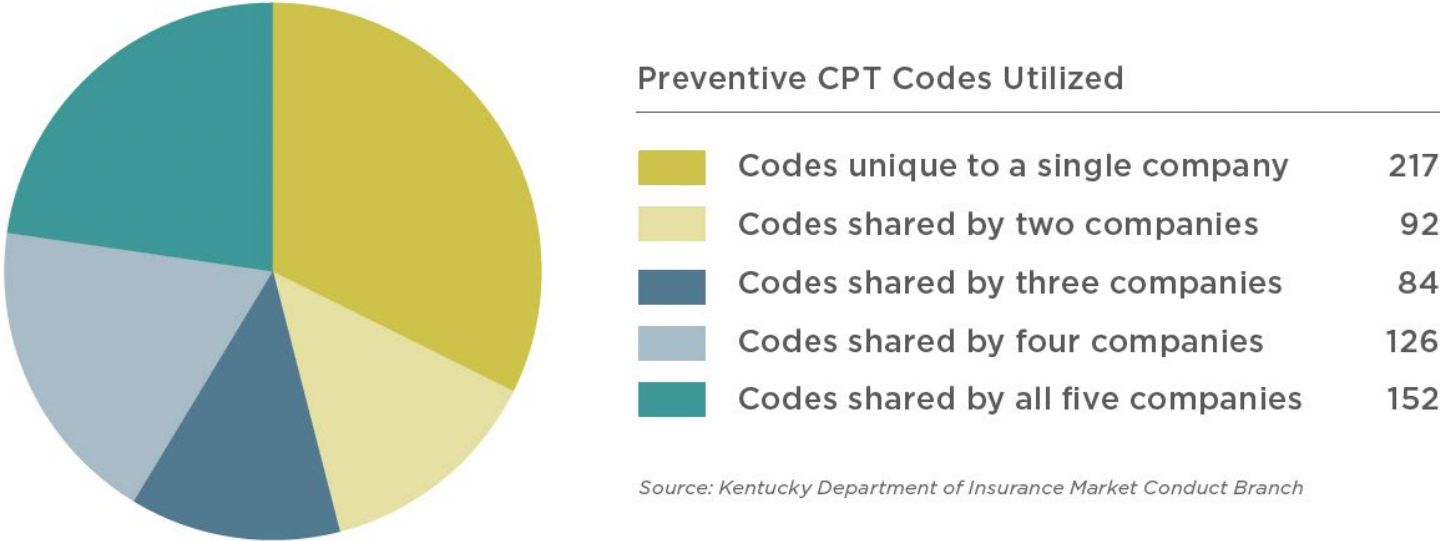
3) PAYER GUIDANCE DOCUMENTS THAT INFORM CLAIMS ADJUDICATION POLICIES WERE OFTEN INCOMPLETE (CTD)

- **Example**: guidance for postpartum depression screening was missing completely in half the plans reviewed
- **Example**: PrEP includes a number of regular lab services in addition to medication, but guidance rarely specified the specific labs included or the intervals at which they had to be covered without cost sharing
- **Example**: colonoscopies included the most specificity in terms determining eligibility, the components of the intervention, and coverage considerations for providers

WHY PAYER GUIDANCE MATTERS

Lack of specific coverage policies that are well articulated to providers leads to arbitrary coverage decisions

FIGURE 9
Kentucky CPT Code Variation for Preventive Services



Source: Kentucky Department of Insurance Market Conduct Branch

RECOMMENDATIONS FOR REGULATORS

1) UTILIZE DATA CALLS AND MARKET CONDUCT EXAMS TO ASSESS COMPLIANCE

- Both Kentucky and Washington used data calls and market conduct exams to evaluate compliance with preventive services coverage and cost-sharing protections
- Data analysis **MUST** include claims data
- State departments of insurance must also invest in internal capacity to review and analyze claims data

2) ENSURE CONTINUED PREVENTIVE PROTECTIONS W/ STATE LEGISLATIVE AND REGULATORY ACTION

- Even before the Braidwood litigation, many states have enshrined ACA preventive services coverage and cost-sharing protections into state law
- State regulators are also working with plans in the state to ensure continued \$0 cost-sharing plan designs regardless of the Braidwood outcome

3) ENFORCE APPEALS PROTECTIONS FOR MISADJUDICATED OR DENIED PREVENTIVE SERVICES CLAIMS

- Appealing mis-adjudicated claims (e.g., preventive services approved as diagnostic instead of preventive) can be confusing and time consuming for consumers and providers
- Consumers are often left in the middle of disputes between providers (or labs) and the plan

4) ENSURE THAT QUALIFIED HEALTH PLAN (QHP) CERTIFICATION ASSESSES FORMULARIES AND OTHER PLAN DOCUMENTS

- QHP review must ensure that preventive services medications are listed accurately on plan formularies
- Review must also include assessment of plan documents to ensure that coverage policies are compliant with federal and state law as well as up-to-date clinical standards

5) HOLD PLANS ACCOUNTABLE FOR EDUCATING CONSUMERS AND PROVIDERS ON PREVENTIVE SERVICES REQUIREMENTS

- Consumer and provider education on preventive services is a persistent challenge and contributes to pronounced access gaps
- Plans should be encouraged to work more proactively with both covered consumers and providers in plan networks to increase awareness and uptake of preventive services

6) ESTABLISH UNIFORM BILLING AND CODING STANDARDS

- Regulators – and the NAIC – should consider ways to support uniform billing and coding standards that would eliminate the variability in coverage standards across plans
- The standardization that Centers for Medicare and Medicaid Services (CMS) guidance for Medicare claims processing is an example of how this can be done

CONTACT INFORMATION

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- Anna Schwamlein Howard, American Cancer Society Cancer Action Network, Consumer Representative, anna.howard@cancer.org
- Amy Killelea, Consultant to the Consumer Representatives, amyk@killeleaconsulting.com

Agenda Item #7

Hear an Update on Medicaid Redeterminations
—*Miranda Motter (America's Health Insurance Plans—AHIP)*

NAIC Summer 2023 National Meeting

Health Insurance and Managed Care (B) Committee

Medicaid Redeterminations

Monday, August 14, 2023

Miranda C. Motter
AHIP SVP, State Affairs and Policy
mmotter@ahip.org



About AHIP

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

Visit www.ahip.org to learn how working together, we are Guiding Greater Health.



Our Mission Statement

We are champions of care.
Health insurance providers, working together as one.
Making health care better and coverage more affordable
for every American.
Listening. And guiding the conversation on care.
We are advancing mental and physical health.
Always improving how and where we help others.
Harnessing the power of our collective expertise.
Turning healthy insights into helpful innovations.
All for the greater good.
So everyone can thrive in good health.
Together.
That's what care does.
AHIP
Guiding Greater Health

Overview:

- Medicaid Redetermination Environmental Scan
 - Data
 - Updated State Timelines
 - New State Flexibilities
- Transitioning to Other Coverages
 - Coverage Transition Report
 - Resources for Consumers and Employers

First Batch of Medicaid Redetermination Data Reported Under CAA, 2023

On July 28, CMS posted the first batch of Medicaid Redeterminations data reported under the Consolidated Appropriations Act, 2023, [here](#).

The full data set, including state-by-state metrics, is available [here](#).

Key Takeaways from the April 2023 data:

- More than 2 million people went through a full renewal process.
- Of those, nearly half (45.5%) were successfully reenrolled in Medicaid and CHIP, and more than half (55%) of those renewed were done automatically (through an ex parte data review).
- Approximately one third (32.2%) lost their Medicaid and/or CHIP coverage. Within that group, 79% of terminations were for procedural reasons.
- Just over 22% of people due for renewal in April were still pending with the state at the end of the month.
- Many people leaving Medicaid or CHIP may transition to Marketplace coverage. There were nearly 44,000 new plan selections from consumers who previously had Medicaid or CHIP enrollment in the 14 HealthCare.gov states that completed at least one full cohort of renewals by April.

Notes: These data represent the outcome of renewals due in April 2023 (effective May 1, 2023) in 18 states that had completed at least one full cohort of unwinding-related renewals as of April 30: AR, AZ, CT, FL, IA, ID, IN, KS, NE, NH, NM, OH, OK, PA, SD, UT, WV, and WY.

Additional Medicaid Redetermination Data Resources

Georgetown CCF State Unwinding Renewal Data

- *Georgetown University's Center for Children and Families has published an interactive chart showing the share of “ex parte” renewals in which coverage is automatically renewed based on information in the enrollee’s case file or electronic data sources and the enrollee isn’t required to return a form or take any action to maintain Medicaid coverage.*
- *It also shows the share of people being disenrolled for procedural versus eligibility reasons as well as the share of pending cases.*

Kaiser Family Foundation Data

- The KFF Medicaid Enrollment and Unwinding Tracker presents the most recent data on monthly Medicaid enrollment, renewals, disenrollments, and other key indicators reported by states during the unwinding of the Medicaid continuous enrollment provision.
- The unwinding data are pulled from state websites, where available, and from CMS.

State Renewal Timelines: Updated

In July, CMS shared an updated document outlining the 2023 state Medicaid and CHIP [renewal timelines and distribution plans](#).

This is an update to a [similar document](#) released in February, reflecting some state renewal start dates that have changed as well as additional information about the amount of time states plan to spend on renewals.

The updated document also indicates whether the state is prioritizing some or all renewals for individuals likely to be ineligible for Medicaid.

Renewal Spread:

- Extended the renewal spread to 18 months: Alaska
- Extended the renewal spread to 12 months: Arizona, Arkansas Oklahoma
- Shortened the renewal spread to 10 months (from 12-14 months): Oregon

Adjusted Effective Dates for the first anticipated terminations for procedural reasons:

- Arizona (May)
- Arkansas (May)
- Delaware (July)
- Mississippi (July)
- New Jersey (July)
- Oklahoma (May)
- Virginia (June)
- Wisconsin (July)

New State Flexibilities

In June, HHS announced new flexibilities to help keep Americans covered as states resume Medicaid and CHIP renewals.

New flexibilities announced include:

- Allowing managed care plans to assist people with Medicaid with completing their renewal forms, including completing certain parts of the renewal forms on their behalf.
- Allowing states to delay an administrative termination for one month while the state conducts additional targeted outreach. This will give people more time to be reminded to fill out and return their renewal forms.
- Allowing pharmacies and community-based organizations to facilitate reinstatement of coverage for those who were recently disenrolled for procedural reasons based on presumptive eligibility criteria.

States have varied in the number and type of flexibilities they have adopted to date. A link to the waiver approvals is here: <https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html>.

Released Resources:

- [CMS Press Release](#)
- [Secretary Letter to Governors](#)
- [Strategies to Prevent Procedural Terminations](#): Describes multiple strategies states are encouraged to adopt to streamline renewals during the Unwinding period.
- [All Hands On-Deck](#): Strategies to help keep people covered.

Medicaid Redetermination Coverage Transitions

Overview:

Overall, the modeling finds that in nearly all states, the majority of individuals who are no longer Medicaid eligible will transition to employer-provided coverage (EPC).

- Variation across states ranges from the lowest proportion (48.9%) in Georgia, to the highest proportion (57.1%) in Delaware, enrolling in EPC.

Approximately 3.8 million (or 21.2%) of people who lose Medicaid coverage during redetermination are estimated to become uninsured.

- Variation ranges from 17.7% in Massachusetts to 26.2% in South Dakota.

A smaller proportion (5.6%) of those losing Medicaid coverage will end up in subsidized Marketplace coverage.

Links:

[Medicaid Redetermination Coverage Transitions](#)

[Coverage Transition Modeling Dashboard](#)

(Please download for the full state-by-state click-down menu)

Resources: Consumers & Employers

Federal Resources:

- [Letter to Employers, Plan Sponsors, and Issuers](#)
- CMS fact sheet for employers (in [English](#) and [Spanish](#))
- [DOL Flyer](#)
- [CMS Renewal Website](#)
- [DOL Guidance and Contact Information](#)
- [CMS FAQs Addressing Special Enrollment and Employers](#)

National Association of Benefits and Insurance Professionals Slide Video: Finding Affordable Health Coverage:

Offers instructions for Medicaid enrollees on finding affordable health care coverage during the redetermination process. [APTC Slide Presentation - NABIP \(nabipvideos.org\)](#)

AHIP's Medicaid Redetermination Toolkit for Consumers:

Designed to help the millions of Americans with Medicaid and CHIP know what's expected of them during Medicaid redeterminations, and where they may be able to get coverage if they are no longer eligible for Medicaid. Resources are available in English and Spanish. <https://www.ahip.org/resources/medicaid-redetermination-toolkit>.

States are Engaging, Examples include:

- [Resources for Massachusetts Employers on MassHealth Redeterminations and Supporting Employees into New Coverage](#), including letter to employers, newsletter and graphic for employer associations, and employee flyer.
- [The Role of State-Based Marketplaces in Medicaid Unwinding](#)

Medicaid Redetermination: AHIP's Toolkit

Take Action Now!

If you can't renew your Medicaid plan, see if your job offers coverage.

1 **Talk...**ask your employer if you can get health coverage at work.

2 **Choose...**the plan that is best for you.

3 **Enroll...**within 60 days of when your Medicaid plan ends.

If your job does not offer a health plan, you can buy one.

1 **Visit...**Healthcare.gov or call 1-800-318-2596

2 **Find out...**if you can get help paying for a plan.

3 **Use...**doctors in your network to save money with your plan.

**** Available in both English and Spanish**

Medicaid Redetermination: AHIP's Toolkit

WHAT YOU NEED TO KNOW

Moving from Medicaid to Employer-Provided Coverage

Now that the COVID-19 emergency is over, the government is restarting the yearly process of making sure people on Medicaid or CHIP are still qualified for these programs. The process is called Medicaid Redetermination. It helps make sure Medicaid stays strong and can serve those who need it most.

Since COVID began in 2020, things may have changed for you, including where you live, or work, and how much you earn. As a result, some people may lose their Medicaid or CHIP coverage, but you still have other options. You may be able to get health insurance from your employer. Or you may be able to buy a plan – with financial help if you qualify – from the state insurance marketplaces.

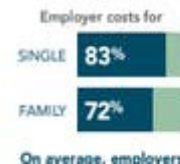
What Is Employer-Provided Coverage?

Things may have changed for you since the start of the COVID-19 pandemic – including where you live, where you work, and how much you earn. As a result, it's possible you are no longer eligible for Medicaid. But you may be able to get health insurance through your job. This type of health insurance is called "employer-provided coverage." While up to 18 million people are expected to no longer be eligible for Medicaid, more than half of them (9.5 million) will be able to get coverage through their employer.¹

Medicaid is health coverage provided by states to people with very low or no income. Employer-provided coverage is offered by an employer to their



About 90% of all American employees work for an organization that offers employer-provided coverage.



TAKE ACTION NOW!

If you have coverage through Medicaid, or if your children are covered by CHIP, you must take action NOW to keep your coverage, or to move to another type of health insurance.

- 1** **UPDATE** Your information with your state's Medicaid program
- 2** **WATCH** In your email, mail, and texts for more information about how to renew your coverage
- 3** **REPLY** As soon as you get information so there's no drop in your health coverage

More about Medicaid in your state: [Renew Your Medicaid or CHIP Coverage | Medicaid](#)

WHAT YOU NEED TO KNOW

Moving from Medicaid to Marketplace Coverage

Now that the COVID-19 emergency is over, the government is restarting the yearly process of making sure people on Medicaid or CHIP are still qualified for these programs. The process is called Medicaid Redetermination. It helps make sure Medicaid stays strong and can serve those who need it most.

Since COVID began in 2020, things may have changed for you, including where you live, or work, and how much you earn. As a result, some people may lose their Medicaid or CHIP coverage, but you still have other options. You may be able to get health insurance from your employer. Or you may be able to buy a plan – with financial help if you qualify – from the state insurance marketplaces.

What Is Marketplace Coverage?

Things may have changed for you since the start of the COVID-19 pandemic – including where you live, where you work, and how much you earn. As a result, it's possible you are no longer eligible for Medicaid. But you may be able to get health insurance through the Health Insurance Marketplace (also known as the "Marketplace" or "exchange"). The Marketplace provides health care coverage options for people who do not have access to coverage through their job and are ineligible for Medicaid and Medicare.

In most states, the federal government runs the Marketplace through [HealthCare.gov](#), although some states run their own Marketplaces at different websites. On average, people shopping for coverage through the Marketplaces can choose coverage from 6 to 7 health insurance providers.

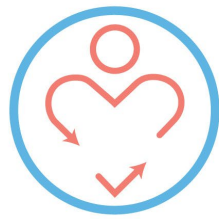
Most people with Marketplace coverage qualify for savings or a subsidy to help lower their health care costs.

TAKE ACTION NOW!

If you lose Medicaid coverage, you may be eligible for free or low-cost coverage through the Health Insurance Marketplace. [Visit HealthCare.gov to find and enroll in a health plan or call the Marketplace Call Center at 1-800-318-2596.](#)

- 1** **UPDATE** Your information with your state's Medicaid program
- 2** **WATCH** In your email, mail, and texts for more information about how to renew your coverage
- 3** **REPLY** As soon as you get information so there's no drop in your health coverage

More about Medicaid in your state: [Renew Your Medicaid or CHIP Coverage | Medicaid](#)



CONNECTING TO COVERAGE COALITION

HELPING AMERICANS GET THE RIGHT COVERAGE

MISSION: A coordinating community for stakeholders working to minimize disruptions in coverage associated with Medicaid redeterminations. A trusted source of information on the status & impact of the Medicaid redetermination process.

WHO: Broad representation from seniors, disability groups, and patient groups; provider associations; employer-related organizations; & Medicaid trade associations. Consumer advocacy groups are playing a supporting role.

WEBSITE: www.connectingtocoverage.org



Agenda Item #8

Hear an Update on the Special (EX) Committee on Race and Insurance Health Workstream Work—*Commissioner Kathleen A. Birrane (MD) and Commissioner Grace Arnold (MN)*

Agenda Item #9

Discuss Any Other Matters Brought Before the Committee
—*Director Anita G. Fox (MI)*