NEBRASKA DEPARTMENT OF INSURANCE

INSURANCE COMMUNITY DISCUSSIONS
SEPTEMBER 27 – OCTOBER 13, 2022

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TODAY'S PRESENTATION

- Nebraska Department of Insurance overview
- Affordable Care Act market, open enrollment and rates
- Surprise balance bills (including air ambulance)
- Appealing a denied health claim
- Top consumer complaints, advice from investigators
- Medicare Advantage open enrollment

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DEPARTMENT OF INSURANCE FUNCTIONS

- General supervision, control, and regulation of insurance in Nebraska § 44-101.01
  - Producer licensing
  - Company licensing
  - Rate and form review
  - Consumer assistance
  - Market conduct examination and corrective actions
  - Financial solvency monitoring and intervention
  - Fraud prevention and investigation
  - Consumer alerts, brochures, and newsletters

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INSURANCE IS IMPORTANT IN NEBRASKA

- Nebraska's domestic insurers rank:
  - First nationally in surplus (assets against liabilities, $339,866,464,516).
  - Third nationally in assets (includes reserves, $873,367,729,891 of oversight responsibility for NDOI).
  - Tenth nationally in premiums written ($53,922,736,110).
- Industry concentration for employment is high. Nebraska has 84% more jobs in the insurance industry than would be expected in a state of its size.
  - This is the second highest insurance job concentration for any state.

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TRENDS IN THE INSURANCE MARKET

- Technology bringing simplification, especially in these areas:
  - Predictive analytics – quantifying and modeling risk, big data indicating broad strokes for quicker decision making.
  - Continuous flow of information – data moves from underwriting to claims administration.
  - Proliferation of different tools and data sources, regulators asking for transparency in understanding how information is being used to affect the consumer.
- Impact of COVID-19
  - How do we assess or reflect the impact?
  - Future inflation, impact on reserves.
- Newer insurance products
  - Pet insurance, identity theft, cyber liability.

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https://www.siliconprairienebraska.com/

HEALTH INSURANCE: ACA MARKETS AND 2023 OPEN ENROLLMENT

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NEBRASKA HEALTH INSURANCE MARKET DISTRIBUTION 2012 to 2019

	2012	2013	2014	2015	2016	2017	2018	2019
Direct-purchase (individual)	7.2%	7.7%	8.8%	8.9%	8.6%	7.9%	7.3%	6.9%
Employment-based	55.1%	54.1%	54.2%	55.4%	55.0%	55.6%	55.2%	56.8%
Medicaid/CHIP	12.5%	13.0%	13.1%	12.9%	12.8%	12.5%	13.3%	12.6%
Medicare	12.0%	12.3%	12.4%	13.1%	12.9%	13.4%	14.0%	14.2%
Military health care	2.2%	2.0%	2.1%	1.8%	1.7%	2.0%	1.8%	1.6%
Uninsured	11.1%	10.8%	9.3%	7.8%	8.9%	8.6%	8.5%	7.9%

2019 is the most recent year available for state-specific market percentages in this table.

Of the remaining uninsured in 2021, 43% were eligible for Medicaid, 33% were eligible for premium subsidies to enroll in the ACA individual market, and 10% were ineligible for ACA individual market premium assistance due to available employer coverage.

Percentage of employment-based plan enrollees that are in a self-insured plan in 2021:

- 73% overall
- 20% of the small group market (less than 50 employees)
- 81% of the large group market (50 or more employees)

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Open Enrollment for plan year 2023 is from November 1, 2022 to January 15, 2023.

- Coverage begins January 1, 2023 if you enroll by December 15.
- Coverage begins February 1, 2023 if you enroll between December 15 and January 15.
- Healthcare.gov
  - Includes subsidies and available plans
- Consult an agent to understand all your options and pick the plan that is best for you.

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2022 ACA INDIVIDUAL MARKET ENROLLMENT STATS

Number of people enrolled in an ACA plan on healthcare.gov									
Year	2014	2015	2016	2017	2018	2019	2020	2021	2022
Insured People	42,975	74,152	87,835	84,371	88,213	87,416	90,845	88,688	99,011

- Of the 99,011 enrollees in 2022:
  - 94,382 received APTC (reduced premiums based on income)
    - 95% of total healthcare.gov enrollees
  - 22,200 received CSR (lower copays, coinsurance, and deductibles based on income)
    - 22% of total healthcare.gov enrollees

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NEBRASKA ENROLLMENT DATA FOR 2022

Metal level	Total	Catastrophic	Bronze	Silver	Gold
Enrollees	99,011	393	67,982	22,992	22,992

% FPL	<100%	100%-138%	138%-150%	150%-200%	200%-250%	250%-300%	300%-400%	400%-500%	>500%
People	369	4,286	9,981	17,577	19,554	15,231	18,746	5,279	6,168

Age	<18	18-25	26-34	35-44	45-54	55-64	>65
People	16,860	9,214	15,149	16,282	15,583	25,256	667

Rural v. Non-Rural	Rural	Non-Rural
People	52,024	46,987

Premiums, APTC and CSR	Average Premium	Average Premium after APTC	<$10 after APTC	Receive APTC	Receive CSR
$ or People	$707	$97 (average for receiving APTC)	31,686 (32% of total enrollees)	94,457 (95% of total enrollees)	22,200 (22% of total enrollees)

INSURERS SELLING INDIVIDUAL ACA COVERAGE IN NEBRASKA, 2014 TO 2023

Insurer	Aetna or Coventry	BCBSNE	CoOportunity	Medica	Time	UHC	Bright Health	Nebraska Total Care	Oscar
3 in 2014	2014	2014	2014						
4 in 2015	2015	2015	2015*		2015				
4 in 2016	2016	2016		2016		2016			
2 in 2017	2017			2017					
1 in 2018				2018					
1 in 2019				2019					
2 in 2020				2020			2020		
2 in 2021				2021			2021		
4 in 2022				2022			2022	2022	2022
4 in 2023		2023		2023				2023	2023

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INDIVIDUAL MARKET PREMIUMS 2014 – 2022

	Single Young Adult	Family 2 Adults 2 Kids	Single Older Adult	Older Couple (No Kids)
2014	$239.22	$744.68	$700.83	$1,528.36
2015	$288.35	$918.64	$844.77	$1,867.38
2016	$334.25	$1,028.96	$979.26	$2,094.72
2017	$407.10	$1,651.72	$1,192.68	**$2,996.08**
2018	$495.16	$2,105.18	$1,450.67	$2,831.46
2019	**$504.17**	**$2,143.48**	**$1,477.06**	$2,488.94
2020	$444.23	$1,851.90	$1,301.45	$2,278.48
2021	$422.05	$1,689.54	$1,236.47	$2,263.74
2022	$465.98	$1,779.78	$1,365.16	$2,441.74
2023	$472.87	$1,806.32	$1,385.36	$2,477.18
Increase 2014 to 2022*	97%	142%	97%	62%

- "Single Young Adult" is a 26-year-old in Lincoln on a **silver plan**
- "Family 2 Adults 2 Kids" is 2 adults age 35 and 2 children in Omaha on a **silver plan**
- "Single Older Adult" is a 64-year-old in Lincoln on a **silver plan**
- "Older Couple (No Kids)" is 2 adults age 60 in Omaha on a **gold plan**

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PREMIUM SUBSIDIES AND COST-SHARING ASSISTANCE

- **Advance Premium Tax Credit (APTC)** is a tax credit you can take in advance to lower your monthly health insurance payment.
- APTC is based on your estimated expected income for the year.
  - This matters because your payment is a percentage of what you earn – not a percentage of the total premium price.
  - APTC is based on the premium for the second-lowest cost silver plan, not the plan you select.
- **Cost Sharing Reductions (CSR)** provide lower dollar amounts for copayments or coinsurance, paid at the time of service for things like doctor visits or prescription refills, or deductibles, which must be paid before the plan begins paying toward the service.
  - For people who earn between 138% and 250% of FPL and purchase a Silver plan, the ACA gives them a discount on cost sharing.

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2022 FEDERAL POVERTY GUIDELINES ARE USED FOR 2023 APTC AND CSR

Household Size	138%	150%	200%	250%	300%	400%
1	$18,754	$20,385	$27,180	$33,975	$40,770	$54,360
2	$25,268	$27,465	$36,620	$45,775	$54,930	$73,240
3	$31,781	$34,545	$46,060	$57,575	$69,090	$92,120
4	$38,295	$41,625	$55,500	$69,375	$83,250	$111,000
5	$44,809	$48,705	$64,940	$81,175	$97,410	$129,880
6	$51,322	$55,785	$74,380	$92,975	$111,570	$148,760
7	$57,836	$62,865	$83,820	$104,775	$125,730	$167,640
8	$64,349	$69,945	$93,260	$116,575	$139,890	$186,520
Insured pays	0%	0%-2%	2%-4%	4%-6%	6%-8.5%	8.5%

The “Insured pays” percentages reflect the ARPA increase in money from the federal government to pay part of premiums. Congress renewed them for three more years (2023 to 2025) in the Inflation Reduction Act.

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AMERICAN RESCUE PLAN ACT AND INFLATION REDUCTION ACT CHANGES TO APTC

- Beginning April 1, 2021 and continuing for all of 2022, the American Rescue Plan Act (ARPA) gave people increased APTC.
  - As a result of the federal government paying more of the premium and the insured paying less, over a third of the people with individual market coverage paid $10 or less per month for most of 2021 and all of 2022.
  - People earning more than 400% FPL no longer faced the “subsidy cliff.”
    - Instead, anyone who would have to pay more than 8.5% of their income for health insurance could qualify for subsidies, no matter what percentage of FPL.
- In 2022, the Inflation Reduction Act extended the ARPA changes to APTC for another three years.
  - For all of 2023, 2024, and 2025, the new APTC numbers will be in effect.

CHANGES TO APTC PERCENTAGES

Income Range (% of FPL)	Range of Applicable Percentages for 2021 before 4/1/21	Range of Applicable Percentages under the ARPA and IRA
100%-133%	2.07%	0%
133%-150%	3.10%-4.14%	0%
150%-200%	4.14%-6.52%	0%-2%
200%-250%	6.53%-8.33%	2%-4%
250%-300%	8.33%-9.83%	4%-6%
300%-400%	9.83%	6%-8.5%
400% and higher	N/A	8.5%

The applicable percentage is the share of a consumer's income they must generally pay toward the second-lowest-cost silver plan with premium tax credits. Within the ranges shown the applicable percentage increases linearly.

PEOPLE OVER 400% FPL PAY 8.5% OF THE BENCHMARK

Income Range (% of FPL)	Range of Applicable Percentages for 2021 under Prior Law	Range of Applicable Percentages for 2021 and 2022 under the ARP
400% and higher	N/A	8.5%

The applicable percentage is the share of a consumer's income they must generally pay toward the second-lowest-cost silver plan with premium tax credits. Within the ranges shown the applicable percentage increases linearly.

What this means for households earning over 400% of FPL:

- If household income is more than 400% of FPL, the premiums are 8.5% of the second lowest-cost silver plan available in their area.
- If 8.5% of the household's income is more than the premium for the second lowest-cost silver plan available in their area, then the household pays the full premium.
- We are calling this new aspect of premium subsidies the "FPL cutoff."

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“FPL CUTOFF” USING 2023 BENCHMARK SINGLE PERSON EXAMPLE

- The highest income where an individual would still receive an APTC.
- Anyone earning more would not receive a subsidy.

	Age 25 Cutoff	Age 45 Cutoff	Age 64 Cutoff
Area 1	$60,825.88	$87,481.41	$181,747.76
Area 2	$55,455.53	$79,759.06	$165,704.47
Area 3	$59,223.53	$85,177.41	$176,960.47
Area 4	$76,236.71	$109,647.53	$227,796.71

- The formula: Take 8.5% of the household MAGI, then compare it to the price for the second-lowest cost silver plan available in your area for a household with the same number of people at the same ages.
- Takeaway: You cannot know if you are over the “FPL cutoff” until you know the price for your household for the second-lowest cost silver plan.

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WAYS TO FIND OUT IF YOU QUALIFY FOR A SUBSIDY

- Compare your household income to the FPL percentage chart for a household with the right number of people.
- Use the Kaiser Family Foundation tool at https://www.kff.org/interactive/subsidy-calculator/
- Use the CMS tool at https://www.healthcare.gov/lower-costs/
- These tools are currently using last year's FPL and plans because plans and rates are still being loaded into the federal website.

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BENCHMARKS – 2022 vs 2023

- The second lowest silver plan in each area.
- These are just examples, prices vary based on age.
- Benchmarks are important because they are used to calculate how much the federal government will pay toward your premium.
  - Higher benchmark = more money to shop for a free bronze plan.

Area	Age 25 – 2022/2023	Age 45 – 2022/2023	Age 64 – 2022/2023
1	$423.95 / $430.85	$609.74 / $619.66	$1,266.77 / $1,287.38
2	$388.04 / $392.81	$558.10 / $564.96	$1,159.49 / $1,173.74
3	$496.27 / $419.50	$713.76 / $603.34	$1,482.88 / $1,253.47
4	$632.80 / $540.01	$910.12 / $776.67	$1,890.83 / $1,613.56

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Enter Information About Your Household

1. Select a State

Nebraska

Enter your zip code

69341

Your county is **SCOTTS BLUFF**.

2. Enter yearly household income as...

(•) 2022 Dollars ( ) % of Poverty

18000

3. Is coverage available from your or your spouse's job?

( ) Yes (•) No

4. Number of people in family

1

5. Number of adults (21 to 64) enrolling in Marketplace coverage

1 Adult

Age? 45

Uses Tobacco? ( ) Yes (•) No

6. Number of children (20 and younger) enrolling in Marketplace coverage

No Children

Clear form SUBMIT

Results

You are likely eligible for financial help

Based on the information you provided, your income is equal to **140%** of the poverty level. This means you are likely eligible for financial help through the Health Insurance Marketplace. An estimate of your cost for coverage and amount of financial help in 2022 are provided below. To find out your actual amount of financial help and to get coverage, you must go to Healthcare.gov or your state's Health Insurance Marketplace.

Estimated financial help:	**$910** per month ($10,921 per year) as a premium tax credit. This covers 100% of the monthly costs.
Your cost for a silver plan:	**$0** per month ($0 per year) in premiums (which equals 0% of your household income).
The most you have to pay for a silver plan:	**0%** of income for the second-lowest cost silver plan
Without financial help, your silver plan would cost:	**$910** per month ($10,921 per year)

Other Levels of Coverage

The costs above are for a silver plan in your area. Silver plans are one of four levels of coverage that you can buy with financial help. These levels – bronze, silver, gold, and platinum – tell you about how much financial protection the plan will offer you if you get sick. Bronze plans have the lowest monthly costs, but when you need medical care, you will pay more for your care. Gold and platinum plans offer more financial protection if you get sick, but these plans have higher monthly costs. You can receive financial help to purchase any of these levels of coverage.

For example, you could enroll in a bronze plan for about **$0** per month ($0 per year), which is **0%** of your household income). By enrolling in a bronze plan, you would receive $8,486 in subsidies, which would cover the entire amount of your bronze premium. For most people, the bronze plan represents the minimum level of coverage required under health reform. Although you would pay less in premiums by enrolling in a bronze plan, you will face higher out-of-pocket costs than if you enrolled in a silver plan.

Out of Pocket Costs

Although your insurance company may cover most of the cost of your medical care, you generally have to pay something when you go to the doctor or have a hospital stay. These costs – which are in addition to the amount you pay each month – are called your "out-of-pocket" costs. The health reform law sets limits on the amount you have to pay out-of-pocket each year. Your out-of-pocket limit for a silver plan can be no more than **$2,900** in 2022. Whether you reach this maximum level will depend on the amount of health care services you use. Keep in mind that this only protects you when you go to doctors and hospitals that are in your insurer's network. If you go to a doctor or hospital that is not in the network, you could end up paying much more.

Enter Information About Your Household

1. Select a State

Nebraska

Enter your zip code

69341

Your county is **SCOTTS BLUFF**.

2. Enter yearly household income as...

(•) 2022 Dollars ( ) % of Poverty

65000

3. Is coverage available from your or your spouse's job?

( ) Yes (•) No

4. Number of people in family

1

5. Number of adults (21 to 64) enrolling in Marketplace coverage

1 Adult

Age? 45

Uses Tobacco? ( ) Yes (•) No

6. Number of children (20 and younger) enrolling in Marketplace coverage

No Children

Clear form SUBMIT

Results

You are likely eligible for financial help

Based on the information you provided, your income is equal to **505%** of the poverty level. An estimate of your cost for coverage in 2022 is provided below. To find out your actual amount of financial help and to get coverage, you must go to Healthcare.gov or your state's Health Insurance Marketplace.

Estimated financial help:	**$450** per month ($5,396 per year) as a premium tax credit. This covers 49% of the monthly costs.
Your cost for a silver plan:	**$460** per month ($5,525 per year) in premiums (which equals 8.5% of your household income).
The most you have to pay for a silver plan:	**8.5%** of income for the second-lowest cost silver plan
Without financial help, your silver plan would cost:	**$910** per month ($10,921 per year)

Other Levels of Coverage

The costs above are for a silver plan in your area. Silver plans are one of four levels of coverage that you can buy with financial help. These levels – bronze, silver, gold, and platinum – tell you about how much financial protection the plan will offer you if you get sick. Bronze plans have the lowest monthly costs, but when you need medical care, you will pay more for your care. Gold and platinum plans offer more financial protection if you get sick, but these plans have higher monthly costs. You can receive financial help to purchase any of these levels of coverage.

For example, you could enroll in a bronze plan for about **$257** per month ($3,089 per year), which is **4.75%** of your household income, after taking into account $5,396 in subsidies). For most people, the Bronze plan represents the minimum level of coverage required under health reform. Although you would pay less in premiums by enrolling in a Bronze plan, you will face higher out-of-pocket costs than if you enrolled in a silver plan.

Out of Pocket Costs

Although your insurance company may cover most of the cost of your medical care, you generally have to pay something when you go to the doctor or have a hospital stay. These costs – which are in addition to the amount you pay each month – are called your "out-of-pocket" costs. The health reform law sets limits on the amount you have to pay out-of-pocket each year. Your out-of-pocket limit for a silver plan can be no more than **$8,700** in 2022. Whether you reach this maximum level will depend on the amount of health care services you use. Keep in mind that this only protects you when you go to doctors and hospitals that are in your insurer's network. If you go to a doctor or hospital that is not in the network, you could end up paying much more.

POST-APTC BRONZE PLANS BY ISSUER FOR A 45-YEAR-OLD AT 500% FPL

The lowest Post-APTC Bronze plans that each issuer has available for a 45-year-old at 500% FPL.

	Area 1	Area 2	Area 3	Area 4
Medica	$ 326.57	$ 388.69	$ 395.81	$ 427.83
Ambetter	$ 330.72	$ 342.21	$ 332.76	$ 290.08
BCBS	$ 335.55	$ 410.99	$ 390.26	$ 388.21
Oscar	$ 446.48	$ 486.12	$ 565.44	$ 453.39

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POST-APTC SILVER PLANS BY ISSUER FOR A 45-YEAR-OLD AT 500% FPL

The lowest Post-APTC Silver plans that each issuer has available for a 45-year-old at 500% FPL.

	Area 1	Area 2	Area 3	Area 4
Medica	$ 490.51	$ 555.25	$ 578.42	$ 682.84
Ambetter	$ 483.30	$ 480.74	$ 480.70	$ 480.51
BCBS	$ 481.25	$ 563.06	$ 547.76	$ 598.38
Oscar	$ 624.67	$ 659.72	$ 774.91	$ 681.53

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POST-APTC GOLD PLANS BY ISSUER FOR A 45-YEAR-OLD AT 500% FPL

The lowest Post-APTC Gold plans that each issuer has available for a 45-year-old at 500% FPL.

	Area 1	Area 2	Area 3	Area 4
Medica	$ 515.67	$ 580.81	$ 606.44	$ 690.89
Ambetter	$ 515.56	$ 510.02	$ 511.97	$ 520.77
BCBS	$ 519.35	$ 602.84	$ 588.95	$ 653.34
Oscar	$ 599.59	$ 635.28	$ 745.42	$ 649.42

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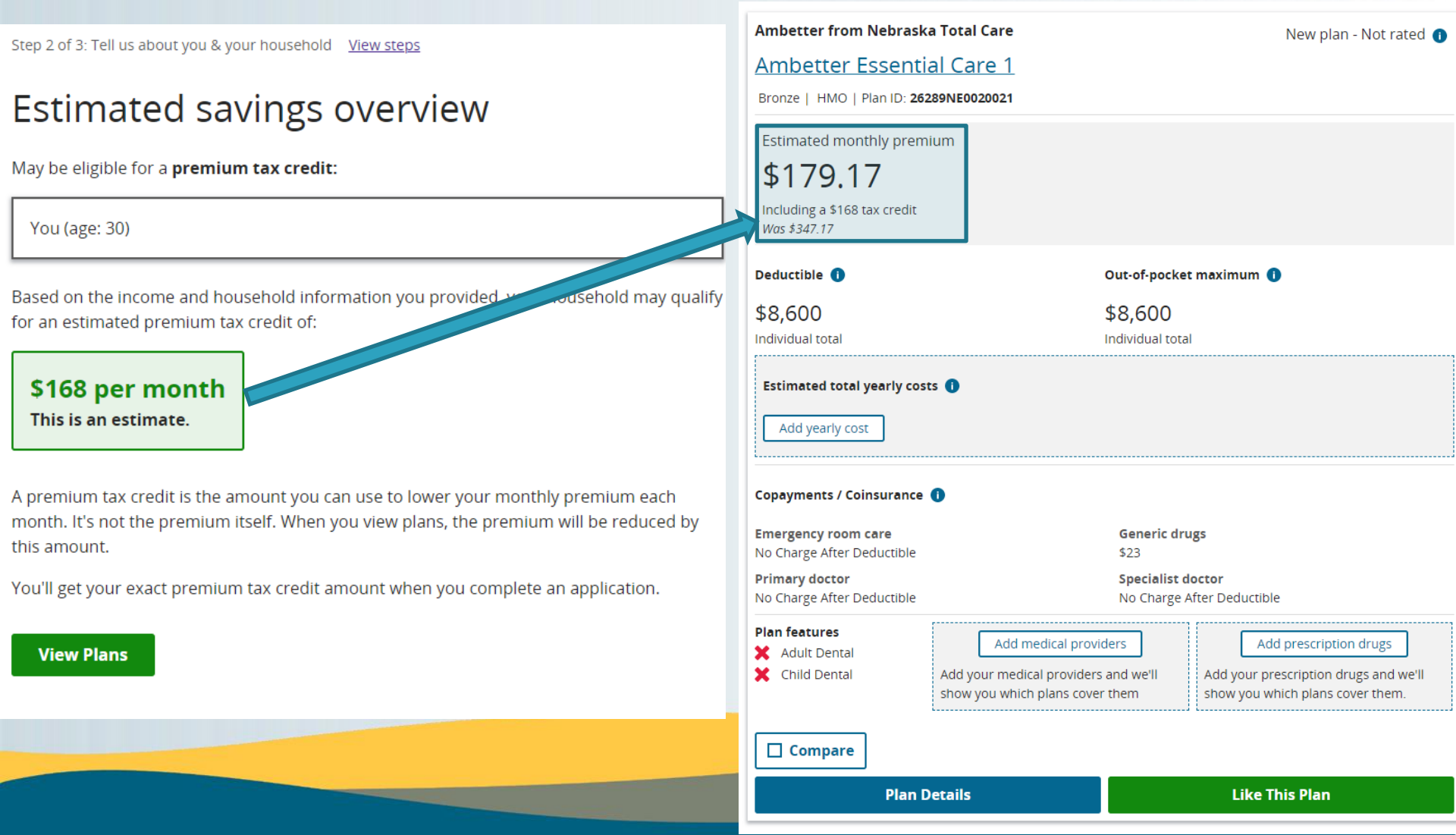
HEALTHCARE.GOV

- https://www.healthcare.gov/lower-costs/



FAMILY GLITCH – CHANGES FOR 2023

- A revised IRS rule issued October 11, 2022 updates the method for determining when an employer offer is affordable, beginning with plan year 2023.
- Affordability now considers the cost of coverage for the entire family when determining the eligibility for spouses and dependents.
  - Family members qualify for premium tax credits when they are otherwise eligible and the cost of family coverage exceeds 9.12% of household income.
  - The employee's eligibility is determined by the affordability of employee-only coverage.
  - **When employee-only coverage costs less than 9.12% of household income and family coverage requires a higher share of income, the employee would not be eligible for a premium tax credit, but family members would be eligible.**
- In prior years, the entire family was ineligible for premium tax credits when the cost of employee-only coverage was less than the specified share of household income. This was frequently referred to as the "family glitch."

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MEDICAID ENROLLMENT: EXPANSION AND COVID-19 CONTINUOUS COVERAGE

- Nebraska Medicaid expansion went into effect on October 1, 2020.
- Medicaid expansion moved people that earned between 100% and 138% of the Federal Poverty Level (FPL) from the individual market into Medicaid.
- Coverage also became available for people between 0% and 100% of FPL.

Month	Sep 2020	Aug 2021	Aug 2022
Total Medicaid	269,583	335,744	366,202

- Provisions in the Families First Coronavirus Response Act (FFCRA) require states to provide continuous coverage for Medicaid enrollees until the end of the month in which the COVID-19 public health emergency (PHE) ends in order to receive enhanced federal funding.
- Estimated 10% of the current Medicaid population will be found ACA coverage qualified (over 138% FPL) when the PHE ends.

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ACA SMALL GROUP MARKET

- Carriers offering small employer coverage for 2023:
  - Blue Cross and Blue Shield of Nebraska
  - UnitedHealthCare
  - Medica
  - Aetna
- June 2022 membership is 35,406.
- Projected enrollment for 2023 is 31,004
  - Overall rates for the products with highest membership are increasing 5.56% and 7.10%.
    - This is just an average, some plans will have higher or lower rates.

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SHOPPING FOR HEALTH INSURANCE ACA AND OTHER OPTIONS

- Identify your current health care needs and keep these in mind as you compare health insurance policies.
  - Doctors
  - Services
  - Prescription drugs
  - Excluded services or waiting periods for pre-existing conditions (if non-ACA plan)
- Compare the costs, including:
  - Premiums
  - Copays
  - Deductibles
  - Maximum out-of-pocket
  - Annual or lifetime limits (if non-ACA plan)

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HEALTH INSURANCE: SPECIAL TOPICS

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NEBRASKA TELEHEALTH LAWS

- LB257 (2015) Insurer must provide description of services included in telehealth and any coverage for transmission costs or limitations to coverage.
  - Written consent required for telehealth.
- LB92 (2017) Insurer cannot exclude a service from coverage solely because the service is delivered through telehealth.
  - Includes services originating from any location where the patient is located.
- LB400 (2021) Adds audio-only services for individual behavioral health for an established patient.
  - Services originating from any location where a patient is located are covered.
  - Allows consent for telehealth to be given verbally, then followed up with written consent.
- LB487 (2021) Insurer cannot require higher cost-sharing for telehealth.
  - Reimbursement for **mental health** telehealth at in-person rates.

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NEW MENTAL HEALTH PARITY COMPLIANCE REQUIREMENTS

- **Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).**
- MHPAEA requires that health insurers provide mental health and substance abuse disorder benefits at parity with medical and surgical benefits.
  - Co-payments and other cost-sharing dollar amounts cannot be higher for mental health and substance abuse disorder, compared to similar medical and surgical services.
  - Non-quantitative treatment limitations, for example a prior authorization requirement or standard for medical necessity, also must be provided in parity, but this is more difficult to analyze and demonstrate.
- The Consolidated Appropriations Act of 2021 includes Title II, Section 203 (referred to as “Section 203”), which aims to improve compliance with MHPAEA.
- Under Section 203, health insurers must perform and document comparative analyses of how every plan design they offer applies non-quantitative treatment limitations for mental health and substance use disorders, and make this analysis available to the federal HHS and DOL upon request.
  - States also have authority to request this documentation.

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SURPRISE BALANCE BILLS

- Balance bills are a frequent occurrence.
  - 1 in 5 emergency claims.
  - 1 in 6 in-network hospitalizations.
- Insured patients are left to pay hundreds or thousands of dollars for care at an in-network facility because an out-of-network provider was involved in the episode of care.
- In the past two years, state and federal laws have been passed to address surprise balance bills.
- **Nebraska Out-of-Network Emergency Medical Care Act (2020)**
  - Limited to emergency services at a healthcare facility.
  - Defines emergency as treatment to stabilize the patient.
  - Payment at 175% of Medicare rates is presumed reasonable, but the provider can return that payment and go to mediation to ask for higher payment.

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NO SURPRISES ACT

- **Federal No Surprises Act (signed in the closing days of 2020)**
  - https://www.cms.gov/nosurprises
  - Allows state balance billing laws to remain in place but fills in gaps where the federal law goes further.
  - Emergency is defined to last longer into a hospital stay past stabilization.
  - Reimbursement amounts are negotiated using informal dispute resolution (IDR), each party submits a best final offer, the IDR determines which is most reasonable.
    - The plan's median in-network rate can be considered, but the billed charge and Medicare rates cannot be considered.
  - Non-emergency services provided by an out-of-network provider at an in-network facility are covered, but a patient can waive protection and agree to balance billing if they wish to use a particular provider.
  - Enforcement will be a joint effort between the state and federal governments.

NO SURPRISES ACT – WHAT PATIENTS NEED TO KNOW

- The law applies to individual and group major medical insurance, and also applies to self-insured employer plans.
- For emergency services, surprise bills are banned, even if you go to an out-of-network facility.
  - For emergency services, all you will be charged is your plan's in-network cost sharing (copay, coinsurance, deductible) even if you go to an out-of-network facility.
- For non-emergency services at an in-network facility, surprise bills are banned for certain additional services.
  - Examples: anesthesiology, radiology, and labs.
- Healthcare providers are required to give you an easy-to-understand notice explaining the applicable billing protections, who to contact if you have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections.
- Non-emergency services at an out-of-network facility can still be balance billed.

AIR AMBULANCE BILLS AND THE NO SURPRISES ACT

- Air ambulance bills are subject to No Surprises Act balance bill protection, ground ambulance bills are not.
- States' previous efforts to protect patients from high air ambulance bills were challenged in court, with judges finding that state laws were preempted by the Airline Deregulation Act.
  - Air ambulance rides are not the same as regular commercial flights, so states argue, the Airline Deregulation Act should not prevent state action to address rising costs.
    - The patient is unable to choose an air ambulance – whichever air ambulance is closest and available will be used.
    - The patient is unable to compare prices during an emergency health crisis.

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AIR AMBULANCE BILLS ARE EXPENSIVE

- Around 3/4 of air ambulance transports for private insurance patients were out-of-network, nationally, between 2014 and 2017.
- A recent study from FAIR Health provides additional insight into the problem of air ambulance bills:
  - Utilization grew steadily from 2016 to 2020, by 30%.
  - The average charge for a rotary-wing air ambulance rose 22.2% from $24,934 in 2017 to $30,446 in 2020.
  - Average insurer payment for a rotary-wing ambulance rose 60.8% from $11,608 in 2017 to $18,668 in 2020.
  - Average Medicare for a rotary-wing ambulance rose 4.7% from $3,570 in 2017 to $3,739 in 2020.

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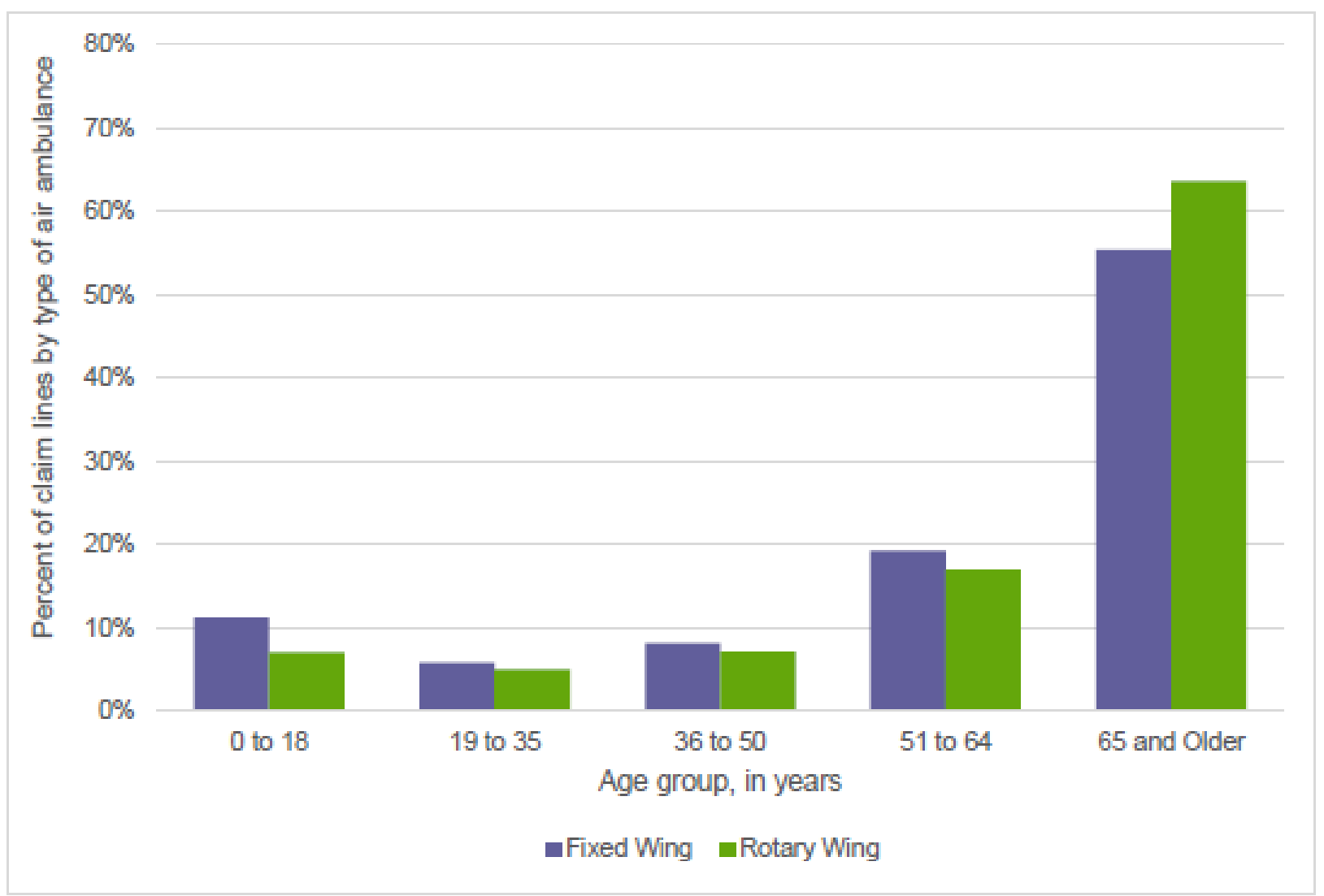
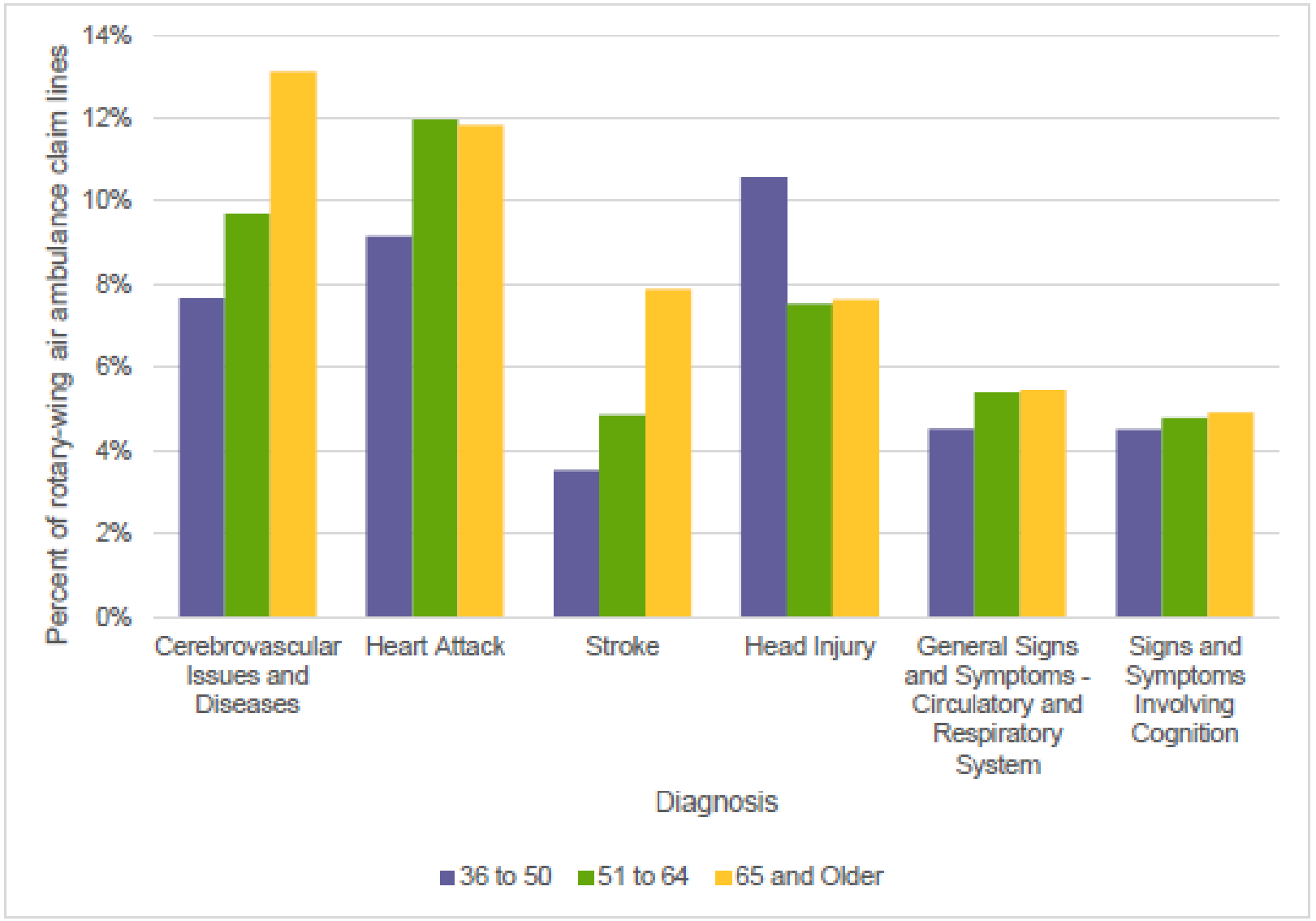
AIR AMBULANCE CLAIMS BY AGE GROUP



AIR AMBULANCE CLAIMS BY DIAGNOSIS



STATES WITH HIGH AIR AMBULANCE USE

- Alaska
- Wyoming
- South Dakota
- Montana
- New Mexico
- Idaho
- West Virginia

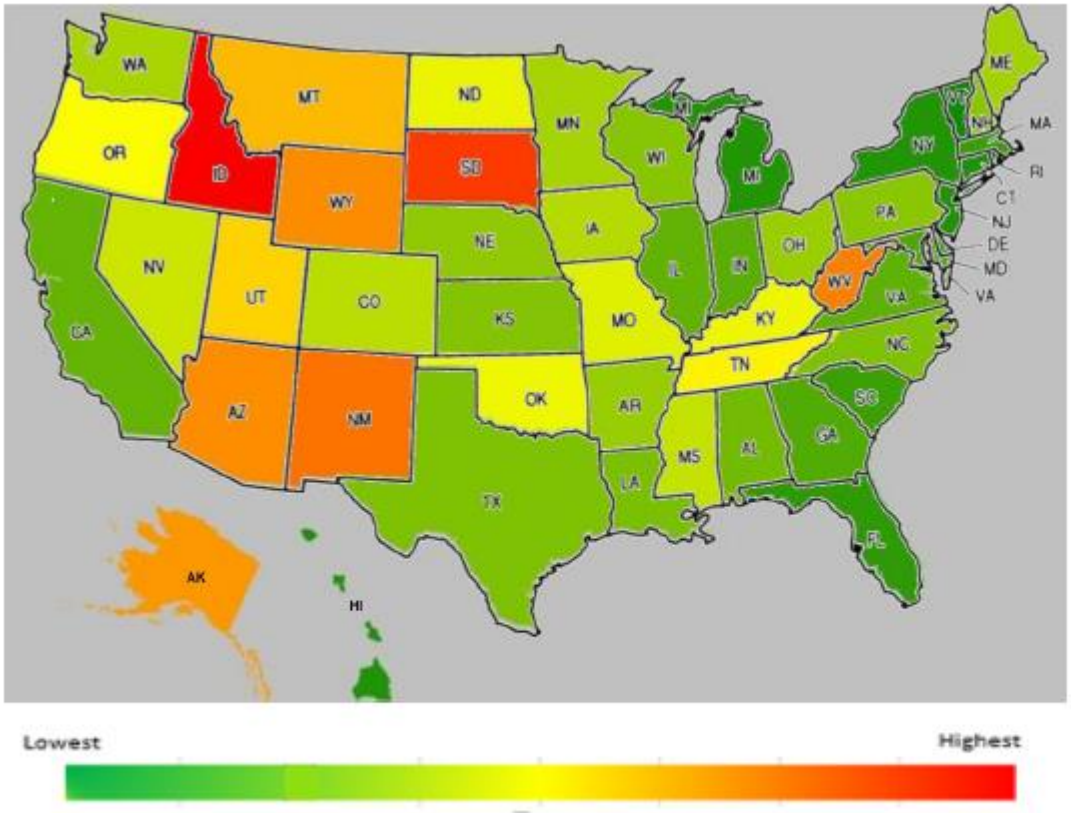


Figure 18. Rotary-wing air ambulance claim lines as a percentage of all medical claim lines by state, 2020

BROKER COMMISSION DISCLOSURES AND THE NO SURPRISES ACT

- The No Surprises Act requires disclosure of the amount of compensation paid to brokers.
  - Includes short-term limited-duration insurance, ACA major medical, and self-insured employer health plans.
  - Requires disclosure of direct and indirect compensation.
  - Applies to brokers earning over $1,000 annually.
- Plans must report information on broker compensation annually.
- “Good faith compliance” based on the proposed rule until a final rule is issued.

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PREVENTIVE SERVICES AT NO COST

- The ACA preventive services mandate for individual, small group, and large group coverage requires certain preventive services be covered in-network without cost-sharing for plan participants.
- The ACA uses the following when determining the preventive services that must be covered:
  1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force (USPSTF) recommendations.
  2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention (CDC).
  3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
  4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA) that are not otherwise addressed by the recommendations of the USPSTF.
- The final preventive services regulations, issued in July 2015, contain guidelines for when plans must incorporate any modified recommendations.
  - A group health plan must cover a new or updated recommended preventive service starting in the plan year that begins on or after exactly one year from the issue date.

NEW OR MODIFIED PREVENTIVE CARE RECOMMENDATIONS

- Adults with cardiovascular disease risk factors recommended to have behavioral counseling interventions to promote healthy diet and physical activity. (update from 2014 recommendation)
- Lung cancer screening for adults aged 50-80 who have a 20 pack-year smoking history and currently smoke or quit within the past 15 years. (update from 2013 recommendation)
- Colorectal cancer screening age range expanded from ages 50-75 to ages 45-75.
- HIV PrEP recommended for individuals not infected with HIV who are at high risk of HIV infection.
  - FAQ issued 7/19/21 to clarify coverage of PrEP. Clarifies that cost-sharing protections extend to ancillary and support services needed for an effective PrEP regimen.

HOW TO APPEAL A DENIED HEALTH CLAIM

Jordan Blades
External Review Specialist

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APPEALING A DENIED HEALTH CLAIM

- A health insurance claim can be denied before a service is performed if the insurer refuses to preauthorize treatment, or the claim could be denied after the health care provider sends a bill to the insurer.
- The first step is to appeal to the insurance company.
  - This is called an “internal appeal.”
  - Appeals must be filed within 180 days of receiving the claim denial.
- Be ready to provide:
  - Claim number and any insurer paperwork denying the claim.
  - Typically, the denial is in an “explanation of benefits.”
  - Plan number or ID number from your insurance card.
  - Any additional information you want the insurer to consider, to help explain why you believe the company’s decision is wrong.
    - A letter from your doctor explaining why the treatment is needed can be helpful.

INTERNAL APPEAL

- If the insurer won't authorize services or refuses to pay the portion of health care services you believe should be covered, you can file an internal appeal.
- Denial reasons include:
  - The benefit isn't offered under your health plan
  - You received health services from a health provider or facility that isn't in your plan's approved network
  - The requested service or treatment is "not medically necessary"
  - The requested service or treatment is an "experimental" or "investigative" treatment
  - Insured is no longer enrolled or eligible to be enrolled in the health plan
  - Carrier is revoking or cancelling coverage because insured gave false or incomplete information when applying for coverage

EXTERNAL REVIEW BASICS

- The term “external” review means that the reviewer is not affiliated with the insurance company.
  - The Department of Insurance assigns external reviews to Independent Review Organizations (“IROs”) to avoid insurers selecting a favorite.
- External review is only available after an internal appeal to give the insurer a chance to correct a mistake or change its mind.
- You can appoint your doctor as an authorized representative to help advocate about details of the medical service.
- The external reviewer will have experience in the type of medical service involved in the claim.
- Denial reasons include:
  - The requested service or treatment is “not medically necessary”
  - The requested service or treatment is an “experimental” or “investigative” treatment

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STATE AND FEDERAL EXTERNAL REVIEW

- Nebraska DOI enforces the state External Review Act, which applies to:
  - ACA major medical for individual, small group, and large group
  - Short-term limited duration insurance
- Federal Department of Labor enforces the external review provisions in federal law, which apply to:
  - Self-insured employee health plans
  - Federal employees
- How to find out if your employer plan is self insured:
  - Your insurance card will have an insurance company's name on it, even if the plan is self insured.
    - The employer hired a health insurer to act as administrator for health benefits.
    - The card does not say "self insured."
  - Ask your employer's HR representative to find out if the plan is self insured.
  - The plan documents will include contact information for how to file an external review.

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TIMELINES FOR APPEAL AND EXTERNAL REVIEW DECISIONS

	Standard	Expedited
Internal Appeal	Within 15 working days from insurer receipt of the request for review	Within 72 hours
External Appeal	Within 45 days from eligibility determination	Within 72 hours

Expedited Review is only available:

- In urgent situations when the regular turnaround time would jeopardize the life or health of the insured or the ability of the insured to regain maximum function.
- When the insured could be moved to a different level of care or discharged from the hospital.

Concurrent expedited internal and external reviews are available in the rare cases where waiting 72 hours for expedited internal appeal would jeopardize the patient's life or ability to regain maximum function.

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EXTERNAL REVIEW BY THE NUMBERS

Year	Total	Ineligible	Upheld	Overturned	Partially Overturned
2018	256	59	115	80	2
2019	251	71	96	80	4
2020	274	97	90	86	1
2021	238	47	83	105	3
2022 (through Sept.)	178 (10 pending)	23	72	71	2

- Number of external reviews remains fairly consistent.
- Overturned rate is increasing.
  - In 2018, of the eligible cases, 41% were overturned.
  - In 2019, of the eligible cases, 44% were overturned.
  - In 2020, of the eligible cases, 49% were overturned.
  - In 2021, of the eligible cases, 56% were overturned.
  - Through September 2022., of the eligible cases, 50% were overturned.

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MOST COMMON EXTERNAL REVIEWS FOR DRUGS AND SERVICES

Drug	2019 cases	2020 cases	2021 cases	2022 cases (through Aug.)
Humira	1/6	5/6	4/4	2/3
Stelara	2/4	6/6	1/2	1/2
Repatha	2/3	5/7	1/4	6/7
Dupixent	4/6	2/6	2/3	4/7
Otezla	3/5	3/5	1/1	1/2
Genetic testing	2/11	7/13	4/8	4/7
Imaging	10/15	9/17	5/17	10/17
Lumbar surgery	3/6	4/10	2/7	1/4
Neurostimulator implant			1/4 (all since 9/16/21)	0/5

Red numbers indicate times the IRO told the insurer to pay for the drug or service.

Blue numbers indicate the total external reviews performed.

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MORE INFORMATION ONLINE AND EXTERNAL REVIEW PORTAL

- Department of Insurance web page for health insurance appeals and external reviews: https://doi.nebraska.gov/appealing-denied-health-claim
  - Includes explanations of each step of an appeal and resources.
- Secure portal for online external reviews is linked on this page.
- Portal features:
  - All users have verified credentials to keep information safe.
  - External review paperwork is all completed online.
  - Healthcare providers can complete paperwork and contribute additional information through the portal.
  - Insurers provide information on the internal appeal in the portal.
  - Independent Review Organizations issue their decisions through the portal to all participants' email.

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ADVICE FROM THE FRONT LINES

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TOP COMPLAINTS TO THE DEPARTMENT

- Life and Health Insurance:
  - Claim denied or delayed
  - Premiums or billing
  - Misrepresentations
  - Coverage questions
  - Life:
    - Cash value of policy, surrendering policies
  - Health:
    - Out-of-network providers
- Property and Casualty Insurance:
  - Auto:
    - Liability and comparative negligence
    - Total loss settlement
  - Homeowners:
    - Roof damage vs. wear and tear
    - Siding matching
    - Ground water vs. sewer backup

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ADVICE FROM INVESTIGATORS (HEALTH)

- Contact the Department of Insurance sooner rather than later with insurance issues.
- Consult with an agent when searching for ACA individual major medical insurance.
  - Know what companies are selling ACA-compliant health plans in Nebraska before browsing online for coverage.
- Health care providers can leave or join a network during the plan year, so verify the provider is in-network with each visit.
- Health insurance premiums should be paid in full, not partial payments.
  - This will avoid policy termination for failure to fully pay.
  - Understand that the grace period will not last forever, it is important to keep current on payments.
- Ask questions and know what you are buying.
  - Lower premiums for health insurance typically mean the plan is not as comprehensive as an ACA major medical policy.

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ADVICE FROM INVESTIGATORS (AUTO)

- If your vehicle is totaled, the company does not owe you for a new car.
  - It will pay you the actual cash value (ACV) of your vehicle.
  - The ACV is what your vehicle was worth before it was totaled, based on third-party data.
- Nebraska law allows the use of aftermarket parts to repair vehicles.
  - The parts must be of equal kind, fit, and quality.
  - If you want the original equipment manufacturer (OEM) parts, you will pay the difference in cost.
- Nebraska law does not require an insurance company to provide you with a rental car if you are a third-party claimant in an accident.
  - The at-fault driver's insurer may provide a rental car to you as a courtesy if that insurer accepts liability for the accident.
  - The only time rental coverage is given is if you have purchased rental car coverage under your own policy.

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MORE ADVICE FROM INVESTIGATORS

- Don’t sign anything before you read it and understand it.
- A roofer/siding salesperson may not be your best guide to Nebraska insurance law.
  - Nebraska is not a matching state for siding and/or roofing. The company owes for direct physical damage caused by a covered peril.
  - The regulation says reasonable match in the area, and the NEDOI does not determine reasonable match.
- Check your life insurance beneficiary designations.
- The Department of Insurance:
  - Does not mediate claims settlements.
  - Will investigate a company’s claim handling to ensure a thorough claims investigation was done in accordance with applicable laws and regulations.

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LIFE INSURANCE POLICY LOCATOR

- The NAIC Life Policy Locator can help find life insurance policies and annuity contracts of a deceased family member or close relationship.
- The Life Insurance Policy Locator has matched more than $1 billion in life insurance benefits and annuities to beneficiaries.
- When a request is received, the NAIC will:
  - Ask participating companies to search their records to determine whether they have a life insurance policy or annuity contract in the name of the deceased you entered.
  - Ask participating companies that have policy information to respond to you, as the requestor, if you are the designated beneficiary or are authorized to receive information.
- Online at https://eapps.naic.org/life-policy-locator/#/welcome

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COVID-19, INVESTIGATIONS INTO PRICE GOUGING AND DOUBLE BILLING

- When Congress wrote the law to ensure that Americans wouldn't have to pay for coronavirus testing, it required insurers to pay certain laboratories whatever "cash price" they listed online for the tests, with no limit on what that might be.
  - Americans could ultimately pay some of the cost of expensive coronavirus tests in the form of higher insurance premiums.
- Many health insurers have refused to pay high test charges, some contending that the laboratory is price-gouging during a public health crisis.
  - Example: a $380 test compared to a $20 rapid test at the drugstore.
- Another complaint: rapid antigen tests combined with an antibody test.
  - There is little reason to order both of those tests on the same day, say some doctors. The tests serve different purposes, and would not be systematically ordered as a result of suspected Covid exposure.
  - The lab responded that patients are offered a menu of tests and can choose which one to get.
- This issue will play out in the courts.

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HEALTH CARE SHARING MINISTRIES

Disclaimer required for all applications and guideline materials distributed by or on behalf of a Health Care Sharing Ministry, per Neb. Rev. Stat. § 44-311:

IMPORTANT NOTICE. This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the Nebraska Department of Insurance. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

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COMPLAINT EXAMPLE

She's Stuck With $75,000 in Bills After Her "Health Care Sharing Ministry" Refuses to Pay

Boston Globe (06/01/21) Murphy, Sean P.

To save money on health insurance, Betsy Hargreaves switched to a religious-based plan called OneShare Health about two years ago. She had to undergo double hip-replacement surgery in March, followed by a four-day stay in the hospital and extensive physical therapy. Although the surgery was successful, Hargreaves' plan refused to cover any of the costs, citing a preexisting condition, and left her with nearly $75,000 in medical bills.

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MEDICARE

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ANNUAL OPEN ENROLLMENT - PARTS C & D

October 15 – December 7 is the annual opportunity to compare Medicare options.

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IN 2023 THERE WILL BE $35 INSULIN COPAYS FOR ALL MEDICARE PLANS

- The Inflation Reduction Act limits monthly cost sharing for insulin products to no more than $35 for Medicare beneficiaries.
  - Includes insulin under both Part D and Part B.
  - No deductible applies to insulin.
  - All 2023 plans.
- All Part D plans, both stand-alone and part of Medicare Advantage drug plans, are required to charge no more than $35 for whichever insulin products they cover.
  - Plans are not required to cover all insulin products.
- In 2020, the average out-of-pocket cost per prescription across all insulin products was $54.
- The Congressional Budget Office estimates that the federal government will spend an additional $5.1 billion over ten years associated with the insulin cost-sharing limits in the Inflation Reduction Act.

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GROWING MEDICARE ADVANTAGE ENROLLMENT

- Nebraska enrollment in MA plans has increased.

Year	% Enrolled in MA Plans
2016	13%
2017	14%
2018	16%
2019	18%
2020	22%
2021	25%
2022	26%

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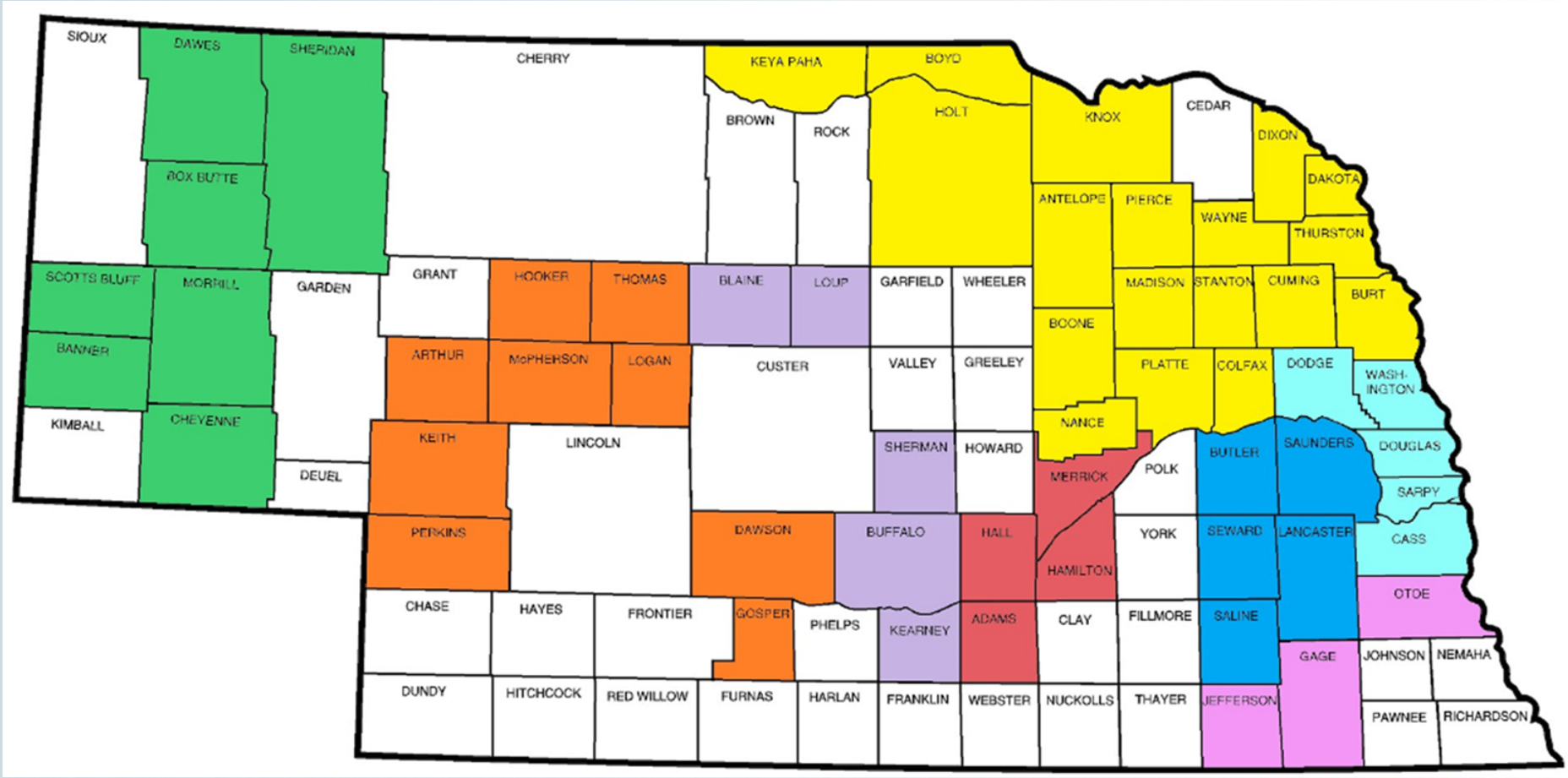
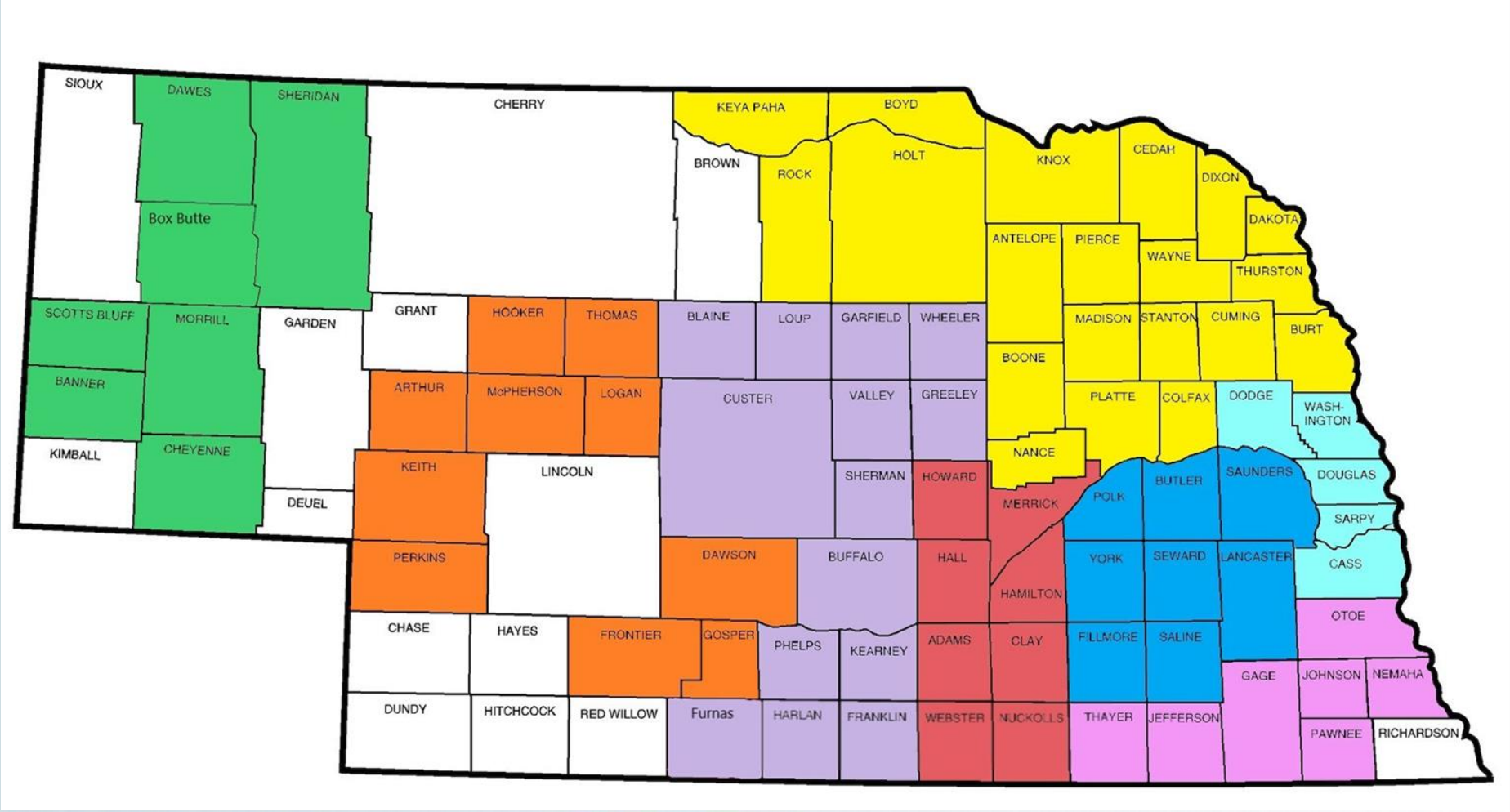
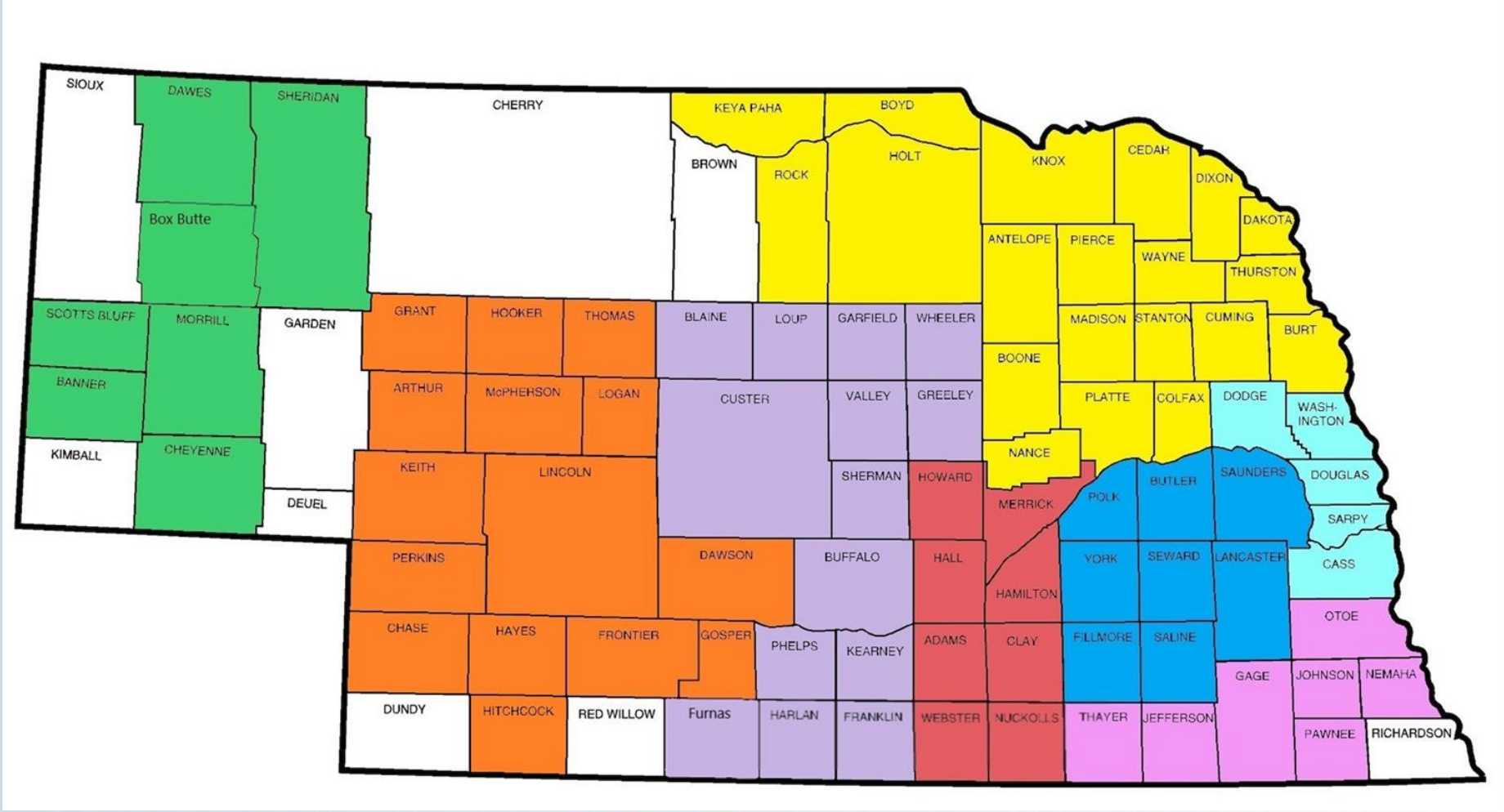
2019 MEDICARE ADVANTAGE PLANS: AVAILABLE COUNTIES



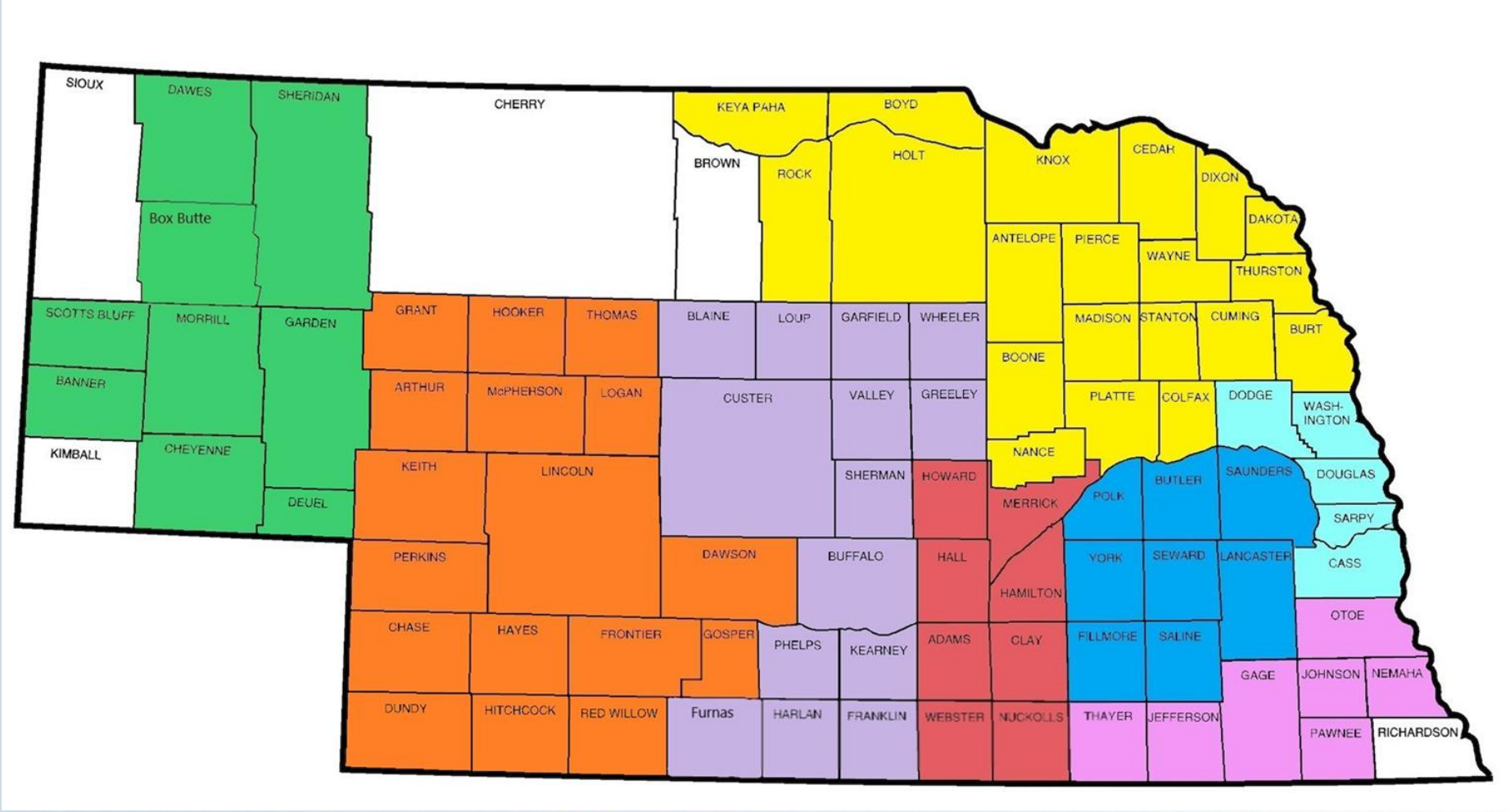
2020 MEDICARE ADVANTAGE PLANS: AVAILABLE COUNTIES



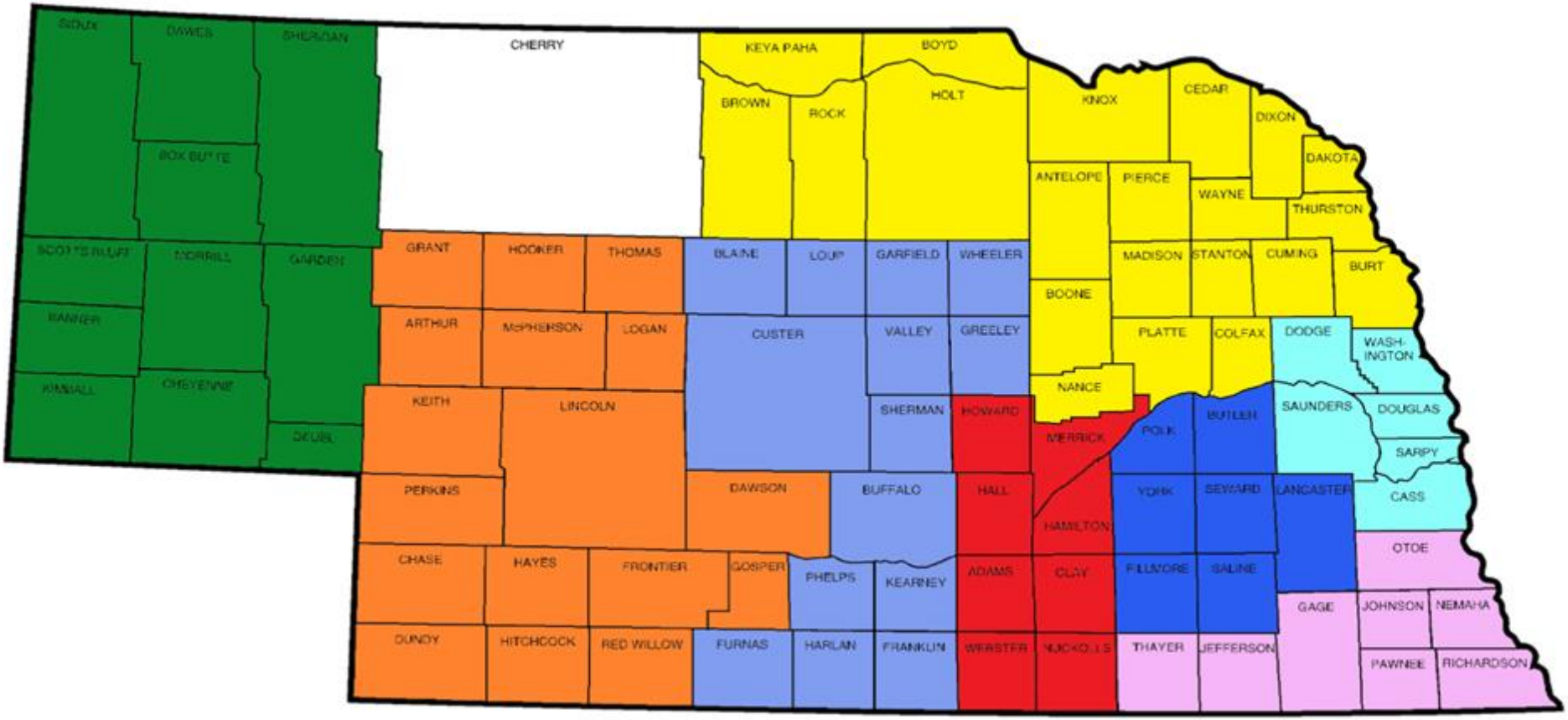
2021 MEDICARE ADVANTAGE PLANS: AVAILABLE COUNTIES



2022 MEDICARE ADVANTAGE PLANS: AVAILABLE COUNTIES



2023 MEDICARE ADVANTAGE PLANS: AVAILABLE COUNTIES



PROTECT YOURSELF FROM MEDICARE FRAUD

- **Guard your Medicare card like it's a credit card.** Remember:
  - Medicare will never contact you for your Medicare number or other personal information unless you've given them permission in advance.
  - Medicare will never call you to sell you anything.
  - You may get calls from people promising you things if you give them a Medicare Number. Don't do it.
  - Medicare will never visit you at your home.
  - Medicare can't enroll you over the phone unless you called first.
  - Learn more tips to help prevent Medicare fraud.
- **Check regularly for Medicare billing fraud.** Review your Medicare claims and Medicare Summary Notices for any services billed to your Medicare number you don't recognize.
  - Learn more about how to spot fraud.
- **Report anything suspicious to Medicare.** If you suspect fraud, call 1-800-MEDICARE.
  - Learn how to report fraud.

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MEDICARE QUESTIONS? SHIP CAN HELP!

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Local help for Nebraskans with Medicare

- **Nebraska State Health Insurance Assistance Program (SHIP)**
- Federally funded member of the SHIP National Network
- Administers Nebraska's SMP (Senior Medicare Patrol)
- Division of the Nebraska Department of Insurance
- Eight locations statewide
  - Beatrice, Grand Island, Kearney, Lincoln, Norfolk, North Platte, Omaha, and Scottsbluff
  - Network of over 285 Certified Volunteer Counselors

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SHIP EDUCATION AND COUNSELING SERVICES

- Nebraska SHIP provides Medicare education and counseling.
  - Free, unbiased, and confidential Medicare information
  - Medicare information by phone, in-person or via WebEx
  - Cost comparisons for Part C, Part D & Supplements
  - Medicare enrollment help and problem solving
  - Fraud prevention education and reporting
  - Low Income Subsidy application assistance
  - Presentations for your group
- 1-800-234-7119
- www.doi.nebraska.gov/SHIP

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THANKS FOR YOUR KIND ATTENTION!

- We appreciate the opportunity to hear from you.
- What do you want to know more about?

- Agents, don't forget to sign the sheet to get continuing education credit!

- Find Us on Social Media:
  - LinkedIn: Nebraska Department of Insurance
    - https://www.linkedin.com/company/insurance-nebraska-department-of/
  - Facebook: @NDOIHealth
    - https://www.facebook.com/NDOIHealth/

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- Maggie.Reinert@Nebraska.gov, 402-471-4638
- Jordan.Blades@Nebraska.gov, 402-471-1432

- Department of Insurance web site: https://doi.nebraska.gov/
- Consumer Affairs Hotline 402-471-0888 or (in-state only) 877-564-7323
- Online complaint form: https://doi.nebraska.gov/consumer/consumer-assistance
- External review information: https://doi.nebraska.gov/appealing-denied-health-claim

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