NEBRASKA DEPARTMENT OF INSURANCE

INSURANCE COMMUNITY DISCUSSIONS
OCTOBER 2021

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TODAY'S PRESENTATION

- Nebraska Department of Insurance overview
- Affordable Care Act market, rates, changes in the law
- Appealing a denied health claim
- Top consumer complaints, advice from investigators
- Fraud and misrepresentation multi-state investigations
- Medicare Advantage

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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, $341,153,881,401).
  - Third nationally in assets (includes reserves, $853,019,688,439 of oversight responsibility for NDOI).
  - Eleventh nationally in premiums written ($45,272,790,775).
- 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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HEALTH INSURANCE: ACA MARKETS AND 2022 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%

	2014	2015	2016	2017	2018	2019	2020	2021
Number of individuals who selected an ACA plan on healthcare.gov	42,975	74,152	87,835	84,371	88,213	87,416	90,845	88,688

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Open Enrollment for plan year 2022 is from November 1, 2021 to January 15, 2022.

- Coverage begins January 1, 2022 if you enroll by December 15.
- Coverage begins February 1, 2022 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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INSURERS SELLING INDIVIDUAL ACA COVERAGE IN NEBRASKA, 2014 TO 2022

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

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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
Increase 2014 to 2022*	94.8%	139.0%	94.8%	59.8%

- "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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2021 NEBRASKA ENROLLMENT IN DETAIL

Rating Area	Total Enrolled	Receive APTC	Receive CSR
Area 1 (Omaha)	28,887	23,107	6,004
Area 2 (Lincoln)	20,426	16,829	6,203
Area 3 (Mid-State)	30,331	26,036	7,378
Area 4 (Western)	11,650	9,813	2,359
Totals	91,294	75,785	21,944

Enrollment data is based on insurers' most recent numbers.

Takeaways:

- Individual ACA enrollees represent 4.67% of Nebraska's population (91,294/1,951,996 total population)
- Advance Premium Tax Credits are received by 83% of all enrollees.
- Cost Sharing Reductions are received by 24% of all enrollees.

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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.
  - For a family of four with a household income of $66,250, the family's payment will be 3% of household income ($166 per month), no matter what the insurance costs.
- **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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2021 FEDERAL POVERTY GUIDELINES ARE USED FOR 2022 APTC AND CSR

Household Size	138%	150%	200%	250%	300%	400%
1	$17,774	$19,320	$25,760	$32,200	$38,640	$51,520
2	$24,040	$26,130	$34,840	$43,550	$52,260	$69,680
3	$30,305	$32,940	$43,920	$54,900	$65,880	$87,840
4	$36,570	$39,750	$53,000	$66,250	$79,500	$106,000
5	$42,835	$46,560	$62,080	$77,600	$93,120	$124,160
6	$49,100	$53,370	$71,160	$88,950	$106,740	$142,320
7	$55,366	$60,180	$80,240	$100,300	$120,360	$160,480
8	$61,631	$66,990	$89,320	$111,650	$133,980	$178,640
After 4/1/21 and for all of 2022, insured pays	0%	0%-2%	2%-4%	4%-6%	6%-8.5%	8.5%

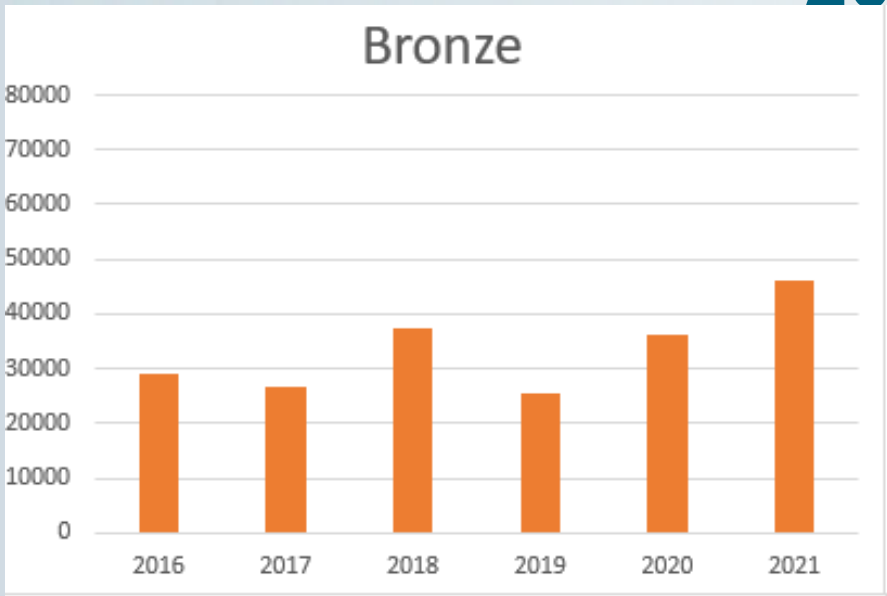
POLICY OR MARKET CHANGES THAT AFFECT PREMIUMS

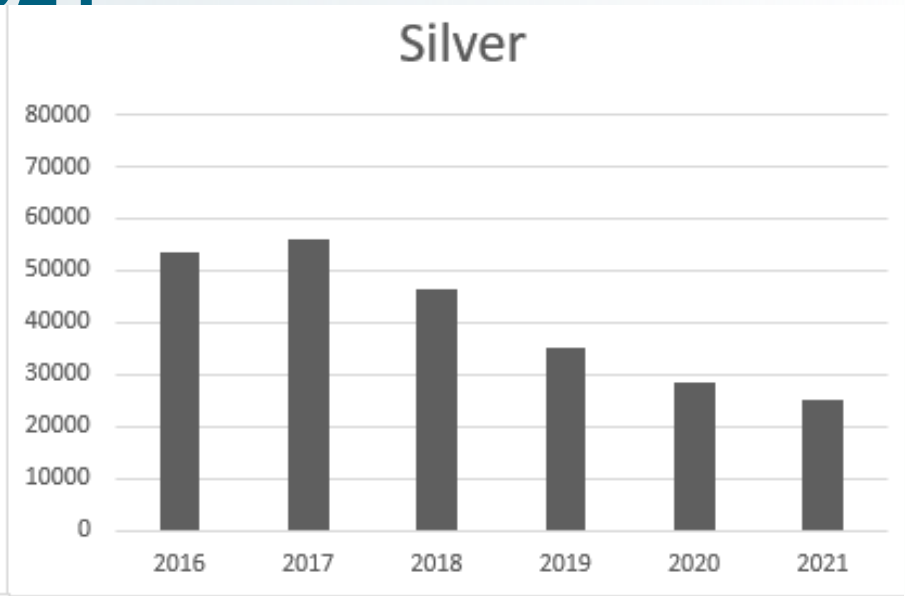
- These events influence the premiums ACA individual market customers pay.
- In October 2017, the federal government stopped paying CSRs.
  - Insurers raised the prices for silver plans in response.
  - CSRs are only available for on-exchange silver plans, so this was allowed.
  - Premiums for silver plans went up slightly in 2018, then reflected the full cost of CSRs by 2019 when it became clear the government was not going to return to reimbursing insurers for CSRs.
- In early 2021, the American Rescue Plan Act lowered the percentage of premium that customers pay and increased the amount the government pays.
  - People received even more APTCs, so there were even more free bronze or gold plans after the ARP Act went into effect on 4/1/21.
- For 2022, two new carriers are entering the Nebraska market, and the cost of some silver plans will drop.
  - Lower silver plans mean lower dollar amounts of subsidies. This affects people over 250% FPL who use APTC money to shop for a free bronze or gold plan, because fewer plans will be free.

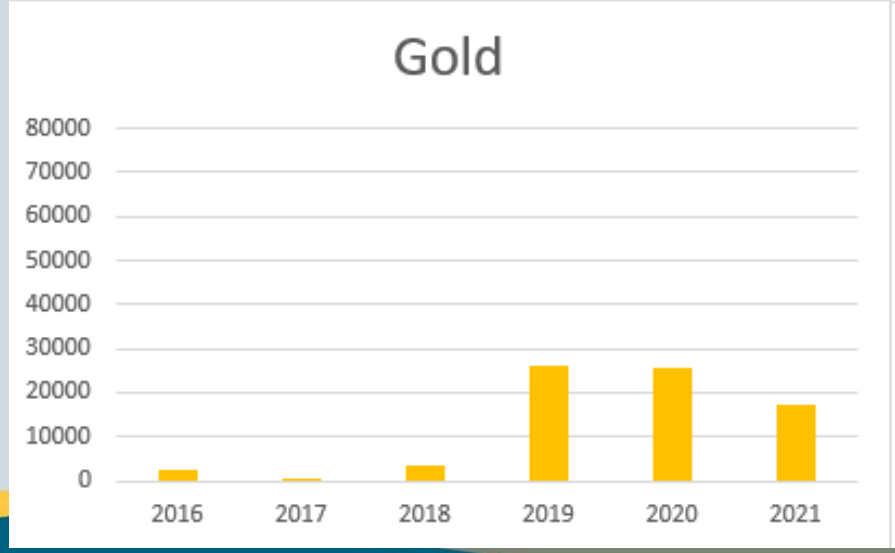
COST-SHARING REDUCTIONS AND SILVER LOADING

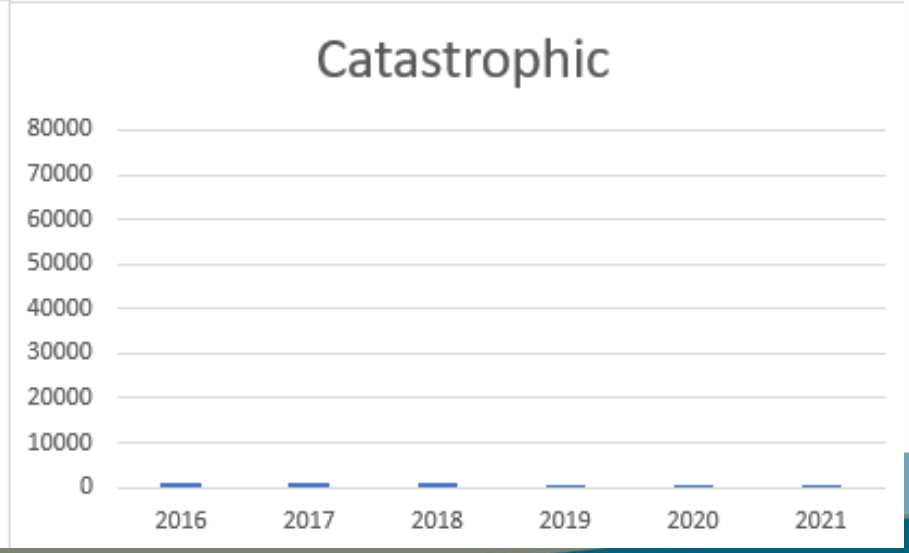
- If a person qualifies for CSRs, the summary of benefits for the plan they receive will include lower cost sharing (deductibles and copayments) than regular silver plans.
  - This is another form of subsidy – insurers are reimbursed by the government for the cost-sharing difference.
- On October 12, 2017, the federal government announced that CSR payments to insurers would end, effective immediately.
  - Rates had already been finalized for 2018 but were reopened and somewhat adjusted to account for non-payment of CSRs.
- Since 2019, insurers have charged significantly more for on-exchange silver plans to make sure the non-payment of CSRs is only charged to on-exchange silver plans (the only plans that can offer CSRs).
- Because APTC is set based on the second-lowest-cost silver plan, APTC has been inflated to reflect non-payment of CSRs.
  - If a person earning above 250% FPL takes the APTC money and shops for a gold or bronze plan, that plan may end up being free because the silver plans cost so much more.

ENROLLMENT BY METAL LEVEL, 2016-2021

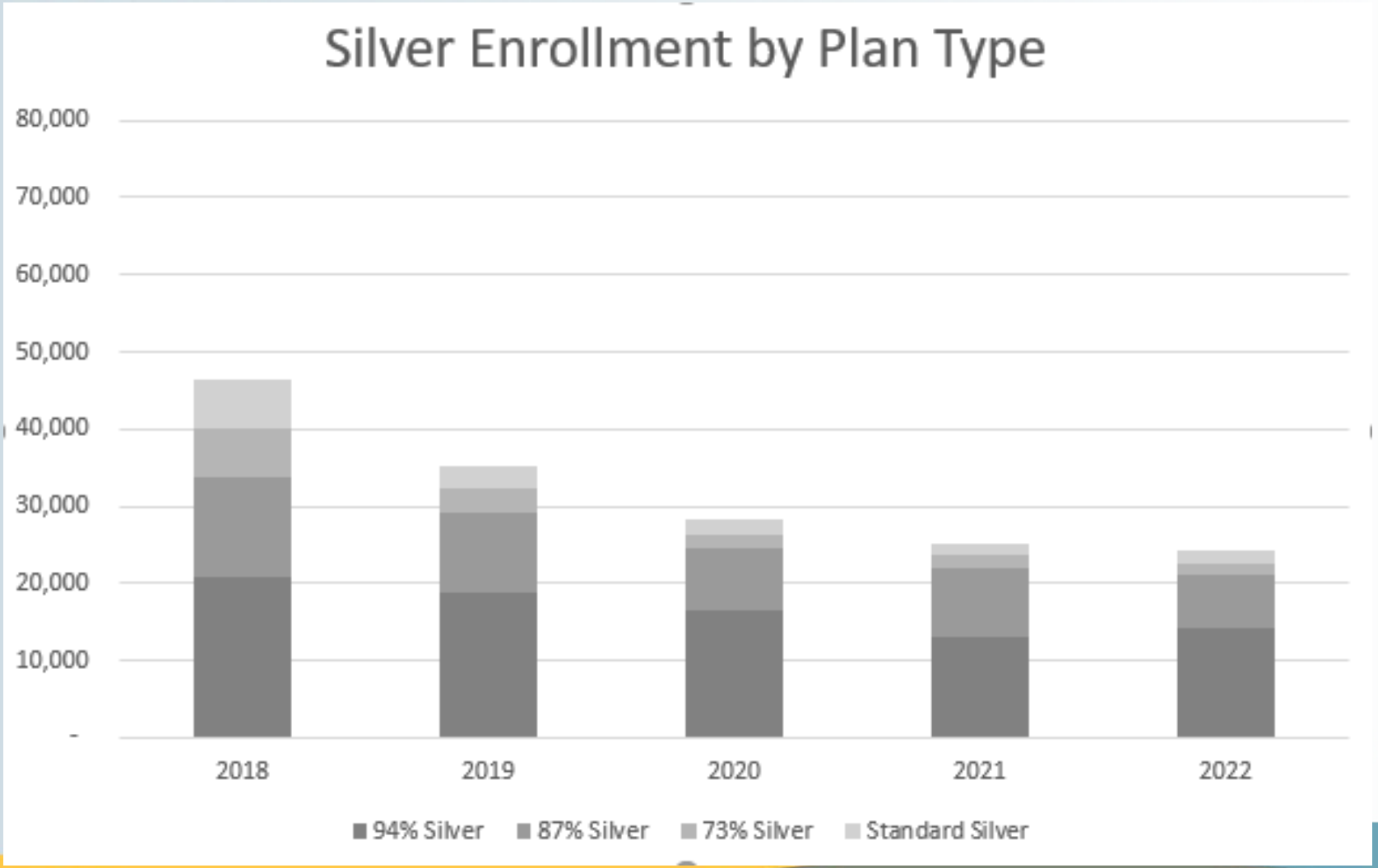








SILVER PLAN COST-SHARING ENROLLMENT, 2018 TO EXPECTED 2022



AMERICAN RESCUE PLAN ACT CHANGES TO APTC AND OPEN ENROLLMENT

- Most of 2021 has been an open enrollment period.
  - From February 15, 2021 to August 15, 2021 there was a COVID Special Enrollment Period.
  - Regular Open Enrollment starts November 1, 2021 and runs until January 15, 2022 (one month longer than prior years).
- Beginning April 1, 2021 and continuing for all of 2022, the American Rescue Plan (ARP) Act gives 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 pay $10 or less per month for most of 2021 and all of 2022.
- In 2022, there will be a monthly Special Enrollment Period for people under 150% of the Federal Poverty Level.

CHANGES TO APTC PERCENTAGES BEGINNING APRIL 1, 2021

Income Range (% of FPL)	Range of Applicable Percentages for 2021 before 4/1/21	Range of Applicable Percentages after 4/1/21 and all of 2022 under the ARP
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 WILL PAY 8.5% OF THE BENCHMARK IN 2021 AND 2022

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 2022 BENCHMARK SINGLE PERSON EXAMPLE

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

Rating Area	Single, Age 25	Single, Age 45	Single, Age 64
1 (Omaha)	$60,765.18	$87,395.29	$181,568.47
2 (Lincoln)	$76,209.88	$109,608.00	$227,716.24
3 (Mid-state)	$87,557.65	$125,929.41	$261,626.82
4 (Western)	$91,929.88	$132,217.41	$274,688.47

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"FPL CUTOFF" USING 2022 BENCHMARK FAMILY OF FOUR EXAMPLE

- The highest income where a Family of four (two parents, two children) would still receive an APTC. A family earning more would not receive a subsidy.

  Young Family: Both parents age 25; Children ages under 14.
  Middle Age Family: Both parents age 45; Children ages 15, 18.
  Older Family: Both parents age 64; Children ages 21, 24.

Rating Area	Young Family of 4	Middle Age Family of 4	Older Family of 4
1 (Omaha)	$211,227	$276,660	$477,616
2 (Lincoln)	$193,365	$253,263	$437,223
3 (Mid-state)	$247,184	$323,757	$558,922
4 (Western)	$314,812	$412,334	$711,845

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MORE PLANS UNDER $10 AVAILABLE AFTER APRIL 1, 2021, 150% FPL

- At 150% FPL.
- The only thing that changed was the APTC percentage.
- Before federal changes to ATPC in blue.
- 2021 rates after April 1, 2021 federal changes to APTC in red.

Metal Tier	Age 25 - $0 Plans		Age 45 - $0 Plans		Age 64 - $0 Plans		Total Plans Available
Expanded Bronze	48	55	51	55	54	55	57
Silver	4	15	4	15	4	13	31
Gold	2	9	2	9	2	9	16

- Fewer free plans will be available in 2022 because the benchmark silver plans will be lower.

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MORE PLANS UNDER $10 AVAILABLE AFTER APRIL 1, 2021, 200% FPL

- At 200% FPL.
- The only thing that changed was the APTC percentage.
- Before federal changes to ATPC in blue.
- 2021 rates after April 1, 2021 federal changes to APTC in red.

Metal Tier	Age 25 - $0 Plans		Age 45 - $0 Plans		Age 64 - $0 Plans		Total Plans Available
Expanded Bronze	36	52	46	52	51	55	57
Silver	2	4	4	4	6	4	31
Gold	2	2	2	2	2	8	16

- Fewer free plans will be available in 2022 because the benchmark silver plans will be lower.

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MORE PLANS UNDER $10 AVAILABLE AFTER APRIL 1, 2021, 250% FPL

- At 250% FPL.
- The only thing that changed was the APTC percentage.
- Before federal changes to ATPC in blue.
- 2021 rates after April 1, 2021 federal changes to APTC in red.

Metal Tier	Age 25 - $0 Plans		Age 45 - $0 Plans		Age 64 - $0 Plans		Total Plans Available
Expanded Bronze	8	45	29	48	48	52	57
Silver	0	4	0	4	4	4	31
Gold	0	2	1	2	2	2	16

- Fewer free plans will be available in 2022 because the benchmark silver plans will be lower.

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MORE PLANS UNDER $10 AVAILABLE AFTER APRIL 1, 2021, 400% FPL

- At 400% FPL.
- The only thing that changed was the APTC percentage.
- Before federal changes to ATPC in blue.
- 2021 rates after April 1, 2021 federal changes to APTC in red.

Metal Tier	Age 25 - $0 Plans		Age 45 - $0 Plans		Age 64 - $0 Plans		Total Plans Available
Expanded Bronze	0	0	3	7	31	42	57
Silver	0	0	0	0	2	4	31
Gold	0	0	0	0	1	2	16

- Fewer free plans will be available in 2022 because the benchmark silver plans will be lower.

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MORE PLANS UNDER $10 AVAILABLE AFTER APRIL 1, 2021, 500% FPL

- At 500% FPL.
- The only thing that changed was the APTC percentage.
- Before federal changes to ATPC in blue.
- 2021 rates after April 1, 2021 federal changes to APTC in red.

Metal Tier	Age 25 - $0 Plans		Age 45 - $0 Plans		Age 64 - $0 Plans		Total Plans Available
Expanded Bronze	0	0	0	0	0	29	57
Silver	0	0	0	0	0	0	31
Gold	0	0	0	0	0	1	16

- Fewer free plans will be available in 2022 because the benchmark silver plans will be lower.

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LOWER SILVER PLAN PREMIUMS IN 2022 MEAN LOWER SUBSIDIES IN 2022

- 2021 second-lowest-silver plans are in blue, 2022 second-lowest-silver plans are in red.

Rating Area	2nd Lowest Silver Plan-Age 25		2nd Lowest Silver Plan-Age 45		2nd Lowest Silver Plan-Age 64	
1 (Omaha)	$430.42	$423.95	$619.05	$609.74	$1,286.11	$1,266.77
2 (Lincoln)	$539.82	$388.04	$776.39	$558.10	$1,612.99	$1,159.49
3 (Mid-state)	$620.20	$496.27	$892.00	$713.76	$1,853.19	$1,482.88
4 (Western)	$651.17	$632.80	$936.54	$910.12	$1,945.71	$1,890.83

- The second lowest silver plan in each area for ages 25, 45, and 64. These values would be the APTC received for an individual at 150% FPL and will decrease with higher incomes.
- Lower silver plan prices mean lower APTC payments because APTC is the difference between the percentage of income the insured has to pay and the full price of the second-lowest-cost silver plan in the area.

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EXAMPLE OF WHAT THE CUSTOMER PAYS IN PREMIUMS AT 500% FPL

- This chart compares **what the insured pays in premiums after tax credits** ("post-APTC premium") for a gold plan from before and after April 1, 2021, the date the American Rescue Plan went into effect, then in 2022, when the lower benchmark results in lower APTC.
- These example premiums are for a 64-year-old at 500% FPL using the lowest rate available for a gold plan in each area.

Rating Area	Pre-4/1/21 Premium Post-APTC	4/1/21 Premium Post-APTC	% Change	2022 Premium with new APTC
1 (Omaha)	$1,251.15	$421.21	-66.3%	$538.93
2 (Lincoln)	$1,212.91	$56.09	-95.4%	$600.75
3 (Mid-state)	$1,393.53	$0.00	-100.0%	$476.79
4 (Western)	$1,897.08	$407.54	-78.5%	$398.30

ACA INDIVIDUAL MARKET PRICES: PUTTING IT ALL TOGETHER

- Silver plans are rated higher than you'd expect because they include an extra charge for non-payment of CSRs.
  - "Silver loading" makes the on-exchange silver rate around 15% to 20% higher than it would otherwise be.
- Silver loading results in higher premium subsidies because APTC is based on the difference between a percentage of a person's income and the total price of the second-lowest-cost silver plan available in the area.
  - The customer can take those higher subsidies and shop for a free bronze or gold plan.
- The American Rescue Plan made changes to the APTC percentage of income as of 4/1/21.
  - As a result of the ARP, customers pay less and the government pays more. This means more free plans were available after 4/1/21.
- New market entrants for 2022 introduced plans that lower the benchmark – the second-lowest-cost silver plan has a lower price in 2022.
  - This is expected, competition means lower prices.
  - Because less APTC will be available, there will be fewer free bronze and gold plans in 2022.

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PUTTING IT ALL TOGETHER

Market Activity	Effect on Amount the Federal Government Pays	Effect on Percentage the Customer Pays	Effect on Amount the Customer Pays
Non-payment of CSRs and silver loading in response	Increase because of higher APTC (higher prices mean more APTC)	None	Increased APTC means customer has more subsidy money to shop for free bronze or gold.
ARP Act change of APTC percentages	Increase because the customer pays a lower percentage	Decrease	Decrease
New market entrants with lower prices	Lower because of lower APTC (lower prices mean less APTC)	None	If receiving APTC, lower APTC means fewer free bronze or gold.

MEDICAID EXPANSION ENROLLMENT

- **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	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021
Total Medicaid	269,583	287,089	295,765	304,573	309,171	313,804	318,626	320,223

- As of August 2021:
  - 335,744 people enrolled in Medicaid/CHIP in some form.
  - 51,127 expansion enrollees.

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ACA SMALL GROUP MARKET

- Carriers offering small employer coverage for 2022:
  - Blue Cross and Blue Shield of Nebraska
  - UnitedHealthCare
  - Medica
  - Bright Health
  - Aetna
- Approximately 40,643 enrollees in 2021.
- Increases for 2022 range from 0% to 8.7%.

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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 health insurance policies.
- Compare the costs, including:
  - Premiums
  - Copays
  - Deductibles
  - Maximum out-of-pocket
  - Annual or lifetime limits (if non-ACA plan)

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GENERAL QUESTIONS TO ASK

- How long does coverage under this policy last?
- Does this policy cover pre-existing conditions? Is there an additional charge?
- If I develop a health condition, can this policy be cancelled or not renewed, even if I've paid my premiums?
- Will my doctor or hospital bill the insurance company, or do I have to pay up front and get reimbursed?
- Does the policy require that I use a specific network of doctors or hospitals?
- Are my doctor and hospital in this plan's network?
- Is there a point where I no longer have to pay anything out-of-pocket for health care services (MOOP)?

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QUESTIONS TO ASK: COVERAGE FOR SERVICES

- Ask if these services are covered, and if there are limits on the number of covered visits or limits on what you pay out-of-pocket:
  - Physician office visit
  - Specialist office visit
  - Preventive care (physicals, wellness visits, immunizations)
  - Urgent care
  - Hospital emergency care
  - Hospital inpatient care
  - Outpatient services
  - Laboratory services
  - Maternity care
  - Mental health and substance use disorder – inpatient
  - Mental health and substance use disorder – outpatient
  - Physical, occupational, or speech therapy; chiropractic

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SPECIFIC QUESTIONS TO ASK: PRESCRIPTION DRUGS

- Does this policy cover prescription drugs?
- Does this policy cover the drugs I use?
- Are there limits or requirements for approval before I fill a prescription?
- What will I have to pay out-of-pocket for prescription drugs?
  - Tier 1
  - Tier 2
  - Tier 3
  - Mail order
  - Specialty drugs

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SPECIFIC QUESTIONS TO ASK: COMPARING COSTS

- **Premium questions:**
  - How much will I pay for coverage each month?
  - Are there any other fees like application or membership fees?
  - Will I pay more because I have a pre-existing condition?
  - Will I receive financial help with out-of-pocket costs?
  - Am I eligible for premium subsidies with this policy?
- **What will I have to pay out-of-pocket, in addition to premiums?**
  - Deductible amounts:
    - In network
    - Out-of-network
    - Separate deductible for other services (like drugs)
  - Coinsurance percentage
  - Is there an annual limit on coverage (I pay all costs after the insurer pays a certain amount)?
  - Is there a lifetime limit on coverage (I pay all costs after the insurer pays a certain amount)?

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HEALTH INSURANCE: SPECIAL TOPICS

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BEHAVIORAL HEALTH DURING COVID

- Congress appropriated approximately $8 billion to the Substance Abuse and Mental Health Services Administration (SAMHSA) as Covid relief.
- Lifestyle changes instituted to prevent spread of COVID-19 appear to have adversely affected the mental health of many Americans.
  - Some studies show elevated emotional distress, anxiety, depression, substance use, and drug-related overdoses in 2020 and 2021.
- Physical distancing associated with the pandemic required changes in service delivery for behavioral health.
  - In response to the pandemic, the federal government relaxed privacy rules (HIPAA) to allow increased use of telehealth for behavioral health.
  - Some states used mobile units to deliver treatments that cannot be administered by telehealth, such as medication-assisted treatment for opioid use disorder.
- As the pandemic eventually subsides, the federal government will likely consider whether to make some of these relaxed standards permanent.

NEBRASKA TELEHEALTH LAWS

- Laws for Nebraska telehealth:
- 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.
- LB400 (2021)
  - Adds audio-only services for individual behavioral health for an established patient.
  - Clarifies services originating from any location where the patient is located should be 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 **behavioral health** telehealth at in-person rates.
  - “Behavioral health” typically includes both mental health and substance use disorder treatment.

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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).**
- The Consolidated Appropriations Act of 2021 includes Title II, Section 203 (referred to as “Section 203”), which aims to improve compliance with 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.
- 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 AND THE NO SURPRISES ACT

- 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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SURPRISE BALANCE BILLS AND THE NO SURPRISES ACT

- **Federal No Surprises Act (signed in the closing days of 2020)**
  - 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.
  - Federal rulemaking is still happening. Enforcement will be a joint effort between the state and federal governments.

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 and ACA major medical.
  - Requires disclosure of direct and indirect compensation.
- Plans must report information on broker compensation annually.
- Brokers must make disclosure to customers before the individual finalizes plan selection.
- Disclosure of broker and consultant commissions is also required for group health plans.

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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 AND THE NO SURPRISES ACT

- 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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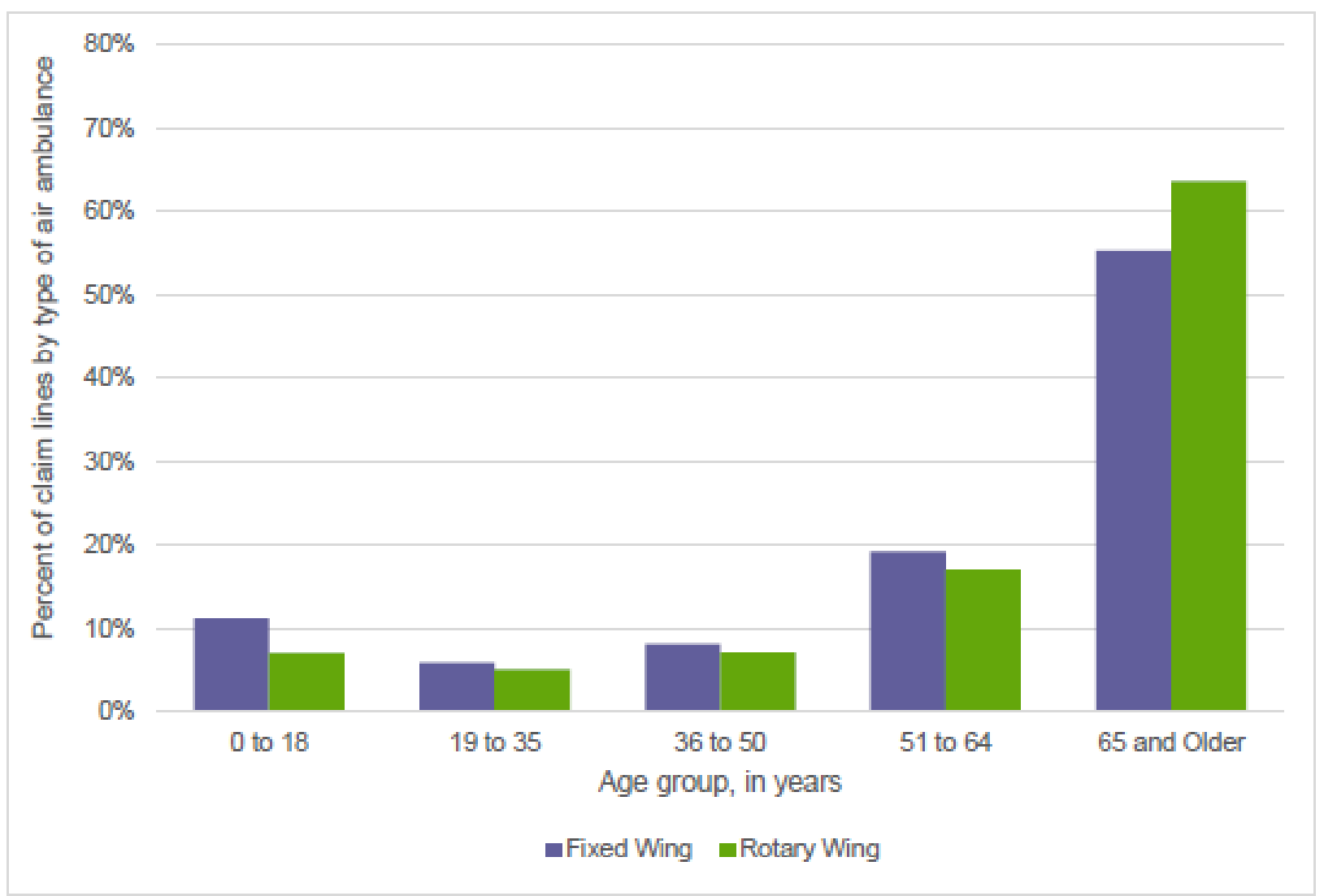
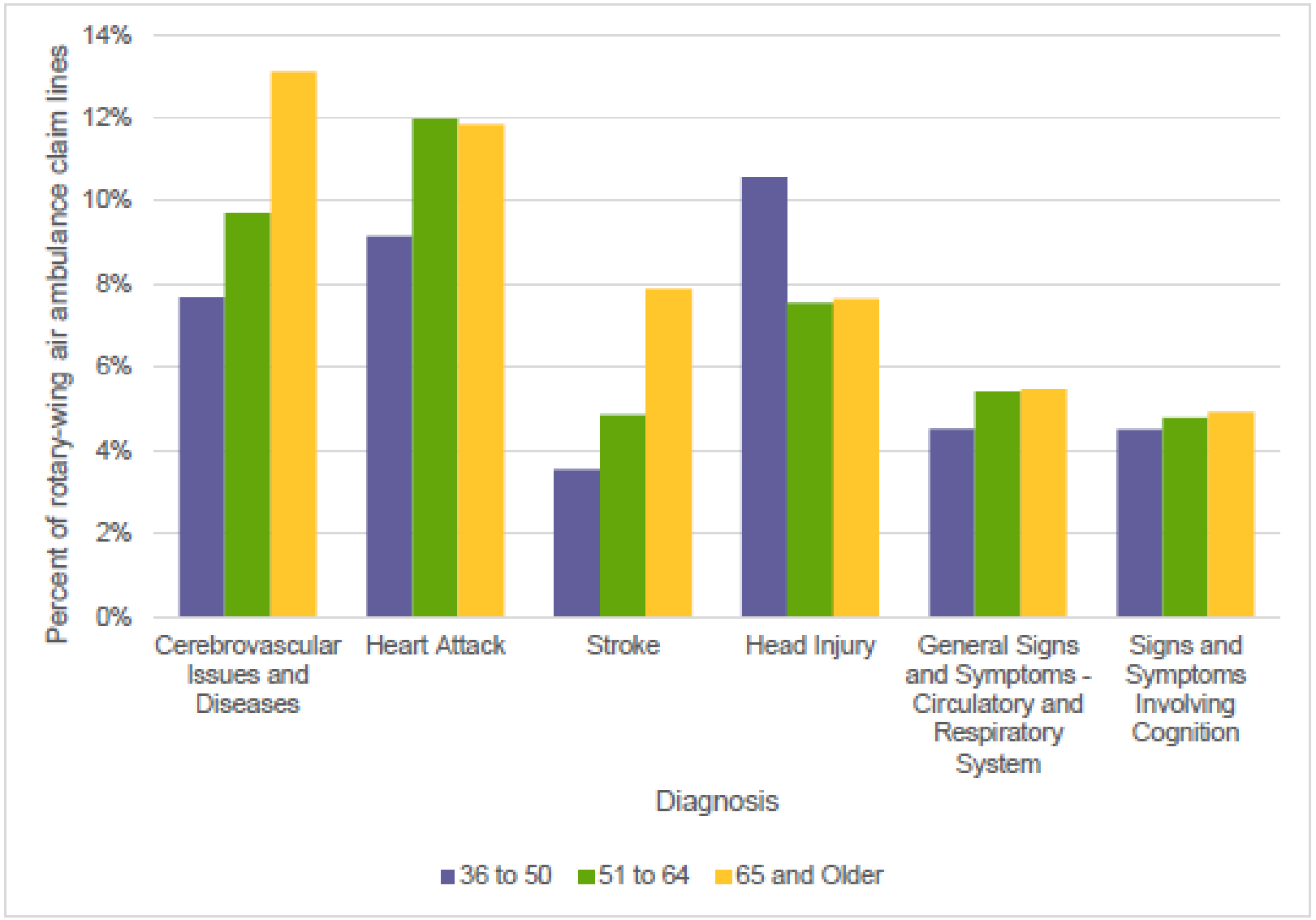
AIR AMBULANCE CLAIMS BY AGE GROUP



AIR AMBULANCE CLAIMS BY DIAGNOSIS



STATES WITH HIGH AIR AMBULANCE USE

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

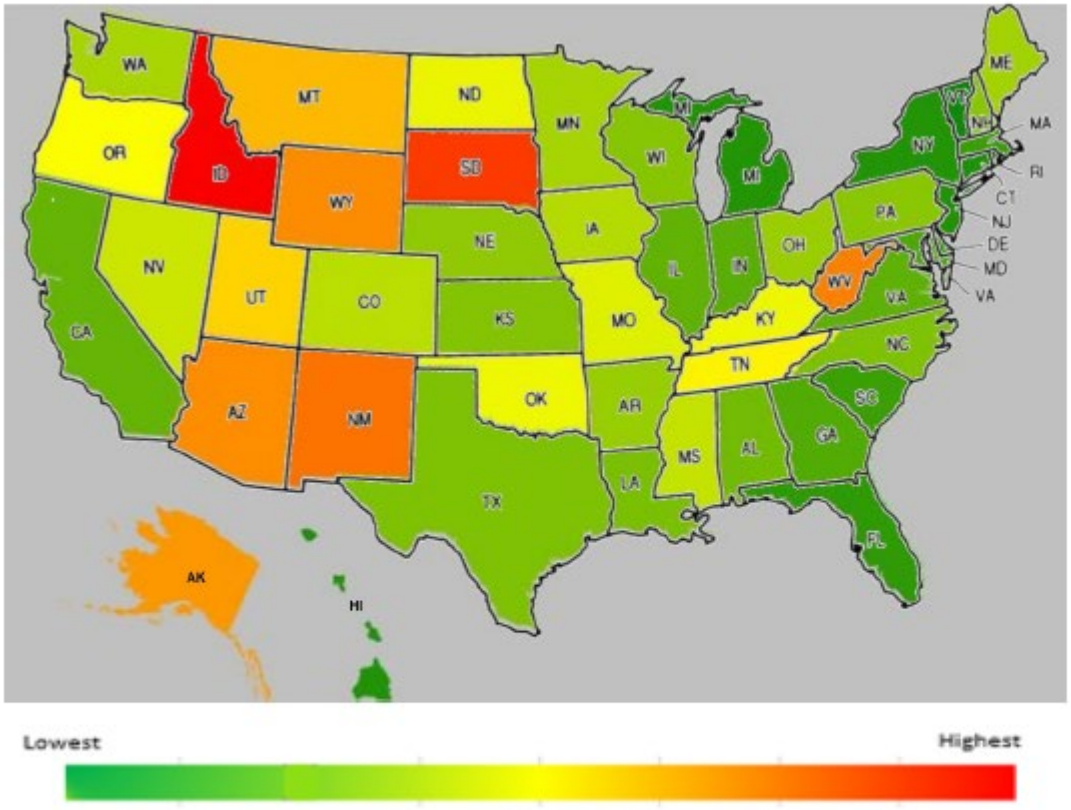


Figure 18. Rotary-wing air ambulance claim lines as a percentage of all medical claim lines by state, 2020

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.

HEALTH INSURANCE CLAIMS: APPEALS AND EXTERNAL REVIEWS

Maggie Reinert
Insurance Analyst

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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

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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 Department of Insurance facilitates:

- ACA major medical large group *if fully insured*
- ACA major medical individual and small group
- Short-term limited-duration insurance

Federal Department of Labor (EBSA) facilitates:

- ACA major medical large group *if not fully insured* (ask your HR rep.)
- Federal employees

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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 (end of July)	142 (11 pending)	29	47	53	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.
  - As of 8/1/21, of the eligible cases, 52% were overturned.

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MOST COMMON EXTERNAL REVIEWS FOR DRUGS AND SERVICES

Drug	2019 overturned rate	2020 overturned rate	2021 (end of July) overturned rate
Humira	1/6	5/6	3/3
Stelara	2/4	6/6	1/2
Repatha	2/3	5/7	1/3
Dupixent	4/6	2/6	2/3
Otezla	3/5	3/5	
Genetic testing	2/11	7/13	3/6
Imaging	10/15	9/17	3/10
Lumbar surgery	3/6	4/10	1/4

Blue numbers indicate the total external reviews performed.
Red numbers indicate times the IRO told the insurer to pay for the drug or service.

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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

- 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 searching 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.
- Check your life insurance beneficiary designations.

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MORE ADVICE FROM INVESTIGATORS

- If your vehicle is totaled, the company does not owe you for a replacement vehicle.
  - It will pay you the actual cash value (ACV) of your vehicle.
  - The ACV is what your vehicle was worth before it was totaled.
- 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.
- Before you hire a public adjuster, make sure you completely understand the contract and the fee you will be charged.

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MORE ADVICE FROM INVESTIGATORS

- 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.
- The Department of Insurance:
  - Does not mediate claims settlements and cannot force your insurer to pay a claim.
  - 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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MULTI-STATE INVESTIGATIONS

Martin Swanson, Deputy Director
and General Counsel

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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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ALIERA AND TRINITY HEALTHSHARE

- A legal health care sharing ministry is a nonprofit organization whose members share a common set of ethical or religious beliefs and share medical expenses consistent with those beliefs.
- A federal lawsuit was filed in Georgia, accusing Aliera of running a scheme to avoid state and federal insurance laws. The lawsuit alleges that Aliera pockets about 84 cents of every dollar its members pay.
- Some states have found that Aliera and Trinity's operations were illegal.
  - Those states have issued cease and desist orders.
  - CA, CT, CO, MD, MO, NH, WA, and maybe more.
  - In some instances, Aliera has paid significant fines and penalties.
- On July 8, 2021, Sharity Ministries, formerly known as Trinity Healthshare, filed for Chapter 11 bankruptcy and later decided to cease operations.
  - The company sought permission from the bankruptcy court to potentially refund member contributions made for the month of July.

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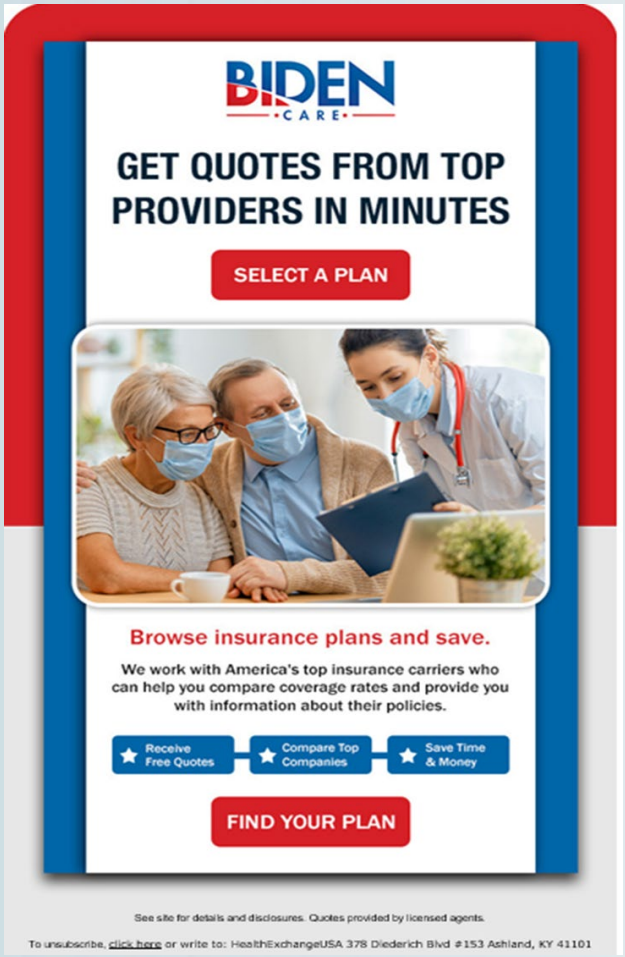
MISREPRESENTATIONS FOR HEALTH INSURANCE SALES

- Health insurance has varying levels of coverage.
  - "Major medical" coverage is either ACA compliant or short-term limited-duration insurance.
    - Short-term medical is also referred to as STLDI, "mini-med" or "short-term medical."
  - Supplemental insurance under the "health" umbrella includes hospital indemnity, limited benefit, specified disease, or disability insurance.
  - Discount medical plans (just a discount, not insurance) and health care sharing ministries (not insurance) also fall under this umbrella.
- Even before plans were required to fully comply with the ACA, bad actors selling health insurance would overstate the coverage to get a sale.
  - These misrepresentations were typically made during telephone sales.
  - This problem has intensified now that some people believe all health insurance must be ACA compliant.
- All of the products discussed on this slide serve a good purpose in the market, but people need to understand what they are buying.

TELEMARKETERS AND INTERNET ADVERTISING

- Internet misrepresentations usually start with a customer searching for health insurance online.
  - Pop-up internet ads or posts on social media are two common methods used to reach people.
- Once the customer contact has been established, internet chats or phone calls are where the misrepresentations get made.
- Sometimes just the fact that a person searched for ACA individual market plans and this website came up as a result can be misleading.
  - Example: “healthcare.com” instead of “healthcare.gov”
- Lead generators may collect information about people looking to purchase health insurance, then sell those contacts to agents.
  - This is a good reason to beware when contacted by someone with a health insurance offer, if that person asks for personal information.

EXAMPLES



Martin,

View updated Health Insurance plans available in NE.

Compare Trumpcare plans from the top insurance companies. Huge savings on healthcare costs may be available.

View Plans →

LOCAL EXAMPLE

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ANOTHER 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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FEDERAL ACTIONS

- Both the Federal Trade Commission (FTC) and the Federal Communications Commission (FCC) have reported on lead generating companies and taken action.
- FCC fine issued March 18, 2021 against Texas-based telemarketer for $225 million for illegally transmitting approximately 1 billion robocalls
  - Many calls were illegally spoofed
  - Callers were selling short-term limited-duration health insurance.
  - Telemarketer company was Rising Eagle Capital Group LLC and its affiliates.
- FCC public notice on October 6, 2020 about a telemarking firm that lures customers into submitting personal information on their website, “healthcare.com.” (not “healthcare.gov”)
  - Information submitted by a consumer is not a formal request for a quote, but consumers start to receive frequent calls and texts for which they may end up paying fees.
  - List of 1,892 Healthcare Inc. partners on the entity’s website.

MORE FEDERAL ACTIONS

- The FTC sued Day Pacer, LLC on April 12, 2019 for allegedly making unwanted calls as part of a scheme that used the same bait-and-switch.
  - People shared their phone numbers to get help applying for jobs, health insurance, unemployment benefits, and other assistance.
  - Instead of help, they got unwanted phone calls from Day Pacer with sales pitches to enroll in post-secondary and vocational schools operated by their clients.
- The FTC filed a complaint in federal court against Simple Health Plans LLC, Steven Dorfman, and five other entities for misrepresenting that people would get comprehensive health coverage.
  - People thought they would get coverage for pre-existing conditions, prescription drugs, primary and specialty care treatment, inpatient and emergency hospital care, surgical care, and medical testing.
  - The plans people actually got were not this comprehensive.

STATES ACTING TOGETHER TO INVESTIGATE

- A coordinated effort spearheaded by Nebraska and Delaware used these federal actions to learn more about these entities.
  - Research on several lead generators indicates the people running these companies frequently move on to a new corporate name and continue the same schemes.
- The most recent investigation focused on “Obamacareplans” and “Bidencare open enrollment”
  - The plans are advertised to start from $30 per month.
  - The plans are not ACA compliant and are not ACA compliant – this makes the $30 per month suspicious.
- Dangers to consumers include both identity theft and theft of premium dollars.
  - Victims are also left with little or no health coverage, forcing them to pay large medical bills out-of-pocket.

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NAIC IMPROPER MARKETING OF HEALTH PLANS WORKING GROUP

- Nebraska and Delaware are co-chairs of the new Improper Marketing of Health Plans Working Group.
- The group's focus is robocalls, search engine advertisements, mailers, and telemarketing efforts to steal from people seeking comprehensive health insurance.
  - Sometimes a single web form completion can result in more than 40 contacts per day. Dedicated phone lines are required for investigators to field these intrusive, rapid-fire robocalls and text messages.
- State and federal regulators participate in these working group meetings.
  - Typically, there are between 200 and 250 regulators on the call.
- The Working Group's official charges include:
  - Coordinate with regulators, both on a state and federal level, to provide assistance to and guidance on monitoring the improper marketing of health plans, and coordinate appropriate enforcement actions, as needed, with other NAIC Committees, task forces, and working groups.
  - Review existing NAIC Models and Guidelines, including laws and regulations, that address the use of lead generators for sales of health insurance products and identify models and guidelines that need to be updated or developed to address current marketplace activities.

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MEDICARE

Preventing fraud, SHIP, and Medicare Advantage

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COVID-19 SCAMS AND MEDICARE

- Medicare covers the COVID-19 vaccine at no cost to you, so if anyone asks you to share your Medicare number or pay for access to the vaccine, you can bet it's a scam.
- Here's what to know:
  - You can't pay to put your name on a list to get the vaccine.
  - You can't pay to get early access to a vaccine.
  - Don't share your personal or financial information if someone calls, texts, or emails you promising access to the vaccine for a fee.
- Con artists may try to get your Medicare number or personal information so they can steal your identity and commit Medicare fraud. Medicare fraud results in higher health care costs and taxes for everyone.

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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!

NEBRASKA SHIP
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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FREE, UNBIASED, AND CONFIDENTIAL

- 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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SHIP PROVIDES A VALUABLE SERVICE

- In 2020, Nebraska SHIP
  - Assisted over **29,000 Nebraskans** with Medicare questions and issues
  - Helped Nebraskans save over **$17,000,000**
    - Cost savings as a result of comparing Medicare Part D options, assistance in appealing denies claims, and assistance to complete LIS and Medicaid applications

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ANNUAL OPEN ENROLLMENT - PARTS C & D

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

- Contact Nebraska SHIP for a free, unbiased comparison of Medicare options:
  - Best Coverage
  - Lowest Price
- In 2020, Nebraska SHIP helped Nebraskans save over $8,000,000 in prescription costs.

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MEDICARE ADVANTAGE AVAILABLE IN MORE NEBRASKA COUNTIES

- Over the past three years, Nebraska's Medicare market has seen a vast expansion of Medicare Advantage Plans
  - Increase in the number of plans and companies available
  - Significant increase in the number of counties MA plans are offered

- This trend is expected to continue

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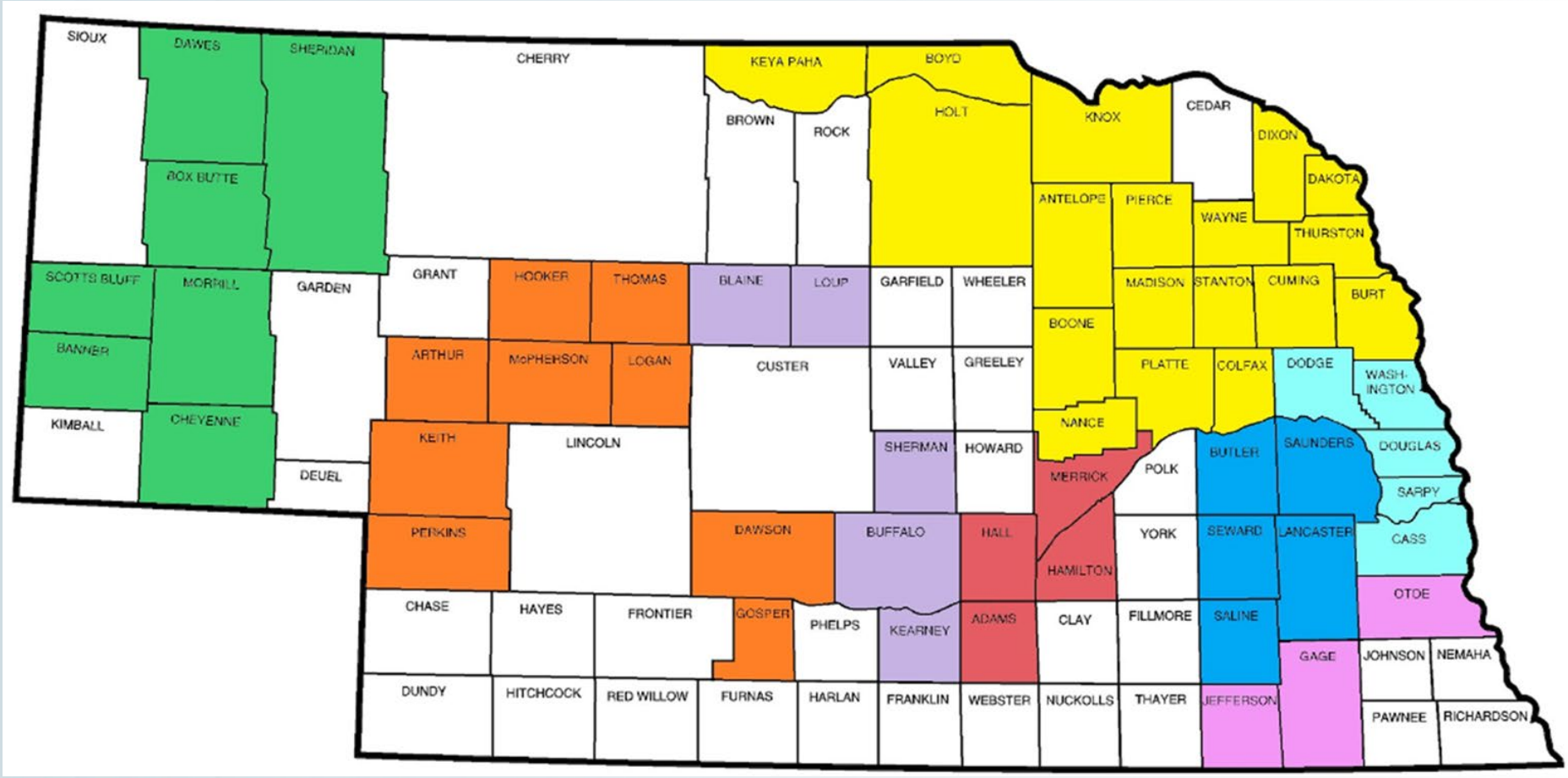
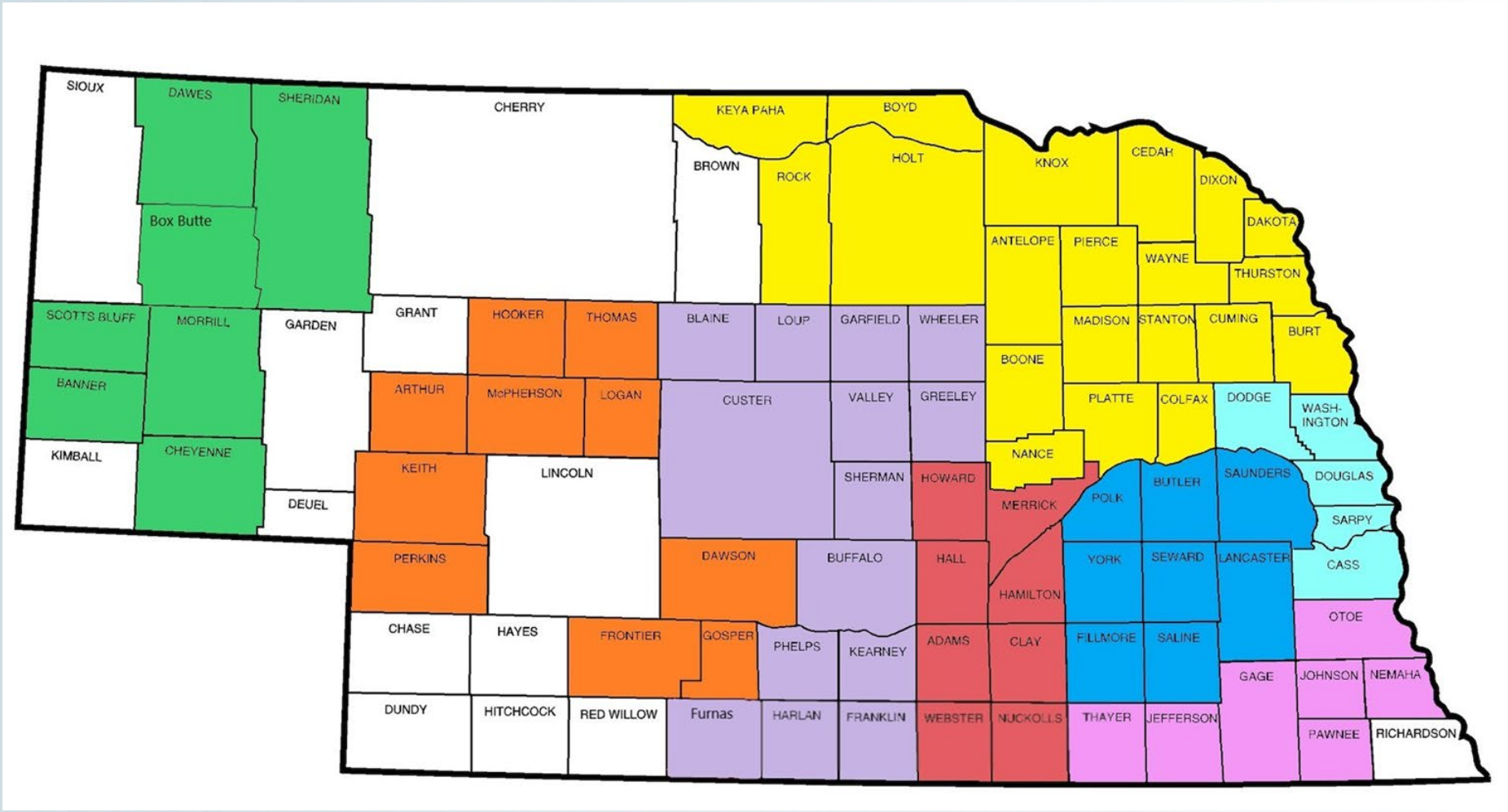
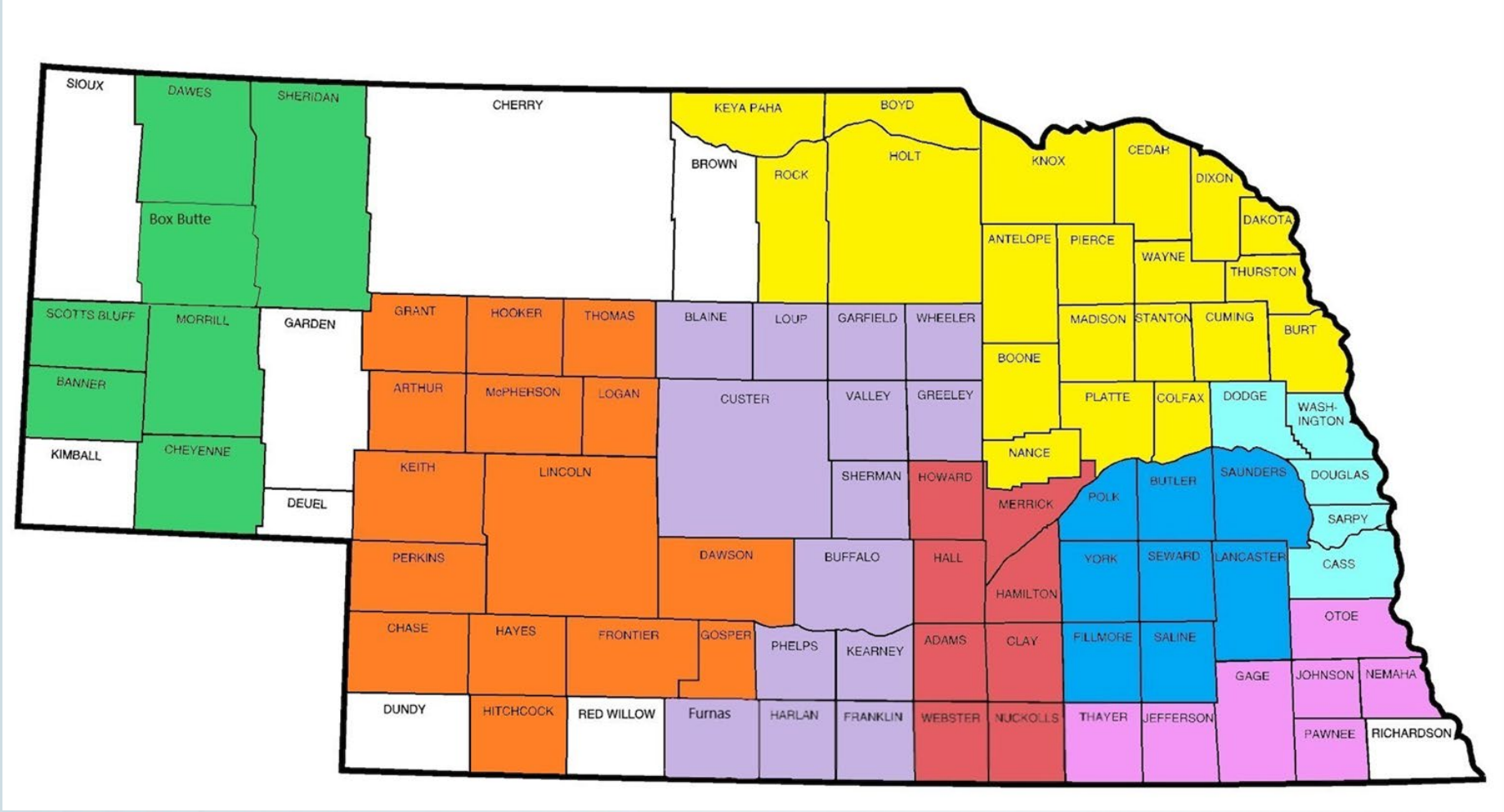
2019 MEDICARE ADVANTAGE PLANS: AVAILABLE COUNTIES



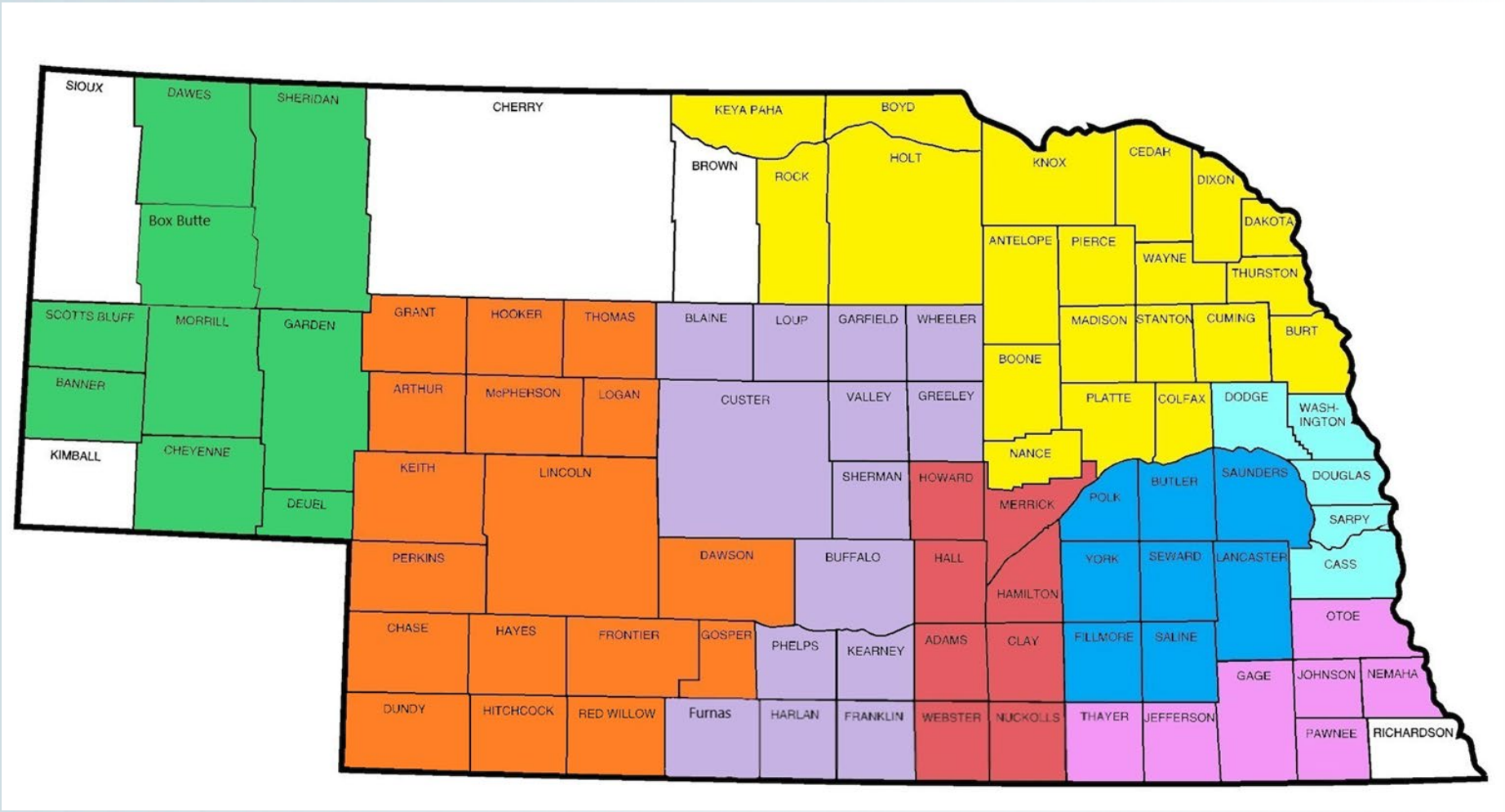
2020 MEDICARE ADVANTAGE PLANS: AVAILABLE COUNTIES



2021 MEDICARE ADVANTAGE PLANS: AVAILABLE COUNTIES



2022 MEDICARE ADVANTAGE PLANS: AVAILABLE COUNTIES



GROWING MEDICARE ADVANTAGE ENROLLMENT

- Beneficiary enrollment into MA Plans has also seen an increase
  - Percentage of Nebraskans with Medicare choosing MA Plans

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

**As of June 2021*

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard

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NEW IN 2021 – SENIOR SAVINGS MODEL

- Senior Savings Model (SSM)
  - New in 2021
  - Applies to Prescription Drug Plans (Part D) and Medicare Advantage Plans that **choose** to participate
  - Participating plans have agreed to charge no more than $35 copay for one month of select insulins in all coverage levels
    - Formularies vary from plan to plan
    - One month supply equals what the beneficiary's 30-day prescription is written for.
- Senior Savings Model Plans must cover at least one vial and pen dosage form of each type of insulin:
  - Rapid acting
  - Short acting
  - Intermediate acting
  - Long acting
- Plans must offer the benefit at all pharmacy types; preferred and non-preferred, retail and mail.

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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?
- 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/
  - Instagram: @ndoihealthdivision
    - https://www.instagram.com/ndoihealthdivision/
  - Twitter: @NDOIHealth
    - https://twitter.com/NDOIHealth

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- Maggie.Reinert@Nebraska.gov, 402-471-4638

- 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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