Protecting Consumers During COVID-19

Recommendations for State Policymakers from the NAIC Consumer Representatives

August 2020

Support for this report was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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The NAIC works closely with consumer representatives to assist state regulators in their primary objective of protecting insurance consumers. The individuals who prepared this report do not represent or work for the NAIC, and the views expressed here do not necessarily reflect the views of the NAIC. More information about consumer participation at the NAIC is available at naic.org/consumer_participation.htm.

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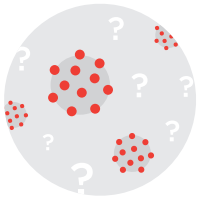
Introduction



The COVID-19 pandemic is perhaps the greatest public health crisis of the past century and has already exacted an unprecedented human and economic toll. In the United States, the disease was met by a woefully underfunded public health system, an ill-equipped health care system, and long-standing systemic health and social inequities that put people of color—especially Black people and American Indian or Alaska Natives—at heightened risk of being exposed to, and dying from, COVID-19.

As of this writing, more than 155,000 Americans have lost their lives. About half of all deaths occurred in long-term care settings, and communities of color have been disproportionately affected by COVID-19. According to the Centers for Disease Control and Prevention, Black people and American Indian or Alaska Natives are 5 times more likely to be hospitalized for COVID-19 than white people; the rate is 4 times higher for Hispanic or Latino people. And mortality rates for Black and Hispanic or Latino people are as much as ten times higher than those of white people. Health disparities like these have long existed but have been laid bare at a time of renewed focus on systemic racism in response to the murders of George Floyd, Breonna Taylor, Ahmaud Arbery, and countless others.

Beyond the tragic loss of life, those who survive COVID-19 may require intensive care, leading to potentially lifelong complications and yet-unknown long-term effects on adults or children. The ongoing public health and economic uncertainty is also exacerbating mental health issues, the opioid crisis, and substance use disorders. The pandemic is clearly impacting childhood development, the extent to which we may not discover for years. And the disruption caused by the crisis has left millions more unable to obtain cancer screening and other regular care needed to treat acute or chronic conditions.

Even setting aside its direct health impacts, the pandemic has resulted in significant financial insecurity and widespread job losses. No one has been left untouched by the disease, which has upended work schedules and school and family life. Many of those fortunate enough to maintain their job—especially essential workers in nursing homes, health care settings, grocery stores, farms, schools, public transportation, and warehouses—cannot remain at home and are at a heightened risk of contracting COVID-19.

As consumer representatives to the National Association of Insurance Commissioners (NAIC), we remain deeply concerned about the impact of the COVID-19 pandemic on patients, their families, the health care system, and the economy. We believe that access to comprehensive health insurance is central to controlling the pandemic and promoting the health and well-being of consumers. State insurance regulators play a crucial role in 1) ensuring that health insurance coverage is accessible, affordable, and comprehensive and 2) combating racial and ethnic health disparities.

Given the unprecedented nature of the challenges we face today, we prepared this report to assist state policymakers in responding to the crisis. This report makes recommendations regarding access to health insurance coverage, access to health care, health equity and racial justice, long-term care, and consumer education. Each section includes a brief overview, identifies challenges faced by consumers, and makes recommendations for state and federal policymakers. The report was drafted by the consumer representatives to the NAIC. The specific recommendations were not presented to the NAIC or the organizations with which the drafters are affiliated for formal endorsement.

While this report focuses primarily on health insurance-related issues—for those who are uninsured as well as those who have lost their jobs and coverage—we urge the NAIC and state insurance regulators to maximize flexibility for consumers across all lines of business. Doing so will help alleviate the burdens consumers currently face and are fully within the authority of state insurance regulators. We urge the NAIC and state insurance regulators to adopt the following principles:

- **Only allow mid-year plan changes that benefit consumers.** Pro-consumer changes might include expanded benefits or new modes of delivery or cost-sharing waivers. Insurers should not be allowed to make mid-year changes that limit access to care or reduce services.

- **Minimize paperwork.** Given the stress caused by COVID-19 and a lack of access to printers, fax machines, scanners, and the internet, consumers should not be penalized for failing to submit paperwork during the crisis. This is especially true because government offices or employers' physical locations are closed, and paperwork may be difficult to obtain. Insurers should waive paperwork burdens in favor of consumer attestations.

- **Proactive regulation is critical.** With millions of families prioritizing basic needs, caring for loved ones, or juggling work and school, most are simply unable to fight with their insurance company or file a complaint with the insurance department. Now is not the time for state regulators to rely on consumer complaints to unearth regulatory concerns. Regulators must be more diligent than ever in proactively identifying fraud, collecting data, and reviewing and approving products for sale.

- **Conduct robust rate review.** State and federal insurance regulators should undertake a robust review of 2021 proposed rates. Affordability is one of the biggest reasons people forgo coverage, and premium increases in 2021 could put coverage further out of reach for many consumers who face significant financial uncertainty. Unjustified rate increases will undermine market stability at a time when coverage is critical.

- **Consider how regulations and other policy actions impact those who are at greatest disadvantage.** State and federal insurance regulators should inform their decisions as much as possible using data disaggregated by race, ethnicity, gender, sexual orientation, gender identity and expression age, socioeconomic status, and disability status. These data better reveal which populations are struggling most under the current system and would be most impacted by policy actions.

ACCESS TO HEALTH INSURANCE COVERAGE

Marketplace Coverage

- **Urge Emergency SEPs.** The NAIC and its members should continue to advocate for an emergency special enrollment period (SEP) through HealthCare.gov to allow broad enrollment, including among the uninsured and underinsured, during the public health emergency. As the crisis continues, the NAIC and its members should also urge the federal government to provide an extended open enrollment period for 2021 plans.
- **Expand Enrollment Opportunities.** State-based Marketplaces should use their authority to create new enrollment opportunities that are broadly available whenever possible. This could include: establishing and further extending emergency SEPs, ensuring these SEPs function much like a new open enrollment period and are open to all, creating an SEP triggered by a job loss (even if the person did not have job-based health benefits), and extending the 2021 open enrollment period.
- **Simplify Enrollment Processes.** State and federal policymakers should extend deadlines, streamline enrollment procedures, and simplify verification requirements. States should simplify the requirements people have to meet to apply for and maintain coverage in health programs that the state controls, including Medicaid.
- **Improve Affordability.** The NAIC and its members should urge Congress to improve affordability by, at a minimum, making Marketplace financial assistance more generous, extending Marketplace premium tax credits to those at higher incomes, and eliminating the "family glitch."

Medicaid

- **Increase the FMAP.** The NAIC and its members should support efforts to further increase federal Medicaid matching funds (FMAP) in response to COVID-19. We urge support for the proposal led by the National Governors Association to increase the FMAP by at least an additional 5.8% and maintain that increase until the national unemployment rate falls below 5%.
- **Maximize Partnership with Medicaid.** State insurance regulators should partner closely with state Medicaid agencies and community partners to maximize Medicaid and CHIP enrollment outreach, including in states that use HealthCare.gov.
- **Expand Medicaid Programs.** The NAIC and its members should support Medicaid expansion in the states that have yet to adopt this program.
- **Monitor Medicaid Managed Care.** State insurance regulators should work with state Medicaid agencies to reevaluate managed care capitation rates and enforce medical loss ratio requirements on Medicaid plans to reflect current and anticipated utilization.

Navigating Coverage Transitions

- **Invest in Outreach.** State and federal insurance regulators should increase investments in outreach and marketing to ensure that consumers are aware of their options to access comprehensive coverage. This includes partnering with state unemployment offices and state Medicaid offices to inform consumers of their options.
- **Support Enrollment Assistance.** State and federal insurance regulators should increase support for enrollment assistance to ensure that consumers fully understand their coverage options and have the help they need to enroll in comprehensive coverage.
- **Maximize Targeted, Proactive Approaches.** State insurance regulators should proactively reach out to the workers of employers announcing layoffs or health coverage cutoffs. States should develop easy-to-understand notices that employers can use to inform employees about their range of options, including COBRA, Marketplace, and Medicaid coverage.

Premium Grace Periods

- **Prohibit Plan Cancellations.** State insurance regulators should prohibit plan cancellations for failure to pay timely premiums and extend premium nonpayment grace periods for commercial, Medigap, and long-term care policies. Enrollees should have a fair opportunity to catch up on premiums.
- **Require Clear and Timely Notices.** State insurance regulators should require insurers to provide written notice to consumers who are in danger of losing their coverage before plan cancellations take effect. Notices should be written in clear language with taglines on the availability of translated materials. These notices should additionally inform recipients about their rights, comprehensive coverage options through the Marketplace and Medicaid or CHIP, and the availability of enrollment assistance.
- **Eliminate Coverage Lock-Out Policies.** Federal insurance regulators should abandon a policy that allows insurers to deny coverage in the next coverage year to those who fell behind on premiums in the prior coverage year.

ACCESS TO HEALTH CARE

COVID-19 Testing

- **Address Testing Gaps.** To address consumer confusion and gaps in the coverage of COVID-19 testing, state insurance regulators should issue additional guidance on testing coverage requirements, including further defining asymptomatic testing requirements for individuals with "recent exposure" (to include, for instance, occupational exposure for nursing home staff).
- **Prohibit Surprise Medical Bills.** States should prohibit providers and labs from sending surprise medical bills or balance bills for COVID-19 and related testing.
- **Coordinate with Public Health Officials.** State insurance regulators should coordinate closely with state and local public health authorities to ramp up testing and provide clear and consistent information to consumers about how to access testing and anticipated costs.
- **Prioritize Equitable Distribution.** State policymakers should prioritize equitable distribution of new testing centers and promote access in underserved communities. COVID-19 tests should be accessible for those who rely on public transportation and people with disabilities.

COVID-19 Treatment

- **Prohibit Cost-Sharing for Treatment.** States should require insurers to cover treatment for COVID-19 or suspected COVID-19 without cost-sharing.
- **Prohibit Surprise Medical Bills.** States should prohibit providers from sending surprise medical bills or balance bills for treatment for COVID-19 or suspected COVID-19.
- **Enable Participation in Clinical Trials.** States should require insurers to cover all costs for patients enrolled in COVID-19-related clinical trials without cost-sharing.

Prescription Drugs

- **Ensure Access to Prescription Drugs.** State insurance regulators should require insurers to provide ongoing access to medications, including those used for opioid use disorder treatment. Insurers should be required to authorize 90-day supplies and early refills of prescription drugs, allow medication synchronization, waive prior authorization requirements for ongoing treatment needs, and enable home delivery or mail order.
- **Monitor Supply Chain Disruption.** State policymakers should closely monitor supply chain disruption and drug shortages to coordinate with insurers, pharmacies, and drug manufacturers and ensure uninterrupted access to medications.

Prior Authorization

- **Waive Prior Authorization for Testing.** State insurance regulators should direct insurers to waive prior authorization for COVID-19 diagnostic and antibody testing, including testing conducted as part of ongoing surveillance.
- **Ensure Appropriate Prior Authorization Criteria**. State insurance regulators should require prior authorization criteria to reflect clinical guidelines and evidence-based standards for appropriate medical use of the treatment and review standards as part of the plan certification process.
- **Promote Consumer Education and Track Appeals**. State insurance regulators should educate consumers about how to use internal and external appeals processes and track prior authorization appeals and reversals to monitor whether plans are using prior authorization as an inappropriate barrier to patient care.
- **Promote Plan Transparency.** State insurance regulators should promote plan transparency by requiring insurers to publicly post prior authorization standards and procedures online alongside a complete list of services for which prior authorization is required. This information should reflect any changes to prior authorization standards and procedures due to COVID-19.
- **Establish Timeliness Standards.** State insurance regulators should establish timeliness standards for responding to prior authorization requests, including expedited or emergency approvals.

Surprise Medical Bills

- **Adopt and Enforce Comprehensive Protections.** States should enact comprehensive protections against surprise medical bills in emergency and non-emergency settings and protect patients from financial harm due to COVID-19 or other health conditions. Insurance regulators in states with existing protections should fully enforce these requirements and ensure that consumers do not receive surprise medical bills, especially for COVID-19 testing and treatment.
- **Call on Congress.** The NAIC and its members should continue to call on Congress to adopt comprehensive federal protections against surprise medical bills, including from air ambulances. Federal protections should not preempt current or future state laws.
- **Ensure Network Adequacy.** States should require plans to maintain adequate provider networks and ensure that networks can fully serve those with COVID-19 as well as account for increased utilization and new patient care needs. Insurers should take steps to hold patients harmless and minimize out-of-network care during the public health emergency.
- **Require Accurate Provider Directories.** States should require plans to maintain accurate, easily accessible provider directories so consumers can make informed decisions about their care and avoid out-of-network services as much as possible.
- **Suspend Medical Debt Collection.** States should suspend medical debt collection activity during the pandemic. Providers and their third-party collection agencies should be required to cease all legal actions and involuntary medical debt collection activity during the state of emergency.

ACCESS TO HEALTH CARE *continued*

Telehealth

- **Ensure Compliance with Civil Rights Laws.** State insurance regulators should ensure that telehealth policies provide access for people with disabilities and limited English proficiency and comply with all existing civil rights laws. This includes the use of interpreters and provision of materials in alternative formats and non-English languages.
- **Limit Cost-Sharing.** If insurers choose to impose cost-sharing requirements for telemedicine visits, state insurance regulators should require that cost-sharing should be less than or equal to an equivalent in-person visit.
- **Promote Access to Providers.** State insurance regulators should allow insurers to make mid-year plan changes to add additional providers that accommodate increased access to telehealth and ensure that enrollees are aware of these additional coverage options. Telehealth services should supplement, not replace, the availability of in-person care. Plans should continue to be required to meet network adequacy requirements based on in-person services.
- **Eliminate Barriers to Telehealth.** States should eliminate barriers to telehealth services. Insurers should be prohibited from using policies that limit access to telehealth such as limiting the device or platform that can be used; requiring a prior relationship between the provider and the patient; limiting coverage to in-network providers when one is not available to provide the necessary telehealth services; requiring greater documentation for claims; requiring an in-person visit for prescribing medication, durable medical equipment, or other services; or imposing more stringent prior authorization requirements for telehealth services.
- **Require Rate Transparency**. State insurance regulators should require insurers to disclose the impact of increased access to telehealth services on rates during the rate review process.
- **Educate Consumers.** State insurance regulators should require insurers to provide patients with easy-to-understand information about the availability of telehealth services.
- **Relax Credentialing Requirements.** States should relax credentialing requirements to allow consumers to access licensed physicians in other states and expand access to broadband to rural and other underserved communities.
- **Collect Comprehensive Data.** State insurance regulators should collect consumer complaints and data from carriers to identify gaps or problems. Data collection should include demographic data on usage and outcomes by the following categories individually and in combination: race, ethnicity, age, disability status, preferred language, sex, sexual orientation, gender identity, socioeconomic status, insurance coverage, and geographic location.

Mental and Behavior Health Access

- **Increase Access to Mental Health Services.** State insurance regulators should require insurers to expand plan provider networks to include more high-quality mental health providers. Plan networks should include mental health providers that are culturally competent and knowledgeable about social determinants of mental health, especially the factors that perpetuate racial and ethnic health disparities that result from systemic racism.
- **Enforce and Strengthen Mental Health Parity Laws.** State insurance regulators should proactively enforce and strengthen mental health parity and network adequacy laws. State insurance regulators should also take steps to promote patient access to telemental health services.
- **Increase Funding for Mental Health Services.** States should expand the availability of crisis services and increase funding for community health centers.

HEALTH EQUITY AND RACIAL JUSTICE

- **Expand Medicaid Programs.** The NAIC and its members should support Medicaid expansion in the states that have yet to adopt this program. People of color are more likely to be in the Medicaid coverage gap and are disproportionately low-wage workers, many of whom are essential workers on the frontlines of the COVID-19 pandemic.
- **Collect Comprehensive Data.** The NAIC and state and federal insurance regulators should collect and publish demographic data that includes race, ethnicity, gender, sexual orientation, gender identity and expression, age, socioeconomic status, and disability status. Ongoing collection of demographic data by state insurance regulators—from enrollment to complaints—is critical to understanding racial inequities and the intersectionality of race and ethnicity with other factors, such as disability. The collection and public reporting of demographic data is necessary to develop and target interventions to protect those most at risk.
- **Incorporate Equity into Regulatory Review.** State insurance regulators should incorporate an equity component into rate and form review processes. States should not sanction products that use benefit designs, rating methodologies, or marketing practices that discriminate against racial, ethnic, and other populations subject to health inequities. Regulators should require health insurers to explicitly disclose how their product design and activities advance health equity and reduce disparities.
- **Promote Language Access.** States should adopt state-level language access requirements—such as translation services and notifications—to ensure that persons with limited English proficiency have the information they need from health insurers and health care providers to make informed decisions about accessing health services.
- **Partner with Community Leaders.** State insurance regulators should partner with leaders in underserved communities to ensure that consumers fully understand their health insurance rights and responsibilities and to hear firsthand about consumer concerns. These partnerships could advance

consumer education and position the insurance department as a source of support among communities of color and underserved communities.

- **Leverage Assisters and CAPs.** State insurance regulators should leverage the work of consumer assistance programs and community-based enrollment assisters. These assisters are often deeply rooted in the communities they serve and can help advise regulators on issues faced by their communities and the policies needed to address these concerns.

LONG-TERM CARE

- **Allow for Remote Assessments.** State insurance regulators should require LTC insurers to provide policyholders with the option of undergoing telephonic assessments, health record reviews, and other remote methods to determine whether the LTC insurance trigger has been met.
- **Support Family Members as Paid Caregivers.** State regulators should support attempts by insurers to allow substitution of family members as paid caregivers when an insured meets the criteria for receiving benefits. Regulators should recognize how COVID-19 can affect consumers' capacity and willingness to use their LTC insurance benefits and support insurers in allowing an appropriate family member to provide care at home during the public health emergency.
- **Work with Insurers to Promote COVID-19 Safety.** State regulators should inform insurers about and support their adoption of a wide range of reasonable benefits that could be offered to policyholders that would reduce their exposure to COVID-19 and increase their ability to safely draw on needed benefits.
- **Prohibit Plan Cancellations and Require Clear, Timely Notices.** States should prohibit plan cancellations through at least the end of the national public health emergency and require insurers to provide consumers in danger of losing coverage with a fair opportunity to catch up on premium payments. Before policy cancellations take effect, insurers should be required to provide clear written notice to consumers who are in danger of losing their coverage. Notices should be written in clear language with taglines on the availability of translated materials and inform policyholders on ways to preserve their coverage and options to delay premium payment.
- **Promote Equitable Coverage and Benefits Across Settings.** State regulators should initiate work groups with insurers and consumer advocates focused on the elimination of funding disparities between institutional care and home and community-based care in LTC products. Successful efforts by such working groups would relieve consumers of tough choices between greater coverage and care benefits in LTC facilities where COVID-19 risks have proven difficult to manage, or receiving limited coverage and care benefits in home and community-based care settings.
- **Waive Premiums for Those Who Require Nursing Home Level of Care.** State regulators should allow insurers to waive premiums for individuals who meet the criteria for requiring a nursing home level of care.
- **Help Policyholders Use Benefits Safely.** State regulators should recognize and support reasonable attempts by LTC insurers to provide temporary accommodations that will help policyholders use their needed benefits in ways that maximize the safety and choices of insured consumers and their families during these unprecedented times.

CONSUMER EDUCATION

- **Share Clear, Evidence-Based Information.** Elected officials and policymakers should use nonpartisan, evidence-based language to discuss the virus, its health effects, prevention measures, and comprehensive coverage options. Clear, evidence-based information has never been more important for consumers.
- **Invest in Outreach.** State and federal insurance regulators should increase investments in outreach and marketing to ensure that consumers are aware of their options to enroll in comprehensive coverage and to maximize awareness of special enrollment period opportunities. This includes partnering with state unemployment offices and state Medicaid offices to inform consumers of their options.
- **Maximize Targeted, Proactive Outreach.** All state agencies—from the insurance department to unemployment offices to social workers to benefits coordinators—should provide consumers with clear, easy-to-understand information about how to apply for and enroll in Marketplace coverage, Medicaid, or CHIP as well as the availability of enrollment assistance. Employers should provide employees with the same information in addition to the COBRA notices.
- **Use All Communication Channels.** State and federal insurance regulators should take advantage of all available information channels to ensure that consumers understand their coverage options. These channels may include social media, press conferences, digital outreach, and local/regional media.

Access to Health Insurance Coverage

The uninsured rate has been rising since 2016, and nearly 31 million people (about 1 in 10) were uninsured in the first half of 2019, long before the pandemic struck.[1] The uninsured rate was even higher (nearly 14 percent) for adults aged 18 to 64. And many of the communities most vulnerable to a higher risk of severe COVID-19—including Black people, Native Americans, and lower-income people—are more likely to lack adequate health insurance.[2]

The COVID-19 crisis will undoubtedly increase the uninsured rate. As we await comprehensive federal data, estimates of coverage losses vary significantly. But millions of people are likely to be affected.[3]

While some job losses are only temporary and some employers continue to provide coverage to laid-off and furloughed employees,[4] this likely will not remain an option as the crisis continues. Survey data from mid-May to early June suggests that about 20 percent of adults who had job-based coverage are now uninsured, while 53 percent remained covered while furloughed and another 10 percent opted for COBRA coverage.[5]

Given this impact, the Marketplaces and Medicaid will serve as important sources of coverage during the public health emergency. This section includes recommendations to maximize access to Marketplace coverage and Medicaid, ways to help consumers navigate coverage transitions, and the need for premium grace periods.

Marketplace Coverage

Access to Marketplace coverage is critical during the public health emergency, as people experience job loss and income reductions and worry about their health and the health of their family members.

The ACA provides premium tax credits and cost-sharing assistance for Marketplace plans, and this has helped millions of people afford health coverage. Nationwide, nearly one-third of people who recently lost job-based coverage qualify for Marketplace premium tax credits.[6] Access to Marketplace coverage is especially important in the states that have not yet expanded their Medicaid programs: in these states, 55 percent of people who have lost jobs are eligible for financial assistance to make coverage more affordable.[7] But many people who are eligible for this assistance remain uninsured, often because the net premium they owe, even with a premium tax credit, is higher than they can afford.

Most people who enroll in Marketplace coverage do so during the annual open enrollment period each fall. But when the pandemic hit, open enrollment for 2020 plans had already ended. This means that many who need coverage, including those who are eligible for financial assistance, must qualify for a special enrollment period (SEP). Most SEPs are triggered by the loss of other coverage or major life events such as having a baby or moving to a new geographic location.[8]

CHALLENGES

Some people are not eligible to enroll in the Marketplace coverage under current rules because they did not have job-based coverage before losing their job and do not otherwise qualify for an SEP. And some people who are eligible will opt not to enroll because of financial and other barriers. Many millions could become or remain uninsured at the worst possible time.

Among states that run their own Marketplaces, all but one quickly adopted an emergency SEP in response to the pandemic and economic fallout that is available to the uninsured. Many of these states have seen significant SEP growth in 2020, far surpassing that of the states that rely on the federal Marketplace, known as HealthCare.gov. The surge in SEP enrollments in the state-based Marketplaces in Connecticut, California, Colorado, the District of Columbia, Rhode Island, and Washington State is a sign that an emergency SEP could help expand enrollment in 38 HealthCare.gov states as well.[9]

But the federal government has yet to make a similar emergency SEP available. The federal government declined to do so despite widespread stakeholder support from insurer associations, executives of gig economy companies, members of Congress, state officials, and a broad coalition of more than 200 organizations.[10] The federal government also reinstituted burdensome SEP verification procedures for HealthCare.gov, requiring people to produce paper documents (such as letters from former employers) before they can enroll in coverage, at a time when this is especially challenging to do.[11]

Affordability problems are also more acute during the pandemic. For people who lose their jobs or experience sharp drops in income this year, their annual incomes, which are used to calculate the amount of premium tax credit they are eligible for, will be higher than their current monthly income (after the loss of a job or income). That will make it harder for them to afford the monthly contributions toward premiums they must make to maintain health insurance for themselves and their families. In addition, because premium tax credits are not available to people with incomes greater than 400 percent of the federal poverty line (about $50,000 for an individual in 2020), some people face high premium costs relative to their incomes but are not eligible for any assistance. This problem is particularly common among older people.[12]

RECOMMENDATIONS

- The NAIC and its members should continue to advocate for an emergency SEP through HealthCare.gov to allow broad enrollment, including among the uninsured and underinsured, during the public health emergency. As the crisis continues, the NAIC and its members should also urge the federal government to provide an extended open enrollment period for 2021 plans.

- State-based Marketplaces should use their authority to create new enrollment opportunities that are broadly available whenever possible. This could include: establishing and further extending emergency SEPs, ensuring these SEPs function much like a new open enrollment period and are open to all, creating an SEP triggered by a job loss (even if the person did not have job-based health benefits), and extending the 2021 open enrollment period.

- State and federal policymakers should extend deadlines, streamline enrollment procedures, and simplify verification requirements. States should simplify the requirements people have to meet to apply for and maintain coverage in health programs that the state controls, including Medicaid.

- The NAIC and its members should urge Congress to improve affordability by, at a minimum, making Marketplace financial assistance more generous, extending Marketplace premium tax credits to those at higher incomes, and eliminating the "family glitch."

Medicaid

Medicaid and CHIP provide health care for millions of low-income people and families. States and the federal government both finance the Medicaid program, with the federal government paying an average of 62% of the costs of Medicaid services. Nearly 70% of Medicaid and CHIP beneficiaries are enrolled in private, risk-based managed care plans.

Medicaid and CHIP play an important role in combatting the COVID-19 pandemic as millions experience job and income losses. Medicaid is particularly critical for extending access to coverage and care for people with preexisting conditions and people who are disproportionately impacted by COVID-19, including Black people, indigenous people, and other people of color who are disproportionately impacted by COVID-19. Those who qualify for Medicaid or CHIP can enroll at any time during the year, with no need for a special enrollment period.

CHALLENGES

Millions more people are likely to enroll in Medicaid and CHIP because of the recession, the large majority of whom would otherwise become uninsured.[13] The growing need for Medicaid coincides with an unprecedented state budget crisis. During past budget crises, states restricted Medicaid eligibility (including for seniors, people with disabilities, and pregnant women); made it harder for people to enroll in and maintain Medicaid coverage; eliminated or cut key benefits; and cut payments to physicians, hospitals, nursing homes, and other providers. Such cuts, if made now, would worsen people's access to care, health, and financial security—and undermine the response to COVID-19.

Recognizing the importance of Medicaid during the crisis, Congress temporarily increased federal Medicaid matching funds to states (the FMAP) by 6.2% during the public health emergency. While critical, this falls short of what is needed as the pandemic and economic crisis continues.

Key state stakeholders, led by the National Governors Association, have asked for an even greater FMAP increase.[14] In addition, states have implemented emergency waivers easing restrictions on health care access and eligibility to improve patient care and to stop the spread of COVID-19.

Given Medicaid's central role in the COVID-19 response, the states that have implemented the Medicaid expansion for low-income adults are better positioned than those that have not to address the health and economic fallout of the crisis.[15] If those additional states expanded their Medicaid programs, an estimated 5 million people could be eligible for expanded Medicaid coverage, including 2.8 million people who are currently in the Medicaid coverage gap and whose income is too low to qualify for Marketplace financial assistance.[16]

Further, the pandemic and economic downturn has led to an overall decrease in health care utilization, including routine screenings and preventive care, for Medicaid patients who already faced barriers in accessing care. The disruption wrought by COVID-19 could thus have a disproportionate impact on Medicaid enrollees, leading to untreated chronic conditions and worse health outcomes. At the same time, states continue to pay Medicaid managed care companies at rates that assume normal use of services, even as utilization has declined due to the crisis.[17]

RECOMMENDATIONS

- The NAIC and its members should support efforts to further increase the FMAP in response to COVID-19. We urge support for the proposal led by the National Governors Association to increase the FMAP by at least an additional 5.8% and maintain that increase until the national unemployment rate falls below 5%.

- State insurance regulators should partner closely with state Medicaid agencies and community partners to maximize Medicaid and CHIP enrollment outreach, including in states that use HealthCare.gov.

- The NAIC and its members should support Medicaid expansion in the states that have yet to adopt this program.

- State insurance regulators should work with state Medicaid agencies to reevaluate managed care capitation rates and enforce medical loss ratio requirements on Medicaid plans to reflect current and anticipated utilization.

Navigating Coverage Transitions

Over 40 million people have filed for unemployment insurance since the start of the pandemic. This is a conservative estimate that will continue to rise over time as states process additional claims and employers continue to lay off employees. Many employees who lose their jobs also lose their health benefits. As a result of the Affordable Care Act, those who lose job-based coverage have more options to turn to as coverage sources, but many may be unfamiliar with the Marketplace or Medicaid. Further, as businesses reopen, or open with reduced staff and hours, employees' eligibility for health coverage may change multiple times throughout the year.

CHALLENGES

Consumers who lose their jobs will have many coverage options to grapple with, whether through COBRA coverage, a spouse's job-based plan, Marketplace coverage, or Medicaid. The best option for a consumer will vary based on their income, health needs, access to certain providers, and whether, for instance, their state has expanded its Medicaid program. Of the millions who lost job-based coverage as of May, nearly 80 percent were estimated to be eligible for Medicaid or for Marketplace financial assistance.[18]

We are concerned that consumers are not aware of their options and thus cannot make an informed choice based on their personal needs. We are particularly concerned that some consumers may enroll in short-term, limited duration insurance or other non-comprehensive coverage that discriminates against people with preexisting medical conditions because of misleading or fraudulent marketing practices, or because they simply do not understand the drawbacks of these policies.[19]

RECOMMENDATIONS

- State and federal insurance regulators should increase investments in outreach and marketing to ensure that consumers are aware of their options to access comprehensive coverage. This includes partnering with state unemployment offices and state Medicaid offices to inform consumers of their options.
- State and federal insurance regulators should increase support for enrollment assistance to ensure that consumers fully understand their coverage options and have the help they need to enroll in comprehensive coverage.
- State insurance regulators should proactively reach out to the workers of employers announcing layoffs or health coverage cutoffs. States should develop easy-to-understand notices that employers can use to inform employees about their range of options, including COBRA, Marketplace, and Medicaid coverage.

Premium Grace Periods

Premium grace periods have long been an important protection for low-income consumers who face income uncertainty. Under the Affordable Care Act, Marketplace consumers who qualify for financial assistance who fall behind on their premium payments cannot be terminated by their insurer until after the end of a 90-day grace period. But this protection does not apply to unsubsidized consumers. Grace periods for these consumers are set by state law and are generally limited to 30 days. Even in 2016, with no economic downturn, one in 10 HealthCare.gov enrollees had their coverage terminated for the nonpayment of premiums. Medigap enrollees and long-term care insurance policyholders may need similar flexibility regarding premium grace periods.

CHALLENGES

The COVID-19 crisis means that many consumers may be unable to make timely premium payments. The ability to afford monthly premium payments could become highly unpredictable for consumers as income falls and finances are stretched to meet basic needs, such as housing, food, and transportation. While some insurers have announced premium grace periods, more consumers will need further protection to maintain their coverage. In recognition of this challenge, some states have prohibited plan cancellations by insurers for some period during the pandemic.[20]

The challenge of keeping up with premium payments is likely to worsen as state and federal COVID-19 financial relief programs expire. This is particularly true if rent and mortgage, enhanced unemployment support, and the paycheck protection programs expire or sunset, leading to even greater numbers of jobless or financially insecure consumers.

RECOMMENDATIONS

- State insurance regulators should prohibit plan cancellations for failure to pay timely premiums and extend premium nonpayment grace periods for commercial, Medigap, and long-term care policies. Enrollees should have a fair opportunity to catch up on premiums.
- State insurance regulators should require insurers to provide written notice to consumers who are in danger of losing their coverage before plan cancellations take effect. Notices should be written in clear language with taglines on the availability of translated materials. These notices should additionally inform recipients about their rights, comprehensive coverage options through the Marketplace and Medicaid or CHIP, and the availability of enrollment assistance.
- Federal insurance regulators should abandon a policy that allows insurers to deny coverage in the next coverage year to those who fell behind on premiums in the prior coverage year.

Access to Health Care

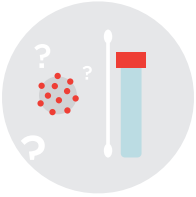
The COVID-19 pandemic has had a dramatic impact on patient care and health care delivery. Regular care for chronic and all but the most acute conditions was cancelled or delayed to minimize exposure to the virus, preserve personal protective equipment, and enable hospitals to prepare for patient surges. Patients and providers had to quickly adjust care models to reduce reliance on in-person visits, leading to a dramatic expansion in telemedicine. And many patients—especially those with compromised immune systems—face challenges in accessing prescription drugs out of fear of contracting COVID-19. The pandemic also increased the likelihood that a patient will receive a surprise medical bill, and potentially go into medical debt, because of COVID-19 testing and treatment.

Beyond these impacts to the health care system, many consumers may avoid needed care due to cost, potentially spreading the virus even further. Without cost-sharing protections or assured coverage, individuals who otherwise need to be tested or treated for COVID-19 may decline to seek care. This could further spread the virus and lead to a higher mortality rate. Affordability concerns are heightened for those who are uninsured or underinsured—and may be further exacerbated by an economic downturn that results in reduced hours and incomes for workers.

Insurance regulators in many states have already directed insurers to protect patients during the public health emergency. Guidance has required insurers to waive cost-sharing for COVID-19 testing and treatment, allow early prescription refills, expand access to off-formulary prescription drugs due to shortages, expand telehealth services, waive prior authorization limits, provide premium relief, and protect patients from surprise medical bills.[21]

Because the crisis is ongoing, these protections are just as important as when they were initially adopted. Patients need continued flexibility in waiving various requirements and expanding access to services. This section makes recommendations on COVID-19 testing, COVID-19 treatment, access to prescription drugs, prior authorization, surprise medical bills, and access to mental health and behavioral health services.

COVID-19 Testing



COVID-19 testing is critical to combatting the pandemic, and no individual who suspects they have, or have been exposed to, COVID-19 should forego testing because of cost. Ensuring widespread access to COVID-19 testing is also challenging due to America's fragmented coverage system. Most people are enrolled in health insurance through their or a family member's employer.

Others receive coverage through Medicare, Medicaid, or CHIP. Millions more are covered in the individual market and through military programs. And millions more are uninsured.

Access to COVID-19 testing also varies greatly by location. Although access to testing has expanded, underserved communities—often communities of color who are the hardest hit by the pandemic—continue to face barriers in testing access. In some cases, testing sites were not available in the hardest hit neighborhoods. Access was further limited by reduced access to public transportation, mistrust of the medical system, and limited information about the availability of tests.

Recognizing the importance of testing and the need to eliminate cost barriers, Congress required insurers and group health plans to cover diagnostic testing for COVID-19 and related items or services without cost-sharing for the duration of the public health emergency.[22] In implementing this requirement, the Departments of Labor, Treasury, and Health and Human Services confirmed that this requirement includes tests that identify active infection and serologic tests that detect the presence of antibodies, which indicates past infection.[23]

CHALLENGES

What tests are covered, and the circumstances under which insurers and plans must cover COVID-19 testing, has caused significant consumer confusion and affordability challenges, leading consumers to face high out-of-pocket costs for COVID-19 tests that they thought would be fully covered by their insurer. The media has highlighted several stories where consumers have faced high cost-sharing for a COVID-19 or related test when they expected their insurance to cover the cost.[24]

Confusion over coverage requirements has been exacerbated by federal guidance that limited the scope of the federal testing mandate only to individuals "with signs or symptoms compatible with COVID-19, as well as asymptomatic individuals with known or suspected recent exposure."[25] According to the guidance, federal testing requirements do not extend to workplace health and safety tests or public health surveillance.

Notably, this guidance is inconsistent with evidence-based testing guidelines from the Centers for Disease Prevention and Control (CDC) on recommendations for the testing of asymptomatic individuals.[26] The CDC guidelines recommend testing for asymptomatic individuals even without known or suspected exposure for early identification in special settings, which the CDC describes as "settings with vulnerable populations in close quarters for extended periods of time."

RECOMMENDATIONS

- To address consumer confusion and gaps in the coverage of COVID-19 testing, state insurance regulators should issue additional guidance on testing coverage requirements, including further defining asymptomatic testing requirements for individuals with "recent exposure" (to include, for instance, occupational exposure for nursing home staff).

- States should prohibit providers and labs from sending surprise medical bills or balance bills for COVID-19 and related testing.

- State insurance regulators should coordinate closely with state and local public health authorities to ramp up testing and provide clear and consistent information to consumers about how to access testing and anticipated costs.

- State policymakers should prioritize equitable distribution of new testing centers and promote access in underserved communities. COVID-19 tests should be accessible for those who rely on public transportation and people with disabilities.

COVID-19 Treatment

The treatments needed for COVID-19 are generally covered by a consumer's health insurance, but cost-sharing varies significantly by plan. Since different plans have different cost-sharing configurations and actuarial values, consumers who need treatment could be left with significant medical bills, at least up to their plan's annual out-of-pocket maximum. One study estimated that potential treatment costs—for large employer health plans and enrollees—could range from about $10,000 (for patients with no complications or comorbidities) to $20,000 (for patients with major complications or comorbidities).[27] Costs for even limited treatment reached $35,000 for one uninsured patient.[28]

CHALLENGES

There is currently no federal requirement for private insurers to cover COVID-19 treatment without cost-sharing. This has resulted in significant variation across states and insurers. Several states have mandated COVID-19 treatment without cost sharing for individual and group plans, and many issuers have voluntarily put in place policies addressing access to COVID-19 treatment.[29] In addition, the COVID-19 treatment regimens going through clinical trials and approval include both oral formulations and infusion drugs administered in hospital settings, with different coverage and cost-sharing implications.

RECOMMENDATIONS

- States should require insurers to cover treatment for COVID-19 or suspected COVID-19 without cost-sharing.

- States should prohibit providers from sending surprise medical bills or balance bills for treatment for COVID-19 or suspected COVID-19.

- States should require insurers to cover all costs for patients enrolled in COVID-19-related clinical trials without cost-sharing.

Prescription Drugs

Many patients, particularly those with serious chronic conditions, have struggled to maintain access to prescription drugs during the public health emergency. This was true initially because of stay-home orders but has remained challenging due to prescription drug shortages and fears of community spread. Utilization management—such as prior authorization that relies on lab panels or in-person visits—has also resulted in barriers for vulnerable patients, particularly those in need of medications to treat opioid use disorders.[30]

Federal law requires Medicare Part D and Medicare Advantage plans to provide up to a 90-day supply of medications for enrollees.[31] However, there are no analogous federal requirements for commercial insurers or group health plans. Several states have issued emergency regulations or required insurers to offer a 90-day supply of prescription drugs or early refills; others have required plans to lift prior authorization requirements.[32]

CHALLENGES

Variability in pharmacy benefits results in significant concerns about the safest and most efficient ways to access medications while also adhering to physical distancing. These challenges disrupt access to treatment and lead to consumer confusion about refill and supply exceptions. Patients also have to grapple with supply chain challenges, particularly for drugs with potential COVID-19 treatment benefits or that depend on component parts from countries where manufacturing has been disrupted. These supply chain disruptions make accessing 90-day fills (or even 30-day fills in some cases) difficult.[33]

RECOMMENDATIONS

- State insurance regulators should require insurers to provide ongoing access to medications, including those used for opioid use disorder treatment. Insurers should be required to authorize 90-day supplies and early refills of prescription drugs, allow medication synchronization, waive prior authorization requirements for ongoing treatment needs, and enable home delivery or mail order.

- State policymakers should closely monitor supply chain disruption and drug shortages to coordinate with insurers, pharmacies, and drug manufacturers and ensure uninterrupted access to medications.

Prior Authorization

Prior authorization is a common utilization management tool used to control costs by limiting, restricting, or denying coverage for certain treatments. Prior authorization can be overly burdensome and negatively impact patient care. A 2019 survey by the American Cancer Society Cancer Action Network found that 70% of physicians reported that prior authorization and other utilization management limit their ability to provide quality care and impose significant administrative burdens that interfere with patient care.[34] Despite these negative impacts on care, some plans routinely deny prior authorization requests.[35] The American Medical Association found that over one-third of patients will abandon treatment due to the complexity of prior authorization.[36]

CHALLENGES

Prior authorization requirements and other utilization management tools are particularly concerning during the COVID-19 crisis. Recognizing that such tools can present a barrier to needed patient care, Congress expressly prohibited insurers and group health plans from requiring prior authorization or other utilization management for COVID-19 testing for the duration of the public health emergency. Prior authorization requirements during the pandemic make even less sense for patients in need of ongoing treatment because many providers are working outside of their usual environment and thus may be less able to meet the requirements to secure prior authorization.

Some states have required plans to waive prior authorization for COVID-19 testing and in some cases treatment. Some Medicaid programs have suspended prior authorization for some outpatient prescription drugs or extended authorization periods to facilitate patient access.

RECOMMENDATIONS

- State insurance regulators should direct insurers to waive prior authorization for COVID-19 diagnostic and antibody testing, including testing conducted as part of ongoing surveillance.
- State insurance regulators should require prior authorization criteria to reflect clinical guidelines and evidence-based standards for appropriate medical use of the treatment and review standards as part of the plan certification process.
- State insurance regulators should educate consumers about how to use internal and external appeals processes and track prior authorization appeals and reversals to monitor whether plans are using prior authorization as an inappropriate barrier to patient care.
- State insurance regulators should promote plan transparency by requiring insurers to publicly post prior authorization standards and procedures online alongside a complete list of services for which prior authorization is required. This information should reflect any changes to prior authorization standards and procedures due to COVID-19.
- State insurance regulators should establish timeliness standards for responding to prior authorization requests, including expedited or emergency approvals.

Surprise Medical Bills

Surprise medical bills posed a significant risk to consumers before the pandemic. Two-thirds of Americans were already worried about being able to afford an unexpected medical bill, and millions faced the risk of a bill from an out-of-network provider during an emergency, during surgery, and during a stay at an in-network facility.[37] There is broad bipartisan consensus that consumers should be protected from surprise medical bills, and 16 states have adopted comprehensive protections against surprise medical bills. But these protections extend only to state-regulated plans and do not protect people with group health plans, which will require action by Congress.

Surprise medical bills also lead to medical debt that can influence individual and family care choices and threaten financial security. Prior to the COVID-19 pandemic, 23% of working-age American adults—about 45 million people—had medical debt or medical bills they were paying off over time.[38] Two-thirds were uninsured at the time they incurred these bills while one-third had coverage that did not sufficiently protect them. Those with medical debt, whether uninsured or underinsured, are three times more likely to postpone care than those not experiencing medical bill problems.[39]

CHALLENGES

The COVID-19 pandemic increases the likelihood that consumers will face surprise medical bills.[40] Disruptions to the health care system have led to the creation of temporary testing sites and clinics, which may be staffed by providers from out-of-state to add capacity. The same is true of hospitals: in staffing up emergency rooms or urgent care centers: staff brought in to help may not be in insurance networks for all patients. Patients, especially those that end up incapacitated and alone, will be unable to ensure that they receive all health care services from network providers.

Beyond COVID-19-specific treatment, patients with serious and chronic conditions may have less access to traditional in-network providers. In-network providers may not be as available or may be operating under restricted hours, which could force patients to see out-of-network providers. This could require patients in need of routine treatment to shift to different providers and facilities, increasing the risk that they will receive an out-of-network surprise bill.

Fear of high medical bills and medical debt could lead consumers to avoid COVID-19 testing or treatment and other urgent health care services. While the federal government has tried to offer some protections against surprise medical bills, these policies do not offer comprehensive protections for patients and are limited to treatment for COVID-19.[41] Potential surprise medical bills will not only discourage patients from seeking appropriate care and lead to worse health outcomes but they will also perpetuate the spread of COVID-19 and prolong the virus's health and economic impacts. When consumers receive surprise bills that they are unable to pay, research shows that debt collection and wage garnishments are more frequent in Black communities, exacerbating financial insecurity.[42]

RECOMMENDATIONS

- States should enact comprehensive protections against surprise medical bills in emergency and non-emergency settings and protect patients from financial harm due to COVID-19 or other health conditions. Insurance regulators in states with existing protections should fully enforce these requirements and ensure that consumers do not receive surprise medical bills, especially for COVID-19 testing and treatment.

- The NAIC and its members should continue to call on Congress to adopt comprehensive federal protections against surprise medical bills, including from air ambulances. Federal protections should not preempt current or future state laws.

- States should require plans to maintain adequate provider networks and ensure that networks can fully serve those with COVID-19 as well as account for increased utilization and new patient care needs. Insurers should take steps to hold patients harmless and minimize out-of-network care during the public health emergency.

- States should require plans to maintain accurate, easily accessible provider directories so consumers can make informed decisions about their care and avoid out-of-network services as much as possible.

- States should suspend medical debt collection activity during the pandemic. Providers and their third-party collection agencies should be required to cease all legal actions and involuntary medical debt collection activity during the state of emergency.

Telehealth

Telehealth has long been an important care delivery method for improving access in underserved communities, particularly rural areas, areas with physician shortages, and areas with limited access to primary care services. But the COVID-19 pandemic has brought renewed and urgent interest in using telehealth to enable remote access to care across service areas and provider types.

Telehealth, including telemedicine and telemental health, helps reduce gaps in access to services and care. Telemedicine can ensure access to specialized providers and promote continuity of care when in-person visits are not a safe option. This enables patients to continue to physical distance and avoid the possibility of exposure. Telemental health enables people to access care to address the fear, stress, and anxiety caused by COVID-19. This is a concern for individuals with underlying health conditions who are at higher risk for severe illness and increased stress due to COVID-19. Access and continuity of care are essential to ensuring patients' health and well-being both during the pandemic and in the future.

CHALLENGES

State and federal policymakers have already increased access to telehealth in response to the pandemic. Doing so has reduced the strain on hospitals and providers while enabling patients to receive care and maintain physical distancing. Congress required insurers and group health plans to cover telehealth-related visits for COVID-19 testing and allowed high-deductible health plans to cover telehealth services on a pre-deductible basis.

The federal government has also issued guidance to make it easier for plans to expand the use of telehealth. This includes relaxing site of care rules for Medicare beneficiaries; allowing audio-only services for Medicare beneficiaries; and allowing Federally Qualified Health Centers and Rural Health Clinics to serve as distant sites for telehealth during the COVID-19 emergency period. But these policy changes are temporary and only in place for the duration of the public health emergency. When the declared public health emergency expires, patients with serious health conditions could lose these new telehealth services, putting their health at risk.

Many states have already required or encouraged insurers to expand access to telehealth services. States can and should continue to eliminate barriers to the use of telehealth and provide permanent solutions that will increase access to care beyond the pandemic.

RECOMMENDATIONS

- State insurance regulators should ensure that telehealth policies provide access for people with disabilities and limited English proficiency and comply with all existing civil rights laws. This includes the use of interpreters and provision of materials in alternative formats and non-English languages.

- If insurers choose to impose cost-sharing requirements for telemedicine visits, state insurance regulators should require that cost-sharing should be less than or equal to an equivalent in-person visit.

- State insurance regulators should allow insurers to make mid-year plan changes to add additional providers that accommodate increased access to telehealth and ensure that enrollees are aware of these additional coverage options. Telehealth services should supplement, not replace, the availability of in-person care. Plans should continue to be required to meet network adequacy requirements based on in-person services.

- States should eliminate barriers to telehealth services. Insurers should be prohibited from using policies that limit access to telehealth such as limiting the device or platform that can be used; requiring a prior relationship between the provider and the patient; limiting coverage to in-network providers when one is not available to provide the necessary telehealth services; requiring greater documentation for claims; requiring an in-person visit for prescribing medication, durable medical equipment, or other services; or imposing more stringent prior authorization requirements for telehealth services.

- State insurance regulators should require insurers to disclose the impact of increased access to telehealth services on rates during the rate review process.
- State insurance regulators should require insurers to provide patients with easy-to-understand information about the availability of telehealth services.
- States should relax credentialing requirements to allow consumers to access licensed physicians in other states and expand access to broadband to rural and other underserved communities.
- State insurance regulators should collect consumer complaints and data from carriers to identify gaps or problems. Data collection should include demographic data on usage and outcomes by the following categories individually and in combination: race, ethnicity, age, disability status, preferred language, sex, sexual orientation, gender identity, socioeconomic status, insurance coverage, and geographic location.

Mental and Behavioral Health Access

Access to behavioral health care has improved in recent years, partly due to parity laws that require carriers to equally cover mental health and physical health benefits and partly due to cultural shifts that help reduce the stigma associated with seeking these services. While these policy and cultural shifts have increased access and utilization, significant and inequitable barriers remain. These prior barriers have only been exacerbated by the COVID-19 crisis, and many COVID-19- relevant solutions are the same solutions that mental health advocates have long championed.

CHALLENGES

Access to mental health care was a problem even before the pandemic. In 2020, nearly a quarter of American adults wanted, but could not access, mental health services, a rate that has not declined since 2011.[43] There are also significant racial disparities in mental health care. Black people have a disproportionately higher need for mental health care due to structural racism and the trauma it inflicts while facing disproportionately lower access to that care.[44] The pandemic has further exposed and exacerbated these barriers by dramatically increasing the need for mental health services due to heightened stress, anxiety, and depression stemming from isolation caused by social distancing measures, economic insecurity, and job loss.[45]

The increased demand for mental health services has further exposed the inadequacy of provider networks and shortage of mental health providers. Many consumers struggle to find providers, particularly providers who are in-network, located close to them, and open to new patients. With many more people seeking care, provider shortages are likely to get worse. The virus also complicates access to in-person care. Many people with preexisting mental health needs are choosing to forego

in-person care to practice physical distancing, while others are choosing to receive in-person care at the risk of contracting the virus. While telehealth has improved access to care for some, complications remain in ensuring parity for providers and patients alike.

Coverage is also a barrier for people in need of mental and behavioral health care. Adults with serious psychological distress are more likely to be uninsured, and many are unable to afford the full cost of mental health services.[46] As the uninsured rate rises, it will become even more challenging for those in need to afford and access the care they need.

RECOMMENDATIONS

- State insurance regulators should require insurers to expand plan provider networks to include more high-quality mental health providers. Plan networks should include mental health providers that are culturally competent and knowledgeable about social determinants of mental health, especially the factors that perpetuate racial and ethnic health disparities that result from systemic racism.

- State insurance regulators should proactively enforce and strengthen mental health parity and network adequacy laws. State insurance regulators should also take steps to promote patient access to telemental health services.

- States should expand the availability of crisis services and increase funding for community health centers.

Health Equity and Racial Justice

Inequities in our country's health care system are systemic, deeply entrenched, and only heightened during a public health crisis. The disproportionate impact of COVID-19 in communities of color shines a spotlight on the systemic racism and economic inequities that affect peoples' health and well-being. The crisis also underscores the importance of addressing structural barriers to access to affordable health coverage and high-quality care for immigrants, people with limited English proficiency, people with complex medical needs, LGBTQ people, and people with disabilities.

Prior to the COVID-19 pandemic and even as the uninsured rate declined nationally, Black people and Hispanic people were 1.5 times and 2.5 times more likely to be uninsured, respectively, than white people.[47] Despite some progress under the Affordable Care Act, one-third of Hispanic people and one-third of American Indian and Alaskan Natives (AIAN) remain uninsured.[48]

Disparities in access to quality providers is equally troubling. More than 100 rural hospitals—located primarily in the South and serving predominately communities of color and low-income communities—have closed their doors in recent years.[49] Similarly, underfunding and provider shortages in the Indian Health Service have led to a crisis of inadequate access to care and poorer health outcomes for the AIAN population.[50] Moreover, even with access to a provider, barriers to culturally competent care and insufficient language access services can deter people, such as those with communications disabilities or those who have limited proficiency in English, from seeking care in the first place or reduce the quality of care.[51]

Systemic racism also creates barriers outside of the health care system that harm the health of people of color. Employment discrimination, food insecurity, lack of affordable and safe housing, and inequities in education are all significant contributors to many chronic health issues.[52]

CHALLENGES

Communities of color have been disproportionately affected by COVID-19: in infection rates, severity, and death.[53] To improve health equity across various lines of business, and to begin to address structural racism in health care, state regulators and policymakers must center equity in their COVID-19 response efforts while also looking for solutions to help address inequities that existed long before the pandemic.[54]

RECOMMENDATIONS

- The NAIC and its members should support Medicaid expansion in the states that have yet to adopt this program. People of color are more likely to be in the Medicaid coverage gap and are disproportionately low-wage workers, many of whom are essential workers on the frontlines of the COVID-19 pandemic.

- The NAIC and state and federal insurance regulators should collect and publish demographic data that includes race, ethnicity, gender, sexual orientation, gender identity and expression age, socioeconomic status, and disability status. Ongoing collection of demographic data by state insurance regulators—from enrollment to complaints—is critical to understanding racial inequities and the intersectionality of race and ethnicity with other factors, such as disability. The collection and public reporting of demographic data is necessary to develop and target interventions to protect those most at risk.

- State insurance regulators should incorporate an equity component into rate and form review processes. States should not sanction products that use benefit designs, rating methodologies, or marketing practices that discriminate against racial, ethnic, and other populations subject to health inequities. Regulators should require health insurers to explicitly disclose how their product design and activities advance health equity and reduce disparities.

- States should adopt state-level language access requirements—such as translation services and notifications—to ensure that persons with limited English proficiency have the information they need from health insurers and health care providers to make informed decisions about accessing health services.

- State insurance regulators should partner with leaders in underserved communities to ensure that consumers fully understand their health insurance rights and responsibilities and to hear first-hand about consumer concerns. These partnerships could advance consumer education and position the insurance department as a source of support among communities of color and underserved communities.

- State insurance regulators should leverage the work of consumer assistance programs and community-based enrollment assisters. These assisters are often deeply rooted in the communities they serve and can help advise regulators on issues faced by their communities and the policies needed to address these concerns.

Long-Term Care

Health insurance issues have largely overshadowed long-term care (LTC) insurance issues during the global pandemic. But for policyholders who currently or may soon need LTC, their health and their LTC coverage are deeply and urgently entwined. Older and disabled persons who live in congregate living facilities, as well as the employees who work there, face an elevated risk of both contracting COVID-19 and dying from the virus. At least 63,000 coronavirus-related deaths of residents and staff have occurred in LTC facilities, representing at least 50% of all COVID-19 deaths in 23 states, a number which is expected to rise as additional states compile and share their data.[55]

Testing of nursing home residents and staff of nursing homes has been inconsistent,[56] and a great majority of nursing home workers report infections at their facilities, with 25% indicating a lack of confidence in their workplace's ability to handle an outbreak.[57] Recent data from hotspot states shows not only increased community infection among younger persons but also infection spikes in LTC facilities across 23 states ranging as high as 23 to 51%.[58]

CHALLENGES

In this context, LTC insurance policyholders who need to trigger the benefits of a LTC insurance policy, or are already receiving benefits at home or in a nursing home, face several dilemmas. Initiating benefits can require an in-person assessment by at least one nurse or social worker, potentially exposing the disabled policyholder and anyone else living in the home. And outside caregivers could be a potential and ongoing source of exposure for a policyholder and for any immune-compromised family members. Families are balancing the risk of continued services from outside providers against the risk of reduced care, leading to lost functional capacity and worsening health that could, in turn, require transition to a LTC facility. Such a transition would be a more expensive covered benefit payment with even greater exposure to COVID-19.

Some policyholders are fortunate to have family caregivers in the home or nearby but they often are excluded as paid caregivers by the language of a LTC insurance policy. This exclusion applies during the elimination period before benefits are paid and throughout the benefit period. Yet family caregivers can be a safe, lower-risk care provider. Family members living with a policyholder or nearby are less likely to present a risk of infection to a person with underlying medical conditions. This has led some family members to successfully negotiate payment for a family caregiver from their insurer on a month-to-month basis during the public health emergency. But others have not taken this route or been refused the option to collect benefits when a family member.

Even policyholders who do not have any imminent need for LTC may, during this time of widespread unemployment and economic crises, face challenges in making timely premium payments in the face of competing demands for meeting basic costs of housing, food, and health insurance. Moreover, some insureds who continue to owe premium payments while receiving home care benefits may feel great financial pressure to end those premiums by entering a nursing home, even though that brings a far higher risk of COVID-19 infection.

Finally, LTC insurance policyholders, older persons, and individuals with preexisting conditions will be affected by the COVID-19 crisis for an extended period beyond the declared public health emergency. Even when infection and death rates fall, and a vaccine is developed, it will take time before herd immunity is achieved and shelter-in-place requirements can be relaxed. While these concerns affect all Americans, they will disproportionately impact vulnerable populations.

RECOMMENDATIONS

State insurance regulators should:

- Require LTC insurers to provide policyholders with the option of undergoing telephonic assessments, health record reviews, and other remote methods to determine whether the LTC insurance trigger has been met.

- Support attempts by insurers to allow substitution of family members as paid caregivers when an insured meets the criteria for receiving benefits. Regulators should recognize how COVID-19 can affect consumers' capacity and willingness to use their LTC insurance benefits and support insurers in allowing an appropriate family member to provide care at home during the public health emergency.

- Inform insurers of a range of reasonable benefit options that could be offered to policyholders that would reduce their exposure to COVID-19 and increase their ability to safely draw on needed benefits.

- Prohibit policy cancellations through at least the end of the national public health emergency and require insurers to provide consumers in danger of losing coverage with a fair opportunity to catch up on premium payments. Before policy cancellations take effect, insurers should be required to provide clear written notice to consumers who are in danger of losing their coverage. Notices should be written in clear language with taglines on the availability of translated materials and inform policyholders on ways to preserve their coverage and options to delay premium payment.

- State regulators should initiate work groups with insurers and consumer advocates focused on the elimination of funding disparities between institutional care and home and community-based care in LTC products. Successful efforts by such working groups would relieve consumers of tough choices between greater coverage and care benefits in LTC facilities where COVID-19 risks have proven difficult to manage, or receiving limited coverage and care benefits in home and community-based care settings.

- Allow insurers to waive premiums for individuals who meet the criteria for requiring a nursing home level of care.

- Recognize reasonable attempts by LTC insurers to provide temporary accommodations that will help policyholders use their needed benefits in ways that maximize the safety and choices of insured consumers and their families during these unprecedented times.

Consumer Education

Health insurance literacy was low before the COVID-19 pandemic, and consumers often struggle to understand insurance terminology and plan design.[59] Even consumers who understand their plans may face surprise out-of-network bills that they expected would be covered by their insurer. Consumers also face significant challenges in understanding the differences between short-term plans, health care sharing ministries, and other types of coverage.[60] This is especially true when these products are aggressively marketed in a fraudulent or misleading way. At the same time, COVID-19 fraud is on the rise as bad actors attempt to take advantage of the crisis. Scams have involved claims about COVID-19 vaccines, cybercrime, medical scams, charity scams, phishing and malware scams, and investment scams, among others.[61]

CHALLENGES

Consumer confusion, coupled with fraudulent marketing, is rampant even as millions need comprehensive coverage and face financial instability. At the same time, consumers are less sure of where to turn for trusted information about the pandemic, and messages have changed as our understanding of the virus has evolved. Information sources include federal and state press briefings, print media, social media, community organizations, and word of mouth.

Fortunately, state officials, including insurance commissioners, remain trusted messengers. In fact, state leaders are among the most trusted sources of public information—behind only the CDC and health care providers.[62] Given the trust of the public, state officials should prioritize clear, actionable information about how consumers can protect themselves and their communities from the virus and how changes in life circumstances impact their health coverage options.

RECOMMENDATIONS

- Elected officials and policymakers should use non-partisan, evidence-based language to discuss the virus, its health effects, prevention measures, and comprehensive coverage options. Clear, evidence-based information has never been more important for consumers.
- State and federal insurance regulators should increase investments in outreach and marketing to ensure that consumers are aware of their options to enroll in comprehensive coverage and to maximize awareness of special enrollment period opportunities. This includes partnering with state unemployment offices and state Medicaid offices to inform consumers of their options.
- All state agencies—from the insurance department to unemployment offices to social workers to benefits coordinators—should provide consumers with clear, easy-to-understand information about how to apply for and enroll in Marketplace coverage, Medicaid, or CHIP as well as the availability of enrollment assistance. Employers should provide employees with the same information in addition to the COBRA notices.
- State and federal insurance regulators should take advantage of all available information channels to ensure that consumers understand their coverage options. These channels may include social media, press conferences, digital outreach, and local/regional media.

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