HEALTH INSURANCE CONSUMER PROTECTIONS

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WHERE CAN CONSUMERS GO FOR COVERAGE?

Discounted Marketplace Coverage

- www.bewellnm.com
- Healthcare.gov (for now!)
- 1-800-318-2596

Medicaid

- www.yes.state.nm.us
- 1-800-283-4465

New Mexico High Risk Pool

- For individuals who do not qualify for other major medical coverage or Medicaid due to lack of open or special enrollment period or immigration status
- www.NMMIP.org
- 1-844-728-7896

Household Size	Income Limit for Adult Medicaid	Income Limit for Discounted Marketplace Premiums
	Annual Income	
1	$17,609	$51,040
2	$23,792	$68,960
3	$29,974	$86,880
4	$36,156	$104,800
5	$42,339	$122,720
6	$48,521	$140,640
7	$54,704	$158,560
8	$60,886	$176,480

2021 HEALTH INSURANCE RATES

Individual Health Insurance Rates on beWellnm

	# of Plans				Average "Age 40" Rates			% Change from Prior Year		
Region	Bronze	Silver	Gold		Bronze	Silver	Gold	Bronze	Silver	Gold
1	12	8	7	2020	$289.48	$361.47	$364.19			
	15	12	9	2021	$250.84	$328.15	$335.90	-13.3%	-9.2%	-7.8%
2	10	7	6	2020	$345.13	$435.68	$437.13			
	15	12	9	2021	$300.94	$392.61	$400.60	-12.8%	-9.9%	-8.4%
3	10	7	6	2020	$327.36	$446.67	$448.01			
	15	12	9	2021	$295.95	$386.33	$395.07	-9.6%	-13.5%	-11.8%
4	11	9	7	2020	$318.22	$421.72	$427.20			
	15	12	9	2021	$296.94	$387.41	$396.48	-6.7%	-8.1%	-7.2%
5	11	9	7	2020	$335.75	$450.58	$455.64			
	15	12	9	2021	$306.98	$400.97	$410.53	-8.6%	-11.0%	-9.9%

SHOP Health Insurance Rates (Small Business)

	# of Plans					Average "Age 40" Rates				% Change from Prior Year			
Region	Bronze	Silver	Gold	Platinum		Bronze	Silver	Gold	Platinum	Bronze	Silver	Gold	Platinum
1	4	8	8	2	2020	$365.20	$392.32	$476.92	$563.20				
	8	8	9	4	2021	$301.53	$339.65	$410.74	$582.96	-17.4%	-13.4%	-13.9%	3.5%
2	4	8	8	2	2020	$511.28	$502.17	$607.73	$788.48				
	8	7	8	4	2021	$400.10	$460.86	$550.71	$816.14	-21.7%	-8.2%	-9.4%	3.5%
3	4	8	8	2	2020	$511.28	$491.23	$593.79	$788.48				
	8	7	8	4	2021	$388.58	$447.86	$534.77	$816.14	-24.0%	-8.8%	-9.9%	3.5%
4	5	8	8	2	2020	$365.20	$376.57	$456.86	$563.20				
	8	8	9	4	2021	$304.29	$342.75	$414.49	$582.96	-16.7%	-9.0%	-9.3%	3.5%
5	4	8	8	2	2020	$511.28	$510.46	$618.28	$788.48				
	8	7	8	4	2021	$403.24	$464.59	$555.78	$816.14	-21.1%	-9.0%	-10.1%	3.5%

WHAT TYPES OF HEALTH-RELATED INSURANCE DOES OSI REGULATE?

Fully-insured major medical insurance

- Individual/non-group
- Small group
- Large group

Short-term limited duration plans

Limited or excepted benefits plans

- Hospital indemnity
- Disability insurance
- Accident or injury policy
- Other related types of coverage

Superintendent of Insurance Russell Toal

Photo by Luis Sánchez Saturno/The New Mexican

OSI does not regulate self-funded/self-insured employer based health plans.

MAJOR MEDICAL CONSUMER PROTECTIONS

1) Grievances and Appeals

2) Surprise Billing and Out-of-Network Protections

3) Prior Authorizations

GRIEVANCE AND APPEALS

Different appeals tracks based on whether the insurance company declines to cover benefits based on:

- Medical necessity reasons
  - For example, insurer does not believe drugs/services are clinically indicated
  - Called “adverse decision appeals”
- Administrative reasons
  - For example, no prior authorization obtained, coverage was no longer in effect, plan operations, etc.
  - Decisions are NOT based on any kind of medical necessity
  - Called “administrative appeals”

TWO DIFFERENT TRACKS FOR ADMINISTRATIVE AND ADVERSE APPEALS

Adverse Appeals (Medical Necessity)

- Involves doctors
  - Plan's medical director (1st level)
  - Independent Review Org or internal panel review (2nd Level)
  - OSI Review (3rd Level) may appoint doctors to the medical review panel
- Allows covered person to present evidence of medical necessity
- Allows covered person to call their own experts

Administrative Appeals

- Billing and coverage (contractual) disputes
- Usually no one is waiting for care

CLIENT ASSISTANCE

NOTICE: Carefully monitor timelines to appeal

File appeals directly with the insurance company

- NOT a doctor
- NOT an agent/broker or their company liaison
- Not OSI

Summary of Process - https://www.osi.state.nm.us/wp-content/uploads/2019/06/Summary-of-Health-Insurance-Grievance-Procedures.pdf

Rule – 13.10.17 NMAC

OSI Complaint Form - https://www.osi.state.nm.us/index.php/managed-healthcare-complaint/

SURPRISE BILLING

Definitions

(1) Emergency care provided by out-of-network provider
   a. May be at an in-network hospital
   b. Has to be medically necessary care

(2) Non-emergent care provided at an in-network facility rendered by a out-of-network provider where
   a. An in-network provider is unavailable;
   b. Out-of-network provider renders unforeseen care; or
   c. Out-of-network provider renders care for which the covered person has not given specific consent

(3) IS NOT – a situation where a covered person knowingly sought out-of-network care

SURPRISE BILLING

Hold harmless

- Consumers are held harmless for anything other than their in-network cost-sharing (deductible, co-insurance, copays)
- Insurance company and provider work out payment based on set benchmarks
- Providers are PROHIBITED from balance billing

EXCEPT – Air ambulance (federal preemption Airline Deregulation Act)

- No benchmark for payment or obligation on air ambulance provider to accept payment for anything less than billed charges ($$$$)
- Insurers still required to hold consumers harmless for anything above their in-network costs
- HOWEVER, air ambulance companies known to try to extort payment from covered persons
- Call insurance company IMMEDIATELY

CLIENT ASSISTANCE

Pattern of providers surprise billing clients in spite of statute? **CONTACT OSI**

- OSI has the right to fine providers who do not comply with the law.

OSI complaint form - https://www.osi.state.nm.us/index.php/managed-healthcare-complaint/

Surprise Billing - N.M.S.A. 1978, § 59A-57A-1 et seq

Air Ambulance Hold Harmless - N. M. S. A. 1978, § 59A-57-4(B)(3)(d)

OTHER OUT-OF-NETWORK CARE RIGHTS

No in-network providers available?

- If a medically necessary service is unavailable in network, a carrier is required to cover the service from an out-of-network service at in-network cost-sharing to the consumer.
  - 13.10.22.8(E) NMAC

Mistaken referral?

- If an in-network provider mistakenly makes a referral to an out-of-network provider the covered person is held harmless for anything other than in-network costs unless the covered person/provider has been previously notified that the referred provider is out-of-network
  - 13.10.22.8(C) NMAC

PRIOR AUTHORIZATIONS (ALSO APPLIES TO MEDICAID)

- 7 business days for standard MEDICAL prior authorization requests
- 3 days for drug formulary/step-therapy protocol exception requests (and all other prescription drug prior authorization requests for state-regulated plans ONLY)
- 24 hours for urgent/emergent care requests

QUESTIONS?

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