Legislative Health and Human Services Committee Update

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Health Insurance Consumer Complaint Process

New Mexico Patient Protection Act – N.M.S.A. 1978, § 59A-57-1

- Passed in 1998
- Broadly covers all health insurance plans offered in NM, including plans offered to public employees through Healthcare Purchasing Act
- Provides for:
  - Transparency in health plan documents
  - Utilization review program requirements
  - Process for consumers to complain about coverage denials, delays, etc.

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Grievance Procedures

- Latest version in effect Jan. 1, 2017
- New rules compliant with consumer grievance procedure requirements under the ACA
- Have federal approval
- Largely based on model law developed by the National Association of Insurance Commissioners (NAIC)
  - NAIC develops model laws to encourage uniform regulation across states

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Standard v. Expedited Initial Determination

Standard Initial

- Non-urgent requests
- Carrier makes decision five days after receipt of the request
- Carrier can extend decision timeline to 10 days for good cause

Expedited Initial

- Urgent requests
- Required to be made in accordance with the medical exigencies of the case, but no longer than 24 hours after request for review
- Expedited review not available for post-service claims

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Administrative v. Adverse Determination Grievance

Administrative

- Billing issues
  - Premium payment disputes
  - Claims payment disputes – not whether the service is covered, but how much the policy pays for service
  - Administrative practices of the plan (ID card issuance, EOB issuance, etc.)

Adverse Determination

- Health care access issues
  - Rescission of coverage
  - Coverage denials or limitations based on a covered person's eligibility to participate in a plan
  - Coverage denials or limitations resulting from the application of utilization review
  - Coverage denials or limitations based on medical necessity determinations or benefits deemed experimental or investigational

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Adverse Determination Appeals Review

Standard Review Process

- Applies where there are not urgent/emergent health care needs
- Review of appeal NOT expedited
- Access to Independent Review Organization (IRO)

Expedited Review Process

- Covered person/representative can request expedited internal review of case in urgent care situation
- Access to Independent Review Organization (IRO)

Final decision by Superintendent is appealable to district court.

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Administrative Appeal

- Timeline similar to standard adverse determination process
- No Independent Review Organization (IRO) process
- External review conducted by Office of Superintendent of Insurance

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Utilization Review

- The process by which a health insurance carrier reviews a request for medical treatment or services
- The purpose of utilization review is to confirm that the health benefits plan provides for coverage of the requested service and that the requested service is medically appropriate for the requested reason.

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Utilization Review

- Activities included in utilization review process:
  - Certification or denial of prior authorization
  - Certification or denial of exemption from drug formulary
  - Certification or denial of request from exemption for step therapy
  - Case management
  - Discharge planning

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Managed Health Care Bureau

- Assists consumers with understanding their rights to appeal coverage and claims denials of requested health care services
- Website for filing a complaint and more information - http://osi.state.nm.us/ConsumerAssistance/index/aspx
- Phone: 1-844-4-ASK-OSI

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Health Care Accessibility

- Network Adequacy
- Surprise Billing
- Air Ambulance

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Network Adequacy

Why do health insurance carriers use provider networks?

Health insurers use provider networks to help keep premium costs down because health insurers negotiate better prices with the health care providers and facilities in network.

Lower prices from in network providers mean consumers pay less in insurance premiums and other charges for health care services.

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Network Adequacy

Regulatory Authority:

- New Mexico Insurance Code gives Superintendent the authority to regulate insurance companies' use of provider networks to control health care costs.

*Patient Protection Act, N.M.S.A 1978, 59A-57-1 et. seq.

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Network Adequacy

Current Regulations:

- Developed in 1998
- Ahead of their time in consumer protections offered
- Cause confusion in enforcement

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Network Adequacy

New Regulation Development:

- Draft regulation language from NAIC model law, neighboring states' regulations (Colorado, Nevada, Arizona, California)
- Stakeholder feedback from providers, carriers, consumer advocates, agents and brokers

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Network Adequacy

Draft Regulations:

- Clarify reporting required for health insurer's access plans. Requires reporting on:
  - Geographic accessibility standards
  - Timeliness of care
  - Procedures for ensuring access to needed medical care
  - Transparency of provider accessibility to consumers

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Network Adequacy

Draft Regulations:

- Provider Access
  - Standards for timely access to care
    - Wait times for various types of appointments
      - Primary Care
      - Specialty Care
      - Emergent Care
  - Geographic Accessibility
    - Time and distance standards based on where insured resides:
      - Metropolitan, micropolitan, rural, and frontier
      - Primary Care, in-patient care, specialty care

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Network Adequacy

Draft Regulations:

- Provider Directories
  - Audit Requirements
    - Once a year, carrier required to audit provider directory
      - Requires carriers to remove providers who have not billed and don't respond to requests for information about network participation from carrier
      - Requires carriers to be more transparent about accuracy of information about actively billing providers

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Network Adequacy

Draft Regulations:

- Provider Directories
  - Requires monthly updates of online directories
  - Requires timely investigation/response to reports of directory inaccuracies
  - Standardizes information provided in directories
  - Requires searchable formatting
  - Requires transparency in provider network tiering, if utilized
  - Continues protections for consumers who rely on provider directory information that is inaccurate to obtain health care services

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Surprise Billing

Legislation Introduced in 2017 Regular Session:

- House Bill 313
  - Addresses out-of-network emergency care and out-of-network care obtained unknowingly at in-network facilities
  - Holds consumers harmless for surprise, out-of-network bills – consumers only pay what they would owe for in-network services
  - Created process for carriers/providers to work out payment of surprise bills
  - Arbitration process for resolution of disputes where provider/carrier can't work out billing disputes
  - Requires carriers to disclose to consumers information about expected out-of-pocket costs for health care services/procedures provided in advance

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Surprise Billing

House Bill 313:

- Response:
  - Providers/carriers want standardized reimbursement rates rather than uncertainty of "work it out amongst yourselves"
  - Request to clarify what constitutes a "surprise bill" for PPO members
  - Concerns with automatic assignment of benefits if provider directly bills insurer for out-of-network costs

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Surprise Billing

Road Ahead:

- Additional Stakeholder Convenings:
  - First convening on July 27th
  - Participants include carriers, providers, consumer advocates, agents and brokers, policymakers
  - Will discuss the first major issue – reimbursement rates
- Surprise Billing Survey
  - Consumer survey developed using Consumer's Union national survey on surprise billing
  - Circulated electronically
  - Preliminary results

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Surprise Billing

Surprise Billing Survey PRELIMINARY Findings:

- 48% of survey respondents reported that they had received a medical bill where the health plan paid much less than they thought it would (or perhaps not at all).
  - 45% of those who answered yes two this question reported that the bill was between $100-$500.
  - 26% responded that the bill was between $501 and $1,000
  - 24% responded that the bill was over $1,000
- Of respondents with surprise medical bills:
  - 21% reported that the bill was from a doctor they did not expect a bill from
  - 10% reported that they got separate bills from multiple providers
  - 12% reported that they were charged at an out-of-network rate when they thought they provider was in-network

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Surprise Billing

Surprise Billing Survey PRELIMINARY Findings:

- Did you take any action to resolve this billing issue?
  - 66% Yes
  - 31% No
- If not, why not?
  - 44% said they didn't think it would make any difference
  - 14% said not worth their time
  - 11% said too complicated
- Of those respondents who referred to health insurance plan documents for information, 48% said the documents were not very helpful or not helpful at all, compared to 34% who said documents were helpful
- Of those with billing issues, 30% responded that the issue was resolved, but not how they liked, and 25% reported that the problem was not resolved

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Surprise Billing

Surprise Billing Survey PRELIMINARY Findings:

- In past two years, 31% of respondents said that they were surprised to find out that a doctor, labor, or facility that they thought was in network was actually out-of-network
- 23% reported that on-line provider directories were difficult to use
- 73% typically assume that doctors at an in-network hospital are also in-network
- 96% think hospitals should have to notify patients if a doctor or technician involved in a procedure performed at that hospital will be out-of-network
- 45% of respondents believe that if an error in their health plan's provider directory causes them to go to a doctor or hospital that is actually out-of-network, they are still required to pay the extra cost of the out-of-network visit

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Surprise Billing

In the meantime:

- Bulletin outlining current consumer protections:
  - NM Patient Protection Act - requires that managed health care plans provide covered persons reasonable access to emergency care that is immediately available without prior authorization and "is not subject to additional costs" to the covered person.
    - N.M.S.A. 1978, 59A-57-4(B)(3)(d)
    - Applies to all health insurance plans that offer emergency room care
- Additional protections
  - Continued requirement to provide access to out-of-network specialty/other care at in-network cost to consumers where in-network care is unavailable

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Air Ambulance

House Bill 402

- Set rates for reimbursement of air ambulance insurers for commercial insurance plans sold in NM
- Caps health insurance reimbursement at no more than 250% of Medicare per air ambulance flight as a requirement of insurance contracts issued to consumers in NM

Federal Airline Deregulation Act

- Has been interpreted to prohibit states from regulating air ambulance charges
- HB 402 tried to get around this by regulating the "business of insurance," rather than the air ambulance company
- Air ambulance company since made arguments that ADA preempts states' federally granted authority to "regulate business of insurance" in this context

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Air Ambulance

North Dakota

- Passed legislation copying NM HB 402
- Waiting to get sued – for the second time

Woodall Amendment

- Representative Rob Woodall, Athens, GA introduced amendment to Federal Aviation Administration reauthorization act to require a stakeholder committee to examine health care charges of air ambulance providers and recommend consumer protections for air ambulance services

Government Accountability Organization

- Federal GAO will soon release report about air ambulance industry

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