# Health Insurance Rate Review Grant

## & Consumer Assistant Program

## Grant Updates

NMPRC Division of Insurance

NEW MEXICO
PUBLIC REGULATION COMMISSION

PRC

*Working for You!*

November 2, 2011

# *NEW MEXICO PUBLIC REGULATION COMMISSION*

1120 PASEO DE PERALTA
P.O. Box 1269
Santa Fe, New Mexico 87504-1269
1(888) 427-5772/(505) 827-4601

Insurance Division

**NM Aging and Long-term Service Department**
**(Medicare and long term care services)**
2550 Cerillos Road
Santa Fe, NM 87505
1-800-432-2080

**NM Department of Health**
**(Complaints against Health Care Facilities)**
1190 S. St. Francis Dr.
Santa Fe, NM 87502
1-800-752-8649

**NM Department of Health - Incident Management**
**(Complaints against community based programs)**
1190 S. St. Francis Dr.
Santa Fe, NM 87502
1-800-455-6242

**New Mexico Human Services Department**
**Medical Assistance Division (Medicaid)**
Office of Director
PO Box 2348
Santa Fe, NM 87504
1-888-997-2583
505-827-3100

**NM Health Insurance Alliance**
**(Small employers and individuals)**
1-800-204-4700

**NM Independent Insurance Agents Association**
**(Administers products and services)**
1-800-621-3978

**NM Medical Board**
**(Complaints against Physicians & Physician Assistants)**
2055 S. Pacheco Street Bldg 400
Santa Fe, NM 87505
505-476-7220
1-800-945-5845

**NM Medical Insurance Pool**
**(Individuals denied coverage and uninsurable)**
1-866-622-4711

Managed Health Care Bureau

**NM Public Schools Insurance Authority (NMPSIA)**
410 Old Taos Highway
Santa Fe, NM 87501
1-800-548-3724

**NM Retiree Health Care Authority**
4308 Carlisle Blvd., NE Suite 104
Albuquerque, NM 87107
1-800-233-2576

**NM Risk Management**
**(State Employees)**
1100St. Francis Drive
P.O. Box 6850
Santa Fe, New Mexico 87502
505-827-0442
1-877-301-8041

**NM Workers' Compensation Administration**
2410 Centre Avenue SE
P.O. Box 27198
Albuquerque, NM 87125-7198
1-800-255-7965

**The Centers for Medicare and Medicaid (CMS)**
7500 Security Boulevard
Baltimore MD 21244-1850
1-800- Medicare (1-800-633-4227)

**US Department of Labor**
**(ERISA- Self Funded)**
525 Griffin St.
Dallas, TX 75202-5025
1-972- 850-4500

**US Office of Personnel Management**
**(Military & Federal Gov)**
Office of Insurance Programs
1900 E. Street NW
Washington, DC 205145
(202)606-1800

# 2010 Annual Health Plan Grievance Report

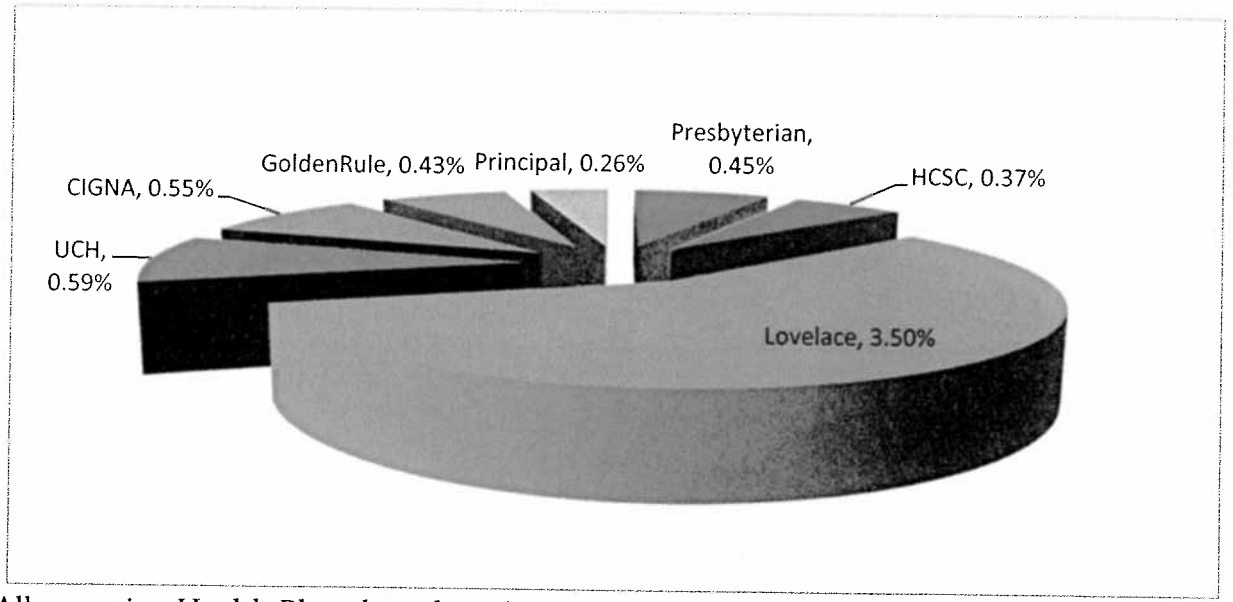
NEW MEXICO
PUBLIC REGULATION COMMISSION
PRC
INSURANCE DIVISION
Managed Health Care Bureau

# TOTAL NUMBER OF GRIEVANCES REPORTED BY INSURANCE COMPANIES SUBJECT TO MHCB GREIVANCE PROCEDURE

| | |
|---|---|
| • *PRESBYTERIAN (PHP) MEMBERS REPORTED:* | *1,340* |
| • *HEALTH CARE SERVICE CORP (HCSC) MEMBERS REPORTED:* | *1,015* |
| • *LOVELACE (LHP) MEMBERS REORPTED:* | *1,758* |
| • *UNITED HEALTH CARE (UCH) MEMBERS REPORTED:* | *145* |
| • *CIGNA* | *27* |
| • *GOLDEN RULE* | *11* |
| • *PRINCIPAL* | *9* |

# MEMBERSHIP by CARRIER for 2010

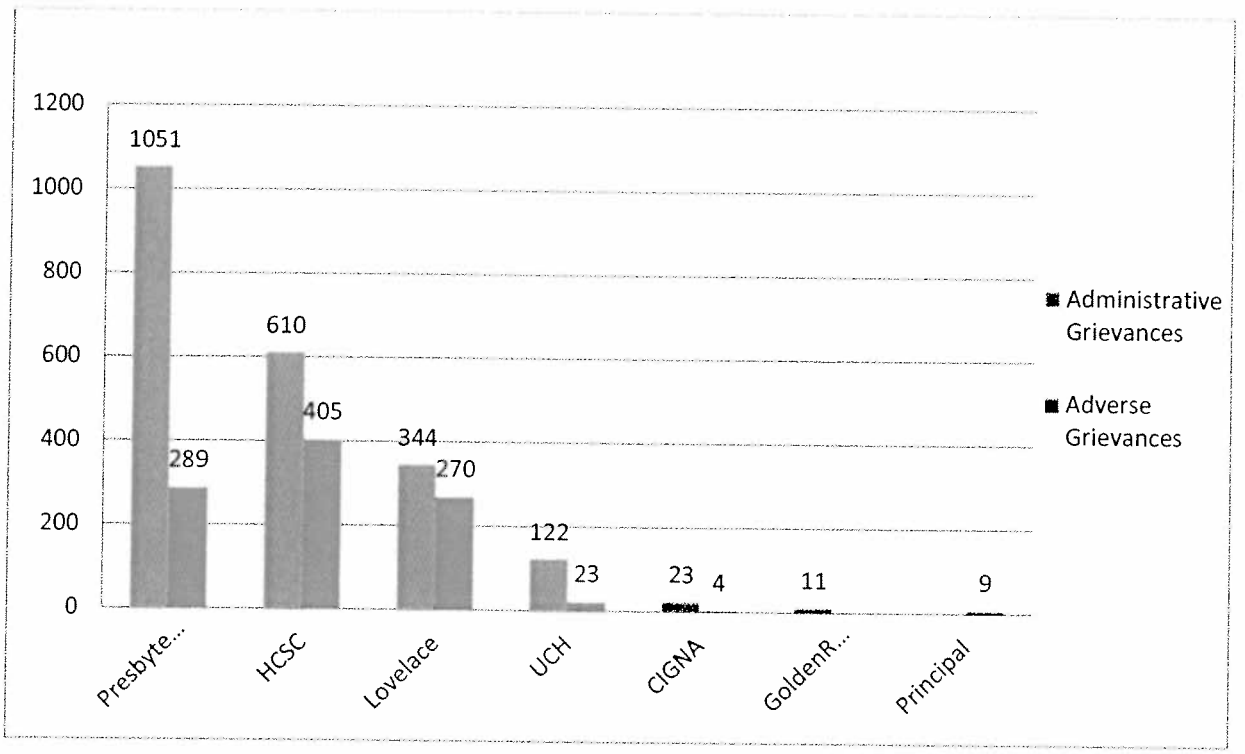
| | |
|---|---|
| • *PRESBYTERIAN (PHP) MEMBERS REPORTED:* | *296,694* |
| • *HEALTH CARE SERVICE CORP (HCSC) MEMBERS REPORTED:* | *275,661* |
| • *LOVELACE (LHP) MEMBERS REORPTED:* | *50,225* |
| • *UNITED HEALTH CARE (UCH) MEMBERS REPORTED:* | *24,449* |
| • *CIGNA* | *4,889* |
| • *GOLDEN RULE* | *2,576* |
| • *PRINCIPAL* | *3,442* |




All reporting Health Plans have less than 4% consumer grievances ratio based on their membership with plans regulated by the Division of Insurance.

# HEALTH CARE INSURANCE COMPLAINTS BY TYPE

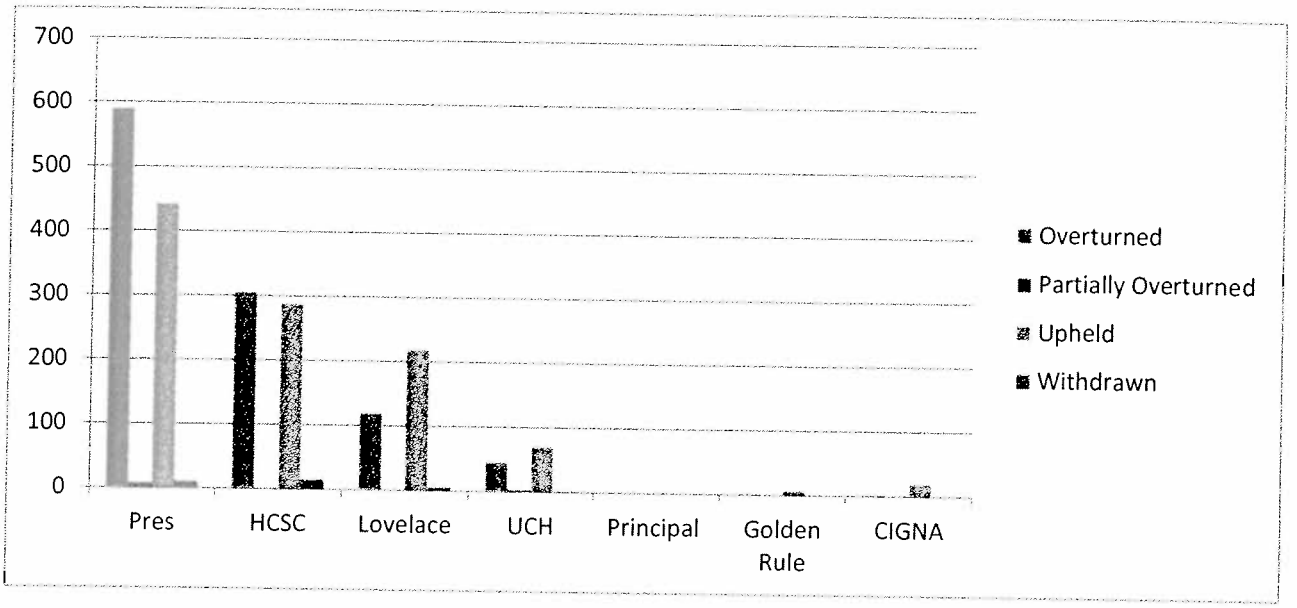
Each individual eligible to purchase insurance, which has been denied coverage, or is covered and dissatisfied with the determination of the health care plan's decision, has the right to file a grievance and appeal the plan's decision. There are two types of grievances – administrative and adverse determination. The chart below shows the amount of administrative and adverse determination grievances filed by each health insurance carrier.




1. Administrative grievances – Complaints regarding any aspect of a health benefits plan other than a request for health care services, including but not limited to:

1. Administrative practices of the health care insurer that affects the availability, delivery, or quality of health care services;
2. Claims payment, handling or reimbursement for health care services; and Terminations of coverage.

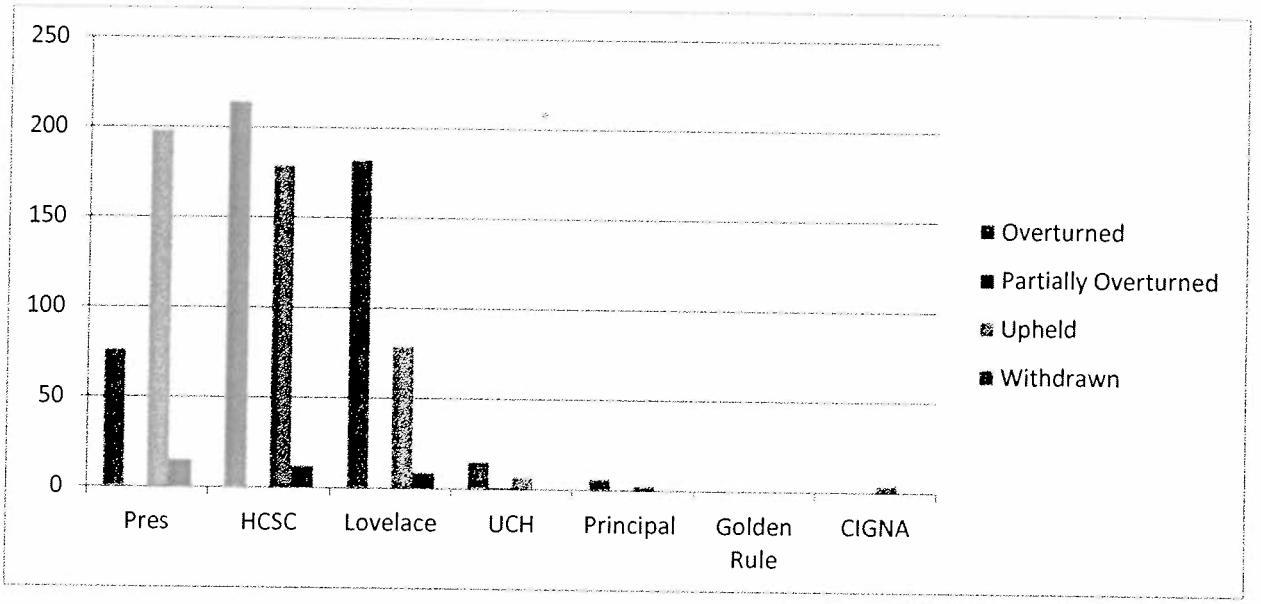
## Results of Review for Administrative Grievances




2. Adverse Determination Grievances – Complaints regarding a decision made either pre-service or post service, by a health care insurer that a health care service requested by a provider or covered person has been reviewed and based upon the information available does not meet the health care insurer's requirements for coverage or medical necessity, and the requested health care service is therefore denied, reduced or terminated. Adverse determinations also include, but are not limited to, rescissions of coverage except in the case of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of material fact.

Every grievant who is dissatisfied with the determination of the health care plan's final decision may request an independent review called an external review by the Superintendent of Insurance. If the request for an external review is complete and meets the criteria, an informal hearing will be set to determine whether the covered person was deprived of medically necessary covered services. The Superintendent shall designate a panel (an attorney and two licensed health care professionals) to review the case and provide the Superintendant with a recommended decision regarding the adverse determination. Based on the panel's recommendation, the Superintendent will issue an appropriate order.
Administrative grievances do not proceed to hearing. If the request meets the criteria for an external review, the Superintendent will review all documents submitted and issue a written decision based on the information provided.

## Results of Review of Adverse Determinations




## Managed Health Care Insurance Grievance Levels

There are two levels for each Health Insurance Carrier's internal grievance process.

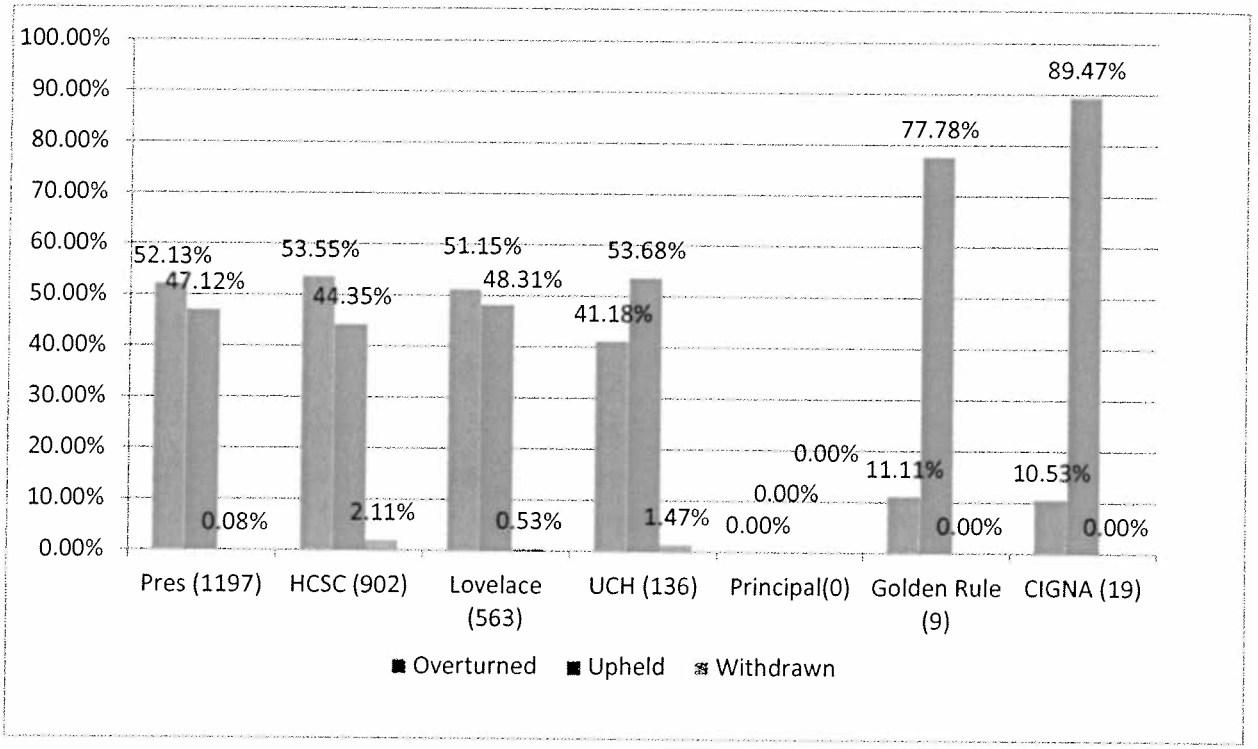
- ❖ 1st level is a review of the initial denial and completed by health insurance carrier's medical director or his designee.
- ❖ 2nd level is review of the first level denial by a medical panel. At this stage of review it allows for member representation along with other members.

The 3rd level is a complaint that has exhausted level one and level two of the internal review process and meets the criteria for an external review.

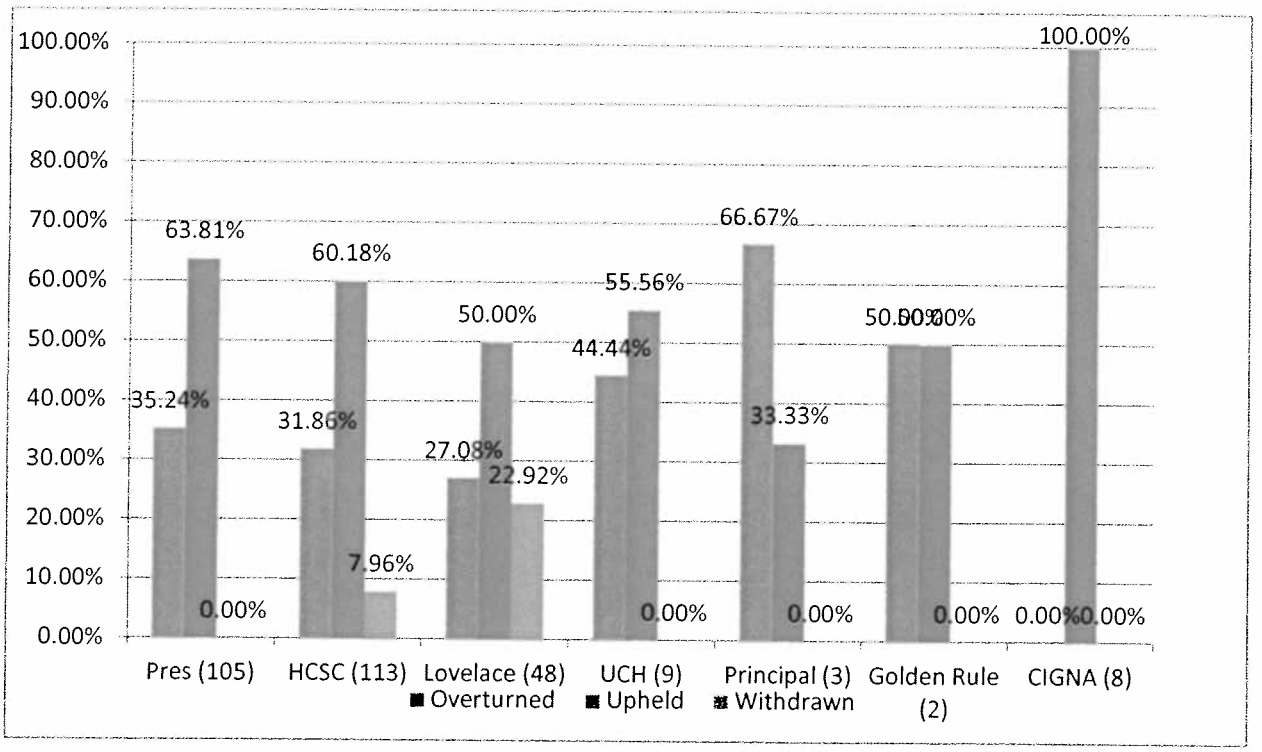
## Facts and Findings

- *1015 - Total complaints were filed with Health Care Service Corporation. 12.53% of the initial complaints went to the 2nd Level*
- *1758 Total Complaints were filed with Lovelace. 8.53% of the initial complaints filed were taken to the 2nd Level*
- *145 – Total complaints filed with United HealthCare. 6.62% of the initial complaints were taken to the 2nd Level.*

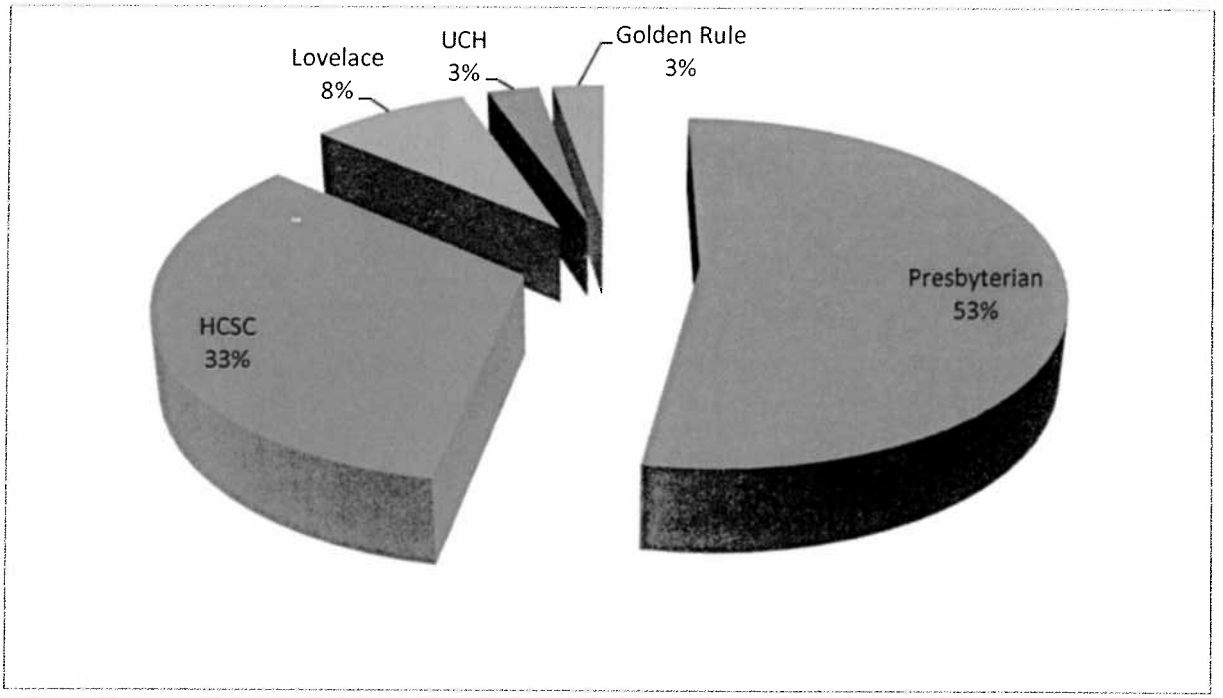
## Internal Review Results at 1St Level




## Internal Review Results at 2nd Level



# External Grievances initiated by Managed Health Care Bureau



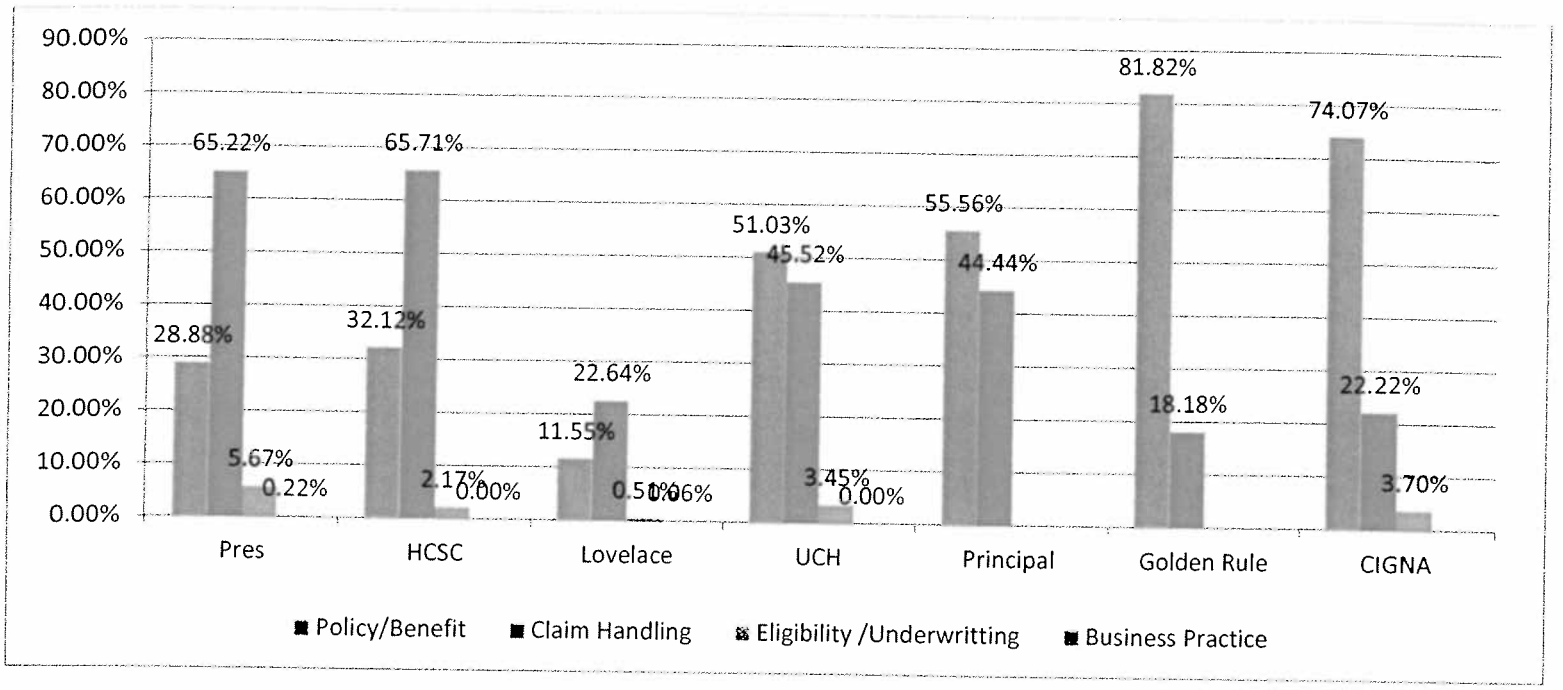

Above is the volume of external grievances that have been initiated by the Managed Health Care Bureau. Not all of the grievances have reached the stage of external review for an informal hearing. Many of the grievances are resolved prior to the scheduled informal hearing.

The withdrawn cases are those that do not have sufficient information to present a case or the grievant does not wish to pursue the grievance any further.

The upheld cases are external reviews that have proceeded through the informal hearing process and an order was issued that ***was not*** in favor of grievant.

The overturned cases are external reviews that have proceeded through the informal hearing process and an order was issued that was in favor of the grievant.

## GRIEVANCE RESASONS PER HEALTH PLAN




| **Eligibility Description** | **Policy Description** | **Claim Handling Description** | **Marketing Description** |
|---|---|---|---|
| Rider | Access to care | Pre-Authorization | HIPPA |
| Termination | Quality of care | Co-Insurance | Misleading Advertising |
| Rescission | Not Covered | Deductible | No benefit Booklet |
| COBRA | Medical Necessity | Balance Billing | Agent Issues |
| Premiums | Experimental/Investigational | UCR | Misrepresentation |
| Pre-Existing | Covered Benefits | Out of Network/In Network | Internal Policy |
| Personal Information | Timeliness | Referral | |
| Carryover | Cosmetic | Assignment of Benefits | |
| | Education | Claim Submitted incorrectly | |
| | Misquote | Secondary Provider | |

National Association of Insurance commissioners (NAIC) is the organization of state insurance regulators for all 50 of the United States. Above is a list of categories of complaints, recognized by the NAIC, which allows uniformity in reporting the most common reasons for complaints. .

# DOLLARS SAVED TO THE CONSUMERS

Of the inquiries/grievances researched by the Managed Health Care Bureau recorded a savings to the consumers in the amount of $977,328.27.

167 Inquiries/complaints for Health Care Service Corporation were initiated through the MHCB. 23 of the inquiries were referred to proper agency, 74 of the remaining complaints were referred to rates/contract, and of the remaining 70 complaints, dollars saved for the consumer was $125,064.61.

87 inquiries/complaints against Presbyterian Health Plan and Presbyterian Insurance Company were initiated through the Managed Health Care Bureau. 20 of those inquiries were referrals to other agencies and 2 complaints were referred to rates/contracts. Of the remaining 65 complaints, the dollars saved for the consumer was $56,329.89 with Presbyterian Health Plan and $59,725.33 with Presbyterian Insurance Company.

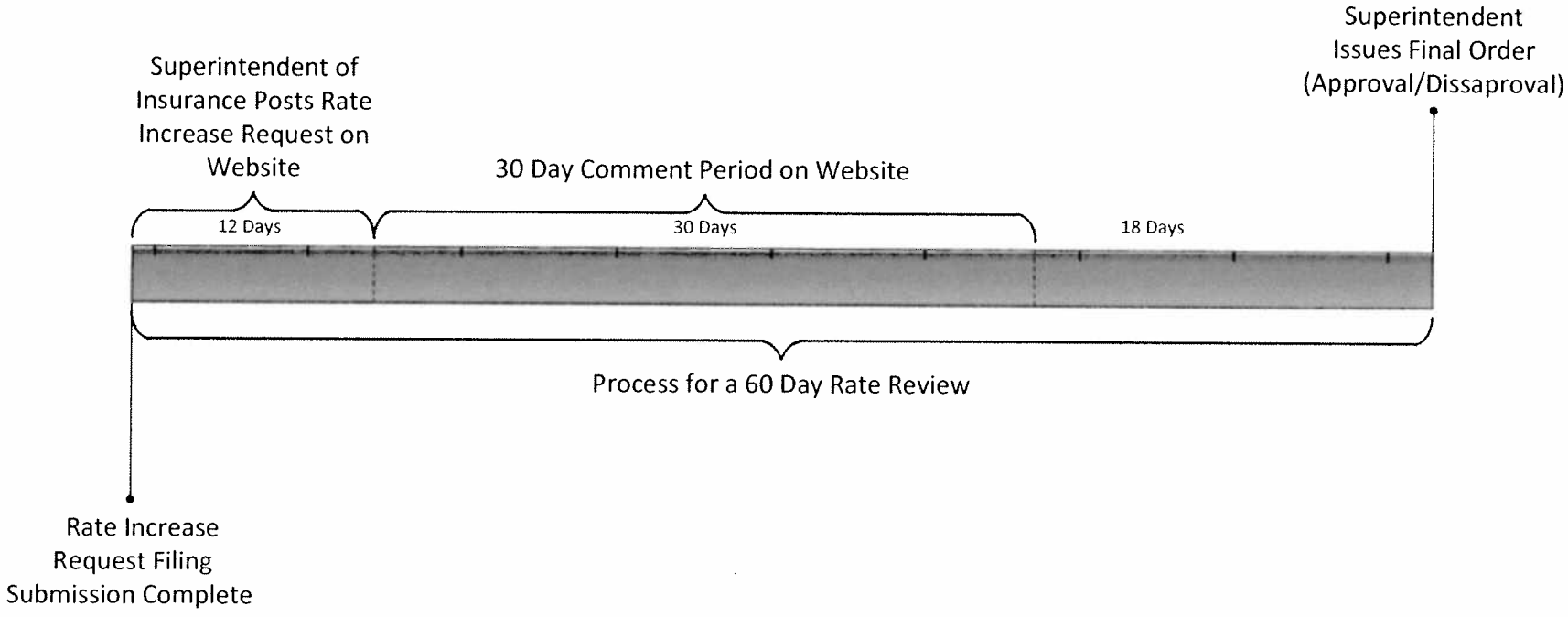
48 Inquiries/complaints against Lovelace Health Plan and Lovelace Insurance Company were initiated through the MHCB. 12 of the inquiries were referrals to other agencies. Of the remaining 36 complaints the dollars saved for the consumer was $159,277.36.

43 inquiries/complaints for United Health Care Insurance Company were initiated through the MHCB. 23 of the inquiries were referrals to other agencies. Of the remaining 20 complaints the dollars saved for the consumer was $42,298.80.

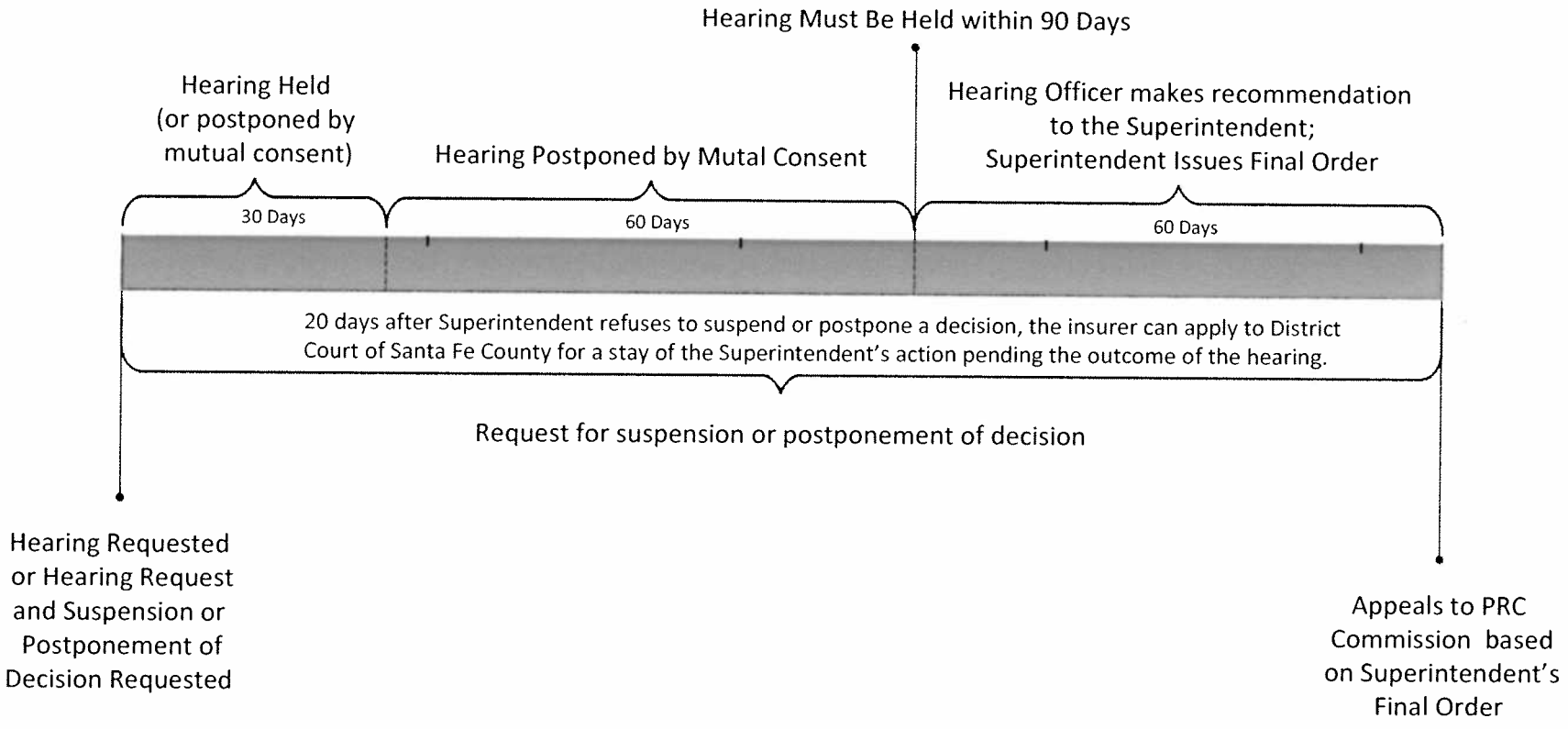
| Primary Insurance Companies | |
|---|---|
| Health Care Service Corporation, A Mutual Legal Reserve Company | **$125,064.61** |
| Lovelace Insurance Company | **$3,040** |
| Lovelace Health Plan | **$156,237.36** |
| Presbyterian Health Plan | **$56,329.89** |
| Presbyterian Insurance Company | **$59,725.33** |

| | |
|---|---|
| United HealthCare Insurance Corporation | **$42,298.80** |
| Other Insurance Companies | **$534,632.28** |

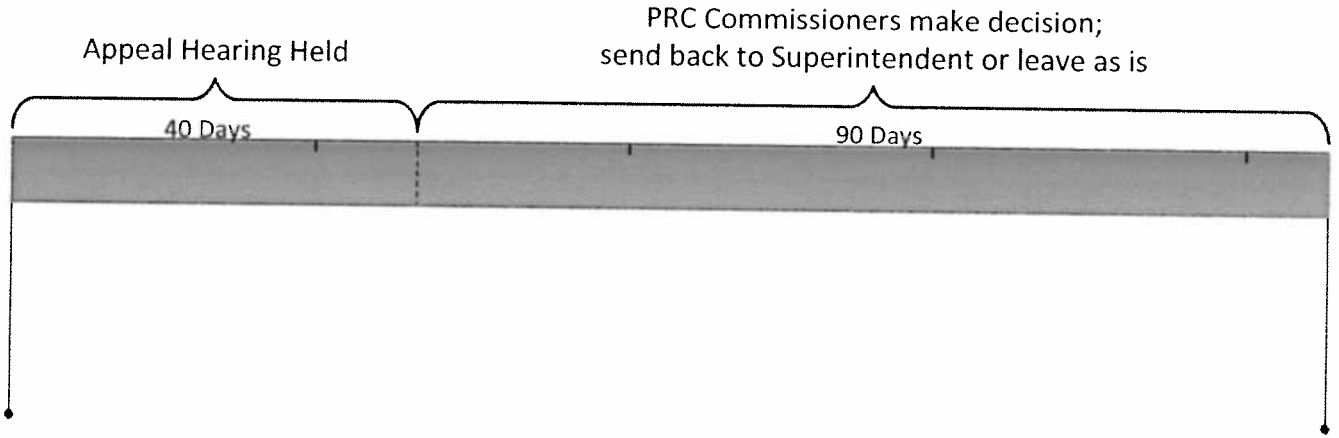
# Rate Request Timeline



# General Hearing Request Timeline



# Hearing Appeals Timeline




Appeal of Hearing Outcome filed with PRC Commission Within 20 Days of Final Order

PRC Commission Decision Made

**Decision may be appealed to the New Mexico State Supreme Court**

## Web Site Enhancements

**Search/Display Rate Filings** (dependent on Web Services)

- Search rate filings based on multiple search criteria
    - Search based on company name, date range of rate submission, all recent submissions
- Display results of search, to include the following elements
    - Provide links to PDF documents (pull the PDF from SERFF)
    - Provide link to submit a comment (may overlap with deliverable Interactive Services)
    - Provide link to request a hearing (may overlap with deliverable Interactive Services)

**Consumer Notification** (dependent on Web Services)

- Allow consumer to "sign up" to be notified when a company (s) submit a rate increase request, or any other notification options
- Allow system to notify consumer when company submits a rate increase request
- Allow system to notify consumer when rate increase request decision has been made by DOI
- Allow system to notify consumer when a hearing is scheduled on a rate increase request

**Interactive Services** (partially dependent on Web Services)

- Allow consumers to submit emails via the website, s independent of the user's email client
- Automatically respond to emails with an predetermined respond depending on topic
- Allow consumers to submit a comment associated with a rate increase request (may overlap with deliverable Search and Display Rate Filings)
- Allow consumers to submit a hearing request associated with a rate increase request (may overlap with deliverable Search and Display Rate Filings)

**Calendar**

- Display calendar events by date
- Display calendar events in calendar format
- Send notification to consumers when events are added to calendar

# Health Care Insurance Premium Budget Narrative

## *RATE REVIEW CYCLE II PHASE I*

### *Breakdown of Proposed budget and Allocation*

The budget breakdown for the allocated amount of one million dollars per year to allow New Mexico to enhance the rate review process and provide information to consumers will be divided up into six overall categories listed below.

### *Breakdown of Proposed Budget and Allocation by Category*

| Category | Proposed Allocation per Year | Proposed Allocation for Grant Term |
|---|---|---|
| Personnel | **364,000.00** | **1,092,000.00** |
| Fringe Benefits | **120,120.00** | **360,360.00** |
| Travel | **27,000.00** | **81,000.00** |
| Supplies & Other Expenses | **43,700.00** | **115,100.00** |
| Contractual | **180,847.00** | **558,540.00** |
| IT | **264,333.00** | **793,000.00** |
| **Total** | **1,000,000.00** | **3,000,000.00** |

***Breakdown of Proposed Budget and Allocation***

| Personnel | Personnel Budget Breakdown per Year | Fringe Benefits Budget Breakdown per Year | Total Proposed Allocation per Year | Proposed Allocation for Grant Term |
|---|---|---|---|---|
| Hearing Officer | 60,000.00 | 19,800.00 | 79,800.00 | 239,400.00 |
| Financial Analyst | 70,000.00 | 23,100.00 | 93,100.00 | 279,300.00 |
| Consumer Analyst | 50,000.00 | 16,500.00 | 66,500.00 | 199,500.00 |
| IT Analyst | 84,000.00 | 27,720.00 | 111,720.00 | 335,160.00 |
| Attorney | 70,000.00 | 23,100.00 | 93,100.00 | 279,300.00 |
| Administrative Support | 30,000.00 | 9,900.00 | 39,900.00 | 119,700.00 |
| **Total** | **364,000.00** | **120,120.00** | **484,120.00** | **1,452,360.00** |

The four positions that have been established and two additional staff including an Attorney and Administrative Assistant as staff for the Consumer and Business Task Force will be dedicated at a 100% level of effort for each of the primary duties listed below:

- The Hearing Officer will oversee the hearing process and serve as the decision-maker in rate increase complaints filed with the Superintendent.
- The Financial Analyst will be responsible for recommendations to the Superintendent and will act as the contact manager for actuarial services.
- The Consumer Analyst will develop and coordinate education and customer service activities.
- The IT Analyst will be responsible for ensuring the filing and rate summaries are accessible on the DOI website, along with additional consumer information. This position will be responsible for all coordination and reporting requirements and will be the contract manager for SERFF enhancements.

- Attorney-To assist the Hearing Office with legal advice. Ensure that the DOI is in compliance with staff and federal regulations for Health Care Reform. Provide legal counsel with expertise in Health Insurance to the DOI. Make sure all federal reporting is current and with the regulation.
- Administrative Support for Attorney and Task Force- This will add administrative assistance for the rate review Task Force employees and staff.

| Travel & Training | Travel & Training Budget Breakdown per Year | Travel & Training Budget Breakdown per Grant Term |
|---|---|---|
| Hearing Officer | 6,000.00 | 18,000.00 |
| Financial Analyst | 3,000.00 | 9,000.00 |
| Consumer Analyst | 6,000.00 | 18,000.00 |
| IT Analyst | 6,000.00 | 18,000.00 |
| Attorney | 6,000.00 | 18,000.00 |
| **Total** | **27,000.00** | **81,000.00** |

The Travel & Training Budget is estimated as follows:

- The Hearing Officer will attend two training seminars in Reno, Nevada at the National Judicial College. This $6,000.00 budget includes $1,500 for airfare, $1,500 for lodging, $2,000 ($1,000 per event) registration and $1,000 for miscellaneous expenses.
- The Financial Analyst will attend one training seminar at a location to be determined. For budgeting purposes the Financial Analyst training was estimated based on participation in a financial training course at the NAIC in Kansas City. The budget $3,000.00 includes $750 for airfare, $750 for lodging, $1,000 registration and $500 for miscellaneous expenses.
- The Consumer Analyst will participate in two relevant training seminars. For budgeting purposes the $6,000.00 budget was estimated based on participating in the NAIC consumer seminars. This $6,000.00 budget includes $1,500 for airfare, $1,500 for lodging, $2,000 ($1,000 per event) registration and $1,000 for miscellaneous expenses.
- The IT Analyst will participate in two relevant training seminars. For budgeting purposes the $6,000.00 budget was estimated based on participating in the NAIC IT seminar and other relevant training in IT topics. This $6,000.00 budget includes $1,500 for airfare,

$1,500 for lodging, $2,000 ($1,000 per event) registration and $1,000 for miscellaneous expenses.

- The Attorney will participate in two relevant training seminars. For budgeting purposes the $6,000.00 budget was estimated based on participating in the NAIC convention and summer meeting. This $6,000.00 budget includes $1,500 for airfare, $1,500 for lodging, $2,000 ($1,000 per event) registration and $1,000 for miscellaneous expenses.

| Supplies & Other Expenses | Supplies & Other Budget Breakdown per year | Supplies & Other Budget Breakdown per Grant term |
|---|---|---|
| Supplies for Task Force | 8,000.00 | 8,000.00 |
| Public Meetings | 20,000.00 | 60,000.00 |
| Miscellaneous Expenses | 15,700.00 | 47,100.00 |
| **Total** | **43,700.00** | **115,100.00** |

The proposed $8,000.00 budget for start-up supplies includes the cost of envelopes, pens, paper, folders and etc.

The budgeted $20,000.00 breakdown for the Public Meetings includes:

- $7,200.00 cost for posting / advertising public meetings
- $1,200.00 per month or $14,400.00 per year for hearing transcription stenographer / court reporter
- Miscellaneous Expenses include:
    - Meeting sites at $500 per month or $6,000 per year.
    - Interpreter at $200 per month or $2,400 per year.
    - $95 per employee per month or $5,700 per year for travel to public meetings

| Contractual Services | Contractual Services Budget Breakdown 1st year | Contractual Services Budget Breakdown 2nd Year | Contractual Services Budget Breakdown 3rd Year | Contractual Services Budget Breakdown per Grant Term |
|---|---|---|---|---|
| Actuarial Services | 100,000.00 | 100,000.00 | 50,000.00 | 250,000.00 |
| IT Development (See IT Section) | 731,800.00 | 731,800.00 | 731,800.00 | 731,800.00 |
| Case Study, Research, & Development | 40,424.00 | 40,424.00 | 40,424.00 | 121,272.00 |
| Public Information | 62,423.00 | 62,423.00 | 62,422.00 | 187,268.00 |
| **Total** | **202,847.00** | **202,847.00** | **152,846.00** | **558,540.00** |

In order to strengthen the rate review process the proposal requires an actuarial contract to review on-going rate requests and provide recommendations to the Superintendent of Insurance. The additional professional review rather than relying on internal opinion before a decision is rendered. The proposal includes the development of a web-based system to disclosed premium rate increases and rate summaries to the public and will require a contract for webmaster services.

Contracts will be sought for consulting services in the development and function of the Task Force and the legislative research for law-making to allow the Superintendent to carry out the proposed enhancements and provides citizens disclosure as well as additional consumer services and consumer education.

Another piece that will be accomplished includes performing a Case Study on integrated delivery systems with a parent Health Plan to identify additional transparency for consumers that can reduce the overall cost of health care and in turn can produce reduce premiums for consumers. A research firm will be contracted to produce quantitative and qualitative reports. A media campaign can be produced to include the Superintendent and or Commissioners in a media commercial to advise consumers of the new changes and empower them with the new laws in laymen's terms as well as direct them to the new website for more information and access to the rate increase filings. Please note the all appropriate contracts will follow the NM Procurement Code, thus and RFP process will be established.

***IT Software Design, Develop and Implementation Cost***

| IT | IT Budget Breakdown per year | IT Budget Breakdown per Grant Term |
|---|---|---|
| IT Contractors Computers | 3,067.00 | 9,200.00 |
| IT Professional Services Contract<br><br>2 Developers @ 70.00/Hr for 1 Year 285,600<br><br>(Recurring Cost for 3 years) | 243,933.00 | 731,800.00 |
| SERFF Enhancements | 7,333.00 | 22,000.00 |
| Web Servers for the Rate Review Enhancement | 5,000.00 | 15,000.00 |
| Software for Developers to Design, Develop and Implement Rate Review Website | 5,000.00 | 15,000.00 |
| **Total for 3 Years** | **264,333.00** | **793,000.00** |

IT Professional Contract Developers will enhance the existing application for Consumer Rate Review Program to align Procuring Agency federal reporting with National Association of Insurance Commissioners (NAIC) . IT Professional Contract Developers will create and enhance web application and database data transfer interfaces. IT

Professional Contract Developers will perform new software development activities The IT Professional Contract Developers are expected to provide Consumer Rate Review Application Programming Services for the following applications during Cycle Two Phase One of the Consumer Rate Review (CoRRe) Project:

- Enhance Consumer Rate Review Application based on new regulatory requirements.
- Enhance the Rate Review Program website to meet the new regulatory requirements.
- Display Hearing Scheduling for the public on the web site
- Enhance the existing document capture application to capture all related Documents based on the new regulatory requirements.
- Integrate Rate Review Application with Document Management
- Develop Interfaces for National Association of insurance commissioners (NAIC )
- Real Time SERFF data transfer portal
- Develop application for consumer feedback E-mail Notifications to appropriate program managers and users

NEW MEXICO
PUBLIC REGULATION COMMISSION

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INSURANCE DIVISION
Managed Health Care Bureau

# Proposed Changes to Current Grievance Procedure Regulations to Comply with Federal Minimum Requirements

- **13.10.17.7B NMAC –Adverse Determination** means a decision made either pre-service or post-service, by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, does not meet the health care insurer's requirements for coverage or medical necessity, and the requested health care service is therefore denied, reduced or terminated. Adverse determination includes but is not limited to recission of coverage except in the case of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of material fact (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of , or a failure to provide or make a payment (in whole or in part) for a benefit including any such denial, reduction, or termination, or failure to provide or make a payment that is based on:

1) A determination of an individual's eligibility to participate in an individual plan or health insurance coverage;
2) A determination that a benefit is not a covered benefit;
3) The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
4) A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

- **13.10.17.7 E NMAC - Culturally and Linguistically Appropriate Manner of Notice means that:**

**(1)** for a plan that covers fewer than 100 participants at the beginning of a plan year, the plan and issuer provide notices upon request in a non-English language in which 25 percent or more of all plan participants are literate only in the same non-English language; or
**(2)** for a plan that covers 100 or more participants at the beginning of plan year, the plan and issuer provide notices upon request in a non-English language in which the lesser of 500 or more participants, or 10 percent or more of all plan participants, are literate only in the same non-English language, and
**(3)** for a plan that meets one of the thresholds described in paragraph E.1 and E.2, above, the plan and issuer must also:

**(a)** include a statement in the English versions of all notices, prominently displayed in the non-English language, offering the provision of such notices in the non-English language;
**(b)** once a request has been made by a claimant, provide all subsequent notices to the claimant in the non-English language; and
**(c)** to the extent the plan or issuer maintains a customer assistance process (such as a telephone hotline) that answers questions or provides assistancew with filing claims and appeals, the plan or ossuer must provide such assistance in the non-English language.

- **13.10.17.7. G NMAC - Grievant** means an individual who may be eligible to receive health care benefits, a covered person, a covered person's authorized representative, or a provider acting on behalf a covered person with their consent.

- **13.10.17.7O NMAC - Rescission of coverage** means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent attributable to a failure to timely pay towards the cost of coverage.

- **13.10.17.9C NMAC - Failure to comply with the internal review process.** If the

health care insurer fails to strictly adhere to all the requirements of the internal appeals process, the grievant is deemed to have exhausted the internal claims process, regardless whether the issuer asserts that it substantially complied with the requirements or that any error it committed was de minimus. Upon such a failure, the grievant may initiate an external review and pursue any available remedies under applicable law, on the basis that the insurer had failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

- **13.10.17.10A (2) NMAC - Information about grievance procedures.** for a person who has been denied coverage, the health insurer shall provide him or her with a copy of the grievance procedure.

- **13.10.17.10A (7) NMAC – a health insurer shall pr**ovide notice to covered persons in a culturally and linguistically appropriate manner, as defined in 13.10.17.7.E NMAC.

- **13.10.17.10A (8)NMAC – a health insurer shall p**rovide continued coverage pending the outcome of an internal appeal.

- **13.10.17.10A (9) NMAC – a health insurer shall** not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advanced review.

- **13.10.17.10A (10)NMAC** -allow individuals in urgent care situations and receiving an ongoing course of treatment to proceed with an expedited external review at the same time as the internal appeals review process.

- **13.10.17.12F NMAC – Record of Grievances Examination.** Health care insurer shall make such record available for examination upon request and provide such documents free of charge to a grievant or State or Federal agency official.

- **13.10.17.14 A(4)NMAC** – A health care insurer shall make its initial certification of adverse determination decision within twenty-four hours (24)whenever in the opinion of the physician with knowledge of the grievant's medical condition, would subject the grievant to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim, or

- **13.10.17.14A (6) NMAC** – A health care insurer shall make its initial certification of adverse determination decision within twenty-four (24) the grievant's claim involves urgent care.

- **13.10.17.16B NMAC - 24- hour Notice of Adverse determination; Explanatory Contents.** The health care insurer shall notify a grievant and provider of an adverse determination by telephone or as required by the medical exigencies of the case, but in no case later than twenty-four (24) hours after making the adverse determination unless the grievant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or have insurance coverage. If the grievant fails to provide such information, he or she must be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Additionally, the health care insurer shall notify the grievant and provider of the adverse determination by written or electronic communication sent within one (1) working day of the telephone notice. The notice shall include:

(1) if the adverse determination is based on a lack of medical necessity, clearly and completely explain why the requested health care service is not medically necessary. A statement that the health care service is not medically necessary will not be sufficient;

(2) if the adverse determination is based on a lack of coverage, identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan. A statement that the requested health care service is not covered by the health benefits plan will not be sufficient;

(3) the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code and corresponding meaning of these codes, the denial code and its corresponding meaning.

(4) include a description of the health care insurer standard that was used in denying the claim;

(5) provide a summary of the discussion which triggered the final determination.

(6) advise the grievant that he or she may request internal review of the health care insurer's adverse determination; and

(7) describe the procedures and provide all necessary forms to the grievant for requesting internal review.

- **13.10.17.16C NMAC - Conflicts of Interest.** The health care insurer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

- **13.10.17.16D NMAC - Full and Fair Hearing.** To ensure that a grievant receives a full and fair review, the health care insurer must, in addition to allowing the grievant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process,

(1) provide the grievant, free of charge, with any new or additional evidence considered, relied upon, or generated by the health care insurer. The information must be provided to the grievant within twenty-four (24) hours to allow the grievant an opportunity to respond prior to the date of the notice of determination, and

(2) before the health care insurer can issue a final internal adverse benefit determination based on a new or additional rationale, provide the grievant, free of charge, with the rationale; the rational must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided, to give the grievant a reasonable opportunity to respond prior to that date.

- **13.10.17.18A (3) NMAC through 13.10.17.18A (5)NMAC - Timeframes for internal review of adverse determinations.** The health care insurer shall complete its internal review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours whenever:

- the provider reasonably requests an expedited decision;
- or, in the opinion of the physician with knowledge of the grievant's medical condition, would subject the grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or
- the medical exigencies of the case require an expedited decision.

- **13.10.17.19A NMAC Internal Review of Adverse Determinations by Third Party Administrator.** This section applies only to group health plans and health insurance issuers offering group health insurance coverage, and only under circumstances wherein a health plan or health insurance issuer conducts the first level of the internal appeal and an entity subject to the Health Care Purchasing Act conducts a second level of the internal appeal. Health insurance issuers that, prior to the effective date of this rule, have conducted two internal levels of appeal shall conduct only one level, described in 13.10.17.20 NMAC. For purposes of this section, "health care insurer" means a group health plan or a health insurance issuer.

- **13.10.17.19D (2) NMAC - Internal Review of Adverse Determinations by Third Party Administrator; Decision to Uphold.** If the health care insurer is unable to contact the grievant by telephone within twenty-four (24) hours of making the decision to uphold the determination, the health care insurer shall notify the grievant by mail of the it's decision and shall include in the notification a self-addressed stamped response form which asks the grievant whether he or she wishes to pursue the grievance further and provides a box for checking "yes" and a box for checking "no." If the grievant does not return the response form within ten (10) working days, the health care insurer shall again contact the grievant by telephone.

- **13.10.17.19D (4) NMAC - Internal Review of Adverse Determinations by Third Party Administrator; Decision to Uphold.** If the grievant does not respond to the health care insurer's telephone inquiries or return the response form, the health care insurer shall, when the review is an expedited review, select a medical panel to further review the adverse determination.

- **13.10.17.20A NMAC - Internal Panel Review of Adverse Determinations.** This section applies to health insurance issuers offering individual health insurance coverage and to group plans and group insurance issuers offering group health insurance coverage under which, prior to the effective date of this rule, all levels of internal review had been conducted by the same entity. As a result of this rule, health insurance issuers that, prior to the effective date of this rule, had conducted two internal levels of appeal shall conduct only one level, unless an entity subject to the Health Care Purchasing Act had conducted one level of appeal in its appeal process.

- **13.10.17.20B NMAC - Selection of an Internal Review Panel.** In cases of appeal from an adverse determination or from a third party administrator's decision to uphold an adverse determination, the issuer shall select an internal review panel to review the adverse determination or the decision to uphold the adverse determination.

- **13.10.17.22B (3) NMAC – Contents of notice of Internal Panel Decision.** The written notice shall contain a description of the evidence relied on by the internal review panel in reaching it's decision.

- **13.10.17.23B NMAC - Exhaustion of internal appeals process of adverse determinations.** The exhaustion of the internal appeals process may be unnecessary if:

**(1)** the health care insurer has waiver the exhaustion requirement;

**(2)** the grievant is considered to have exhausted the internal review process (including by failing to comply with any of the requirements for the internal appeal process); or

**(3)** the grievant has applied for expedited external review at the same time as applying for an

expedited internal review.

- **13.10.17.24A (2) NMAC - Timeframe for filing an external review of adverse determinations:** To initiate an external review, a grievant must file a written request for external review with the superintendent within one hundred twenty (120) calendardays from receipt of the written notice of internal review decision.

- **13.10.17.30G (4) NMAC - Rights of parties during Hearing Procedures for External Review of Adverse Determinations:** Both the grievant and the health care insurer have the right to submit to the ICO, prior to the scheduled hearing, in writing, additional information that the ICO must consider when conducting the external review hearing, and require that the information be submitted to the health care insurer and the staff of the consumer relations division or managed health care bureau, as appropriate.

- **13.10.17.31A NMAC - Identification of ICOs.** The superintendent shall provide for maintenance of a list of licensed professionals qualified to serve as independent co-hearing officers. The superintendent shall select appropriate professional societies, organizations, or associations to identify licensed health care and other professionals who are willing to serve as independent co-hearing officers in external reviews who maintain independence and impartiality of the process.

- **13.10.17.31D NMAC** – The hearing officer and ICOs must maintain written records and make them available upon request to the State.

- **13.10.17.33D NMAC - Internal Review of Administrative Grievances; Failure to comply with the internal review.** If the health care insurer fails to comply with the internal review procedures, the requested health care service shall be deemed approved unless the grievant, after being fully informed of his or her rights, has agreed in writing to extend the deadline.

# What is the Affordable Care Act and what does it mean to you?

The Affordable Care Act is a health care law that aims to improve our current health care system by increasing access to health coverage for Americans and introducing new protections for people who have health insurance.

- ***Young adults can now stay on their parent's health plan up to age 26.***[1]

They may qualify even if they don't live with their parents, they are out of school; they are not financially dependent on their parents, they are married (but their spouse or children will not be covered). Young adults can stay on their parent's plan, or enroll again if they've already gone off it.

Group plans that were in place before March 23, 2010 (grandfathered) are a little different. Until 2014, these plans do not have to offer health coverage to young adults who qualify for group coverage outside of their parent's plan.

- ***Insurance companies can't deny health coverage to kids with pre-existing conditions.***

Health plans that cover children can no longer limit or deny benefits for kids up to age 19 because of a pre-existing condition – a health problem, disease or disability that the child developed before their parents applied for health coverage.

The rule does not apply to "grandfathered" individual health insurance plans – plans outside of your employer coverage that were in place on or before March 23, 2010.

- ***Insurance companies can't place dollar limits on the health care they cover in your lifetime.***

Some health insurance plans can no longer put dollar limits on how much care they cover in your lifetime. The rule applies to employer health coverage and individual insurance policies bought after March 23, 2010.

The ban on lifetime limits takes effect with the plan year or policy year that begins on or after September 23, 2010. For many plans, the effective date was January 1, 2011. Health insurance plans can still put an annual dollar limit on non-essential health care services. The law also gradually gets rid of dollar limits on the care that an insurance company will cover in one year. In 2014, there will be no dollar limits on how much care is covered annually.

- ***New health plans must offer preventive and screening services, such as mammograms, at no cost to the patient.***

Health plans must now offer proven services such as screenings, vaccinations and counseling at no cost to the patient. Depending on your age, you may receive preventive services such as screenings for blood pressure, cholesterol, breast cancer, colorectal cancer, diabetes; vaccinations against measles, polio, and meningitis; flu and pneumonia shots; counseling for quitting smoking, losing weight, treating depression and more. You may need to pay some of the cost if the preventive service is not the main reason for the visit or if your doctor bills you for the services separately.

[1] All source of material, except for footnote 2, obtained from HealthCareandYou.org

This part of the law may not apply to "grandfathered" individual health insurance plans. These are plans that you bought for yourself or your family outside of your employer-sponsored insurance on or before March 23, 2010.

- ***Find health insurance in New Mexico[2]***

Visit http://finder.healthcare.gov This website provides a tool that will help you find the health insurance best suited to your needs, whether it's private insurance for individuals, families, and small businesses, or public programs that may work for you. It was created to help consumers under the health insurance reform law, the Affordable Care Act.

- ***Adults who have been uninsured for at least 6 months and have been denied coverage because of a pre-existing condition may now get coverage through the New Mexico Medical Insurance Pool.***

The New Mexico Medical Insurance Pool is available for adults who have been uninsured for at least 6 months and have been denied coverage because of a pre-existing condition. Also, children up to age 19 can't be denied coverage because of pre-existing conditions. (By 2014, insurance companies will not be able to deny coverage to anyone with pre-existing conditions.) For more information, call (505) 424-7105, Toll Free (866) 622-4711 or visit http://www.nmmip.org

- ***Some small businesses with fewer than 25 employees can get help paying for the cost of providing health insurance.***

New tax credits are helping some small businesses pay for health insurance for their employees. Employers qualify if they provide health care to their workers, have fewer than 25 full-time employees (or the equivalent of 25 full-time employees) and provide average annual wages below $50,000. In 2011, the tax credit will cover 35 percent of health insurance expenses for small businesses (25 percent for non-profit businesses). The tax credit will increase to 50 percent for small businesses (35 percent for non-profits) starting in 2014. For more information, contact your local Internal Revenue Service office.

- ***Those in the Medicare Part D "doughnut hole" get a 50 percent discount on name-brand prescription drugs and a 7 percent discount on generic prescription drugs.***

Before the Affordable Care Act, some people enrolled in Medicare Part D fell into what was called a "coverage gap" or "doughnut hole." This meant that once their health plan spent a certain amount of money on drugs, these people had to pay the full cost of their prescriptions until they spent enough and their drugs were paid for again. The law gradually closes this gap and will get rid of it completely by 2020. For more information, call 1 (800) Medicare or visit https://www.MyMedicare.gov

- ***Those in Medicare can get preventive services and screenings, such as mammograms, at no cost to the patient.***

People with Medicare Part B can now receive some proven preventive services at no cost to them. In addition to a yearly wellness exam, Medicare Part B now covers preventive screenings for cholesterol, diabetes, certain types of cancer, and more. For more information, call 1 (800) Medicare or visit https://www.MyMedicare.gov

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[2] Obtained from HealthCare.gov