

# HEALTH INSURANCE:

- **ACA Individual Coverage for 2018**
- **Appealing a Denied Claim**
- **Policy Benefits Features**

# ACA INDIVIDUAL COVERAGE FOR 2018

Martin Swanson

Health Policy Administrator

[Martin.Swanson@Nebraska.gov](mailto:Martin.Swanson@Nebraska.gov)

NEBRASKA

Good Life. Great Opportunity.

# ACA RATES:

- Health insurance market distribution
- Individual market, 2014 to 2018
- Rates for 2018

# HEALTH INSURANCE MARKET DISTRIBUTION 2014

	NE	NE	US	US
Individual Market (includes pre-ACA plans allowed to continue)	141,412	7.7%	13,024,369	4.2%
Employer-Sponsored Small Group	112,270	6.1%	17,012,181	5.4%
Employer-Sponsored Large Group (Fully Insured)	227,116	12.4%	34,414,807	11.0%
Employer-Sponsored Large Group (Self Insured)	604,512	32.9%	91,601,272	29.3%
Medicaid/CHIP	190,827	10.4%	48,597,331	15.5%
Medicare (over age 65)	271,624	14.8%	44,507,600	14.2%
Other Private Insurance	35,895	2.0%	5,579,654	1.8%
Other Government Program (VA, TriCare, Medicare Disabled)	78,637	4.3%	17,004,390	5.4%
Uninsured	176,167	9.6%	41,223,695	13.2%
TOTAL	1,838,460		312,965,299	

**NEBRASKA**

Good Life. Great Opportunity.

# U.S. HEALTH INSURANCE MARKET DISTRIBUTION 2013 to 2016

	2013	2014	2015	2016
Direct-purchase (individual)	11.4%	14.6%	16.3%	16.2%
Employment-based	55.7%	55.4%	55.7%	55.7%
Medicaid/CHIP	17.5%	19.5%	19.6%	19.4%
Medicare	15.6%	16.0%	16.3%	16.7%
Military health care	4.5%	4.5%	4.7%	4.6%
Uninsured	13.3%	10.4%	9.1%	8.8%

2013 to 2014: Individual increased 3.2%, uninsured decreased 2.9%

2014 to 2015: Individual increased 1.7%, uninsured decreased 1.3%

2015 to 2016: Individual decreased 0.1%, uninsured decreased .3%

2016 to 2017: Individual decreased 4.7% (next slides discuss 2017 enrollment)

**NEBRASKA**

Good Life. Great Opportunity.

# UNINSURED RATE IN NEBRASKA

Year	People Uninsured (estimated)
2013	209,000
2014	179,000
2015	154,000
2016	161,000

# ON-EXCHANGE ENROLLMENT IN NEBRASKA, 2014 – 2017

- **2014** 42,975 on-exchange
- **2015** 74,152 on-exchange – by June, 63,776 had in-force coverage through the exchange.
- **2016** 87,835 on-exchange – by June, 80,213 had in-force coverage through the exchange.
- **2017** 84,371 on-exchange – by June, 74,582 had in-force coverage through the exchange.
  - 2017 enrollment dropped around 4% in Nebraska, on-track with a national drop of 4.7%.

# 2017 NEBRASKA ENROLLMENT IN DETAIL

- Exchange enrollees in Nebraska represent approximately **4.45%** of the population (1,896,000 total population/84,371 marketplace enrollees).
- 84,371 people were enrolled on-exchange at the end of open enrollment
- By June 2017, on-exchange enrollment down to 74,582 on-exchange; 97,064 for all ACA-compliant plans, on- and off-exchange.
  - Area 1 (Omaha) 32,083
  - Area 2 (Lincoln) 20,824
  - Area 3 (Mid-State) 31,217
  - Area 4 (Western) 12,941
- Nebraskans receiving subsidies:
  - **APTC** received by 69,742 (**94%** of exchange, 72% of all ACA)
  - **CSR** received by 41,666 (**56%** of exchange, 43% of all ACA)
  - (more about APTC and CSR in a few slides)



# INSURERS SELLING COVERAGE IN NEBRASKA ON THE FEDERALLY FACILITATED EXCHANGE ("Healthcare.gov")

Number of Insurers and Year	Aetna (Coventry)	Blue Cross & Blue Shield	CoOpportunity	Medica	Time (Assurant)	United HealthCare
3 in 2014	2014	2014	2014			
4 in 2015	2015	2015	2015*		2015	
4 in 2016	2016	2016		2016		2016
2 in 2017	2017			2017		
1 in 2018				2018		

\*CoOpportunity was pulled from the Marketplace in late December 2014. The company is in liquidation.

# PREMIUMS

- Nebraska's average individual market premium increased from \$235 in 2013 to \$595 in 2017, an increase of 153%.
- 2017 rates were, on average, 40% to 52% higher than 2016 rates.
- Medica's 2018 rates are, on average, 17% higher for bronze and gold plans, and 31% higher for silver plans.
- If you move from Aetna to Medica, the increase may be higher.

NEBRASKA

Good Life. Great Opportunity.

# PREMIUM INCREASES 2014 – 2018

	Single Young Adult	Family 2 Adults 2 Kids	Single Older Adult	Older Couple (No Kids)
2014	\$239.22	\$744.68	\$700.83	\$1,528.36
2015	\$288.35	\$918.64	\$844.77	\$1,867.38
2016	\$334.25	\$1,028.96	\$979.26	\$2,094.72
Increase, 2014-2017*	83.28%*	101.65%*	83.29%*	104.75%*
2018	\$495.16	\$2,105.18	\$1,450.67	\$2,831.46
Increase, 2014-2018	206.99%	282.70%	206.99%	185.26%

*\*Average premiums for these scenarios were not developed for 2017. Aetna and Medica's rates were revised and resubmitted in October after another carrier withdrew from the exchange. The average premium increased approximately 40%-55% between 2016 and 2017.*

## Scenarios Defined:

- “Single Young Adult” is a 26-year-old in Lincoln on a **silver plan**
- “Family 2 Adults 2 Kids” is 2 adults age 35 and 2 children in Omaha on a **silver plan**
- “Single Older Adult” is a 64-year-old in Lincoln on a **silver plan**
- “Older Couple (No Kids)” is 2 adults age 60 in Omaha on a **gold plan**

# REASONS FOR LESS CHOICES AND HIGHER PREMIUMS

- **Aetna** announced on May 11, 2017 that it will not sell on- or off-exchange individual products in Nebraska in 2018. Approximately 45,000 people will lose their Aetna plans, and will receive notice of the option to enroll with Medica for 2018. Aetna's announcement cited losses of \$700M between 2014 and 2016, and a projected loss of more than \$200M in 2017, even though Aetna only sold in four states in 2017 (Delaware, Iowa, Nebraska, Virginia).
- **Blue Cross and Blue Shield of Nebraska** announced on June 1, 2017 that it is discontinuing its off-FFM, ACA-compliant bronze and catastrophic plans in 2018. Approximately 12,500 people will lose their BCBSNE plans. In BCBSNE's announcement, the company stated it will likely lose \$12M on its ACA plans in 2017 and would probably lose money in 2018 even if it raised premiums 50%.

# HIGH MEDICAL COSTS DRIVE PREMIUMS

The ACA caps insurers' profits at 15% or 20% depending on the type of insurer and whether the policy is large group, small group or individual.

- That means all of the insurers' profits, plus costs not associated with paying claims to benefit policyholders, cannot equal 15% or 20% of the money collected in premiums, and if the premiums exceed that amount, the extra is returned to policyholders.

## **Risk is heavily concentrated in the highest-cost enrollees.**

- Medical costs in 2016 from a survey of some Nebraska ACA carriers:
  - **The top 1% of insured people incurred 40% of the claims costs.**
  - **The top 5% incurred 72% of the total claims costs.**

Open Enrollment for  
plan year 2018 is from

**November 1, 2017 to  
December 15, 2017.**

Coverage begins January 1, 2018.

NEBRASKA

Good Life. Great Opportunity.

# HOW TO FIND OUT IF YOU QUALIFY FOR A SUBSIDY

- <https://www.kff.org/interactive/subsidy-calculator/>

## ENTER INFORMATION ABOUT YOUR HOUSEHOLD

1. Select a State

US Average ▼ ?

2. Enter income as

2017 Dollars ▼

3. Enter your yearly household income (dollars)

?

4. Is coverage available from your or your spouse's job?

No ▼ ?

5. Number of people in family

1 ▼ ?

6. Number of adults (21 to 64) enrolling in Marketplace coverage

▼ ?

7. Number of children (20 and younger) enrolling in Marketplace coverage

No Children ▼

NEBRASKA

Good Life. Great Opportunity.

# 2018 FEDERAL POVERTY LEVEL (FPL)

Family Size	FPL 100%	FPL 250%	FPL 400%
1	\$12,060	\$30,150	\$48,240
2	\$16,240	\$40,600	\$64,960
3	\$20,420	\$51,050	\$81,680
4	\$24,600	\$61,500	\$98,400
5	\$28,780	\$71,950	\$115,120
6	\$32,960	\$82,400	\$131,840
7	\$37,140	\$92,850	\$148,560
8	\$41,320	\$103,300	\$165,280



# RATE PREVIEW AND WINDOW SHOPPING

- <http://nehealthinsuranceinfo.gov/>



- Healthcare.gov
  - Includes subsidies and available plans

# ADVANCE PREMIUM TAX CREDIT (APTC)

- Advance Premium Tax Credit (APTC) is a tax credit you can take in advance to lower your monthly health insurance payment.
- **APTC** is received by 69,742 (94% of FFM, 72% of all ACA)
- APTC is based on your estimated expected income for the year.
  - If at the end of the year you've taken more APTC than you are due based on your final income, you will have to pay back the excess when you file your federal tax return.
  - If you have taken less than you qualify for, you will get the difference back.

# HOW APTC WORKS

APTC is for individuals and families who earn between 100% and 400% of the Federal Poverty Level (FPL).

- You can use the Kaiser Family Foundation tool to find out if you qualify.  
<http://www.kff.org/interactive/subsidy-calculator/>
- The lower your income, the less you pay (APTC pays the difference)

Example: A family of four makes \$51,000 in household income in 2017. That places the family at 209% of FPL.

- Without financial help, the family would pay **\$1,223 per month** (\$14,677 per year) for a silver plan.
- With financial help, **the family will pay \$287 per month** (\$3,449 per year), which equals 6.76% of the household income.
- That is because the law caps the family's payment as a percentage of income.
- Financial help from **APTC will pay \$936 per month** (\$11,227 per year) in premium tax credits – that is 76% of the monthly cost.

# APTC IS A PERCENTAGE OF HOUSEHOLD INCOME

- This matters because no matter what the cost, your payment is a percentage of what you earn – not a percentage of the premium cost.
- For a family of four with a household income of \$51,000, the family's payment will be 6.76% of household income (\$287 per month), no matter what the insurance costs.
- If rates go up, the family's payment stays the same.

# WHAT IF I EARN MORE THAN 400% FPL?

- There are no APTC benefits for people who earn more than 400% FPL.
- Consider buying a Bronze or Gold plan – the rates for Silver plans are more sharply increased for 2018.
  - Bronze and Gold plans increased an average of 17%, while Silver increased 31%.
  - APTC is set based on the second-lowest cost Silver plan, so there will be more APTC payments to make up for money that might not be paid for another ACA consumer benefit, Cost Sharing Reductions (CSRs).

# COST SHARING REDUCTIONS (CSR)

- For people who earn between 100% and 250% of FPL and purchase a Silver plan, the ACA gives them a discount on cost sharing (“Cost Sharing Reduction” or “CSR”).
- Cost sharing can be copayments or coinsurance, paid at the time of service for things like doctor visits or prescription refills, or deductibles, which must be paid before the plan begins paying toward the service.
- **CSR** are received by 41,666 people (**56%** of exchange, 43% of all ACA).

# PURCHASERS WILL RECEIVE CSRs, EVEN IF THEY ARE NOT FUNDED

- On October 12, 2017, the federal government announced that it will not continue paying for CSRs.
  - This is in line with *House v. Price*, a lawsuit in which the trial court found that the way Congress funded CSRs was unconstitutional – that decision is on hold pending an appeal. The appeal has been repeatedly postponed to give Congress time to act to fund CSRs another way.
- Regardless of whether the government pays for CSRs, insurers are required by law to provide CSR plan variants to insureds.
- If you qualify for CSRs, you are automatically issued one of these plan variants based on household income as a percentage of FPL.
- Plans have discounted CSRs built into them, so that the copays, deductible and maximum out of pocket are written into the policy and wallet card.

NEBRASKA

Good Life. Great Opportunity.

# WHAT NONPAYMENT OF CSRs MEANS

- Plans will still provide CSRs.
- No effect on the CSRs purchasers receive, no effect on who qualifies for CSRs.
- Insurers have to provide the lower copays, deductibles, and other cost-sharing limitations, but insurers will not be reimbursed by the federal government.
- In order to make up for this shortfall (approximately \$34M in 2016), insurers increased the price of silver plans.
  - APTC from the federal government to pay higher silver plan premium subsidies will replace the money that would have reimbursed insurers for CSRs.
  - The cost of silver plans goes up, but if purchasers receive a subsidy, the higher cost is mostly paid by the federal government through APTC.
- If purchasers do not receive a subsidy, gold or bronze plans may be better options.

NEBRASKA

Good Life. Great Opportunity.



# CSR EXAMPLE: COPAYMENTS FOR OFFICE VISITS

Example: The standard primary care office visit copay for a silver plan is **\$28**.

- A family of four with a household income of \$51,000 earns **209% of FPL**, so it qualifies for Cost Sharing Reductions (CSRs). The copay reduced by CSRs is **\$23**.
- If the family of four's household income is \$41,000, that is **168% of FPL**, so the family qualifies for lower CSR, and the reduced copay is **\$17**.
- If the family's income is \$35,000, that is **144% of FPL**, so the family qualifies for even lower CSR, and the copay is reduced to **\$14**.
- If the family's income is \$31,000, that is **less than 100% of FPL**, then the family **does not qualify for CSRs**.

# ANOTHER CSR EXAMPLE: LIMITS ON DEDUCTIBLES

Example: The average annual deductible for medical and prescription expenses combined, is **\$2,559** for regular Silver plans.

- A family of four with a household income of \$51,000 earns **209% of FPL**, so it qualifies for Cost Sharing Reductions (CSRs). The deductible is reduced to **\$2,078**.
- If the family of four's household income is \$41,000, that is **168% of FPL**, so the family qualifies for a further reduced deductible of **\$737**.
- If the family's income is \$35,000, that is **144% of FPL**, so the family qualifies for even lower deductible or **\$229**.
- If the family's income is \$31,000, that is **less than 100% of FPL**, then the family **does not qualify for CSRs**.

# ONE MORE CSR EXAMPLE: MAXIMUM OUT-OF-POCKET (“MOOP”)

Example: The average annual limit on out-of-pocket expenses is **\$5,824** for regular Silver plans.

- A family of four with a household income of \$51,000 earns **209% of FPL**, so it qualifies for Cost Sharing Reductions (CSRs). The MOOP is reduced to **\$4,622**.
- If the family of four’s household income is \$41,000, that is **168% of FPL**, so the family qualifies for a further reduced MOOP of **\$1,691**.
- If the family’s income is \$35,000, that is **144% of FPL**, so the family qualifies for even lower MOOP or **\$879**.
- If the family’s income is \$31,000, that is **less than 100% of FPL**, then the family **does not qualify for CSRs**.

# SMALL GROUP INSURANCE

Small group insurance is employer sponsored coverage for 2-50 employees.

- Options for coverage have decreased this year as well with the withdrawal of Federated Mutual Insurance Company.
- Rates for small group insurance can go up quarterly which is different than the individual market.
- There are fewer carriers currently in the small group market than in years past and rates have also increased for those plans.
  - Aetna Health Insurance Company – 47.30%
  - Aetna Health – 47.30%
  - Aetna Life Insurance Company – 1.10%
  - UnitedHealthCare Ins. Company – 11.40%
  - UHC of the Midlands – 9.60%
  - Blue Cross Blue Shield Nebraska – 18.40%

**NEBRASKA**

Good Life. Great Opportunity.

# HEALTH CARE SHARING MINISTRIES

Disclaimer required for all applications and guideline materials distributed by or on behalf of a Health Care Sharing Ministry, per Neb. Rev. Stat. § 44-311:

**IMPORTANT NOTICE. This organization is not an insurance company, and its product should never be considered insurance.** If you join this organization instead of purchasing health insurance, **you will be considered uninsured.** By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be **totally voluntary**, and **neither the organization nor any participant can be compelled by law to contribute toward your medical bills.** Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, **you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the Nebraska Department of Insurance.** You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

NEBRASKA

Good Life. Great Opportunity.

# APPEALS AND EXTERNAL REVIEW

Maggie Dolezal

External Review Coordinator

[Maggie.Dolezal@Nebraska.gov](mailto:Maggie.Dolezal@Nebraska.gov)

NEBRASKA

Good Life. Great Opportunity.

# EXTERNAL REVIEW APPLIES TO:

- Individual plans (but not “transitional” or “grandfathered” plans).
- Small-group employer plans.
- Large-group, fully insured employer plans.

NEBRASKA

Good Life. Great Opportunity.

# How to appeal a denied health claim

- If an insurance company denies a claim or rescinds coverage their insured has the right to ask the company to reconsider its decision
- There are two stages or “levels” to appeal a health plan decision:

❖ **1. Internal Appeal**

❖ **2. External Review**



# Internal Appeal

- To file an appeal, you need to:
  1. Complete all forms required by the insurance company or write to your insurer with your name, claim number, and health insurance ID number
  2. Submit any additional information you want the insurer to consider, to help explain why you believe the company's decision was wrong.
    - ❖ A letter of medical necessity from the doctor justifying the need for the treatment or procedure can be helpful
    - ❖ The appeal must be filed within 180 days of receiving the claim denial

# What kinds of denials can be appealed?

- An internal appeal can be filed if your health plan won't authorize services or refuses to pay the portion of health care expenses you believe should be covered.
- Denial reasons include:
  - ❖ The benefit isn't offered under your health plan
  - ❖ You received health services from a health provider or facility that isn't in your plan's approved network
  - ❖ The requested service or treatment is "not medically necessary"
  - ❖ The requested service or treatment is an "experimental" or "investigative" treatment
  - ❖ Insured is no longer enrolled or eligible to be enrolled in the health plan
  - ❖ Carrier is revoking or cancelling coverage because insured gave false or incomplete information when applying for coverage

# Important Documents to Keep

- Keep copies of all information related to your claim and the denial
- Examples:
  - ❖ Explanation of Benefits forms or claim denial forms
  - ❖ Dated copy of the request for an internal appeal
  - ❖ Any additional information you sent to the insurance company i.e. letter or medical records from the doctor
  - ❖ Notes and dates from any phone conversations insured had with the insurance company or with the doctor that relate to the appeal.
    - Include: day, time, name and title of the person insured spoke to, and details about the conversation

# How long does an internal appeal take?

- The internal appeal must be completed within 15 working days after the insurance company received the request for review.

# Need a faster decision?

- Expedited appeals are completed within 72 hours and are available:
  - ❖ In urgent situations when waiting 15 days would jeopardize the life or health of the insured or the ability of the insured to regain maximum function would be jeopardized
  - ❖ When the insured has received emergency services but has not been discharged from a facility, for all claim denials concerning an admission, availability of care, continued stay, or health care service
  - ❖ Expedited internal appeal and expedited external review can be done concurrently in the rare cases where waiting 72 hours for expedited internal appeal would jeopardize the patient's life or ability to regain maximum function

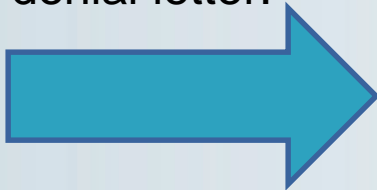
NEBRASKA

Good Life. Great Opportunity.

# What if the internal appeal is denied?

- The insurance company must provide you with a written decision
- For certain types of claim denials, external review may be an option
- The insurance company's final determination must tell you how to ask for an external review

Example from a  
BCBNE appeal  
denial letter:



If you would like to receive a copy of the scientific/clinical information that was used in making our decision, please write to us at: Blue Cross and Blue Shield of Nebraska  
Appeals Department  
PO Box 3248  
Omaha, NE 68180-0001

This information is available to you upon request free of charge.

#### What Happens Next

If you would like to appeal this decision further, please read the following information.

If this denial was the result of a medical determination, you may request an external review of our benefit denial by doing one of the following:

**STANDARD EXTERNAL REVIEW:** If we have denied your original appeal or grievance for the provision of or payment for a health care service or course of treatment, you may have a right to have our decision reviewed by independent health care professionals who have no association with us. If our decision involved making a judgment as to the medical necessity, experimental or investigational nature, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you may submit a request for external review.

The request must be submitted within **four months** of the date of the final adverse determination.

The request should be mailed to: Nebraska Department of Insurance  
P.O. Box 82089  
Lincoln, NE 68501-2089  
[www.doi.nebraska.gov](http://www.doi.nebraska.gov)

For standard external reviews, a decision will be made within 45 days of receiving your request.

For more information, you may call the Department of Insurance toll free at 1.877.564.7323, or contact us using the number on the back of your Blue Cross and Blue Shield of Nebraska ID card. The forms required to request an external appeal are attached, and may be accessed at [www.doi.nebraska.gov](http://www.doi.nebraska.gov) and/or [www.nebraskablue.com](http://www.nebraskablue.com).

**EXPEDITED EXTERNAL REVIEW:** If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, and our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you may be entitled to file a request for expedited external review of our denial, upon certification by your treating physician. You may not have to complete the internal grievance process if you are entitled to an expedited external review of the adverse

**NEBRASKA**  
Good Life. Great Opportunity.

# External Review

## External Review Request Form

This EXTERNAL REVIEW REQUEST FORM must be filed with the Nebraska Department of Insurance within FOUR (4) MONTHS after receipt from your insurer of a denial of payment on a claim or request for coverage of a health care service or treatment. The Department of Insurance mailing address and telephone number are:

Nebraska Department of Insurance  
PO Box 82089  
Lincoln, NE 68501-2089  
(877) 564-7323  
[www.doi.nebraska.gov](http://www.doi.nebraska.gov)

### EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME: \_\_\_\_\_ Covered person/Patient    Provider    Authorized Representative  
(choose one)

#### COVERED PERSON/PATIENT INFORMATION

Covered Person Name: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Covered Person Phone Number: Home (    ) \_\_\_\_\_ Work (    ) \_\_\_\_\_

#### INSURANCE INFORMATION

Insurer/HMO Name: \_\_\_\_\_

Covered Person Insurance ID number: \_\_\_\_\_

Insurance Claim/Reference number: \_\_\_\_\_

Insurer/HMO Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Insurer Phone Number: (    ) \_\_\_\_\_

#### EMPLOYER INFORMATION

Employer's Name: \_\_\_\_\_

Employer's Phone Number: \_\_\_\_\_

Is the health coverage you have through your employer a self-funded plan? \_\_\_\_\_. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

# Steps in the External Review Process

1. Initial Paperwork
2. Eligibility Determination
3. Independent Review Organization Assigned
4. IRO Decision



# What types of denials qualify for external review?

An “adverse determination” qualifies.

- “A determination that a covered health care services doesn’t meet the insurer’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or a denial for a treatment that is considered experimental or investigational”

# Expedited External Review Request

- Only available if your health is in serious jeopardy or the ability to regain maximum function is at jeopardy
- An expedited external review request takes 72 hours

## Certification of Treating Health Care Provider For Expedited Consideration of a Patient's External Review Appeal

### NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The Nebraska Department of Insurance oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our department. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

### GENERAL INFORMATION

Name of Treating Health Care Provider: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

Licensure and Area of Clinic Specialty: \_\_\_\_\_  
\_\_\_\_\_

Name of Patient: \_\_\_\_\_

Patient's Insurance Member ID number: \_\_\_\_\_

### CERTIFICATION

I hereby certify that: I am a treating health care provider for \_\_\_\_\_ (hereafter referred to as "the patient"); adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Treating Health Care Provider's Name (Please Print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**NEBRASKA**

Good Life. Great Opportunity.

# Experimental or Investigational claim denials

- Your doctor **MUST** complete the Physician Certification form for Experimental/Investigational Denials

**Physician Certification**  
**Experimental/Investigational Denials**  
(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for \_\_\_\_\_ (covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

In my medical opinion as the covered person's treating physician, I hereby certify to the following:  
(Please check all that apply) (NOTE: Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).

1) The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

2) The covered person has a condition that qualifies under one or more of the following:  
[please indicate which description(s) apply]:  
 Standard health care services or treatments have not been effective in improving the covered person's condition;  
 Standard health care services or treatments are not medically appropriate for the covered person; or  
 There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

3) The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

4) The health care service or treatment recommended would be significantly less effective if not promptly initiated.

Explain: \_\_\_\_\_  
\_\_\_\_\_

5) It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.

Explain: \_\_\_\_\_  
\_\_\_\_\_

6) Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. Attach additional sheets as necessary.

\_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Helpful Hints When Filing an External Review

## External Review Request Forms

<https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/Chapter87ExternalReviewForms.pdf>

### External Review Request Form

This EXTERNAL REVIEW REQUEST FORM must be filed with the Nebraska Department of Insurance within FOUR (4) MONTHS after receipt from your insurer of a denial of payment on a claim or request for coverage of a health care service or treatment. The Department of Insurance mailing address and telephone number are:

Nebraska Department of Insurance  
PO Box 82089  
Lincoln, NE 68501-2089  
(877) 564-7323  
[www.doi.nebraska.gov](http://www.doi.nebraska.gov)

#### EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME: \_\_\_\_\_ Covered person/Patient \_\_\_\_\_ Provider \_\_\_\_\_ Authorized Representative \_\_\_\_\_  
(choose one)

#### COVERED PERSON/PATIENT INFORMATION

Covered Person Name: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Covered Person Phone Number: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

#### INSURANCE INFORMATION

Insurer/HMO Name: \_\_\_\_\_

Covered Person Insurance ID number: \_\_\_\_\_

Insurance Claim/Reference number: \_\_\_\_\_

Insurer/HMO Mailing Address: \_\_\_\_\_

Insurer Phone Number: ( ) \_\_\_\_\_

#### EMPLOYER INFORMATION

Employer's Name: \_\_\_\_\_

Employer's Phone Number: \_\_\_\_\_

Is the health coverage you have through your employer a self-funded plan? \_\_\_\_\_. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

#### HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

#### REASON FOR HEALTH CARRIER DENIAL (Please check one)

The health care service or treatment is not medically necessary.

The health care service or treatment is experimental or investigational.

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)\*

\_\_\_\_\_

\_\_\_\_\_

\*You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using the attached pages below.

#### EXPEDITED REVIEW

You may request that your external appeal be handled on an expedited basis if a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function. To complete this request, your treating health care provider must fill out the attached form: Certification of Treating Health Care Provider for Expedited Consideration of a Patient's External Review Appeal.

Is this a request for an expedited appeal? Yes \_\_\_\_\_ No \_\_\_\_\_

#### SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, \_\_\_\_\_, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Nebraska Department of Insurance. I understand that the independent review organization and the Nebraska Department of Insurance will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

\_\_\_\_\_  
Signature of Covered Person (or legal representative)\*  
\*(Parent, Guardian, Conservator or Other - Please Specify)

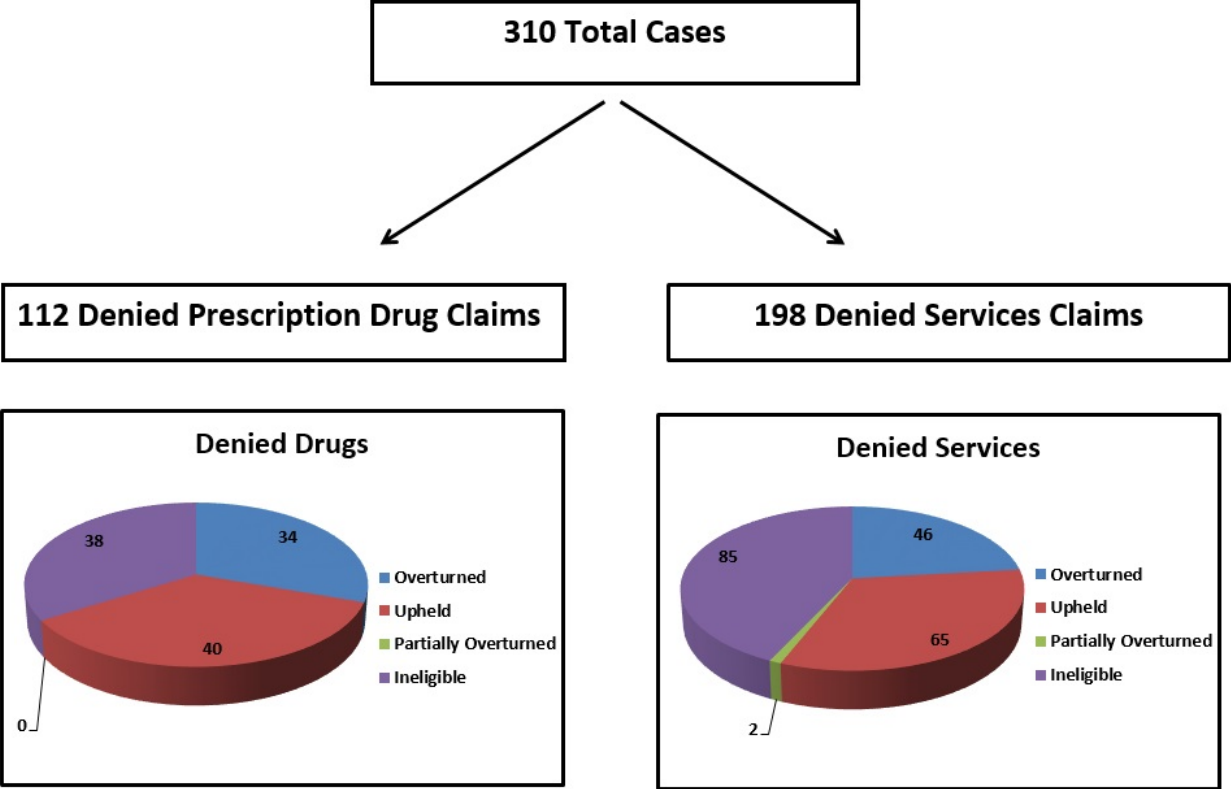
\_\_\_\_\_  
Date

# Helpful Hints (Continued)

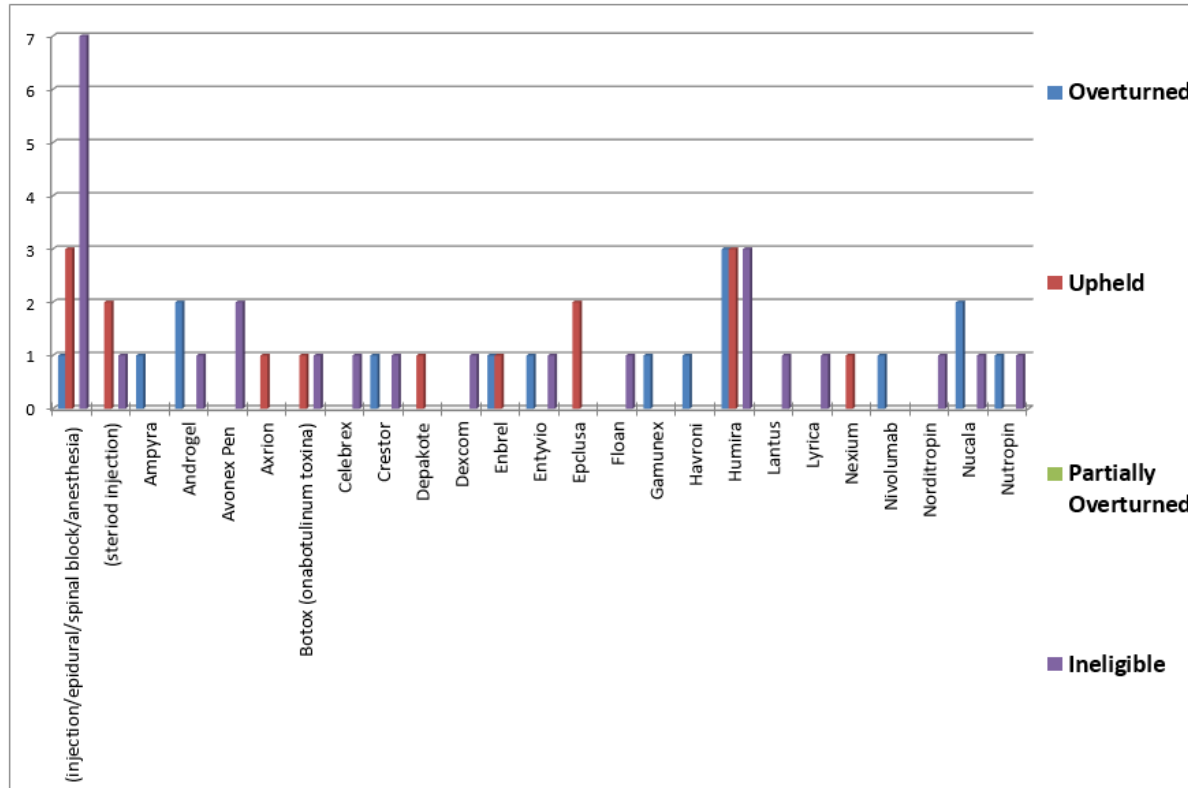
- Designate your doctor or your health care advocate as your authorized representative
- It is important to include:
  - ❖ A letter of medical necessity from your doctor. It is critical that your doctor prove that this service or treatment is medically necessary.
  - ❖ Medical records such as lab reports, family history, record of doctor's visits, any other reports, etc.
  - ❖ A copy of your insurance card
  - ❖ Copies of all claim and appeal denials

# 2016 External Review by the Numbers

## Breakdown of Cases

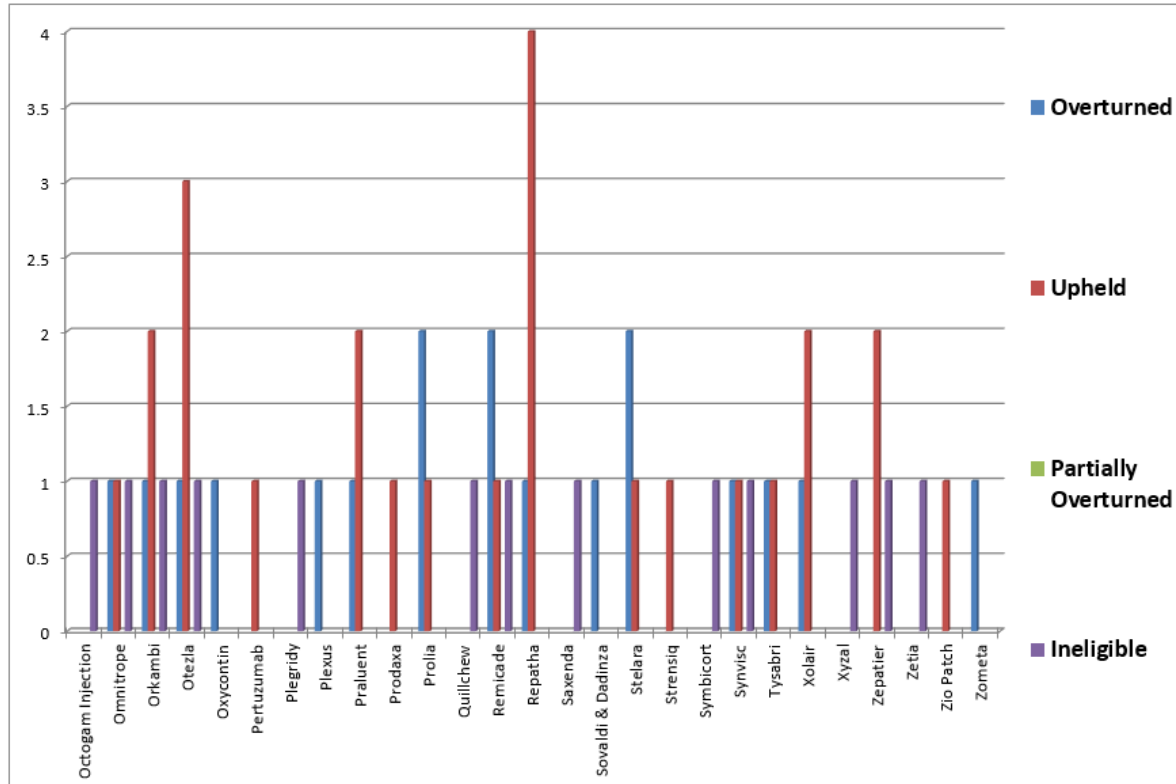


# Denied Drug Breakdown Part One



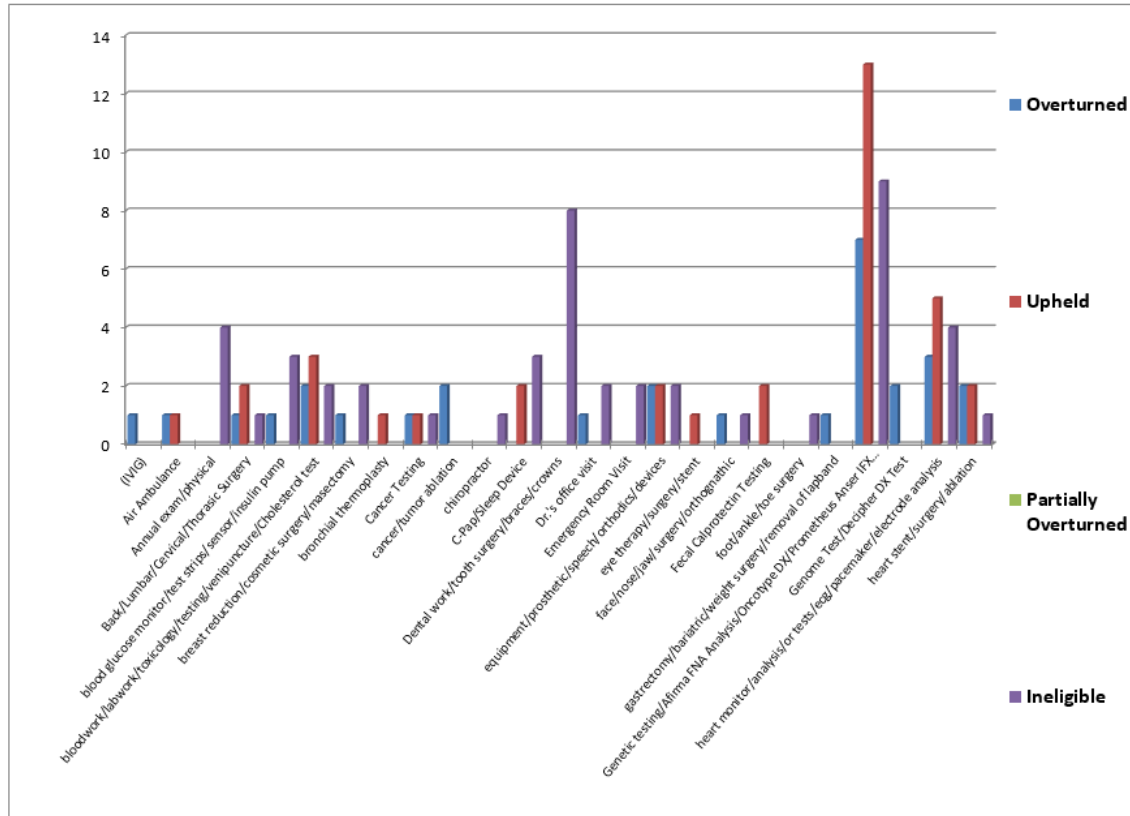


# Denied Drug Breakdown Part Two

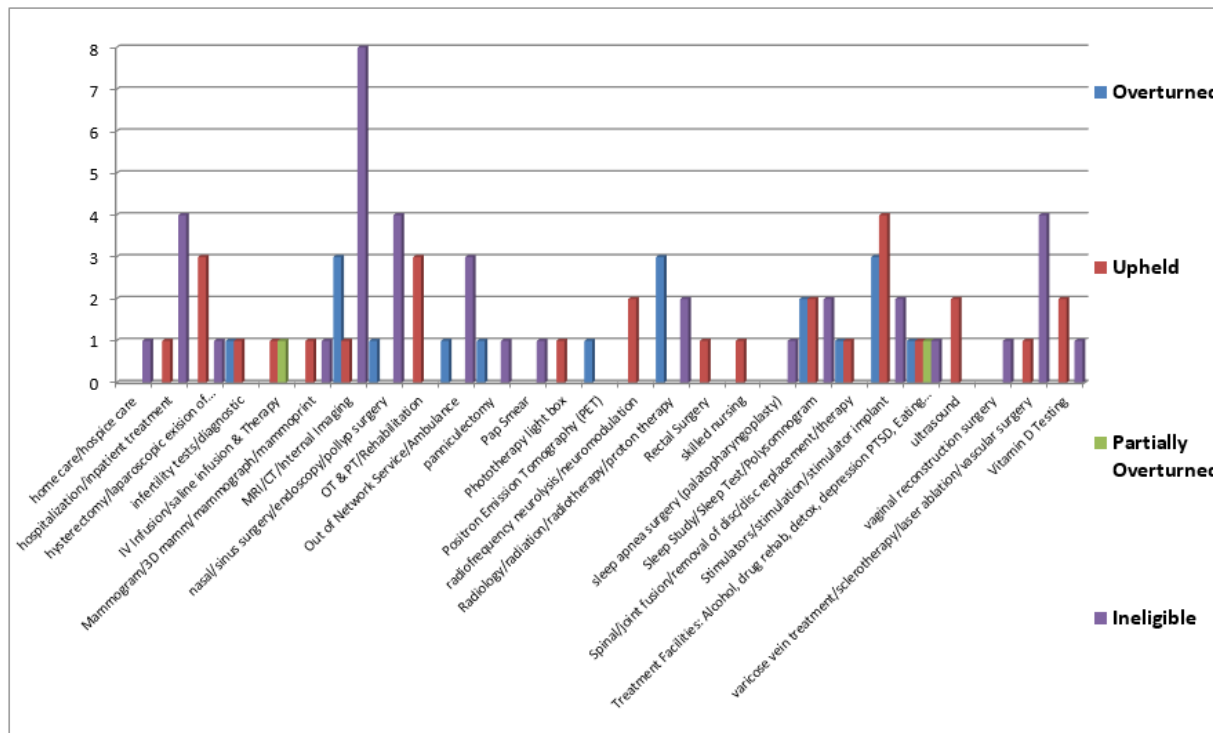




# Denied Services Breakdown Part One



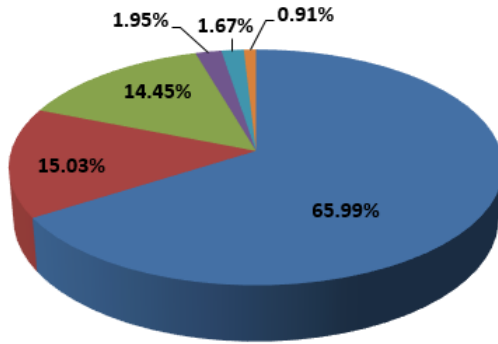
# Denied Services Breakdown Part Two



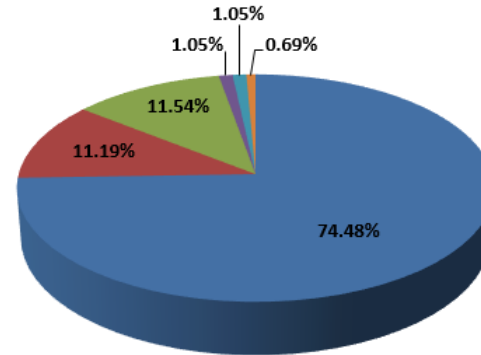
# 2016 Market Share Compared to Amount of External Review Complaints

- BlueCross BlueShield of Nebraska
- Aetna/Coventry
- UnitedHealthCare
- Golden Rule Insurance Company
- Medica Insurance Company
- Federated Mutual

### Market Share Percentage



### Number of Complaints



# PREVENTIVE CARE AND MENTAL HEALTH PARITY

Laura Arp  
Health Policy Counsel  
[Laura.Arp@Nebraska.gov](mailto:Laura.Arp@Nebraska.gov)

# PREVENTIVE CARE PAID AT 100%

## APPLIES TO:

- Individual plans (but not “transitional” or “grandfathered” plans).
- Small-group employer plans.
- Large-group, fully insured employer plans.
- Large-group, self-insured employer plans (if they use a Third Party Administrator).

# FOUR CATEGORIES COVERED

The ACA requires private insurance plans to cover the following four broad categories of services for adults and children:

## 1. Evidence-Based Screenings and Counseling

- As recommended by the United States Preventive Services Task Force.
- Includes screening for depression, diabetes, cholesterol, obesity, various cancers, HIV and sexually transmitted infections, as well as counseling for drug and alcohol use, healthy eating, and other common health concerns.

## 2. Routine Immunizations

- As recommended by the Advisory Committee on Immunization Practices
- Includes influenza, meningitis, tetanus, HPV, hepatitis A and B, measles, mumps, rubella, and varicella.

## 3. Preventive Services for Children and Youth

- As recommended by the Health Resources and Services Administration's Bright Futures Project.
- Includes behavioral and developmental assessments, iron and fluoride supplements, and screening for autism, vision impairment, lipid disorders, tuberculosis, and certain genetic diseases.

## 4. Preventive Services for Women

- Recommended by the Health Resources and Services Administration committee of the Institute of Medicine.
- Includes well-woman visits, all FDA-approved contraceptives and related services, broader screening and counseling for STIs and HIV, breastfeeding support and supplies, and domestic violence screening.

NEBRASKA

Good Life. Great Opportunity.

**Table 1: Summary of Selected Preventive Services for Adults Covered by Non-Grandfathered Private Plans without Cost Sharing**

Cancer	Chronic Conditions	Immunizations	Health Promotion	Pregnancy-Related**	Reproductive Health
<ul style="list-style-type: none"> <li>• <b>Breast cancer</b> <ul style="list-style-type: none"> <li>- Mammography (women 40+<sup>§</sup>)</li> <li>- Genetic (BRCA) screening and counseling (women at high risk)</li> <li>- Preventive medication (women at high risk)</li> </ul> </li> <li>• <b>Cervical cancer</b> <ul style="list-style-type: none"> <li>- Pap testing (women 21+ with cervix)</li> <li>- HPV DNA testing<sup>¶</sup> (women 30-65 with normal pap results)</li> </ul> </li> <li>• <b>Colorectal cancer</b> <ul style="list-style-type: none"> <li>- Fecal occult blood testing, sigmoidoscopy, and/or colonoscopy. (adults 50-75)</li> </ul> </li> <li>• <b>Lung cancer screening</b> <ul style="list-style-type: none"> <li>- Annual tomography (adults 55- 80 with history)</li> </ul> </li> <li>• <b>Skin cancer</b> <ul style="list-style-type: none"> <li>- Counseling (adults 18- 24)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Abdominal aortic aneurysm screening</b> (men 65- 75 who have ever smoked)</li> <li>• <b>Cardiovascular health</b> <ul style="list-style-type: none"> <li>- Hypertension screening</li> <li>- Blood pressure</li> <li>- Lipid disorders screenings (high risk women 20+; at risk men 20-35; all men 35+)</li> <li>- Aspirin (men 45- 79; women 55- 79)</li> <li>- Behavioral Counseling (overweight or obese adults with CVD risk factors)</li> </ul> </li> <li>• <b>Diabetes (Type 2) screening</b> (adults with elevated blood pressure)</li> <li>• <b>Depression screening</b> (adults when follow up supports available)</li> <li>• <b>Hepatitis B screening</b> (adults at high risk for infection)</li> <li>• <b>Hepatitis C screening</b> (high risk adults; one time screening for adults born between 1945 and 1965)</li> <li>• <b>Obesity Screening and Management</b> (all adults via body mass index (BMI))                     <ul style="list-style-type: none"> <li>- Referral for intervention for adults <math>\geq</math> BMI of 30 kg/m<sup>2</sup></li> </ul> </li> <li>• <b>Osteoporosis screening</b> (all women 65+; high risk women &lt;60)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Haemophilus influenzae type b</b> (adults 18+ with risk factors)</li> <li>• <b>Hepatitis A</b> (adults with risk factors)</li> <li>• <b>Hepatitis B</b> (adults with risk factors)</li> <li>• <b>HPV</b> (women 18- 26 and men 18- 21 not previously vaccinated; at risk men 22- 26)</li> <li>• <b>Influenza (yearly)</b></li> <li>• <b>Meningococcal</b> (adults 18+ with risk factors)</li> <li>• <b>Measles, Mumps and Rubella</b> (adults 18- 49; 50+ with risk factors)</li> <li>• <b>Pneumococcal</b> (adults 19- 64 with risk factors; adults 65+)</li> <li>• <b>Td booster, Tdap</b></li> <li>• <b>Varicella</b></li> <li>• <b>Zoster</b> (adults 60+)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Alcohol misuse screening and counseling</b> (risk assessment all adults)</li> <li>• <b>Fall Prevention Counseling and Preventive Medication</b> (community-dwelling adults 65+)</li> <li>• <b>Intimate partner violence screening, counseling<sup>¶</sup></b> (women)</li> <li>• <b>Tobacco counseling and cessation interventions</b></li> <li>• <b>Well-woman visits<sup>¶</sup></b> (women 18- 64; visits for recommended preventive services, preconception care, and/or prenatal care)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Alcohol misuse screening and counseling</b></li> <li>• <b>Breastfeeding supports</b> <ul style="list-style-type: none"> <li>- Counseling</li> <li>- Consultations with trained provider<sup>¶</sup></li> <li>- Equipment rental<sup>¶</sup></li> </ul> </li> <li>• <b>Folic acid supplements</b> (women with reproductive capacity)</li> <li>• <b>Gestational diabetes screenings<sup>¶</sup></b> (after 24 weeks gestation)</li> <li>• <b>Iron deficiency anemia screening</b></li> <li>• <b>Preeclampsia preventive medicine</b> (pregnant women at high risk)</li> <li>• <b>Low-dose aspirin</b> (at risk women after 12 weeks of gestation)</li> <li>• <b>Screenings for pregnant women</b> <ul style="list-style-type: none"> <li>- Hepatitis B</li> <li>- Chlamydia (women <math>\leq</math>24 years; older women at risk)</li> <li>- Gonorrhea</li> <li>- Syphilis</li> <li>- Bacteriurea</li> </ul> </li> <li>• <b>Tobacco counseling and cessation interventions</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Contraception</b> (all women with reproductive capacity)<sup>¶</sup> *                     <ul style="list-style-type: none"> <li>- All FDA-approved contraceptive methods as prescribed</li> <li>- Sterilization procedures</li> <li>- Patient education and counseling</li> <li>- Services related to follow-up, management of side effects, and device removal</li> </ul> </li> <li>• <b>Screenings</b> <ul style="list-style-type: none"> <li>- Chlamydia (sexually active women <math>\leq</math>24 years old, older women at risk)</li> <li>- Gonorrhea ((sexually active women <math>\leq</math>24 years old, older women at risk)</li> <li>- Syphilis (adults at high risk)</li> <li>- HIV (adults 15- 65; at-risk younger adolescents and older adults)</li> </ul> </li> <li>• <b>STI and HIV counseling</b> (adults at high risk; all sexually-active women<sup>¶</sup>)</li> </ul>

Notes: Unless noted, applicable age for the recommendations is age 18+. Pregnancy-related applies to pregnant women. Age ranges are meant to encompass the broadest range possible. Each service may only be covered for certain age groups or based on risk factors. \*The ACA defines the recommendations of the USPSTF regarding breast cancer services to "the most current other than those issued in or around November 2009." Thus, coverage for mammography is guided by the 2002 USPSTF guideline. \*\*Services in this column apply to all pregnant or lactating women, unless otherwise specified. \*\*\*Certain religious employers exempt from this requirement. <sup>¶</sup>Recommendation from HRSA Women's Preventive Services; coverage for these services without cost sharing in "non-grandfathered" plans began August 1, 2012. Coverage without cost sharing for all other services went into effect Sep. 23, 2010.

Sources: CMS, [Affordable Care Act Implementation FAQ's Set 18](#). CMS, [Preventive Health Services for Adults](#). More information about each of the items in this table, including details on periodicity, age, risk factors, and specific tests and procedures are available at the following websites: [USPSTF](#); [ACIP](#); [HRSA Women's Preventive Services](#).



**Table 2: Summary of Selected Preventive Services for Children Covered by Non-Grandfathered Private Plans without Cost Sharing**

Chronic Conditions	Immunizations	Health Promotion	Reproductive Health	Development and Behavioral Health
<ul style="list-style-type: none"> <li>• <b>Cardiovascular health</b> <ul style="list-style-type: none"> <li>- Blood pressure (screening for at risk newborn children – 3 years; children 3 years+)</li> <li>- Lipid disorders screenings (children 2 years+ risk assessment/ screening)</li> </ul> </li> <li>• <b>Depression screening</b> (adolescents 11 years+)</li> <li>• <b>Hepatitis B screening</b> (adolescents at high risk for infection)</li> <li>• <b>Skin cancer counseling</b> (children 10 years+)</li> <li>• <b>Obesity</b> <ul style="list-style-type: none"> <li>- Screening (children 2 years+ via body mass index (BMI))</li> <li>- Counseling and behavioral interventions (obese children 6 years+)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>DTaP</b> (children 2 months– 6 years)</li> <li>• <b>Haemophilus influenzae type b</b> (children 2 months – 4 years)</li> <li>• <b>Hepatitis A</b> ( children 1 year+; 2 years+ with risk factors)</li> <li>• <b>Hepatitis B</b> (at birth; then newborn+)</li> <li>• <b>HPV</b> (children 11 years+)</li> <li>• <b>Inactivated Poliovirus</b> (children 2 months+)</li> <li>• <b>Influenza (yearly)</b> (children 6+ months+)</li> <li>• <b>Meningococcal</b> (children 11 years+; 2 months+ with risk factors)</li> <li>• <b>Measles, Mumps and Rubella</b> (children 1 year+)</li> <li>• <b>Pneumococcal</b> <ul style="list-style-type: none"> <li>- Pneumococcal conjugate (children 2 months – 4 years; 5 years+ with risk factors)</li> <li>- Pneumococcal polysaccharide (children 2 years+ with risk factors)</li> </ul> </li> <li>• <b>Td booster, Tdap</b> (children 7 years+)</li> <li>• <b>Varicella</b> (children 1 year+)</li> <li>• <b>Rotavirus</b> (children 2– 6 months)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Anemia screening, supplements</b> (children 6 months+ iron supplements for high risk 6 – 12 months)</li> <li>• <b>Dental caries prevention</b> <ul style="list-style-type: none"> <li>- Fluoride varnish (infants and children at age of primary teeth eruption)</li> <li>- Fluoride supplements (children 6+ months without fluoride in water source)</li> </ul> </li> <li>• <b>Gonorrhea prophylaxis treatment</b> (newborn)</li> <li>• <b>History and physical exams</b> (prenatal+)</li> <li>• <b>Measurements:</b> <ul style="list-style-type: none"> <li>- Length/height and weight (children newborn– adolescence)</li> <li>- Head circumference, weight for length (newborn – 2 years)</li> <li>- Body mass index (BMI) (children 2 years+)</li> <li>- Blood pressure (risk assessment at birth; children 3 years+)</li> </ul> </li> <li>• <b>Oral health: risk assessment, referral to dental home</b> (children 6 months – 6 years)</li> <li>• <b>Screenings</b> <ul style="list-style-type: none"> <li>- Blood screening (newborn– 2 months)</li> <li>- Critical congenital health defect (newborn)</li> <li>- Lead screening (children risk assessment and/or test 6 months – 6 years)</li> <li>- Metabolic/hemoglobin, phenylketonuria, sickle cell, congenital hypothyroidism screenings (newborn+)</li> <li>- Tuberculin (children risk assessment 1 month+)</li> </ul> </li> <li>• <b>Tobacco counseling and cessation interventions</b> (children 5 years– adolescence)</li> <li>• <b>Vision and hearing screenings/assessment</b> (children newborn+)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Contraception</b> (all women with reproductive capacity)<sup>9*</sup> <ul style="list-style-type: none"> <li>- All FDA-approved contraceptive methods as prescribed</li> <li>- Sterilization procedures</li> <li>- Patient education and counseling</li> <li>- Services related to follow-up, management of side effects, and device removal</li> </ul> </li> <li>• <b>STI and HIV counseling</b> (sexually-active adolescents)</li> <li>• <b>Screenings</b> <ul style="list-style-type: none"> <li>- Chlamydia (sexually active females)</li> <li>- Gonorrhea (sexually active females)</li> <li>- HIV (adolescents and at risk children; screening ages 16– 18)</li> <li>- STIs (risk assessment for adolescents; screening ages 16– 18)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Alcohol misuse screening and counseling</b> (risk assessment adolescents 11 years+)</li> <li>• <b>Autism screening:</b> (infants 18– 24 months)</li> <li>• <b>Developmental screenings and surveillance</b> (newborn+)</li> <li>• <b>Psychosocial/ behavioral assessment</b> (newborn+)</li> </ul>

**Notes:** Age ranges are meant to encompass the broadest range possible, up to age 21. Each service may only be covered for certain age groups or based on risk factors. For specific details on recommendations, please consult the websites listed below. \*Certain religious employers exempt from this requirement. <sup>9</sup>Recommendation from HRSA Women's Preventive Services; coverage for these services without cost sharing in "non-grandfathered" plans began August 1, 2012. Coverage without cost sharing for all other services went into effect Sep. 23, 2010.

**Sources:** CMS, [Affordable Care Act Implementation FAQ's Set 1.8](#). CMS, [Preventive health services for children](#). More information about each of the items in this table, including details on periodicity, age, risk factors, and specific tests and procedures are available at the following websites: [USPSTF](#); [Bright Futures](#) and [American Academy of Pediatrics](#); [ACIP](#); [HRSA Women's Preventive Services](#).



# SOMETIMES INSURERS CAN CHARGE COPAYMENTS AND COINSURANCE WHEN PAYING FOR PREVENTIVE SERVICES

- If the office visit and the preventive service are billed separately, cost-sharing cannot be charged for the preventive service but the insurer may still impose cost-sharing for the office visit itself.
- If the primary reason for the visit is not the preventive service, patients may have to pay for the office visit.
- If the service is performed by an out-of-network provider when an in-network provider is available to perform the preventive service, insurers may charge patients for the office visit and the preventive service. However, if an out-of-network provider is used because there is no in-network provider able to provide the service then cost-sharing cannot be charged.
- If a treatment is given as the result of a recommended preventive service, but is not the recommended preventive service itself, cost-sharing may be charged.

# MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)

Federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

NEBRASKA

Good Life. Great Opportunity.

# PARITY DEFINED

- PARITY means that financial requirements (copayments, deductibles, coinsurance, out-of-pocket maximums) and treatment limitations used by health plans must be comparable for physical health vs. mental health and substance use disorder (MH/SUD).
- There are a set of rules for parity for financial requirements and for treatment limits that you can count (such as number of visits).
- Another set of rules addresses parity in how treatment is accessed and under what conditions (such as obtaining permission from your health plan before going for MH/SUD treatment).

NEBRASKA

Good Life. Great Opportunity.

# MAKING THE MOST OF YOUR MH/SUD BENEFITS

If a mental health or substance use disorder claim is being denied:

- Request the reason for any denial of payment for services for mental health or substance use disorder benefits.
- The plan or insurer must provide an adverse benefit determination containing the specific reason for the denial, reference to the specific plan rules used to make the determination, and a description of the plan's appeal procedures.
- Follow the procedures to file an internal appeal, and if necessary, an external appeal.
- Inform the Department of Insurance if you believe the denial is not justified.

# INSURANCE IN NEBRASKA

- Overview of Regulation
- Consumer Issues
- Consumer Alerts and Brochures

# INSURANCE IS IMPORTANT IN NEBRASKA

- Nebraska's domestic insurers rank:
  - Third nationally in assets (\$611,408,913,512 of oversight responsibility for Nebraska DOI), second only to Iowa and New York.
  - Second nationally in surplus, second only to Illinois.
- Industry concentration for employment is high. Nebraska has 84% more jobs in the insurance industry than would be expected in a state of its size.
  - This is the second highest job concentration among any state.

NEBRASKA

Good Life. Great Opportunity.

# INSURANCE MARKET REGULATION

- Review of policies and rates
- Consumer assistance
- Market conduct examinations
- Financial solvency
- Consumer alerts, brochures, and newsletters

NEBRASKA

Good Life. Great Opportunity.

# TOP SIX CONSUMER ISSUES 2016 – 2017

- Claim handling delays
- Claim denials
- Unsatisfactory settlement offer
- Coverage questions
- Prompt payment
- Underwriting/premium audits

NEBRASKA

Good Life. Great Opportunity.



# CONSUMER ISSUES BY TYPE OF INSURANCE

## PROPERTY AND CASUALTY INSURANCE:

- **Roofs** (*whether replacement is warranted*) & **Siding** (*matching*)
- **Valuation of autos**
- **Comparative negligence**
- **Cancellations/Non-renewals**
- **Work Comp Premium Audits**

## LIFE AND HEALTH INSURANCE:

- **Cost of coverage**
- **Contract exclusions**
- **Marketing misrepresentations**
- **Marketplace-related concerns**
- **Network issues**

NEBRASKA

Good Life. Great Opportunity.

# REMINDERS TO CONSUMERS

- Exercise caution when responding to unsolicited calls from individuals selling “cheap alternatives to major medical health insurance.” Consumer Alert: <https://doi.nebraska.gov/alert/limited-benefit-medical-insurance-plansmini-med-plans>
- Carefully read all correspondence from insurers and CMS and contact the DOI Consumer Affairs Division when issues arise, rather than waiting.
- Check out the NAIC’s Life Insurance Policy Locator service. This has already proven to be a great benefit to consumers in Nebraska.
  - <https://eapps.naic.org/life-policy-locator/#/welcome>
  - As of April 1, 2017, the Policy Locator had matched nearly 1,800 beneficiaries with lost or misplaced life insurance policies or annuities totaling more than \$17 million returned to consumers.

# REMINDERS TO CONSUMERS

- Take steps to guard against identity theft. Nebraska DOI will soon update our consumer alert; meanwhile, here's one released by the NAIC: [http://www.naic.org/documents/consumer\\_alert\\_idtheft.htm](http://www.naic.org/documents/consumer_alert_idtheft.htm)
- Take responsibility for reviewing homeowners policies and understanding the coverage.
  - Many insurers have added wind/hail deductibles to HO policies (“a *wind/hail deductible is expressed as a percentage of the dwelling limit, rather than as a flat dollar amount*”) or they've changed roof coverage to provide actual cash value rather than replacement cost coverage.
  - We've had a number of complaints from policyholders who failed to notice the changes made on renewal. Companies/agents need to notify policyholders, but under the law, policyholders have responsibility for reading their policies. We touch on this in an alert: [https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/BeforeTheStorm-Don%27tWaitUntilItsTooLate\\_0.pdf](https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/BeforeTheStorm-Don%27tWaitUntilItsTooLate_0.pdf)

# REMINDERS TO CONSUMERS

- Things to know about hiring a roofer or contractor:
  - Cannot waive the deductible.
  - If charging a fee for insurance advice, must be licensed.
  - If you assign the claim, know the possible consequences. Read our Post Loss Assignment Consumer Alert before assigning proceeds to a contractor: <https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/ConsumerAlertPostLossAssignments.pdf>
- If you use a coupon to pay at the pharmacy, be aware that the amount the coupon covered is probably not going to count toward your deductible. Most health insurance does not count you as having paid money that you received from a third party, for example, drug coupons.

# PROPERTY AND CASUALTY CONSUMER ALERTS ISSUED 2016 – 2017

- 6/14/2017 - [Consumer Alert: Post Loss Assignments of Claims](#)
- 5/1/2016 - [After the Storm—The Disaster Claims Process.](#)
- 2/1/2016 - [Globetrotting: Consider Travel Insurance Before You Hit the Road](#)
- 5/11/2017 - [Consumer Alert - Summer Safety: Are you insured for summer fun?](#)
- 3/17/2017 - [CONSUMER ALERT - Breaking for Spring Travel](#)
- 2/9/2017 - [CONSUMER ALERT - Insurance Checklist for the New Year - 2017](#)

NEBRASKA

Good Life. Great Opportunity.

# CONSUMER BROCHURES

## HOME AND AUTO

- [Before the Storm](#) Don't Wait Until It's Too Late - Make Sure Your Home is Covered in the Event of a Loss
- [After the Storm](#) The Disaster Claims Process
- [Home Inventory Checklist](#)
- [NFIP Flood Insurance Claims Handbook](#)
  - Website created by FEMA, which oversees the National Flood Insurance Program, to help individuals through the process of filing a claim and appealing the decision on claims.
- [Flood Outreach Toolkit](#)
  - Toolkit put out by FEMA on what you need to know about flooding and flood insurance
- [Auto Liability Insurance Fraud](#)
  - Manufacture or Use of Fake Identification Cards is a Crime
- [Fires and Other Major Damage to Your Home](#)
- [Renter's Insurance](#)
- [Do I Have Hail Damage On My Roof?](#)
- [Nebraska Insured Homeowners Protection Act](#)
  - Whether you are a homeowner, an insurance producer, an insurer or residential contractor, being familiar with the “Insured Homeowners Protection Act” can be an important step in helping yourself or others deal with post-loss repair issues.

# LIFE AND HEALTH

## CONSUMER ALERTS ISSUED 2016 – 2017

- 7/27/2017 - [Consumer Alert: Beware of Fraudulent Attempts to Disburse Funds from Annuity Contracts](#)
- 2/14/2017 - [Brochure - Appealing a Health Plan Decision](#)
- 12/2/2016 - [Consider Purchasing Health Insurance By December 15](#)
- 11/23/2016 - [Looking in The 'Lost and Found', Finding a Life Insurance Benefit When You Don't Have the Policy](#)
- 10/18/2016 - [Making \\$ense of Health Insurance after Retirement](#)
- 10/13/2016 - [Short-Term Health Plans Are Not ACA Compliant](#)
- 8/15/2016 - [CONSUMER ALERT - Insurance Considerations for Caregivers](#)
- 7/1/2016 - [CONSUMER ALERT - Life Insurance Beneficiaries](#)
- 3/1/2016 - [Life Insurance Roadmap](#)

# CONSUMER BROCHURES

## LIFE AND HEALTH

- [Nebraska Comprehensive Health Insurance Pool \(NECHIP\)](#)
- [The Association Scam: How It Works](#)
- [Shopper's Guide for Cancer Insurance](#)
- [Nebraska Funeral and Burial Funding](#)
- [Life Insurance Advertising](#)
- [Appealing a Health Plan Decision](#)

NEBRASKA

Good Life. Great Opportunity.



THANK YOU FOR YOUR TIME!

NEBRASKA  
Good Life. Great Opportunity.

# CONTACT INFORMATION

- Martin.Swanson@Nebraska.gov, 402-471-4648
- Laura.Arp@Nebraska.gov, 402-471-4635
- Maggie.Dolezal@Nebraska.gov, 402-471-1432
  
- Department of Insurance web site: <https://doi.nebraska.gov/>
- Consumer Affairs Hotline 402-471-0888 or (in-state only) 877-564-7323
- Online complaint form: <https://doi.nebraska.gov/consumer/consumer-assistance>
- External review request form:  
<https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/Chapter87ExternalReviewForms.pdf>
  
- Find Us on Social Media:
  - Facebook: @NDOIHealth
    - <https://www.facebook.com/NDOIHealth/>
  - Instagram: @ndoihealthdivision
    - <https://www.instagram.com/ndoihealthdivision/>
  - Twitter: @NDOIHealth
    - <https://twitter.com/NDOIHealth>