NEBRASKA DEPARTMENT OF INSURANCE HEALTH DIVISION

NEBRASKA DEPARTMENT OF INSURANCE
2019 LISTENING SESSIONS

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DEPARTMENT OF INSURANCE FUNCTIONS

- General supervision, control, and regulation of insurance in Nebraska § 44-101.01
  - Producer licensing
  - Company licensing
  - Rate and form review
  - Consumer assistance
  - Market conduct examination and corrective actions
  - Financial solvency monitoring and intervention
  - Fraud prevention and investigation
  - Consumer alerts, brochures, and newsletters

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INSURANCE IS IMPORTANT IN NEBRASKA

- Nebraska's domestic insurers rank:
  - Second nationally in surplus (assets against liabilities, $221,385,871,867).
  - Fifth nationally in assets (includes reserves, $625,937,034,428 of oversight responsibility for NDOI).
  - Twelfth nationally in premiums written ($30,442,590,206).
- 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 insurance job concentration for any state.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC)

- State regulators establish standards and best practices, conduct peer review, and coordinate regulatory oversight.
  - https://www.naic.org/
- States draft model laws and regulations with input from consumers and industry.
  - https://www.naic.org/prod_serv_model_laws.htm
  - Example: https://www.naic.org/store/free/MDL-075.pdf?32
  - Note the implementation chart at the end of each model, giving cites to state laws or regulations.
    - Nebraska is a leader at the NAIC, serving as co-chairs and vice-chairs on multiple NAIC working groups
      - MACRA
      - Health Innovations
      - ERISA
      - Pharmacy Benefit Managers

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NEBRASKA DEPARTMENT OF INSURANCE HEALTH DIVISION

HEALTH INSURANCE:
Individual and Small Group Coverage for 2020

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U.S. HEALTH INSURANCE MARKET DISTRIBUTION 2013 to 2018

	2013	2014	2015	2016	2017	2018
Direct-purchase (individual)	11.4%	14.6%	16.3%	16.2%	16.1%	10.8%
Employment-based	55.7%	55.4%	55.7%	55.7%	56.0%	55.1%
Medicaid/CHIP	17.5%	19.5%	19.6%	19.4%	19.3%	17.9%
Medicare	15.6%	16.0%	16.3%	16.7%	17.3%	17.8%
Military health care	4.5%	4.5%	4.7%	4.6%	4.8%	3.6%
Uninsured	13.3%	10.4%	9.1%	8.8%	8.3%	8.5%

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 0.3%
2016 to 2017: Individual decreased 0.1%, uninsured decreased 0.5%
2017 to 2018: Individual decreased 5.3%, uninsured increased 0.2%

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

Insurer	Aetna or Coventry	Blue Cross & Blue Shield	CoOportunity	Medica	Time (Assurant)	United HealthCare	Bright Health
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			
1 in 2019				2019			
2 in 2020				2020			2020

*CoOportunity was pulled from the Marketplace in late December 2014. The company is *still* in liquidation.

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ON-EXCHANGE (INDIVIDUAL) ENROLLMENT IN NEBRASKA, 2014 – 2019

- **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.
- **2018** 88,213 on-exchange – by June, 81,784 had in-force coverage
- **2019** 87,416 on-exchange - by September 84,241 had in-force coverage

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2019 NEBRASKA ENROLLMENT IN DETAIL

- Exchange enrollees in Nebraska represent approximately 4.5% of the population (1,940,919 total population/87,416 initial marketplace enrollees).
- 87,416 people were enrolled on-exchange at the end of open enrollment
- By September 2019, on-exchange enrollment down to 84,241 on-exchange
  - Area 1 (Omaha) 27,427
  - Area 2 (Lincoln) 17,999
  - Area 3 (Mid-State) 27,436
  - Area 4 (Western) 11,322
- September 2019 enrollment was 84,241 for all ACA-compliant plans, on- and off-exchange. 79,756 remain on the exchange.
- Nebraskans receiving subsidies as of September 2019:
  - APTC received by 75,989 (95% of exchange enrollees; 90% of all enrollees)
  - CSR received by 29,427 (36% of exchange enrollees; 34% of all enrollees)
  - (more about APTC and CSR in a few slides)

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UNINSURED RATE IN NEBRASKA

Year	People Uninsured (estimated)
2013	209,000
2014	179,000
2015	154,000
2016	161,000
2017	159,360
2018	172,741
2019	161,096

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EXCHANGE PURCHASER DEMOGRAPHICS
Based Upon 2019 Data from the Federal Government

CUSTOMER ENROLLEE DATA

New Customers:	18,325
Re-enrollees:	69,091
Active re-enrollees:	55,528
Automatic re-enrollees:	13,563

GENDER DEMOGRAPHICS

Male:	41,704
Female:	45,712

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EXCHANGE PURCHASER DEMOGRAPHICS

Based Upon 2019 Data from the Federal Government, Continued

AGE DEMOGRPAHICS

- Age < 18: 13,466
- Age 18-25: 8,978
- Age 26-34: 14,782
- Age 35-44: 13,964
- Age 45-54: 13,879
- Age 55-64: 21,837
- Age >=65: 83

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EXCHANGE PURCHASER DEMOGRAPHICS

Based Upon 2019 Data from the Federal Government, Continued

URBAN V. RURAL ENROLLEE DISTRIBUTION

Rural: 45,405

Urban: 42,011

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EXCHANGE PURCHASER DEMOGRAPHICS Based Upon 2019 Data from the Federal Government, Continued

% FPL	Number of Insureds
No Request	2,022
100%-150%	22,677
150%-200%	16,198
250%-300%	11,809
300%-400%	15,747
Other FPL	1,732

Metal Level	Number of Insureds
Catastrophic	669
Bronze	25,537
Silver	35,262
Gold	25,948

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2019 PREMIUM DATA FROM THE FEDERAL GOVERNMENT

PREMIUM DATA FROM THE FEDERAL GOVERNMENT

- The average premium statewide per month: $866
- The average premium statewide after APTC: $80

PREMIUM DATA BY METAL LEVEL

Bronze:

- Average premium: $730
- Average premium with APTC: $111

Silver:

- Average premium: $1,005
- Average premium with APTC: $78

Gold:

- Average premium: $823
- Average premium with APTC: $46

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2019 PREMIUMS CONTINUED

Average Premiums for Selected Nebraska Counties

- Dawes County: $971
- Scottsbluff County: $1018
- Lincoln County: $1,105
- Buffalo County: $842
- Hall County: $922
- Otoe County: $822
- Douglas County: $794
- Lancaster County: $727
- Madison County: $951
- Platte County: $972

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INDIVIDUAL ACA 2020 RATES

- Nebraska will have two carriers on the exchange in 2020 – Medica and Bright Health.
- Average rates will see a 5.34% decrease from Medica's rates last year
- *Proposed rates are preliminary only, final rates will be made public on November 1, 2018.*
- Medica and Bright Health utilize an EPO Network structure
  - If you ever have difficulty finding an in-network provider, contact the companies – network adequacy standards apply to these plans.

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INDIVIDUAL ACA RATES, CONTINUED

2020 Medica Final Approved Rate Change Summary (Approved in the Rate Filing on August 18th)

- 2020 Average Rate Change: -6.89% varying by plan and network.
- 2020 Range of Rate Changes: -13.89% to +2.31%
- 2020 Approved Average Rate Changes by Product:
  Medica Insure: -5.50%
  Medica Elevate: -1.93%
  Medica with CHI: -11.26%

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INDIVIDUAL MARKET PREMIUM INCREASES 2014 – 2019

	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
2017	$407.10	$1,651.72	$1,192.68	$2,996.08
2018	$495.16	$2,105.18	$1,450.67	$2,831.46
2019*	$504.17	$2,143.48	$1,477.06	$2,488.94
Increase 2014 to 2019*	110.8%	187.8%	110.8%	62.9%

**** Rates for 2019 are proposed only, and may slightly change after NDOI review.***

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**

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SMALL GROUP INSURANCE 2019 RATES

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

- The ACA requires that small group plans comply with the same high coverage standards as individual plans, and the ACA does not allow insurers to charge different rates to different small employers based on health of the employees.
- These are *proposed average rates only.* Negotiations between NDOI and the insurers will result in some slightly lower final rates.
    - Aetna Health **9.48%**
    - Aetna Life Insurance Company **9.95%**
    - Blue Cross Blue Shield Nebraska **10.84%**
    - UnitedHealthCare Ins. Company **14.27%**
    - UHC of the Midlands **15.96%**

Rates for small group insurance can go up quarterly which is different than the individual market.

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Open Enrollment for
plan year 2019 is from

November 1, 2019 to
December 15, 2019.

Coverage begins January 1, 2020.

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WAYS TO ENROLL

- Healthcare.gov
  - Includes subsidies and available plans
- Consult an agent to understand all your options and pick the plan that is best for you.

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HOW TO FIND OUT IF YOU QUALIFY FOR A SUBSIDY

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

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2020 FEDERAL POVERTY LEVEL (FPL)

Family Size	FPL 100%	FPL 250%	FPL 400%
1	$12,490	$31,225	$49,960
2	$16,910	$42,275	$67,640
3	$21,330	$53,325	$85,320
4	$25,750	$64,375	$103,000
5	$30,170	$75,425	$120,680
6	$34,590	$86,475	$138,360
7	$39,010	$97,525	$156,040
8	$43,430	$108,575	$173,720

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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 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.

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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.

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COST SHARING REDUCTIONS (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.
- For people who earn between 100% and 250% of FPL and purchase a Silver plan, the ACA gives them a discount on cost sharing.

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PURCHASERS WILL RECEIVE CSRs, EVEN IF THEY ARE NOT FUNDED

- 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.
- Plans adjusted to not receiving CSR payments last year.
- Litigation is ongoing in this area.

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WHAT IF I EARN MORE THAN 400% FPL?

- There are no APTC benefits for people who earn more than 400% FPL.
- When shopping for an ACA plan, consider a Bronze, Gold, or ***off exchange*** Silver plan.
- Even more important that you speak with an agent.
- There are other options in the market, and it is important that people understand not all health insurance is the same.

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ACA TAX PENALTY REPEAL AND HARDSHIP EXEMPTION

- For 2019 and into the future, the tax penalty is $0.
- For 2017 and 2018, the federal government may grant a hardship exemption for individuals in a county where only one insurer offered individual health insurance coverage on the federal exchange.
  - A hardship exemption is an approved reason for waiving a penalty fee for not having minimum essential coverage under the ACA.
  - The documentation or written explanation submitted to get the exemption should explain how having only one insurer and a lack of choice on the exchange prevented you from getting coverage from a plan offered on the exchange.
- If you have any questions regarding this exemption, you may wish to talk to your tax preparer or financial advisor.
- Questions about the application form and what constitutes sufficient documentation and/or written explanation of why an exemption may be granted should be directed to healthcare.gov at https://www.healthcare.gov/contact-us/ or 1-800-318-2596.

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SHOPPING FOR HEALTH INSURANCE

- Identify your current health care needs and keep these in mind as you compare health insurance policies.
  - Doctors
  - Services
  - Prescription drugs
  - Excluded services or waiting periods for pre-existing conditions (if non-ACA plan)
- Compare health insurance policies.
- Compare the costs, including:
  - Premiums
  - Copays
  - Deductibles
  - Maximum out-of-pocket
  - Annual or lifetime limits (if non-ACA plan)

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GENERAL QUESTIONS TO ASK

- How long does coverage under this policy last?
- Does this policy cover pre-existing conditions? Is there an additional charge?
- If I develop a health condition, can this policy be cancelled or not renewed, even if I've paid my premiums?
- Will my doctor or hospital bill the insurance company, or do I have to pay up front and get reimbursed?
- Does the policy require that I use a specific network of doctors or hospitals?
- Are my doctor and hospital in this plan's network?
- Is there a point where I no longer have to pay anything out-of-pocket for health care services (MOOP)?

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QUESTIONS TO ASK: COVERAGE FOR SERVICES

- Ask if these services are covered, and if there are limits on the number of covered visits or limits on what you pay out-of-pocket:
  - Physician office visit
  - Specialist office visit
  - Preventive care (physicals, wellness visits, immunizations)
  - Urgent care
  - Hospital emergency care
  - Hospital inpatient care
  - Outpatient services
  - Laboratory services
  - Maternity care
  - Mental health and substance use disorder – inpatient
  - Mental health and substance use disorder – outpatient
  - Physical, occupational, or speech therapy; chiropractic

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SPECIFIC QUESTIONS TO ASK: PRESCRIPTION DRUGS

- Does this policy cover prescription drugs?
- Does this policy cover the drugs I use?
- Are there limits or requirements for approval before I fill a prescription?
- What will I have to pay out-of-pocket for prescription drugs?
  - Tier 1
  - Tier 2
  - Tier 3
  - Mail order
  - Specialty drugs

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SPECIFIC QUESTIONS TO ASK: COMPARING COSTS

- **Premium questions:**
  - How much will I pay for coverage each month?
  - Are there any other fees like application or membership fees?
  - Will I pay more because I have a pre-existing condition?
  - Will I receive financial help with out-of-pocket costs?
  - Am I eligible for premium subsidies with this policy?
- **What will I have to pay out-of-pocket, in addition to premiums?**
  - Deductible amounts:
    - In network
    - Out-of-network
    - Separate deductible for other services (like drugs)
  - Coinsurance percentage
  - Is there an annual limit on coverage (I pay all costs after the insurer pays a certain amount)?
  - Is there a lifetime limit on coverage (I pay all costs after the insurer pays a certain amount)?

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NEBRASKA DEPARTMENT OF INSURANCE HEALTH DIVISION

NEW DEVELOPMENTS AND HOT TOPICS IN HEALTH INSURANCE

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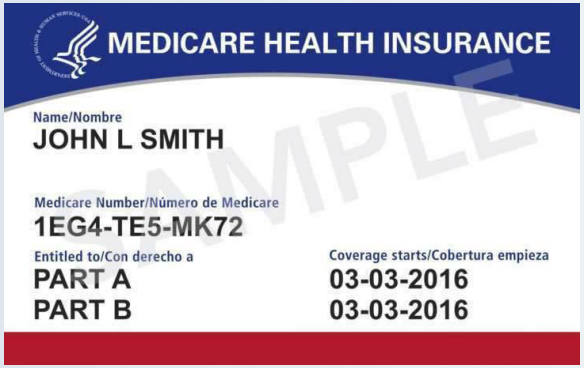
MEDICARE

What is Medicare?

Federal Health Insurance which was created in 1965

In order to qualify one must:

1. Be 65 or older
2. Have a qualifying disability
3. Have End-Stage Renal Disease (ESRD)



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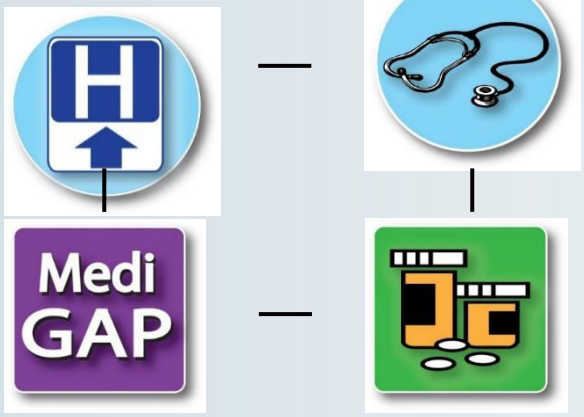
What is Medicare?

Option 1

Part A Hospital

Part B Medical



Supplement

Part D Drugs

OR

Option 2

Part C Medicare Advantage

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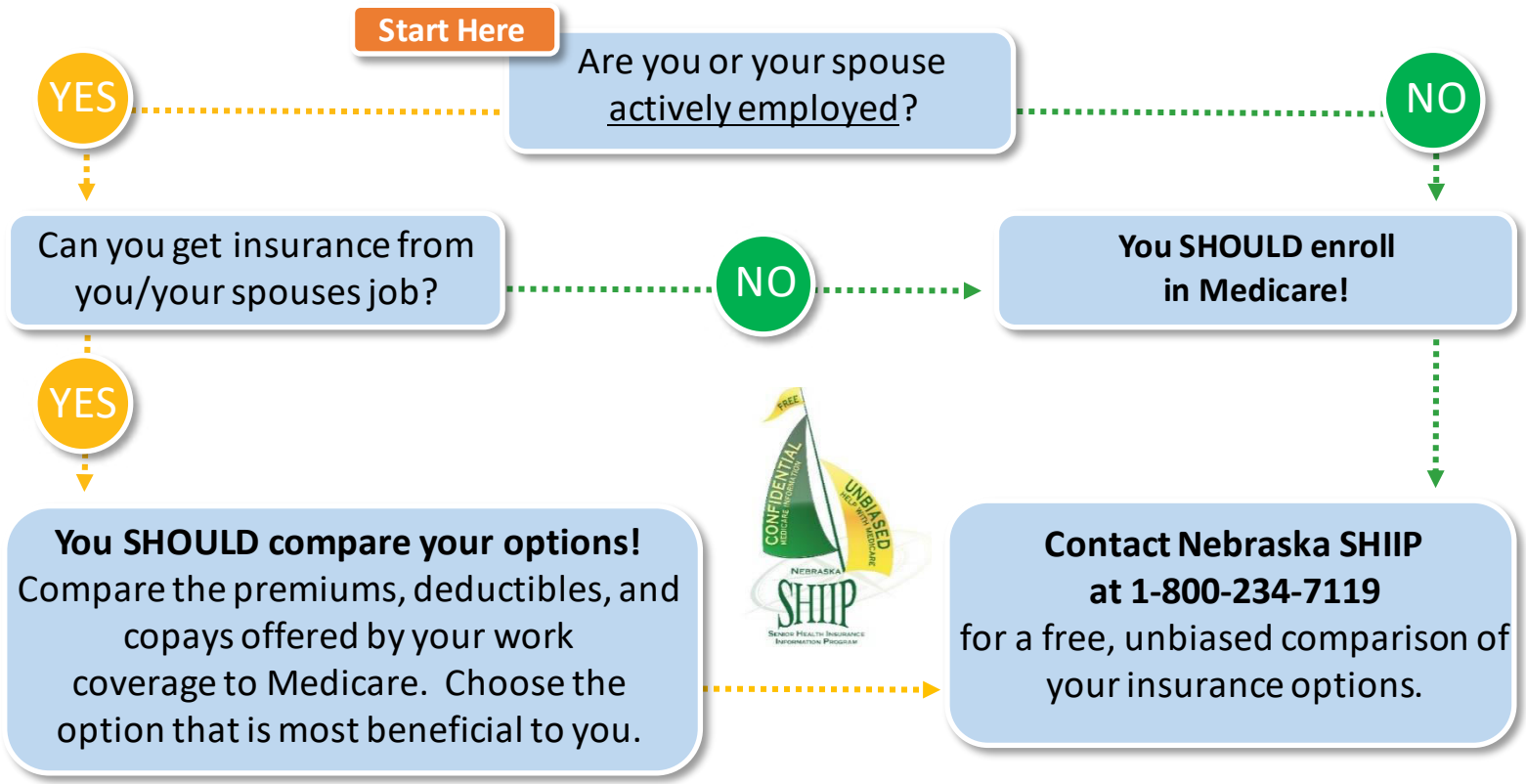
I'm Turning 65, *Should I Enroll in Medicare?*



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Annual Open Enrollment - Part C & D

- Every October 15 – December 7, contact Nebraska SHIIP for a comparison of your Part C or Part D plan
  - Best Coverage
  - Lowest Price
- In 2018, Nebraska SHIIP helped Nebraskans save over $20 million in prescription costs.

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Nebraska SHIIP

- Medicare information by phone, in-person or via WebEx
- Cost comparisons for Part C, Part D & Supplements
- Medicare enrollment help
- Medicare problem solving
- Low Income Subsidy applications
- Presentations for your group
- 1-800-234-7119
- www.doi.nebraska.gov/shiip

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TELL A FRIEND ABOUT SHIIP!

- The Nebraska SHIIP does not sell any products or policies, does not conduct market research, and is not related to any insurance companies.
- SHIIP not only provides presentations at senior centers and other organizations but also maintains a counseling program for Nebraskans who request one-on-one assistance.
- SHIIP counselors provide accurate, objective information; they help you understand your options so that you can make a better-informed decision.
- Private counseling sessions may be scheduled to discuss Medicare benefits, Medicare Advantage products, Medicare Supplement policies, Medicare Part D, or healthcare fraud - just to name a few.
- All SHIIP presentations and counseling sessions are free and unbiased. Also, all counseling sessions are completely confidential.

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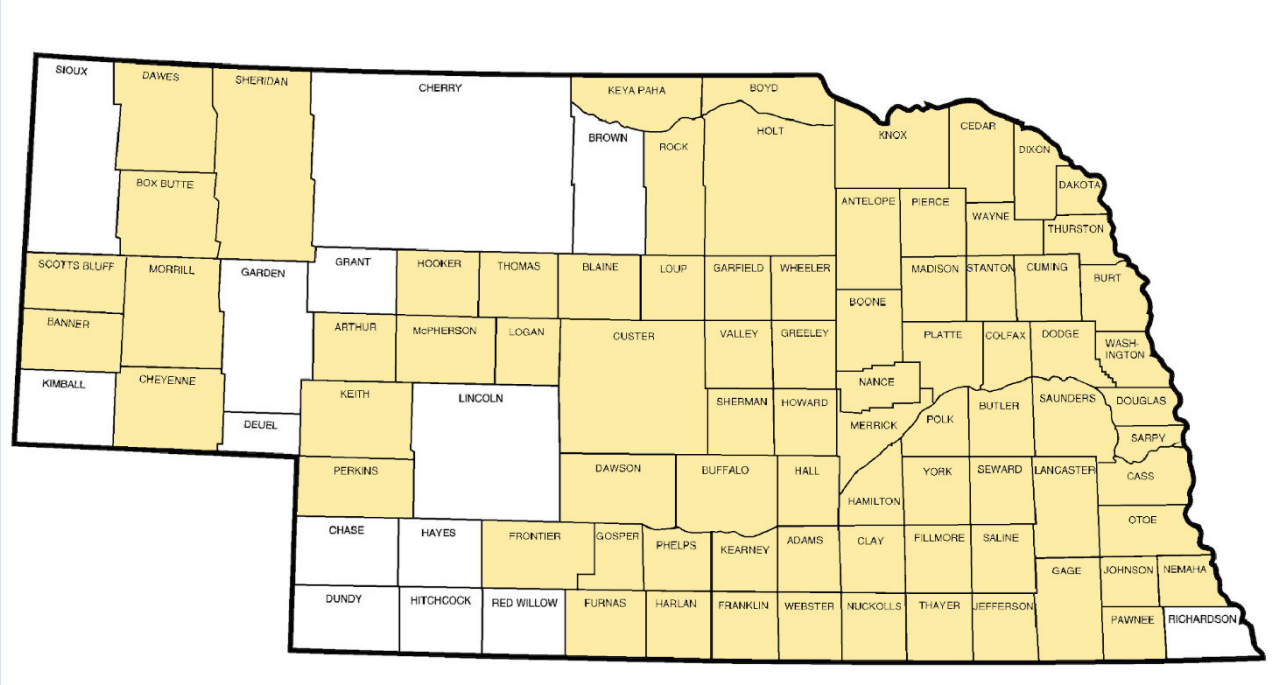
MA and Cost Plan Coverage



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REGULATION CHANGE FOR MEDICARE SUPPLEMENT

- Changes are coming in 2020.
- There is confusion in the market – a consumer can stay in their current plan.
- The changes will impact “newly eligible” people in 2020.
- Newly eligible are those who:
  - Attained age 65 on or after January 1, 2020 or
  - First became eligible due to age, disability or ESRD on or after January 1, 2020.
- Prohibits first-dollar Part B coverage on Medicare Supplement plans (Plans C and F) to newly eligible beneficiaries.
- Creates Plans D and G, the guaranteed issue plans for newly eligible people.

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GENETIC SWABBING AND MEDICARE

- Genetic Testing: A rash of genetic testing entities have popped up around the nation.
  - » Entities have been going into senior centers, assisted living facilities and nursing home to “test” seniors for cancer
  - » Typically, a testing entity will get “consent” from the senior, run a telemedicine check, allegedly for medical necessity, obtain the swab and submit to a contracted lab.
  - » The entity will obtain the Medicare care card and other information from the senior for billing.

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GENETIC SWABBING, CONTINUED

- The lab will bill Medicare or the Medicare Advantage plan
- The bill submitted to a carrier or to Medicare can range from $1,000 to $10,000 **per swab**
- It is possible, depending upon the documents signed by the senior, the senior could be balanced billed for the swabbing.
- CMS allows for the payment of genetic testing for cancer for the purpose of the treating physician to create a treatment plan for that type of cancer, however…..
- CMS has very specific rules as to its' allowance and payment
  - The person being swabbed must have recurrent, relapsed, refractory, metastatic, or advance stages of III of IV cancer
  - The test must be ordered by a treating physician
  - The results must be provided to the treating physician
- In numerous instances, none of aforementioned have been followed
- It is unclear what happens to the genetic material after the test

GENETIC SWABBING, CONTINUED

- The entities have changed tactics and now have decided to clone phone numbers and contact consumers directly to get them a kit
  - One such call came to the administrator for SHIIP in Nebraska. The cloned phone number was from the Office of Rural Health that is located in the Nebraska Department of Health and Human Services.
- We've issued a consumer alert as has the HHS Office of Inspector General.
  - The NAIC has also discussed further action and may issue a letter as well.
  - Carriers have been contacted and are looking into this issue through their SIU units as well.

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NATIONWIDE GENETIC TESTING FRAUD

- https://www.youtube.com/watch?time_continue=44&v=6u0GEvJeCTg

U.S. Department of Health and Human Services
Office of Inspector General

The Department of Health and Human Services Office of Inspector General, with our law enforcement partners, announced in September 2019 our efforts to target genetic testing fraud schemes nationwide. The takedown resulted in charges against 35 individuals for their alleged participation in healthcare fraud schemes involving $2.1 billion in losses. In the alleged scheme, recruiters (aka marketers) get a Medicare beneficiary to take a genetic test. The recruiter then gets a doctor to sign off on the genetic test so a lab will process the test. The recruiter pays the doctor a kickback in exchange for ordering the test. Then the lab processes the test and bills Medicare. Medicare reimburses the lab for the test and the lab shares the proceeds of that payment with the recruiter. This enforcement action shows the positive impact OIG is making to fight fraud and protect HHS programs and beneficiaries.

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EXAMPLE OF A DOI FRAUD INVESTIGATION AND CONVICTION

Dr. Zeno and Good Hands Clinic, Grand Island, Nebraska

The Insurance Fraud Prevention Division (IFPD) has seen organized criminal activity take place in Nebraska. Although the majority of the state does not lend itself to this type of activity due to educated consumers, opportunities do exist.

During 2015 the IFPD learned of suspicious activity involving several self-insured employers in the Grand Island area. One of these self-insured employers noticed a spike in activity when they received their quarterly report from their health care plan administrator. A new clinic was found to have submitted 1,181 employee claims and billed for $3,121,552 within the quarter, with $442,897 actually being paid pursuant to the claims. When reviewing the CPT codes that were billed, the claims became more suspicious noting the uniformity of the treatment plan for all patients receiving treatment at the clinic.

Mayra De Lourdes Zeno reinstated her Nebraska medical license just prior to filing articles of incorporation to open the business Good Hands Clinic, PC. The listed the purpose for the business was to "engage in general medicine providing professional treatments and alike services." The real purpose appears to have been something different. A series of interviews and background checks involving the clinic's associates led to requesting federal authorities to become involved in ultimately a successful prosecution of this provider in both Nebraska and Florida. Dr. Mayra De Lourdes Zeno was indicted in Nebraska on federal charges for knowingly submitting medical claims for services she knew were not provided. The investigation found Dr. Zeno received approximately $448,772.64 from health insurance plans provided to employees through Nebraska employers. Dr. Zeno was sentenced to 70 months' prison, three years' probation upon release and restitution totaling $414,074.50. Dr. Zeno received similar sentencing for the federal charges filed in Florida for the same type of fraudulent health insurance scheme.

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FRAUD STATISTICS FOR 2018

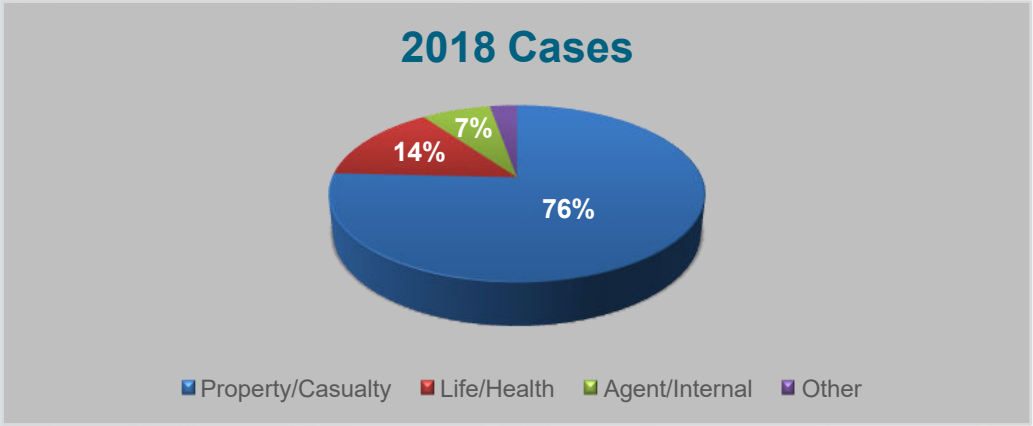
Property and Casualty Cases: 544

Life and Health Cases: 103

Agent or Internal Fraud Cases: 51

Other Fraud: 20

Reported Losses: $14.8M (only 33% of cases reported losses)



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HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs)

- Before the Affordable Care Act (ACA), Health Reimbursement Arrangements (HRAs) allowed employees to use tax-preferred dollars to purchase individual market insurance or *a la carte* health care services; the ACA outlawed most uses of HRAs.
- The Trump Administration has finalized a rule that will allow employers, beginning in January 2020, to offer their employees individual-coverage HRAs that employees could then use to purchase individual market health insurance with an HRA; the rule contains stipulations intended to prevent employers from moving less healthy employees onto the individual market.
- An analysis of the rule by the Treasury Department indicates the rule could boost individual market enrollment, helping to further stabilize the market, while decreasing the number of people without insurance.

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HRAs, CONTINUED

- **Individual coverage HRAs.** Employers would be allowed to fund ICHRAs only for employees *not offered* a group health plan.
- **Excepted-benefit HRAs.** These would be limited to paying premiums for vision and dental coverage or similar benefits exempt from ACA and other legal requirements such as short term duration plans. These HRAs are only permitted if employees *are offered* coverage under a group health plan sponsored by the employer. The amount of contribution is limited to $1,800 per year, indexed for inflation after 2020.

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NEW HEARING AID MANDATE

- LB 15, the Children of Nebraska Hearing Act was enacted and signed into law in 2019. The law mandates health insurance coverage, starting in 2020, for hearing aids for children, up to age 19. The law caps the coverage benefit amount at $3,000 for a 48 month period.
- The mandate only applies to large group insurance (50 or more employees) and individual insurance policies. It does NOT apply to small group insurance (49 or less employees)
- Under federal law, the taxpayers of Nebraska will have to pay for this, or any newly enacted mandated benefit.
  - The insurer's actuary submits a bill for the cost of the benefit to the state. The state must pay the cost.

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NEW PRESCRIPTION SYNCHRONIZATION LAW

- **Prescription Synchronization:** LB 442, which will enable beneficiaries to synchronize their medications, so they could order and receive them on the same day each month instead of having to make multiple visits to the dispensing pharmacy. https://nebraskalegislature.gov/FloorDocs/106/PDF/Slip/LB442.pdf.
- This new law could reduce medication waste, as well as the poor healthcare outcomes that result from decreased medication adherence.
- LB 442 applies to individual and group major medical policies, hospital, medical, or surgical expense-incurred policies except for specified disease or limited-benefit coverage, and non-federal governmental self-funded plans.
- The provisions in LB 442 are drafted to ensure that while the patient will pay a pro-rated daily cost-sharing rate for a partial supply to synchronize medications, a pharmacy will receive a full dispensing fee.

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NEW DRUG PRICE DISCLOSURE LAW

- **Payment at Point of Sale:** LB 316, which provides duties for pharmacists and contracted pharmacies regarding disclosure of cost, price, or copayment of prescription drugs, and prohibits insurers from requiring the insured to pay an amount that exceeds the lesser of:
  - (a) the covered person's copayment, deductible, or coinsurance for that prescription drug, or
  - (b) the amount any individual would pay for that prescription drug if the individual paid in cash.
- Avoids "gag clauses" in contracts with pharmacies.

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PHARMACY COPAY COUPONS

- Drug coupons can save customers money at the pharmacy.
- For Medicare, drug coupons are not allowed because they are viewed as a "kickback" from the drug manufacturer to incentivize purchase of higher cost medications.
- Where a generic is available, the insurer may not count the drug coupon toward deductible or maximum out-of-pocket.
- Even where a generic is not available, the insurer may not count the drug coupon toward deductible or maximum out-of-pocket.
  - This is because the coupon is a "third party payment" and is not payment out of the consumer's pocket.
  - The consumer can still get the price break at the pharmacy, but the consumer cannot use the coupon to reach the annual deductible because it was not the consumer's money.
- Coupons can result in higher premiums.

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SURPRISE MEDICAL BILLS

When a patient obtains services from a provider that is not a part of their insurance network, they can be billed for the total amount of services provided by the medical provider.

A true surprise bill occurs when a patient, through no fault of their own, obtains services from an out of network provider. For example, trips to the emergency room or a radiologist who looks at the patient's images or an air ambulance for emergency transport and the service or provider is not in the patient's network.

The potential cost to patients associated with out-of-network bills from inpatient admissions grew from an average of $804 in 2010 to $2040 in 2016. In 2016, however, the 90th percentile of patients with out-of-network bills faced potential costs of $4,112 or more.

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SURPRISE BILLS, CONTINUED

The surprise bill issue is currently being debated in Congress. The lobbying on both sides is fierce with provider groups, who are owned by investment entities, buying millions of dollars worth of commercial time.

The expectation is that there may be full floor debate on the bills in the late fall.

There have also been some new “standalone” emergency room(s) built in the Omaha metro recently. That facility is not contracted with any insurer and would be considered “out of network” and the patient would be balanced billed.

We suggest you always check to see what facilities and providers are in network, if possible, before utilizing their services.

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BALANCE BILLS AND OUT-OF-NETWORK PROVIDERS

- There are times when going outside your network is simply unavoidable. But, the choice should be up to you, and you should make that choice an informed one. Follow these tips to help manage your costs:
  - Ask your provider to refer you to in-network first unless there is a specific reason why you want to go out-of-network.
  - Before scheduling an appointment with a new provider, ask if he or she participates in your plan (and your network through that insurer).
  - If you are having a complex procedure, like a surgery, ask your doctor if all of your providers participate, including the hospital, assistant surgeon if used, lab and anesthesiologist. Your doctor may be able to change your care to in-network providers for those services.
  - If you choose to go out-of-network, ask the provider's staff how much he or she will charge before your visit. Then, talk to your insurer to find out how much of the cost your plan will cover.
- Most importantly, remember that you are your own best advocate. Speaking up and asking questions up front will help you avoid being surprised at what you may owe.
- https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/ConsumerFactSheetBalanceBillingandOutofNetworkProviders.pdf

SHORT TERM LIMITED DURATION PLANS

- These are “mini med” plans that provide some level of health insurance.
  - They are typically cheaper than non-subsidized ACA coverage.
  - However, they are subject to underwriting, pre-existing condition restrictions, and are not guaranteed issue.
  - The benefits are less than ACA plans.
- They are now issued for up to 364 days, with possible renewal up to 3 years.
- Must contain consumer disclosures.
- Make sure to talk to your agent or broker.
- NDOI guidance at https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/Short-TermDurationMedicalPlanFilingReqs.pdf

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ASSOCIATION HEALTH PLANS

- Association health plans are groups of employers that join together to provide health insurance benefits to their employees.
- This is known as a Multiple Employer Welfare Arrangement or “MEWA.”
- The employers participate in the governance of the association and the health plan it offers.
- Small employers can group together to provide insurance as one large employer, so long as they follow the federal requirements under ERISA and, if they are self-insured, Nebraska law for MEWAs.
- State and federal coverage mandates also apply if the health insurance plan is fully insured.
- If the employer or association retains any risk (obligation to pay health claims), then the plan is not “fully insured” and must comply with Nebraska’s MEWA Act.

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SELF-INSURED MEWAs IN NEBRASKA

- Multiple Employer Welfare Arrangements or "MEWAs."
  - Nebraska MEWA Act at Neb. Rev. Stat. §§ 44-7601 to 44-7617.
  - Regulation at 210 NAC 78 http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Insurance_Dept_of/Title-210/Chapter-78.pdf
- Key provisions of the Nebraska MEWA requirements:
  - "Association of employers"
  - Act specifically excludes "fully insured" MEWAs from the definition, because solvency is assured by the full transfer of risk to a licensed insurer.
  - Applies to any MEWA offering membership to an employer with its principal headquarters or office in Nebraska, regardless of where MEWA is "situsued."
  - Assessment of members if MEWA needs more money to pay claims.
  - Same trade or industry requirement.
  - Must have been engaged in substantive activity for its members other than sponsorship of a health benefit plan for more than three years prior to application for a certificate of registration.
  - Aggregate of 200+ participating employees.

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AHPs THAT INCLUDE SOLE PROPRIETORS

- On June 19, 2018, the U.S. Department of Labor (DOL) released a Final Rule for Association Health Plans (AHPs).
- The new rule did not change or preempt existing Nebraska law that regulates these plans.
- The new rule created a new "pathway" to form an AHP, but does not eliminate the method that already existed. Now, there are two pathways.
- "Pathway 2":
  - Expands the ERISA definition of "employer" to include "working owners," which are sole proprietors;
  - Allows AHPs to cross state borders.
  - Allows employers from different industries to join an AHP if the association has a substantial purpose other than offering insurance.
  - Contains nondiscrimination requirements that AHPs under "pathway 1" are exempt from.

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COURT CHALLENGE TO AHP RULE

- On March 28, 2019, the U.S. District Court for the District of Columbia issued a Memorandum Opinion in *State of New York v. U.S. Department of Labor* (the "AHP lawsuit"). In the Opinion, Judge Bates found the bona fide association and working owner provisions of the Final Rule, codified at 29 C.F.R. §§ 2510.3-5(b), (c) and (e), to be "unreasonable interpretations of ERISA."
- This ruling only affects AHPs that relied on the 2018 Rule to form:
  - Include "working owners" (sole proprietors)
  - Include multiple industries
  - Formed for the purpose of insurance
- The Department of Labor has appealed the trial court's decision, and oral arguments are scheduled for November 14, 2019.
- The Department of Labor also issued a nonenforcement position so that members could spend the rest of the plan year in their AHP.

AHP AFFECTED BY THE LAWSUIT?

	Pathway 1	Pathway 2
Can continue to operate unaffected by the lawsuit	Yes	No
Employers in the same industry or profession	Yes	No – if AHP has a substantial purpose other than insurance
Can charge employers different rates based on health status	Yes	No – new nondiscrimination rule
Can include sole proprietors	No – every employer member must have at least one common-law employee.	Yes – if they meet the new definition of "working owner"
Is a MEWA	Yes	Yes

NONENFORCEMENT IN PLAN YEAR 2019

- https://www.dol.gov/newsroom/releases/ebsa/ebsa20190429
- No federal action taken against AHPs formed in good faith reliance on the 2018 rule.
- No federal action taken against members who enrolled in AHPs in good faith reliance on the 2018 rule.
- Limitations:
  - AHPs cannot enroll new members
  - Nonenforcement is only “through the remainder of the applicable plan year or contract term”
  - AHPs must continue to “meet their responsibilities to association members and their participants and beneficiaries to pay health benefit claims as promised”

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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.

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HIGH MEDICAL COSTS DRIVE PREMIUMS

The ACA caps insurers' profits.

- Insurers' profits, plus costs not associated with paying claims to benefit policyholders, cannot equal 15% or 20% of the money collected in premiums (depending on the type of insurer and type of product), and if non-claims costs exceed 15% or 20%, 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.**

Lack of competition is another cost driver.

- Only one carrier remains in the Nebraska ACA individual market. Others exited the market after losing millions of dollars.
- Many experts argue that lack of competition among health care providers is a major driver of healthcare price increases in a market.

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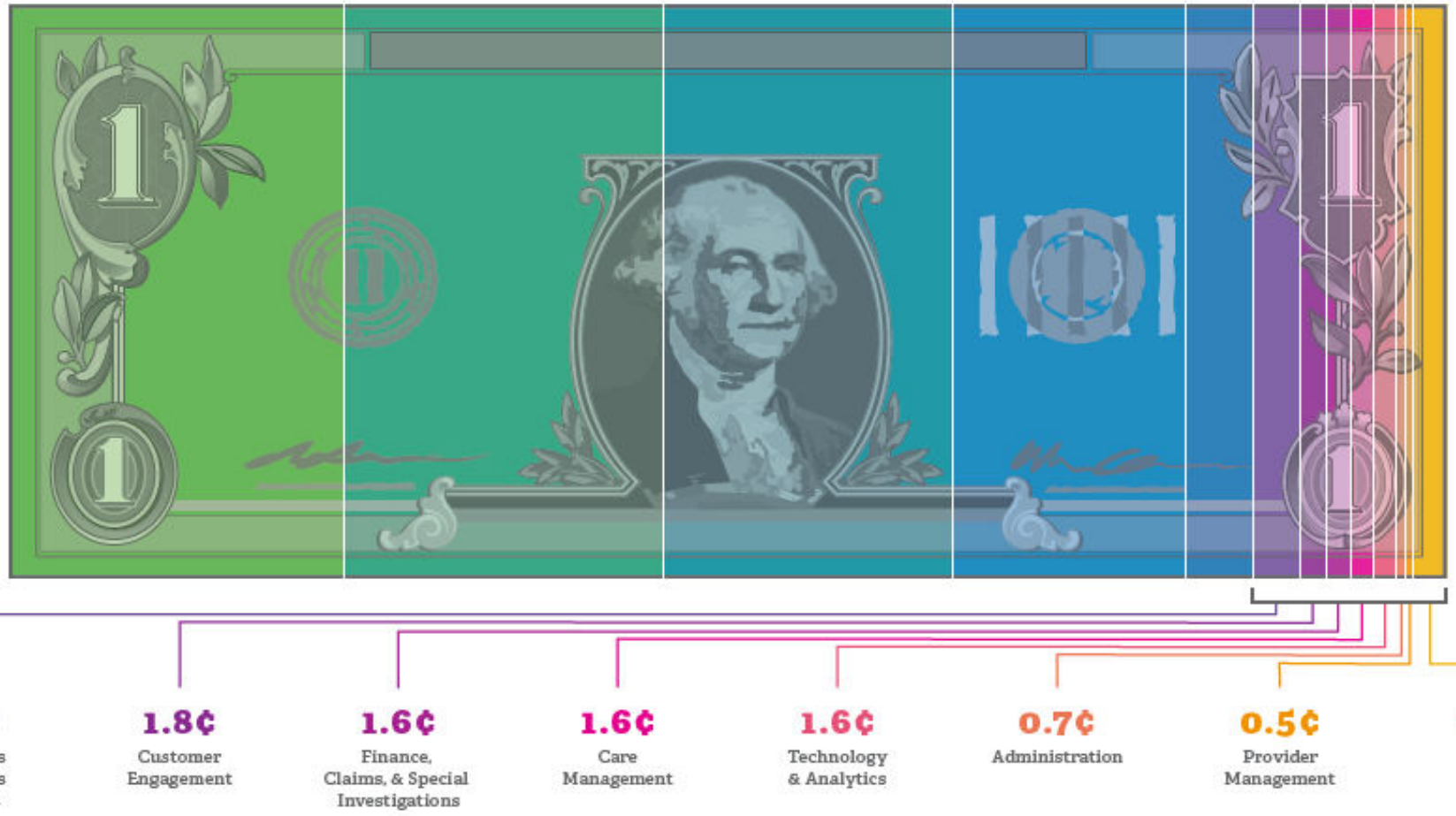
Where Does Your Health Care Dollar Go?

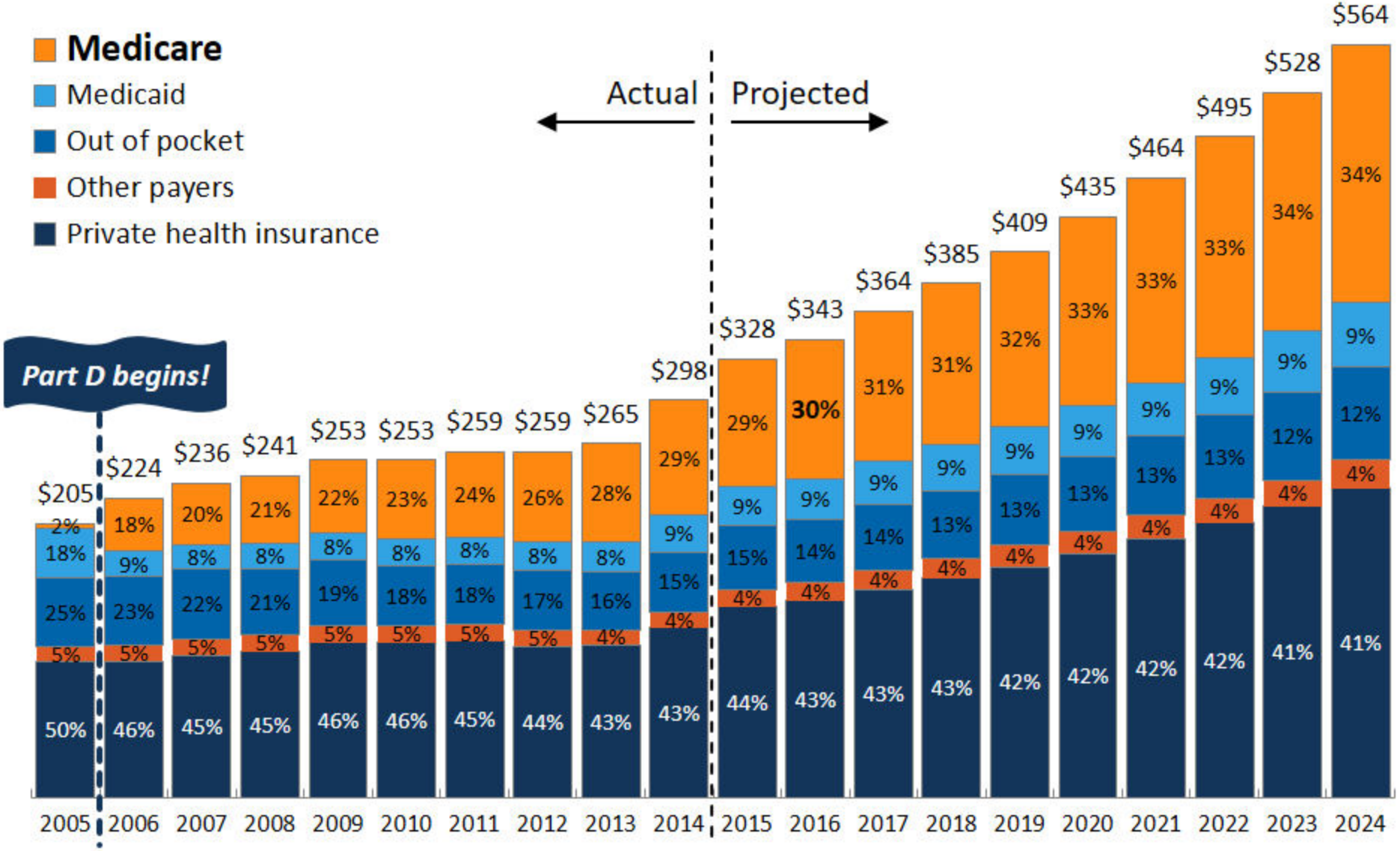
Your premium—how much you pay for your health insurance coverage each month—helps cover the costs of the medications and care you receive. It also helps to improve health care quality and affordability for all Americans. Here is where your health care dollar really goes.



Expenditure estimates above produced by AHIP. Distribution of spending among administrative categories and taxes, based on analysis by Milliman, Inc. Milliman's analysis is available upon request.

AHIP

Total U.S. prescription drug spending, in $ billions:



NOTE: Medicaid prescription drug spending accounts for rebates.
SOURCE: Kaiser Family Foundation analysis of CMS National Health Expenditure Data for Historical (CY2005-2014) and Projected (CY2015-2024) Retail Prescription Drug Expenditures, 2013-2024.

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JAMA | Special Communication

Health Care Spending in the United States and Other High-Income Countries

Irene Papanicolas, PhD; Liana R. Woskie, MSc; Ashish K. Jha, MD, MPH

CONCLUSIONS AND RELEVANCE The United States spent approximately twice as much as other high-income countries on medical care, yet utilization rates in the United States were largely similar to those in other nations. Prices of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference in overall cost between the United States and other high-income countries. As patients, physicians, policy makers, and legislators actively debate the future of the US health system, data such as these are needed to inform policy decisions.

JAMA. 2018;319(10):1024-1039. doi:10.1001/jama.2018.1150

Health spending												
Total spending on health, % of total national GDP	US 17.8	CHE 12.4	Sweden 11.9	Germany 11.3	France 11	Japan 10.9	Denmark 10.8	NLD 10.5	Canada 10.3	UK 9.7	Australia 9.6	11.5
Public spending on health, % of total national GDP	Sweden 10	NLD 9.5	Denmark 9.2	Germany 8.7	France 8.7	Japan 8.6	US 8.3	CHE 7.7	UK 7.6	Canada 7.4	Australia 6.3	8.4
Mean spending on health per capita, US $	US 9403	Sweden 6808	CHE 6787	Denmark 6463	NLD 5202	Germany 5182	Canada 4641	Australia 4357	Japan 3727	France 3661	UK 3377	5419
Health expenditure by function of care as a % of total national health expenditure												
Inpatient care	NLD 32	Australia 31	France 30	CHE 28	Denmark 28	Germany 27	Japan 27	UK 24	Sweden 21	US 19	Canada 17	26
Outpatient care	US 42	Australia 39	Canada 36	Denmark 34	CHE 33	Sweden 31	UK 30	Japan 27	Germany 23	France 23	NLD 22	31
Long-term care	Sweden 26	NLD 26	Denmark 24	CHE 19	Japan 19	UK 18	Germany 16	Canada 14	France 11	US 5	Australia 2	16
Medical goods	Germany 20	France 20	Canada 20	Japan 20	Australia 17	UK 15	US 14	CHE 13	Sweden 12	NLD 12	Denmark 10	16
Governance and administration	US 8	Germany 5	NLD 4	CHE 4	Canada 3	Australia 3	UK 2	Sweden 2	Denmark 2	France 1	Japan 1	3
Home-based care	France 4	US 3	UK 3	Japan 3	Germany 1	Sweden 0	NLD 0	Canada 0	Australia 0	CHE NA	Denmark NA	2
Preventive care	Canada 6	UK 5	NLD 4	US 3	Germany 3	Sweden 3	Denmark 3	Japan 3	France 2	CHE 2	Australia 2	3
Other	France 9	US 6	Australia 6	Germany 5	Sweden 5	Canada 4	UK 3	CHE 1	Japan 1	NLD 0	Denmark 0	4
Population with health care coverage, %	UK 100	Sweden 100	CHE 100	Denmark 100	Canada 100	Japan 100	Australia 100	France 99.9	NLD 99.9	Germany 99.8	US 90	99

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Figure 2. Health Spending as a Percentage of Gross Domestic Product

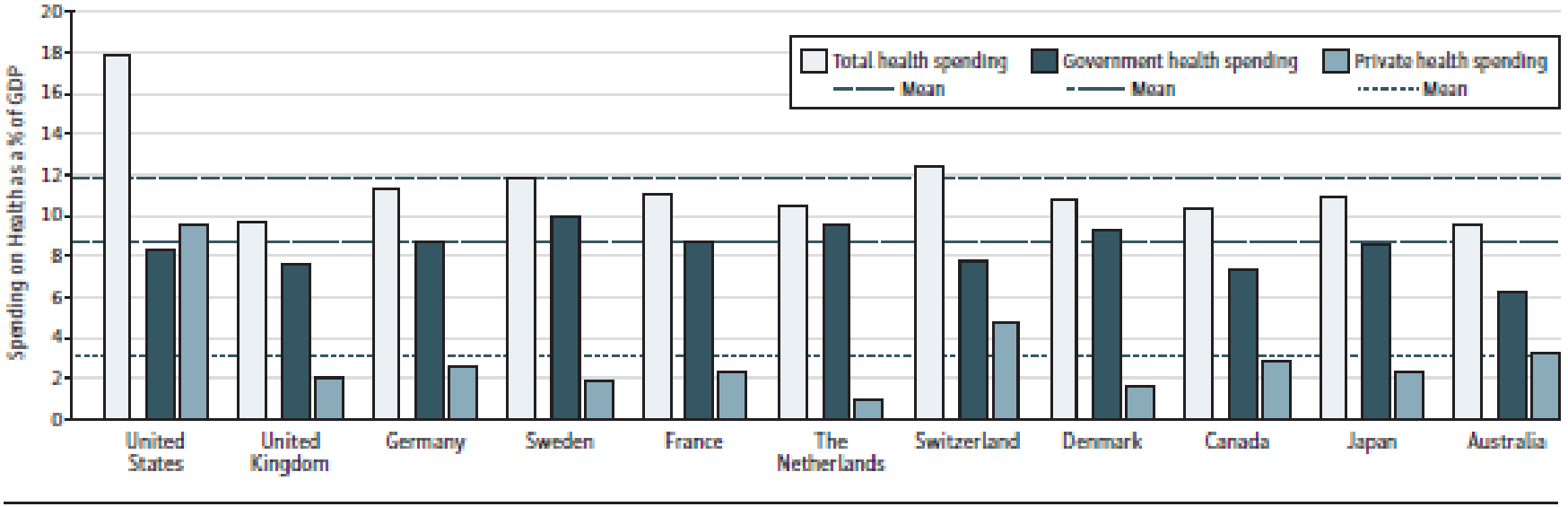

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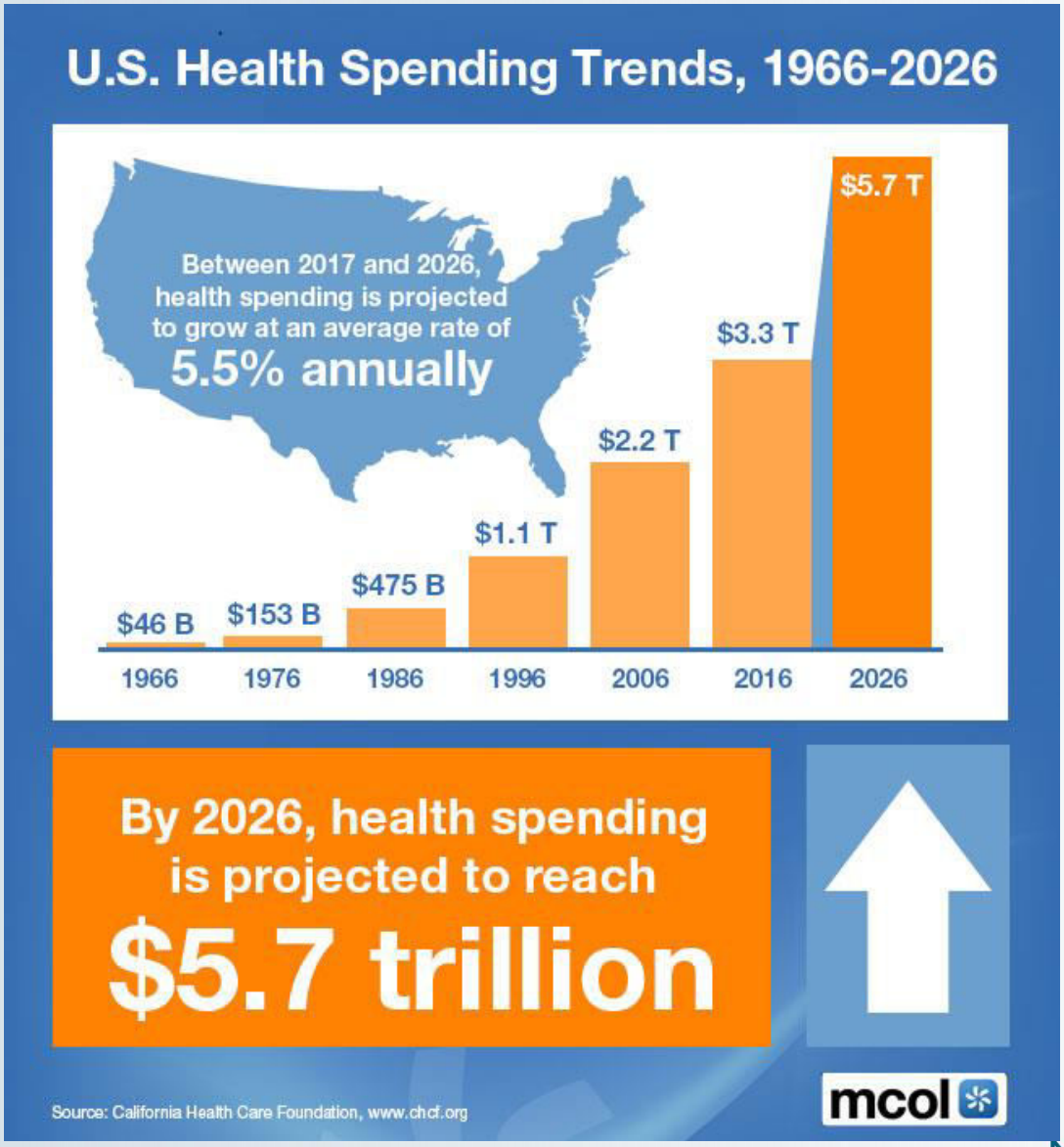
Figure 9. Pharmaceuticals

Rank (highest to lowest)	1	2	3	4	5	6	7	8	9	10	11	Mean
Total spending per capita, US $	US 1443	CHE 939	Japan 837	UK 779	France 697	Denmark 675	Germany 667	Canada 613	Sweden 566	Australia 560	NLD 466	749
Retail pharmaceutical spending per capita, US $	US 1026	CHE 776	Canada 587	Denmark 573	France 541	Sweden 501	Germany 480	Japan 443	UK 383	Australia 346	NLD 292	541
Prices, US $ per mo[a]												
Crestor (cholesterol)	US 86	Germany 41	Canada 32	Japan 29	UK 26	France 20	Australia 9	Sweden NA	NLD NA	CHE NA	Denmark NA	35
Lantus (diabetes)	US 186	Canada 67	UK 64	Japan 64	Germany 61	Australia 54	France 47	Sweden NA	NLD NA	CHE NA	Denmark NA	78
Advair (asthma)	US 155	Canada 74	Japan 51	Germany 38	France 35	Australia 29	UK NA	Sweden NA	NLD NA	CHE NA	Denmark NA	64
Humira (rheumatoid arthritis)	US 2505	Germany 1749	Australia 1243	Canada 1164	UK 1158	France 982	Japan 980	Sweden NA	NLD NA	CHE NA	Denmark NA	1436
New chemical entities, No.[b]	US 111	CHE 26	Japan 18	UK 16	Germany 12	France 11	Sweden NA	NLD NA	Denmark NA	Canada NA	Australia NA	NA
Pharmaceutical expenditure by financing type, % of total spending												
Public spending	France 80	Germany 75	Japan 71	UK 66	NLD 65	Sweden 52	Australia 49	CHE 43	Denmark 43	Canada 36	US 34	56
Private insurance	US 36	Canada 30	CHE 8	Denmark 8	Germany 7	NLD 2	France 1	Japan 1	UK 0	Sweden 0	Australia 0	8
Private out-of-pocket spending	CHE 51	Denmark 51	Australia 50	Sweden 48	UK 36	Canada 34	NLD 33	US 30	Japan 28	France 19	Germany 18	36
Share of generics, % of total[c]												
Volume	US 84	UK 83	Germany 80	France 70	Canada 70	Japan 56	CHE 54	Denmark 54	Sweden 44	Australia 30	NLD 17	58
Value	Germany 37	UK 33	Japan 33	Canada 29	US 28	France 16	NLD 16	Sweden 15	Australia 15	CHE 14	Denmark 14	23
Antibiotic prescribing, defined daily doses per 1000 population[d]	France 29.9	Australia 28.3	Canada 25	US 24	UK 20.1	Denmark 16.6	Germany 14.4	Sweden 12.9	NLD 10.7	CHE NA	Japan NA	20.2



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LAWSUITS!

Legal challenges to ACA, federal rulemaking, and other ACA-related actions

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TEXAS LAWSUIT CHALLENGING ACA

Texas v. U.S.

This case seeks to invalidate the Affordable Care Act in its entirety. A federal district court judge agreed, and the case is on appeal to the 5th Circuit.

- There are three main issues that the court may consider: (A) whether the parties have standing to invoke the court's jurisdiction on appeal; (B) whether the ACA's individual mandate, as amended by the TCJA, is constitutional; and (C) if the mandate is unconstitutional, whether it can be severed from the rest of the ACA, or on the other hand, whether other provisions of the ACA also must be invalidated.

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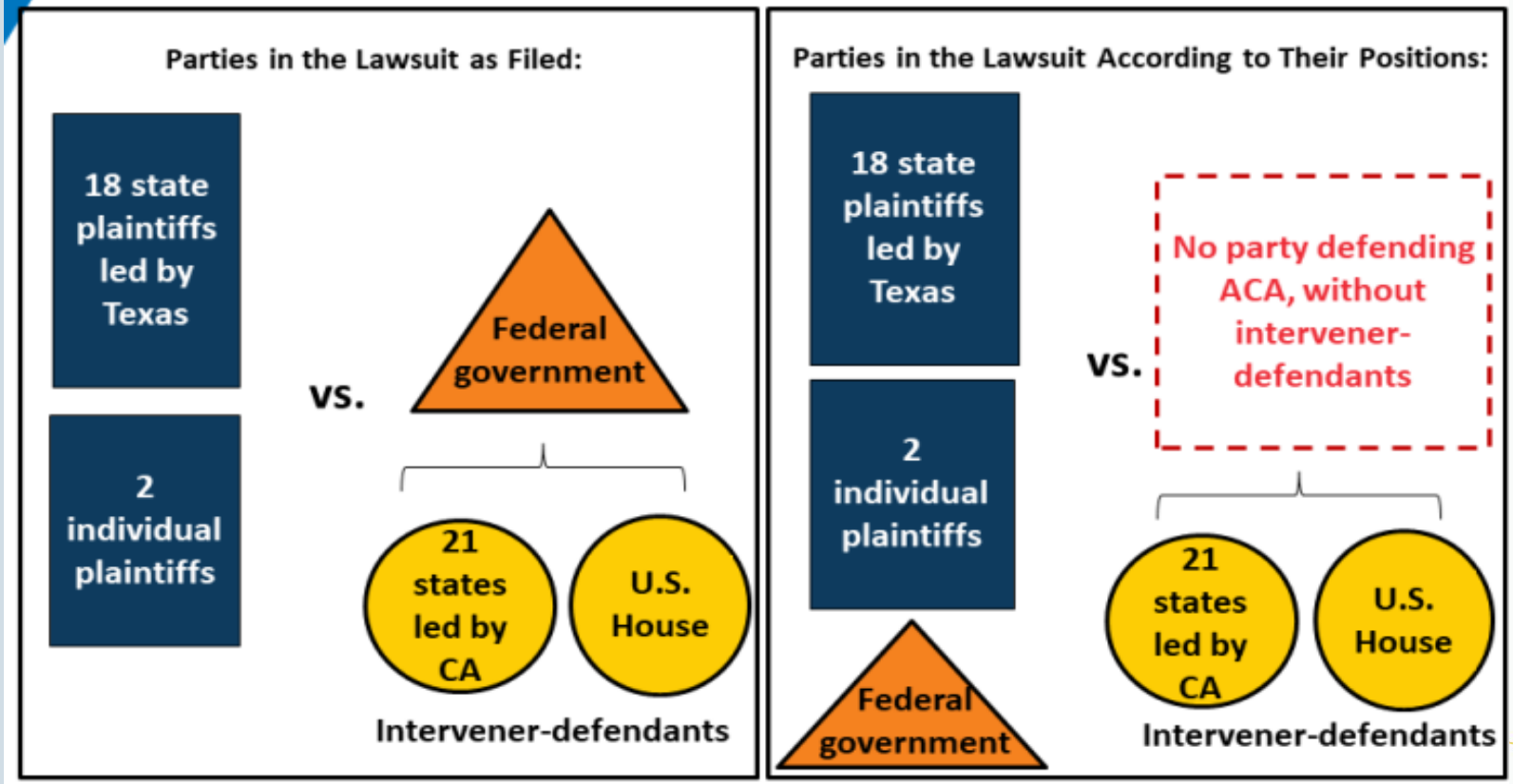
Texas v. U.S.

Figure 4

Alignment of the Parties in *Texas v. U.S.*



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Texas v. U.S.

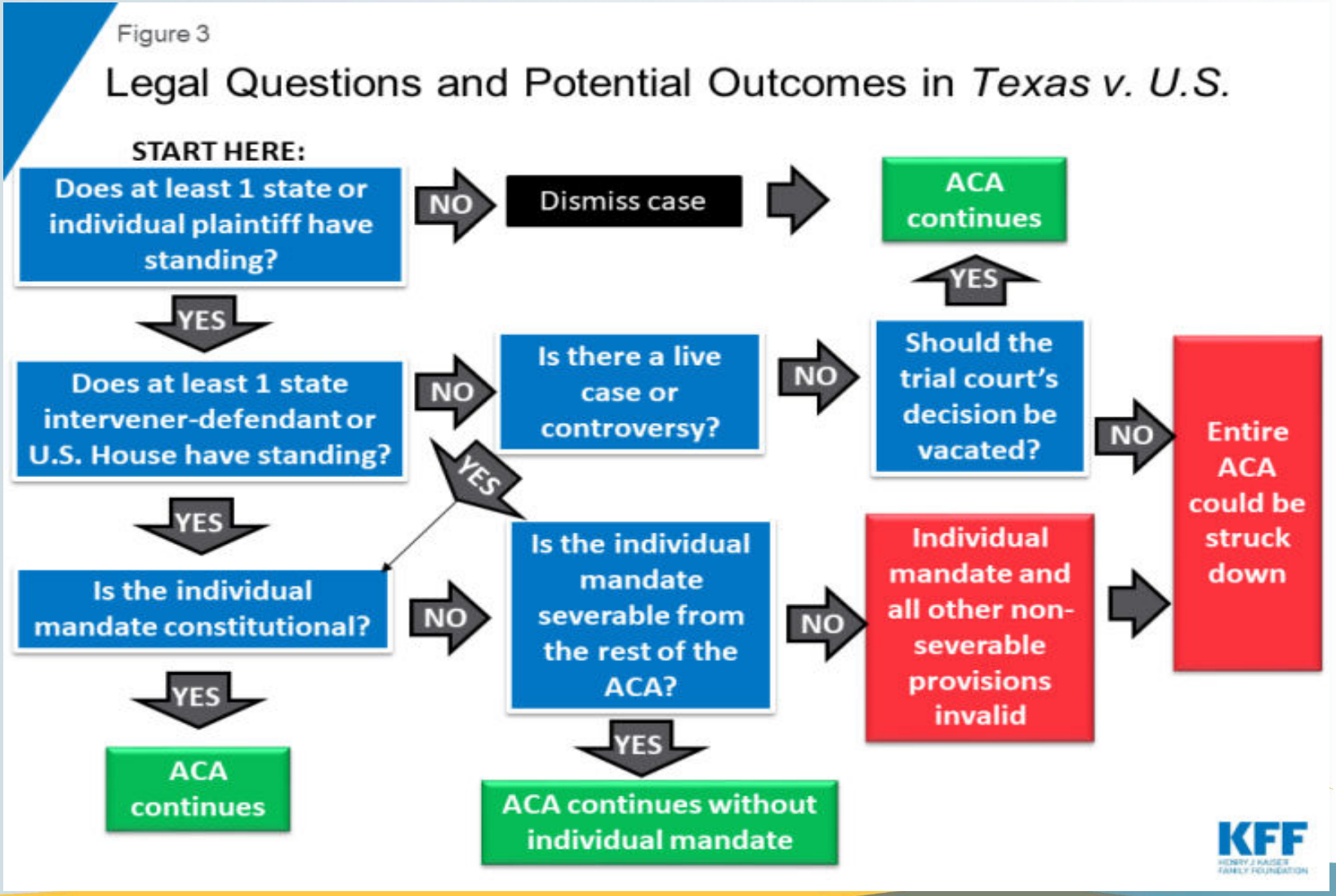
Figure 3
Legal Questions and Potential Outcomes in *Texas v. U.S.*
START HERE:
Does at least 1 state or individual plaintiff have standing?
NO
Dismiss case
ACA continues
YES
YES
Does at least 1 state intervener-defendant or U.S. House have standing?
NO
Is there a live case or controversy?
NO
Should the trial court's decision be vacated?
NO
Entire ACA could be struck down
YES
YES
Is the individual mandate constitutional?
NO
Is the individual mandate severable from the rest of the ACA?
NO
Individual mandate and all other non-severable provisions invalid
YES
YES
ACA continues
ACA continues without individual mandate
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D.C. LAWSUIT CHALLENGING AHP RULE

New York v. U.S. Department of Labor

"…the Court concludes that the bona fide association and working owner provisions of the Final Rule, codified at 29 C.F.R. §§ 2510.3-5(b), (c) and (e), are unreasonable interpretations of ERISA. The Final Rule was intended and designed to end run the requirements of the ACA, but it does so only by ignoring the language and purpose of both ERISA and the ACA. DOL unreasonably expands the definition of "employers" to include groups without any real commonality of interest and to bring working owners without employees within ERISA's scope despite Congress's clear intent that ERISA cover benefits arising out of employment relationships. Accordingly, these provisions are unlawful and must be set aside, pursuant to this Court's authority under the APA, 5 U.S.C. § 706. The Final Rule's bona fide association and working owner provisions are therefore vacated."

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SHORT TERM LIMITED DURATION PLAN RULE LITIGATION

- *Association for Community Affiliated Plans, et.al. v.. U.S.*
- Short term limited duration specifically excluded from the definition of "individual health insurance coverage" in HIPAA back in 1996.
  - But no definition of "short term limited duration" until federal rule supplied a definition.
  - Federal rule proposed in 1997 and finalized in 2004 defined short term limited duration insurance as plans lasting less than 12 months, with unlimited renewals.
- Then the Affordable Care Act (ACA) was enacted in 2010.
  - ACA did not change the HIPAA rule's definition of short term limited duration insurance.
  - ACA exempted short term limited duration from individual and group market reforms.
  - Six years after the ACA was enacted, a new federal definition of short term limited duration insurance was put into the rules, limiting coverage to three months.
  - Then a federal rule was issued reverting back to the HIPAA definition of less than 12 months, adding a limitation on renewals to under 3 years.

Association for Community Affiliated Plans, et.al. v.. U.S.

- Legal challenge to the expansion back to the original HIPAA definition.
- Plaintiffs argue the federal agencies exceeded their rulemaking authority by expanding the definition from three months and no renewals to less than twelve months and renewal less than three years.
- On July 19, 2019, Judge Richard Leon of the D.C. District Court upheld the rule.
  - The Association for Community Affiliated Plans (ACAP), National Alliance on Mental Illness (NAMI), Mental Health America, American Psychiatric Association (APA), AIDS United, National Partnership for Women & Families, and Little Lobbyists filed an appeal in the U.S. Court of Appeals for the D.C. Circuit challenging the decision.

ACA CO-OP LAWSUIT FOR RISK CORRIDOR MONEY

- *Maine Community Health Options v. U.S.*
- The ACA included a "risk corridor" program that paid insurers if their losses paying for medical claims were greater than the premiums they collected.
  - The risk corridor program provided assurance of stability so that insurers would enter the ACA market, and insurers setting rates for this new type of coverage could set lower rates with the risk corridor program providing a safety net.
- Congress failed to appropriate money for the program and some insurers, who relied on that assurance of payment if rates were too low, were not paid when the losses happened.
  - Some insurers, including most of the ACA "co-ops," were eventually placed into liquidation because they were insolvent.
  - Some insurers are still owed millions.
- The case is now at the U.S. Supreme Court.
  - Issue: whether the federal government is required to make the risk corridor payments to insurers as mandated in the ACA.

INSURTECH ON THE SILICON PRAIRIE
The Holland Performing Arts Center
Omaha, NE
October 22, 2019

Insurtech
ON THE SILICON PRAIRIE

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PUBLIC ADJUSTER LICENSES

- On July 19, 2018, Nebraska began issuing public adjuster licenses.
  - Licenses are both individual and business entity.
  - Licensing requirements online at https://doi.nebraska.gov/producers/public-adjuster-license-information-0
- Effective July 19, 2018, a Nebraska insurance consultant license will not include authority to act as a public adjuster.
  - If you hold a consultant license and use it to act as a public adjuster, you will need to reapply for the new public adjuster license.
- Questions regarding the public adjuster licensing process can be sent to the NDOI at doi.licensing@nebraska.gov or by calling the Licensing Division at 402-471-4913.

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NDOI IS "TEMPORARILY" RELOCATED

- Terminal Building fire February 19, 2018.
- Moved into current location in March.
- Use the NDOI post office address on correspondence:
  - PO Box 82089, Lincoln, NE 68501-2089.

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WE CAN HELP!

- Denied health claims
- Advice from the Consumer Assistance Division

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APPEALING A DENIED HEALTH CLAIM

- STEP ONE: Internal appeal with the health insurance company.
  - Insurer has 15 working days to complete (Insured has 180 days to submit appeal after denial)
  - 72 hours if expedited
- STEP TWO: External review through NDOI.
  - Initial paperwork (Insured must submit within 4 months after final adverse determination)
  - Eligibility determination (Insurer has 5 days to determine eligibility)
  - Independent Review Organization assigned
  - IRO Decision (within 45 days)
  - 72 hours if expedited

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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

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EXPEDITED APPEALS

- Expedited appeals are completed within 72 hours and are available:
  - In urgent situations when waiting the regular time frame 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
  - The Insured's Physician must complete and sign the "Certification of Treating Health Care Provider for Expedited Consideration" form in the external review request to verify the patient's life or health is in serious jeopardy

ONLY MEDICAL DECISIONMAKING CAN BE REVIEWED IN AN 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"

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EXPERIMENTAL OR INVESTIGATIONAL CLAIM DENIALS

- Your doctor MUST complete the “Physician Certification form for experimental/investigational denials” form
- This is a way to get coverage for an otherwise excluded experimental/investigational treatment – but only if the conditions in the statute are met.

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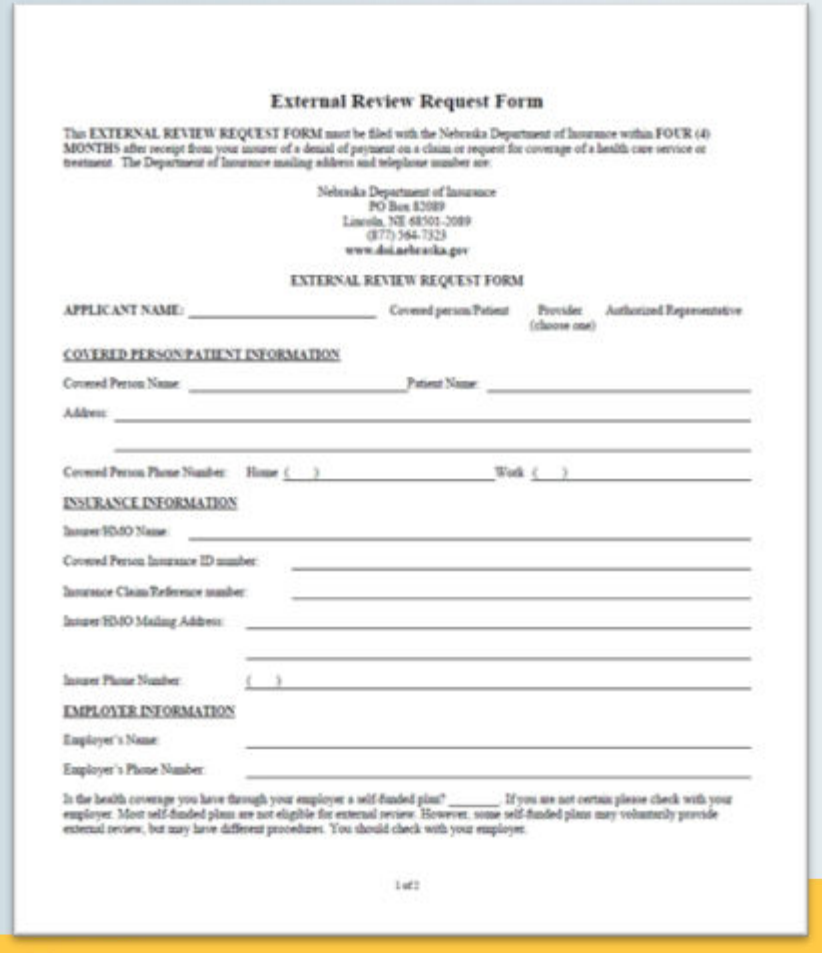
EXTERNAL REVIEW FORMS

Provided by insurers when claim appeals are denied, also available online at:
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

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.

1 of 2

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)* Date

*(Parent, Guardian, Conservator or Other – Please Specify)

2 of 2

ASSIGN THE PROVIDER AS THE AUTHORIZED REPRESENTATIVE

Appointment of Authorized Representative

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other—Please Specify)

Address of Authorized Representative: _____

_____

Phone Number: Daytime ( ) _____ Evening ( ) _____

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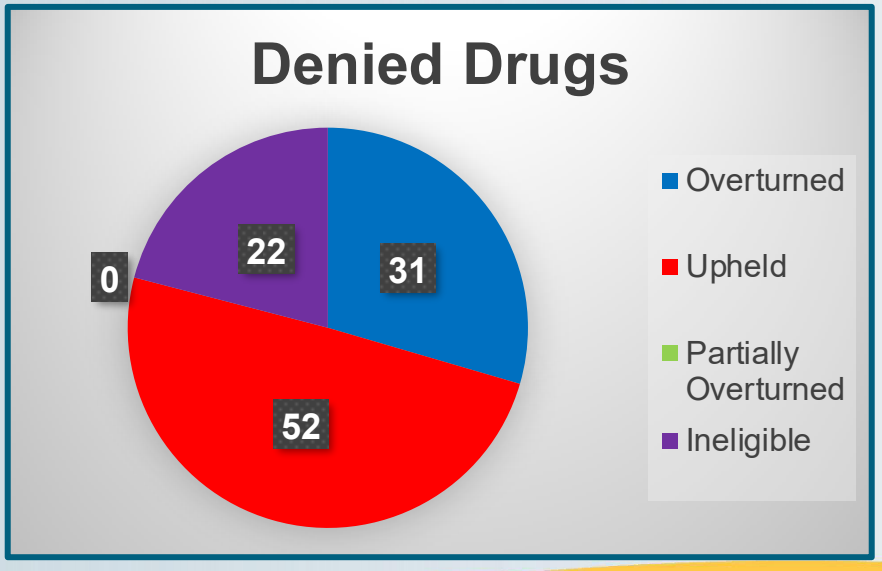
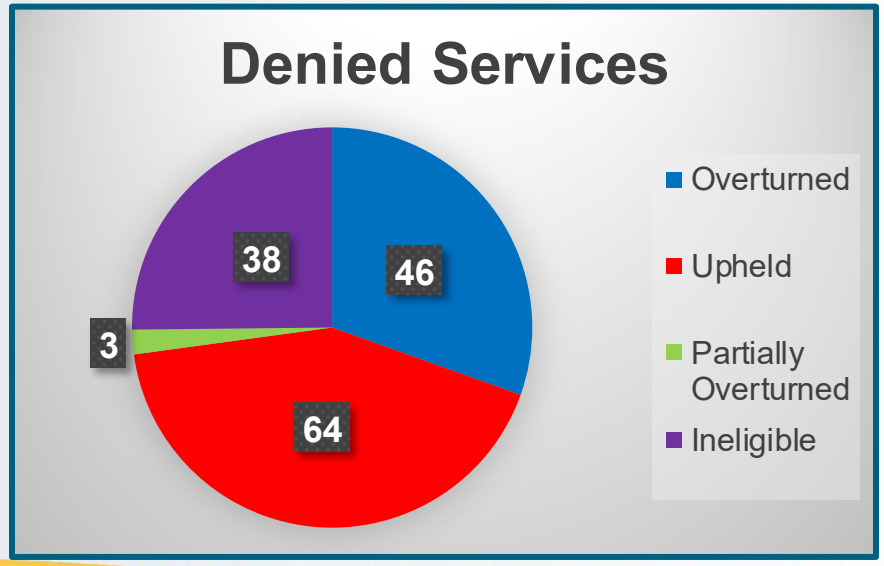
2018 EXTERNAL REVIEW BY THE NUMBERS

256 Total Cases

104 Denied Prescription Drug Claims

152 Denied Services Claims





MOST DENIED DRUGS

1. Repatha
   - 4 denials overturned
   - 9 denials upheld
2. Dupixent
   - 4 denials overturned
   - 1 denial upheld
   - 3 denials ineligible
3. Nerylynx
   - 1 denial overturned
   - 2 denials upheld
   - 1 denials ineligible

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MOST DENIED SERVICES

1. Genetic/Genomic Testing
   - 9 denials overturned
   - 10 denials upheld
   - 9 denials ineligible
2. MRI/CT/PET/Internal Imaging
   - 6 denials overturned
   - 12 denials upheld
   - 1 denial partially overturned
   - 4 denials ineligible
3. Spinal surgery
   - 1 denial overturned
   - 10 denials upheld

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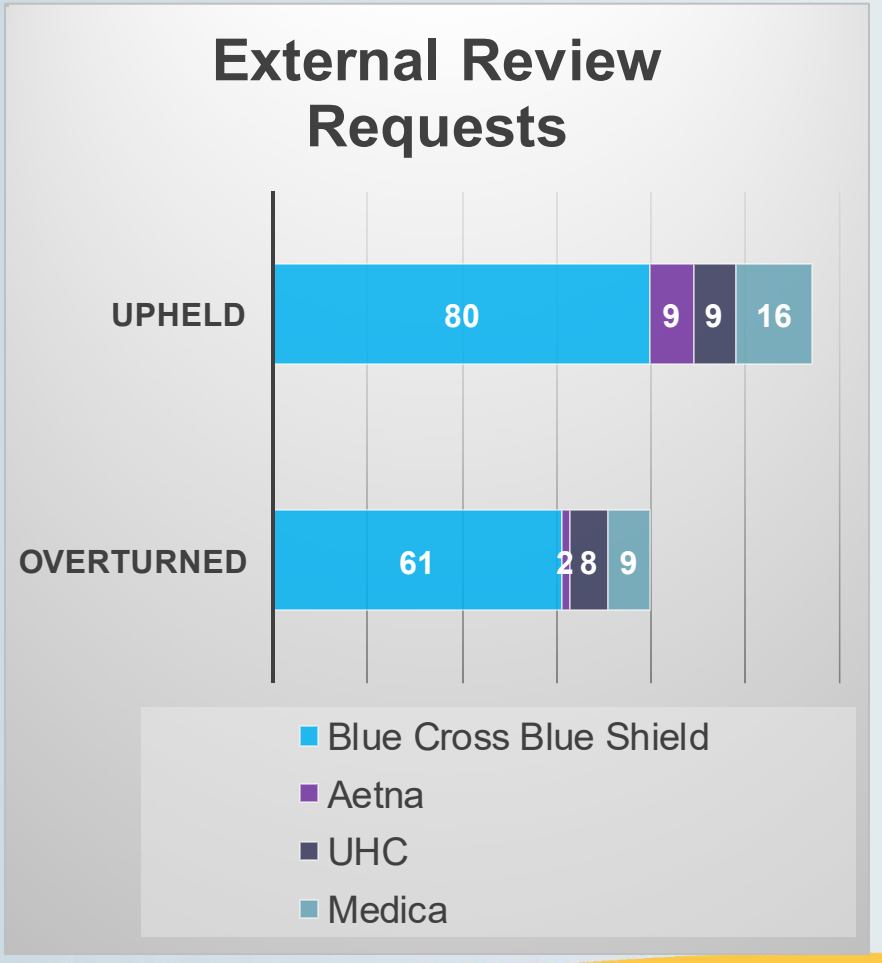
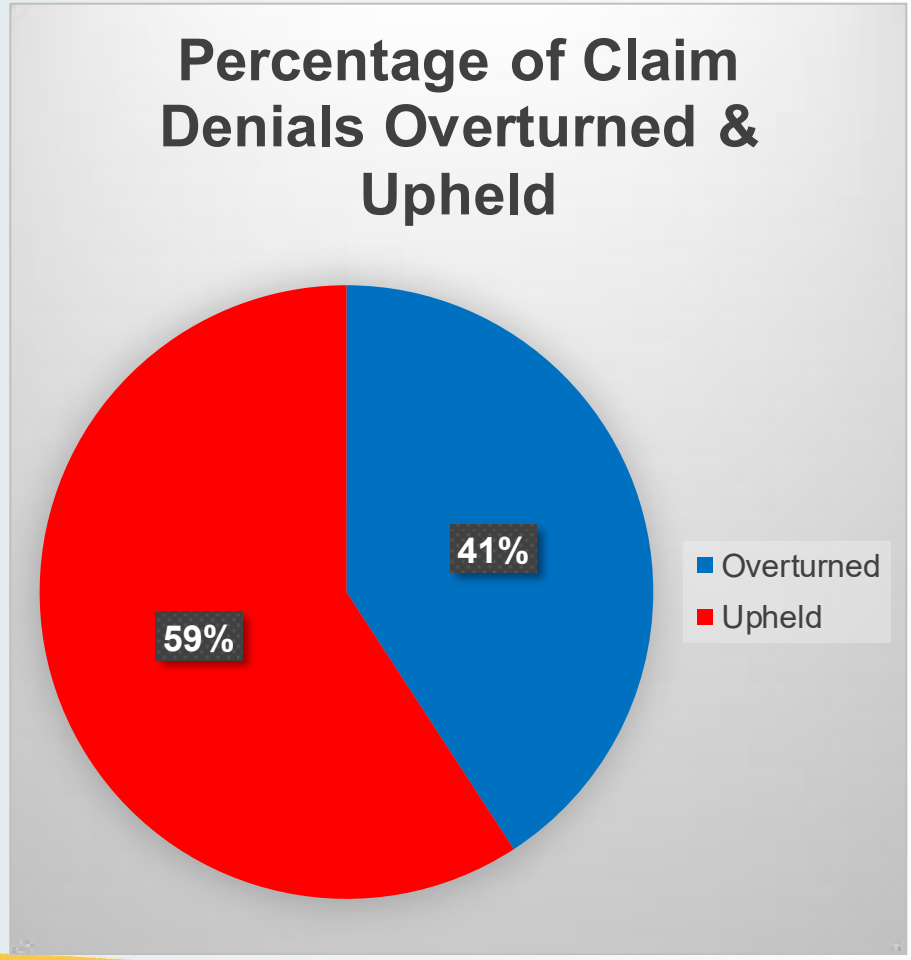
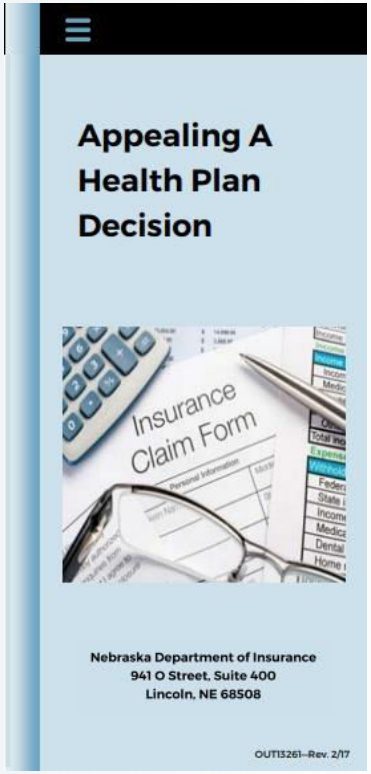
2018 External Review Request Complaints by Insurance Company





HEALTH CLAIM DENIAL RESOURCES

- Appealing A Health Plan Decision Brochure
  - Available on our website: https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/AppealingAHealthPlanDecisionRevised.pdf
- Test Your Knowledge
  - Denied Health Claim Quiz
  - https://doi.nebraska.gov/faq



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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**

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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.

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REMINDERS TO CONSUMERS

- Take steps to guard against identity theft. Nebraska DOI consumer alert at https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/ConsumerAlertIdentityTheft.pdf
- 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

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REMINDERS TO CONSUMERS

- Whether you are a homeowner, an insurance producer, an insurer or residential contractor, being familiar with the "Insured Homeowners Protection Act" (Neb. Rev. Stat. §§ 44-8601 to 44-8604) can be an important step in helping yourself or other deal with post-loss repair issues.
  - A contractor cannot promise to rebate any portion of a deductible as an inducement to the sale of goods or services.
  - Promise to rebate includes granting any allowance or offering any discount against fees charged or paying an insured or person directly or indirectly associated with the real estate any form of compensation, except for any item of nominal value.
  - A fee is charged and a contract is signed.
- Remember that a public adjuster must be licensed with the DOI.
- Read our Post Loss Assignment Consumer Alert https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/ConsumerAlertPostLossAssignments.pdf before assigning proceeds to a contractor.

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REMINDERS TO CONSUMERS

- Pay your premiums on time. For ACA individual coverage, you don't get another opportunity to get a policy until open enrollment the next year if your policy is cancelled for nonpayment.
- Your only option may be, if you are cancelled, a short term duration plan. If so, you are subject to underwriting and your existing medical conditions may not be covered.
- Please read your bills carefully and to contact the carrier if you have questions. Always check your account to make sure that, if you have a direct payment from it, that it is being taken out on time.
- A smart consumer is a vigilant consumer.

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QUESTIONS?

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CONTACT INFORMATION

- Martin.Swanson@Nebraska.gov, 402-471-4648
- Laura.Arp@Nebraska.gov, 402-471-4635
- Maggie.Reinert@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

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