



CONSUMER PROTECTIONS AND INSURANCE REFORMS UNDER THE AFFORDABLE CARE ACT: Maximizing Benefits to All New Mexicans

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and its Blueprint for Health New Mexico Advisory Network

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The mission of the Southwest Women's Law Center is to increase opportunities for women and girls in New Mexico. The Southwest Women's Law Center engages in systemic legal and policy advocacy to address gender discrimination and disproportionate poverty among women and their families, and to increase access to comprehensive healthcare services for women and girls. The Center has been actively engaged in implementation of the Affordable Care Act in New Mexico since its adoption in March 2010. The Center's goals are to ensure that implementation of the Affordable Care Act maximizes healthcare coverage and access to healthcare services among women and girls throughout the state, and that systems are developed so that the law benefits the most vulnerable and hard-to-reach populations in New Mexico. *Con Alma Health Foundation provided funding for this paper.*

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Maximizing Benefits to All New Mexicans

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In 2011, the W.K. Kellogg Foundation awarded Con Alma Health Foundation a strategic planning grant to help New Mexico ensure the successful implementation of the Patient Protection and Affordable Care Act. Con Alma Health Foundation convened a Blueprint for Health New Mexico Advisory Network (“Blueprint for Health New Mexico”) to help develop that strategic plan. This paper is designed to help the Blueprint for Health New Mexico develop its plans related to consumer protections and private insurance reforms as the ACA is implemented in New Mexico.

I. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (the “Affordable Care Act” or the “ACA”)ⁱ ended some of the health insurance industry’s worst abuses. Prior to the ACA, insurance companies frequently denied coverage to children and families outright or restricted the types of coverage they would provide based on pre-existing conditions.ⁱⁱ Sometimes insurers would cancel a child or adult’s coverage when they became sick; a practice called rescission. Insurance companies would frequently set an annual limit—a dollar limit on their yearly spending for covered benefits—or a lifetime limit—a dollar limit on what they would spend during the entire time someone was enrolled in that plan. Families would then be required to pay for the remaining costs of their health care. The Affordable Care Act’s insurance reforms mean that many families will no longer have to face bankruptcy because of health care expenses or choose between buying food and clothing or paying for their children’s health care.

Premium rate increases also have made insurance coverage less and less accessible. In 2010, the cost of health insurance premiums increased by more than 20 percent for many New Mexicans.ⁱⁱⁱ Rapidly increasing premiums frequently results in fewer families being able to afford health insurance coverage, which in turn leads to less access to quality health care.

One of the most significant accomplishments of the Affordable Care Act is the reformation of the private insurance market to address these problems. The private insurance reforms include: (i) guaranteeing new substantive rights for consumers to health care coverage and benefits and making it easier for consumers to challenge insurers if they do not provide those benefits; (ii) premium rate review reforms that will increase transparency and accountability among insurers when they seek to impose premium rate increases; and (iii) support for consumer health assistance programs.

The ACA creates numerous patient protections for individuals who are covered by private insurance plans. These changes range from requiring health insurance plans to cover preventive health services – such as mammograms – to prohibiting insurance plans from refusing to cover a child with a pre-existing condition, such as juvenile diabetes. Many of these insurance reforms have already gone into effect, while the remainder will become effective by January of 2014.

The Affordable Care Act also will make it easier for patients and their families to challenge insurance companies' denial of insurance coverage or denial of claims for specific healthcare services. Without strong consumer protections and a mechanism for enforcement of the new rights to health insurance coverage, the promise of the ACA will not be fulfilled. The Affordable Care Act requires insurance companies to develop an internal process for consumers to use if the insurer has denied coverage of a benefit. The ACA also requires states to establish an external appeals process, which consumers can use if an insurer continues to deny coverage of that benefit.

The Affordable Care Act also addresses the skyrocketing costs of insurance premiums. Premium rate review is a process used by states to ensure that health insurance companies are charging fair prices for their products. In order to ensure that health insurance premiums do not continue to increase faster than wages, medical costs and inflation, the Affordable Care Act established new rules to increase transparency and improve accountability by the health insurance industry. In addition, New Mexico strengthened its own premium rate review law in the Spring of 2011. Rate review reform under the ACA and under New Mexico law, will help children and families retain the health insurance coverage they need to stay healthy by helping to keep health insurance premiums affordable. New Mexico's Division of Insurance, which is part of the New Mexico Public Regulation Commission, has considerable work to do to implement these new rate review requirements under the ACA and New Mexico's own new rate review law.

The ACA also addresses consumers' difficulties in navigating the private health care insurance system. In August 2011, the federal government proposed regulations that will require health insurance policies to provide information to consumers in plain, understandable language and to require all health insurance companies to use the same forms in providing the public with information about their health plans. The ACA requires states to establish a consumer Navigator Program to help consumers learn about and choose from among qualified health plans that will be offered on new health insurance exchanges.^{iv} The ACA also provided grants to states to fund consumer health assistance programs. The New Mexico Division of Insurance received a Consumer Assistance Grant in 2010 but has yet to implement the Consumer Ombudsman program described in the grant. The Consumer Assistance Grant will not receive additional funding. But New Mexico could use other funding opportunities under the ACA to help support a strong consumer health assistance system. These additional funding opportunities include requesting support for the Division of Insurance's Consumer Ombudsman program in the establishment grants the federal government has announced – and New Mexico is seeking – to create a state health insurance exchange.

The Affordable Care Act has the potential to greatly improve access to health care services for New Mexico's children and families by strengthening private insurance coverage and making it easier for families to obtain coverage for the healthcare they need. But the private insurance system continues to confuse and create barriers for many families. Blueprint for

Health New Mexico could help educate New Mexicans throughout the state to learn their rights, to advocate for themselves with their insurance companies, and to fight unreasonable premium rate increases. The Blueprint for Health New Mexico could also work to build a consumer assistance system in New Mexico that meets people where they are and provides them with the tools to obtain and maintain the insurance coverage and the healthcare services they need.

II. OVERVIEW OF THE ISSUES ADDRESSED BY THE ACA'S PRIVATE INSURANCE REFORMS.

Prior to passage of the Affordable Care Act, insurance companies frequently denied coverage to children and families outright or restricted the types of coverage they would provide based on pre-existing conditions.^v Sometimes insurers would cancel a child or adult's coverage when they became sick; a practice called rescission. Insurance companies would frequently set an annual limit—a dollar limit on their yearly spending for covered benefits—or a lifetime limit—a dollar limit on what they would spend during the entire time someone was enrolled in that plan. Families would then be required to pay for the remaining costs of their health care. The Affordable Care Act's insurance reforms mean that many families will no longer have to face bankruptcy because of health care expenses or choose between buying food and clothing or paying for their children's health care.

The increasing cost of private insurance has made it harder for employers to provide health insurance to their employees and for families to obtain coverage themselves on what is called the "individual market" where individuals and families who do not have employer-sponsored insurance can search for health insurance coverage. In 2010, the cost of health insurance premiums increased by more than 20 percent for many New Mexicans.^{vi} Rapidly increasing premiums frequently results in fewer families being able to afford health insurance coverage, which in turn leads to less access to quality health care.

One of the other huge challenges families face in the private insurance market is the complexity of the system. Consumers often face a range of obstacles to accessing quality comprehensive health insurance coverage. Health insurance companies often provide confusing information that consumers must sort through in order to choose an appropriate insurance plan for themselves and their families. And it is extremely difficult to compare one plan to another. Once a consumer has chosen a plan, she must then navigate myriad systems in order to obtain coverage for the specific health care services she and her family need and deserve. If an insurance company denies coverage of a benefit, consumers must find their way through a convoluted appeals process before they receive the care they need. For many families, if the insurance company will not cover the service, they will go without the care they need. The Affordable Care Act addresses all of these issues.

III. AN OVERVIEW OF THE CONSUMER PROTECTIONS AND PRIVATE INSURANCE REFORMS IN THE AFFORDABLE CARE ACT.

The Affordable Care Act ended some of the health insurance industry’s worst abuses and developed opportunities for consumers to more easily navigate the health care system. One of the most significant accomplishments of the Affordable Care Act is its reformation of the private insurance market. These insurance reforms increase access to coverage for children and families and improve the quality of insurance coverage available to New Mexicans. If one of the most significant accomplishments of the Affordable Care Act is its reformation of the private insurance market, another is its creation of uniform requirements for internal and external appeal processes. These processes will ensure that children and families in New Mexico are able to access the health care services they deserve. The Affordable Care Act also establishes new rules for premium rate review in order to increase transparency and improve accountability by the health insurance industry. In addition, the ACA addresses consumers’ difficulty in navigating the health care insurance coverage system by requiring States to establish a consumer Navigator Program in connection with the health insurance exchanges. The ACA also provides funds to States so that they may create or strengthen existing consumer health assistance programs, which will help ensure the effectiveness of the ACA’s insurance reforms and consumer protections.

This paper addresses three major policy areas for Blueprint Health New Mexico to consider in developing its strategic plan: (1) the new substantive rights that consumers have in their private insurance plans and the mechanisms available for enforcing those rights; (2) rate review reforms that are designed to keep insurance premiums reasonable and more affordable; and (3) the need to develop strong Consumer Health Assistance Programs that will help consumers enforce their rights.

A. THE AFFORDABLE CARE ACT CREATES NEW SUBSTANTIVE & PROCEDURAL RIGHTS FOR CONSUMERS WHO OBTAIN HEALTH INSURANCE COVERAGE THROUGH PRIVATE INSURANCE PLANS.

1. New Substantive Rights Under the Affordable Care Act

One of the most significant accomplishments of the Affordable Care Act is its reformation of the private insurance market. The ACA creates numerous patient protections for children and families who are covered by private insurance plans. These changes range from requiring insurance companies to pay for the full cost of preventive care services – such as mammography – to prohibiting insurance plans from refusing to cover a child with a pre-existing condition, such as juvenile diabetes. The insurance reform provisions of the ACA have staggered effective dates and apply in different ways to new plans and what are called grandfathered plans.^{vii} These insurance reforms increase access to coverage for children and

families and improve the quality of insurance coverage available to New Mexicans. The following is an overview of the new substantive rights created by the Affordable Care Act.

1. Prohibition on Lifetime Limits (ACA § 1001 as amended by § 10101; Public Health Service Act ("PHSA") § 2711)^{viii}
2. Prohibition on rescissions (ACA § 1001; PHSA § 2712)
3. Coverage of preventive health services (ACA § 1001; PHSA § 2713)
4. Prohibition of Pre-existing Condition Exclusions for Children (ACA § 1201; PHSA § 2704)
5. Mandatory Coverage for Dependents Younger than 26 (ACA § 1001; PHSA § 2714)
6. Coverage for Emergency Services (ACA § 1001; PHSA § 2719A)
7. Access to Primary and Pediatric Care (ACA § 1001; PHSA § 2719A)
8. Access to Obstetrical and Gynecological Services (ACA § 1001; PHSA § 2719A)
9. Uniform Explanation of Coverage Documents and Standardized Definitions (ACA § 1001; PHSA § 2715)
10. Prohibition on Annual Limits (ACA § 1001 as amended by § 10101; PHSA § 2711)
11. Guaranteed Availability of Coverage (ACA § 1201; PHSA § 2702)
12. Guaranteed Renewability (ACA § 1201; PHSA § 2703)
13. Fair health insurance premiums (ACA § 1201 as amended by 10103; PHSA § 2701)
14. Prohibiting discrimination based on health status (ACA § 1201; PHSA § 2705)
15. Prohibition of Pre-existing Condition Exclusions for Adults (ACA § 1201; PHSA § 2704)
16. Prohibition on excessive waiting periods (ACA § 1201; PHSA 2708)
17. Coverage for individuals participating in approved clinical trials (ACA § 1201 as amended by 10103; PHSA § 2709)
18. Reinsurance for early retirees (ACA § 1102)

The following provisions of the Affordable Care Act went into effect on September 23, 2010:

1. **Prohibition on Lifetime Limits** (ACA § 1001 as amended by § 10101; PHSA § 2711)
Prior to the ACA, insurance companies would set a dollar limit on what they spent on covered benefits during the entire time someone was enrolled in that plan. The consumer was responsible for paying any costs that exceeded that limit. Under the ACA, lifetime limits on most benefits are prohibited in any health plan or insurance policy issued or renewed as of September 23, 2010.
2. **Prohibition on Rescissions** (ACA § 1001; PHSA § 2712)
Rescissions are retroactive cancellations of coverage. In the past when an individual became sick an insurance company would look for inadvertent mistakes on their application. They would then use those mistakes as a reason to cancel coverage. The ACA prohibits all insurance plans from engaging in this practice.

Now insurance companies must give thirty days notice prior to canceling coverage and they may only cancel coverage for the following reasons: nonpayment of premiums;

fraud or intentional misrepresentation on an application for coverage; cessation of the particular type of coverage in the market; if the insured no longer lives within the service area; or if coverage is offered through an association or employer and the insured ceases to be a member or employee.

3. **Coverage of Preventive Health Services** (ACA § 1001; PHSA § 2713)

The ACA requires all new plans to cover certain preventive services without cost sharing. Cost-sharing means a co-pay, deductible or any other type of payment in addition to a premium.

Covered preventive services include mammography and cervical cancer screening, blood pressure, diabetes, and cholesterol tests, and immunization vaccines for children from birth to age 18.^{ix}

4. **Prohibition of Pre-existing Condition Exclusions for Children** (ACA § 1201; PHSA § 2704)

Before the Affordable Care Act became law, insurance companies could deny coverage to individuals with a pre-existing condition or they could limit benefits for that condition. A pre-existing condition is a health problem that developed before the consumer applied for coverage. The ACA now prohibits health plans from limiting or denying benefits or denying coverage for a child younger than age 19 simply because that child has a pre-existing condition.

5. **Mandatory Coverage for Dependents Younger than 26** (ACA § 1001; PHSA § 2714)

Insurance companies are required to cover dependents under the age of 26 regardless of marital status. Your adult children can join or remain on your plan whether or not they are married, living with you, in school or financially dependent on you.

Insurance companies are also required to provide notice of and the opportunity to re-enroll if coverage had lapsed due to age.

6. **Coverage for Emergency Services** (ACA § 1001; PHSA § 2719A)

Insurance companies can no longer require prior authorization for emergency services or charge higher co-pays for emergency services.

7. **Access to Primary and Pediatric Care** (ACA § 1001; PHSA § 2719A)

The Affordable Care Act requires that a plan enrollee be allowed to select their primary care provider, or pediatrician in the case of a child, from any available participating primary care provider.

8. **Access to Obstetrical and Gynecological Services** (ACA § 1001; PHSA § 2719A)

The Affordable Care Act prohibits insurance companies from requiring a referral before an individual seeks coverage for obstetrical or gynecological (OB-GYN) care.

The following provision of the Affordable Care Act will be implemented in 2012:

9. Uniform Explanation of Coverage Documents and Standardized Definitions (ACA § 1001; PHSA § 2715)

Insurance companies frequently send consumers reams of paper covered with complex and confusing information. The Affordable Care Act requires insurers to provide a summary of benefits and an explanation of coverage in language easily understood by the average consumer. The explanation must describe cost-sharing, exceptions, reductions, and limitations on coverage and provide examples illustrating common benefits scenarios. Insurers are also required to provide consumers with uniform definitions of standard insurance and medical terms.

The federal government published proposed regulations implementing this section of the ACA in August 2011 and a proposed standard format for all insurers to use when offering health insurance coverage. A copy of the proposed Summary of benefits and Coverage Template is included in the Appendix.^x The proposed regulations also indicate that insurance companies will be required to provide these documents in a culturally and linguistically appropriate manner if at least ten percent of the county in which the consumer lives is literate only in the same non-English language.^{xi}

The following provisions of the Affordable Care Act will be implemented in 2014:

10. Prohibition on Annual Limits (ACA § 1001 as amended by § 10101; PHSA § 2711)

The Affordable Care Act prohibits plans from imposing annual limits on most benefits beginning in 2014. Prior to 2014, health insurance plans may establish restricted limits set by the federal government.

Prior to 2014 plans may establish restricted annual limits which are limited to:

- \$750,000—for a “plan year” or “policy year” starting on or after September 23, 2010 but before September 23, 2011.
- \$1.25 million—for a plan year or policy year starting on or after September 23, 2011 but before September 23, 2012.
- \$2 million—for a plan year or policy year starting on or after September 23, 2012 but before January 1, 2014.

11. Guaranteed Availability of Coverage (ACA § 1201; PHSA § 2702)

The Affordable Care Act requires insurers to accept every employer and every individual that applies for coverage except that an insurer may restrict enrollment based upon open or special enrollment periods.

12. Guaranteed Renewability (ACA § 1201; PHSA § 2703)

The Affordable Care Act requires insurers to renew coverage or continue it in force at the option of the plan sponsor or the individual.

13. Fair health insurance premiums (ACA § 1201 as amended by 10103; PHSA § 2701)

The Affordable Care Act requires that insurers set premiums based on only the following factors:

- Age (3:1 maximum)
- Tobacco (1.5:1 maximum)
- Geographic rating area
- Whether coverage is for an individual or a family

This means that the ACA abolishes the practice of gender rating in 2014. Note that New Mexico passed a law in 2010 which gradually phases out gender rating. See N.M. Stat. Ann. § 59A-18-13.1.

14. Prohibiting discrimination based on health status (ACA § 1201; PHSA § 2705)

A health insurance plan may not establish rules for eligibility based on any of the following health status-related factors:

- Health status
- Medical condition
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability (including conditions arising out of domestic violence)

15. Prohibition of Pre-existing Condition Exclusions for Adults (ACA § 1201; PHSA § 2704)

Before the Affordable Care Act became law, insurance companies could deny coverage to individuals with a pre-existing condition or they could limit benefits for that condition. A pre-existing condition is a health problem that developed before the consumer applied for coverage. Beginning in 2014, health plans will be prohibited from limiting or denying benefits or denying coverage for anyone with a pre-existing condition.

16. Prohibition on excessive waiting periods (ACA § 1201; PHSA 2708)

The Affordable Care Act will prohibit any waiting periods for group coverage that exceeds 90 days.

17. Coverage for individuals participating in approved clinical trials (ACA § 1201 as amended by 10103; PHSA § 2709)

The Affordable Care Act will prohibit insurers from dropping or limiting coverage because an individual chooses to participate in a clinical trial. This applies to all clinical trials that treat cancer or other life-threatening diseases.

18. Reinsurance for early retirees (ACA § 1102)

The Affordable Care Act creates a temporary reinsurance program that provides grants to employers to help them maintain coverage for early retirees age 55 and older that are not yet eligible for Medicare. Employers and unions will receive reimbursement for medical claims. The savings can be used to reduce employer health care costs and provide premium relief to workers and their families. The program will end on January 1, 2014.

In New Mexico grants for early retiree insurance programs have been awarded to:

- Los Alamos National Security, LLC;
- The New Mexico Public Schools Insurance Authority;
- The New Mexico Retiree Health Care Authority;
- PNM Resources, Inc.;
- Sandia Corporation; and
- The University of New Mexico.^{xii}

2. New Procedural Rights Under the Affordable Care Act

The Affordable Care Act creates numerous patient protections for children and families who are covered by private insurance plans, but without some mechanism for enforcement of these new rights the promise of the ACA will not be fulfilled. The Affordable Care Act requires insurance companies to develop an internal process for consumers to use if the insurer has denied coverage of a benefit. In addition, the ACA requires states to establish an external appeals process, which consumers can use if an insurer continues to deny coverage of that benefit.^{xiii}

This section of the paper provides an overview of internal and external appeals of insurance company decisions under the ACA and current law. It is the most technical section of the paper and includes significant citations to current regulations so that the information is available as a resource for future advocacy in this area.

In some states, the power to regulate insurance is under the authority of an Insurance Commissioner elected directly by the voters. In other states, insurance regulation falls under the jurisdiction of the Governor, who appoints the head of the insurance department. In New Mexico, insurance regulation is under the authority of the Public Regulation Commission (“PRC”) and its Division of Insurance. New Mexico’s Constitution established the Public

Regulation Commission, NM Const. Art. XI, § 1 (2010), and set forth its responsibilities. New Mexico Constitution, Article XI, § 2 states:

The commission shall have responsibility for regulating . . . insurance companies .
. . . ***in such a manner as the legislature shall provide.***

(emphasis added). The Legislature, in turn, has created the Insurance Division within the PRC, see N.M. Stat. Ann. § 59A-2-1 (2011), and made the Superintendent of Insurance the “chief officer” of the Insurance Division. See N.M. Stat. Ann. § 59A-2-2 (2011). Through adoption of the Insurance Code, the Legislature has given the Superintendent of Insurance (“Superintendent”) significant authority to regulate insurance in New Mexico. The New Mexico Patient Protection Act, N.M. Stat. Ann. §§ 59A-57-1 et seq., for example, gives patients in managed health care plans significant rights, sets forth grievance procedures and consumer protections, and gives the Superintendent significant authority to enforce and oversee implementation of that statute.

a. Internal Appeals

Under the Affordable Care Act, health insurance companies are required to establish an internal appeals process. (ACA § 2719(1)).^{xiv} An insurance company’s internal appeals process cannot consist of more than two levels of appeal. (29 CFR 2560.503-1(c)(2)).^{xv} In addition, health insurance companies are required to notify consumers that internal and external appeals processes are available. (ACA § 2719(2)). These notices must be disseminated in a culturally and linguistically appropriate manner. (*Id.*) Insurance companies must provide culturally and linguistically appropriate notices if at least ten percent of the county in which the consumer lives is literate only in the same non-English language. (29 CFR 2590.715-2719(e)(3)). This is particularly significant for New Mexicans because at least eight counties currently satisfy this requirement. (Table 2, 76 FR 37208, 37222 (June 24, 2011)). The effective date of this provision is January 1, 2012. Monitoring compliance with this requirement is an important opportunity to ensure that Affordable Care Act implementation meets the needs of diverse communities in New Mexico.

During the internal appeals process, an insurance company must inform the consumer of its decision whether to cover a service within specified timeframes. In the case of urgent care, an insurance company must inform the consumer of its decision within 72 hours of receipt of the claim. (29 CFR 2560.503-1(f)(2)(i)). If a consumer has not received the service, an insurance company must inform the consumer of its decision no later than 30 days after receipt of the claim. (29 CFR 2560.503-1(f)(2)(iii)(A)). If the consumer has received the service, an insurance company must inform the consumer of its decision no later than 45 days after receipt of the claim. (29 CFR 2560.503-1(f)(2)(iii)(B)). When an insurance company denies a consumer’s claim, they must provide an explanation for denying the claim. (29 CFR 2560.503-1(g)(i)). An insurance company must provide a consumer with at least 180 days following receipt of a denial to appeal the decision. (29 CFR 2560.503-1(h)(3)(i)).

b. External Appeals

The Affordable Care Act requires that each state implement an external review process that includes the consumer protections set out by the National Association of Insurance Commissioners (NAIC) in their model act. (ACA § 2719(4)). Under these requirements an insurance company must notify consumers of their right to an external review of a denial of coverage. (Model Act § 5). The consumer should first go through the insurer's internal review process (Model Act § 7) and then request that the Superintendent of Insurance perform an external review. (Model Act § 6). The consumer must request an external appeal within 120 days following the notice of the final determination in an internal review. The model act then lays out a process for identifying an independent review organization (IRO) whose role is to gather information and make a determination on whether the insurance company should cover the services requested by the consumer. (Model Act § 8). This process must be completed within 45 days of the receipt of the request for an external review. (Model Act § 8). The external review process is binding on the insurer except where additional remedies are available under state law. (Model Act § 11(A)). The review process is also binding on the consumer except where additional remedies are available under state or federal law. (Model Act § 11(B)). The remainder of the model act describes the requirements that an independent review organization must meet in order to perform external reviews.

3. Current Law in New Mexico Regarding Internal and External Appeals

In New Mexico, if an insurance company states that it will not cover a benefit, an insured person has two options. The insured may immediately appeal the denial and await the outcome or they may pay for the benefit themselves and then appeal the denial.

In order to appeal a denial, a consumer must first go through the insurance company's internal review process. During the internal review, the medical director or an appropriate person designated by the medical director, reviews the file and makes a determination. (NMAC § 13.10.17.19). If the person finds that the insurance company's denial is proper, the consumer may ask for a second review. (NMAC § 13.10.17.20). This second review is done by a panel of people usually including the medical director. If that review also finds that the denial was proper, the consumer may then contact the Division of Insurance (DOI) and proceed through their appeals process. During this internal appeal, the insurance company must follow specific deadlines. If they do not, the Division of Insurance may overturn their denial of coverage on procedural grounds. (NMAC § 13.10.17.18).

Once a consumer has gone through the internal appeals process, she has the right to an external appeal. (NMAC § 13.10.17.23). To begin the external appeal process a consumer must obtain a complaint form by calling the DOI or visiting its website. The consumer must file this form within 20 working days after receiving written notice of a denial of coverage from the

health plan's internal review. (NMAC § 13.10.17.24(A)(2)). Once a consumer has submitted the completed form, the DOI will request a copy of the consumer's file from the insurance company. (NMAC § 13.10.17.25). The DOI will then review the file and make a determination about whether the case should go to a hearing. (NMAC § 13.10.17.27). The DOI will hold a hearing on the merits of the appeal, if the health care service that the consumer requested reasonably appears to be covered under the consumer's health insurance policy. (NMAC § 13.10.17.27).

The external review hearing is presided over by three hearing officers; two doctors and a lawyer. (NMAC § 13.10.17.30(A-B)). At least one of the doctors should have expertise in the particular medical specialty being addressed. (NMAC § 13.10.17.30(B)). The adverse parties each have an opportunity to present their case. (NMAC § 13.10.17.30(G)). At the close of the hearing, the hearing officers must review the entire record and then recommend a decision to the Superintendent of the Department of Insurance. (NMAC § 13.10.17.32(A)). The Superintendent must then issue an order stating the outcome of the appeal. (NMAC § 13.10.17.32(B)). The decision is final and binding on both the consumer and the insurance company. (NMAC § 13.10.17.32(B)(1)). However, either party has the right to judicial review by a state or federal court. (NMAC § 13.10.17.32(B)(1)).

4. Policy Issues to Address Related to Substantive and Procedural Reforms and the New Mexico Division of Insurance

a. Substantive Health Insurance Reforms

The Affordable Care Act ended some of the health insurance industry's worst abuses. Many of the new consumer protections created by the ACA are not included in New Mexico statute or regulations. A significant issue facing New Mexico is whether the Superintendent has authority to enforce the substantive insurance reforms in the ACA without legislation giving the Superintendent the direct authority to enforce those requirements under New Mexico law. While the Superintendent currently has authority to inform insurers that they are in violation of the ACA – and insurers have strong incentives to make sure they comply – a statute incorporating the protections of the ACA into New Mexico's Insurance Code would provide the Superintendent of Insurance with an explicit enforcement mechanism. Without such explicit authority, insurance companies might claim that the Superintendent cannot require them to comply with the ACA.

A bill was introduced during the 2011 legislative session by Senator Dede Feldman, SB 608, which would have put into state law the substantive insurance reforms of the ACA that have already gone into effect. The bill did not advance during the session. While there were some technical drafting issues related to the bill, if enacted, SB 608 would have:

- ensured that the Superintendent has explicit authority and a mandate to enforce the provisions of the ACA that are already in effect;

- guaranteed that New Mexico consumers have a forum for disputing an insurance company's denial of benefits or coverage currently guaranteed under the ACA; and
- prevented insurance companies from raising procedural objections and roadblocks to prompt implementation of these critical consumer protections in NM.

The Blueprint for Health New Mexico could ask the Superintendent of Insurance to clarify whether he believes he has the legal authority to enforce the insurance reforms in the ACA, and urge adoption of a statute and/or regulations that will make clear how the Superintendent will enforce those patient protections.

b. Procedural Reforms

The Affordable Care Act made changes to the mechanism used by consumers to appeal an insurance company's denial of coverage. Current New Mexico law is similar to the new internal appeals rules required by the ACA. But New Mexico's process related to external appeals is not in compliance with the Affordable Care Act. In early August 2011, the United States Department of Health and Human Services made a determination that New Mexico's external review process is similar to but does not meet the strict requirements of the Affordable Care Act.^{xvi} The state may continue to operate under its current rules until January 1, 2014. In addition, New Mexico may request a reconsideration of this determination and HHS will make a final determination by October 1, 2011. If New Mexico fails to meet the external review standards in the ACA, the state will need to take the necessary steps to conform with the Affordable Care Act.

The main area that will need to be addressed to comply with the ACA's external review requirements is the use of independent review organizations to perform the external reviews. Currently, New Mexico performs part of the review within the Division of Insurance and the remainder of the review is performed by a panel consisting of a lawyer and at least one doctor. The ACA requires that a list of eligible independent review organizations be maintained and utilized for this function. The current process must be changed so that the state will be in compliance with federal law by 2014.

B. HEALTH INSURANCE PREMIUM RATE REVIEW REFORMS

During the past decade health insurance premiums have risen steadily, outpacing general inflation and wages.^{xvii} As health insurance becomes more expensive fewer families will be able to afford the cost of insurance and will prioritize other expenses such as food and shelter. Premium rate review is a process performed at the State level to ensure that health insurance companies are charging fair prices for their products. Effective rate review helps slow increases in premium rates.

The Affordable Care Act provides new tools to protect consumers and employers from unreasonable health insurance premium increases.^{xviii} It requires the U.S. Department of Health and Human Services ("HHS") to work closely with state insurance regulators to review "unreasonable" premium rate increases and authorizes HHS to provide states with significant grants to strengthen their rate review process and ensure public disclosure of information relating to any premium rate increase requests of 10% or more.

The federal government issued final regulations regarding these new rate review procedures in May 2011.^{xix} The regulations are scheduled to go into effect on September 1, 2011. They require the New Mexico Superintendent of Insurance to review premium rates increases for health insurance coverage in the individual and small group markets that exceed 10% to determine if they are "unreasonable." Proposed increases must be submitted to the Superintendent before they go into effect. An increase of 10% or more will trigger significant public reporting and disclosures. Beginning in September 2012, however, states will be allowed to develop their own state-specific thresholds based on factors related to healthcare costs in the state.

The regulations also address what constitutes a rate increase that is "excessive, unjustified, or unfairly discriminatory, and, therefore, unreasonable."^{xx} There are detailed disclosure requirements but the ACA does not give states the authority to reject a proposed rate increase; that is a matter of state law. The theory behind the extensive reporting and transparency requirements under the ACA is that insurers will be less likely to propose and implement unfair rate increases. HHS will also review rate increases of 10% or more, but will adopt a State's determination as to whether the increase is unreasonable and will post that determination on its website if the state is determined to have an effective rate review program.^{xxi} HHS has determined that New Mexico has an effective rate review program as of August 2011.^{xxii}

The Division of Insurance received a \$1 million rate review planning grant from the federal government in 2010 to implement the strong disclosure and review requirements of the ACA. In August, 2011 it applied for a second Rate Review grant to further develop its capacity to review rate increases and engage the public in addressing the reasonableness of those increases.

In addition to the ACA's significant transparency and accountability provisions, New Mexico adopted a new premium rate review law in 2011. SB 208 (2011 N.M. Laws 144) passed the legislature and was signed into law by Governor Martinez.^{xxiii} It amends several sections of the New Mexico Insurance Code and provides the substantive basis for granting or denying a proposed rate increase. New Mexico's new rate review law goes into effect on January 1, 2012.

SB 208 creates a more fair and transparent process for evaluating health insurance rate increases than existed in New Mexico before 2011. Under the new law, insurers must receive approval from the Superintendent of Insurance for the rates they charge for health insurance or health care plans. Section 5 of SB 208 sets forth the information insurers must disclose regarding any rates or rate changes and requires the Division of Insurance to post that information on its website. Section 6 of SB 208 requires the Superintendent of Insurance to make specific findings before approving a rate change, including that “the proposed rate is reasonable, not excessive or inadequate and not unfairly discriminatory . . .”. It also requires the Superintendent to consider a range of factors when determining whether a rate increase should be approved. These factors include the company’s overall financial situation, whether it has complied with the state’s medical loss ratio standards, and if changes have been made to the benefit package or plan design.

The law also requires that the insurance company provide an explanation for the rate increase in language that the average consumer can understand and to notify its policyholders and beneficiaries of the proposed rate increase. The new law also requires that the state provide a 30 day comment period in response to a rate increase. In addition, the law sets out time limits on the review process so insurance companies can expect a timely decision. These new changes will help consumers understand how their premium dollars are spent and will improve insurance company accountability.

Premium rate review is the key to controlling unreasonable insurance premium rate increases and helping to promote affordable health care plans. Considerable work needs to be done to monitor the Division of Insurance’s implementation of both the ACA and SB 208 and its use of the rate review grant funding from the federal government.

Insurance premium rate increases undermine access to health insurance coverage and to quality health care services. Blueprint for Health New Mexico could develop plans to monitor implementation of these new rate review standards and ensure that consumers are receiving the full benefit of these new laws. By ensuring that the premiums are affordable, these new state and federal consumer protections will help children and families afford the health insurance coverage they need to stay healthy.

C. CONSUMER HEALTH ASSISTANCE PROGRAMS.

Consumers often face a range of obstacles to accessing quality comprehensive health insurance coverage. Given the complexity of the health care system in the United States, it is understandable that many consumers would have difficulty navigating that system. Health insurance companies often provide confusing information that consumers must sort through in order to choose an appropriate insurance plan for themselves and their families. Once a consumer has chosen a plan, they must then navigate myriad systems in order to obtain the health care they deserve. If an insurance company denies coverage of a benefit, consumers

must find their way through a convoluted appeals process before they receive the care they need.

Each of these scenarios would be made more efficient if consumers had access to the information and assistance they needed. In 2010, a Consumer Education and Protection Advisory Group ("Consumer Advisory Group") was organized by the Southwest Women's Law Center to provide recommendations to the legislative work group that was addressing ACA implementation in New Mexico (the Senate Joint Memorial 1 Work Group). The Consumer Advisory Group developed numerous recommendations to help ensure that the benefits of the ACA were realized by all New Mexicans. Among other things, the Consumer Advisory Group recommended creation of an independent non-governmental Consumer Health Assistance Program in New Mexico. A copy of the Consumer Advisory Group's recommendations are included in the Appendix to this paper. Blueprint for Health New Mexico may want to review those recommendations and determine whether to use them as a basis for some of its own strategic plan.

Two opportunities for consumers to more easily navigate the health care system will become more widely available due to the Affordable Care Act. The ACA requires states to establish a consumer Navigator Program to help consumers learn about and choose from among qualified health plans that will be offered on new health insurance exchanges.^{xxiv} The ACA also authorized the federal government to award grants to states in 2010 to fund consumer health assistance programs. The New Mexico Division of Insurance received a Consumer Assistance Grant in 2010 but has yet to implement the Consumer Ombudsman program described in the grant. The Consumer Assistance Grant will not receive additional funding. But New Mexico could use other funding opportunities under the ACA to help support a strong consumer health assistance system. These additional funding opportunities include requesting support for the Division of Insurance's Consumer Ombudsman program in the establishment grants the federal government has announced – and New Mexico is seeking – to create a state health insurance exchange.

Under the Affordable Care Act states will be required to create health insurance exchanges, which are marketplaces for individuals and small businesses to purchase health insurance. Once these exchanges are operating the state must also have a navigator program established so that consumers can obtain assistance enrolling in a plan. The navigator program will also serve a public education function so that consumers understand their rights and responsibilities related to health insurance.

Prior to the Affordable Care Act many communities recognized the need to have a resource for people who needed assistance navigating the entire health care system not just the private health insurance market. These programs are called consumer health assistance programs (CHAPs). These programs have three purposes: (1) educating consumers about their rights and responsibilities ; (2) assisting consumers in their efforts to resolve complaints about their health

care coverage and health care services; and (3) collecting information and providing insight into the types of problems encountered by consumers so that improvements can be made. CHAPs will be a critical component of the health care system as more people gain coverage due to the Affordable Care Act. New Mexico has received a Consumer Assistance Grant from the federal government to establish a consumer health assistance program within the Division of Insurance that is designed to serve all three of the functions described above. But in the long-term, community-based CHAPs that are separate from the agency responsible for regulating insurance will be important to meet the needs of diverse communities throughout New Mexico.

New Mexico has an important opportunity to create a consumer friendly program which will be particularly helpful to families navigating the complexity of the health care system. The state should ensure that it develops an effective program so that children and families are able to have meaningful engagement with their insurance providers and the Division of Insurance, should they need assistance in challenging denials of coverage and benefits.

IV. OPPORTUNITIES TO IMPLEMENT CONSUMER PROTECTIONS AND PRIVATE INSURANCE REFORMS IN NEW MEXICO.

Insurance regulation and reform is beyond the expertise and current focus of most of the members of the Blueprint for Health New Mexico Advisory Network. Yet, it is estimated that approximately 123,000 currently uninsured New Mexicans will be eligible to receive tax credit subsidies to purchase private health insurance beginning in 2014^{xxv} and will need significant assistance dealing with insurance companies, insurance claims, and denials of benefits. There are numerous opportunities for Blueprint for Health New Mexico to have input into the design and implementation of the ACA’s significant consumer protections and insurance reforms. The Division of Insurance will be ultimately responsible for implementation and enforcement, but an engaged collaborative of organizations could have a significant impact on how the Division of Insurance implements those reforms. The following are suggestions for Blueprint for Health New Mexico to consider.

Opportunities for Implementation of all the Consumer Protections and Insurance Reforms

1. Recruit individuals from the four counties represented in the Advisory Network to participate in the Consumer Stakeholder Advisory group to the State’s Office of Health Care Reform. This Stakeholder group has worked with the Division of Insurance to help them develop their plans to implement the first rate review grant and the consumer assistance grant from the federal government but does not have broad geographic representation.

2. Review the recommendations of the Consumer Advisory Group to the Senate Joint Memorial 1 Work Group and determine whether to adopt any or all of them as part of the goals and work of the Blueprint for Health New Mexico.
3. Organize and plan a meeting with the Advisory Network and leadership of the Division of Insurance regarding their plans for ACA implementation and to identify possible roles for members of the Network in implementation.

Opportunities for Implementation Related to the Affordable Care Act's Substantive & Procedural Reforms in Private Insurance Coverage

1. Work to ensure that the New Mexico Superintendent of Insurance has explicit authority to enforce the new consumer protections provided under the Affordable Care Act.
2. Assist in educating New Mexicans about the new rights under the ACA and steps needed to enforce those rights, including information about appealing insurance company denials of coverage and benefits.
3. Conduct outreach to diverse individuals and communities to help determine how the Division of Insurance can ensure that information provided by the Division and by the insurance companies it regulates are culturally and linguistically appropriate and can be understood by all New Mexicans.
4. Work to ensure that the New Mexico internal and external appeals processes comply with the requirements of the Affordable Care Act by 2014 and identify methods of appeal that will meet the needs of diverse New Mexicans who will have private insurance coverage.
5. Consider developing a plan for educating families about the new substantive rights under the ACA that provide protections for children (such as certain preventive health services and a prohibition on denying coverage to children because of pre-existing conditions). This effort could also identify cases where it appears that insurance companies have been denying coverage now guaranteed by law and then seeking review of those decisions to ensure proper enforcement by the Division of Insurance.
6. Address the needs of New Mexicans who receive employer-sponsored health insurance which is regulated by the U.S. Department of Labor, rather than the New Mexico Division of Insurance, so that they understand their rights and learn how to seek support for their enforcement from their employers and, if necessary, the Department of Labor.

Opportunities for Implementation Related to Rate Review

Given the technical nature of rate review and actuarial analysis, it may be helpful for the Blueprint for Health New Mexico to consider obtaining technical assistance from national experts who can help New Mexico design a consumer-oriented approach to addressing unreasonable premium rate increases. The following are specific activities that could help make health insurance more affordable.

1. Conduct greater analysis and public education regarding the role of premium rate increases in making healthcare coverage unaffordable and inaccessible to an increasing number of New Mexicans.
2. Conduct further legal and economic analysis regarding the rate review reforms in both state and federal law and conduct public education and outreach regarding those reforms and the opportunities individuals have to help make them work for their families and communities.
3. Monitor and participate in public comment on rulemaking to implement New Mexico's new rate review law and the new requirements of the ACA.
4. Provide input to the Division of Insurance on how to simplify disclosures by insurance companies and to communicate to diverse individuals about important changes to their insurance coverage, including rate increases.

Opportunities for Implementation Related to Consumer Health Assistance Programs

1. Encourage state officials to include sufficient funding for consumer assistance in their grant proposals to seek funding to establish a state health insurance exchange.
2. Work with the Consumer Ombudsman that the Division of Insurance intends to hire to determine effective strategies for outreach, education and filing of complaints by individuals in the communities participating in the Advisory Network.
3. Develop plans for the establishment of a strong independent Consumer Health Assistance Program that is able to conduct appropriate outreach and education throughout New Mexico and ensure that development of any such program takes into consideration the unique racial, ethnic, linguistic, gender, sexuality, ability and cultural demographics of New Mexico communities.
4. Address ways in which a Consumer Health Assistance Program can avoid being siloed within commercial insurance and may instead address insurance reforms and consumer

protections, the new health insurance exchange, and assistance with public programs such as Medicare and Medicaid eligibility, enrollment and claims disputes.

5. Address ways in which a Consumer Health Assistance Program can assist the uninsured access care even if they are not eligible for premium tax credits or for Medicaid. The safety net for those who will remain uninsured will be a significant issue in New Mexico.
6. Address ways in which existing systems could be developed and strengthened to assist families navigate healthcare delivery systems, not just healthcare coverage systems.

V. ENDNOTES

ⁱ The Patient Protection and Affordable Care Act (Public Law 111-148) was enacted on March 23, 2010. It was amended by the Health Care and Education Reconciliation Act (Public Law 111-152), which was enacted on March 30, 2010. This paper uses the acronym ACA or the term “Affordable Care Act” to refer collectively to both of those laws.

ⁱⁱ For stories on why health insurance reforms were necessary and how the Affordable Care Act is already helping children and their families see <http://www.momsrising.org/page/moms/healthcare-stories-by-state>.

ⁱⁱⁱ See <http://www.healthcare.gov/news/factsheets/rates.html>

^{iv} The Southwest Women’s Law Center has prepared another policy brief for the Blueprint for Health New Mexico that addresses the Navigator Program. See CONSUMER NAVIGATORS UNDER THE AFFORDABLE CARE ACT: Building a Community-Based, Patient-Centered System in New Mexico to Support Greater Healthcare Access and Coverage (Southwest Women’s Law Center: August 31, 2011).

^v For stories on why health insurance reforms were necessary and how the Affordable Care Act is already helping children and their families see <http://www.momsrising.org/page/moms/healthcare-stories-by-state>.

^{vi} See <http://www.healthcare.gov/news/factsheets/rates.html>

^{vii} A grandfathered plan, a health plan available on or before March 23, 2010, is not required to comply with all of the Affordable Care Act’s consumer protections. However, even grandfathered plans are prohibited from imposing lifetime limits on coverage, cannot retroactively cancel (rescind) your coverage, and must provide coverage to dependents under the age of 26 unless they have access to health insurance through their own employer.

^{viii} For ease of reference, this paper cites the relevant sections of the ACA and the Public Health Service Act (PHSA) in the body of the paper. The Affordable Care Act amended and added sections to the Public Health Service Act.

^{ix} For a full list of covered preventive services see <http://www.healthcare.gov/law/about/provisions/services/lists.html>

^x The proposed regulations regarding disclosure of the summary of benefits and coverage available under insurance plans and containing a proposed uniform glossary of terms are found at 76 FR 52242 (August 22, 2011). The new requirements are scheduled to go into effect on March 23, 2012, the two-year anniversary of enactment of the Affordable Care Act. Information about these proposed regulations can be found at <http://www.hhs.gov/news/press/2011pres/08/20110817a.html> (last accessed August 27, 2011).

^{xi} See 76 FR 52442, 52449-52450 (August 22, 2011).

^{xii} See <http://www.healthcare.gov/law/provisions/retirement/states/nm.html>

^{xiii} Insurance regulation is a complicated area of law. Traditionally, states have been the primary regulators of the private insurance market. The ACA has created uniform requirements for private insurance plans throughout the country. In New Mexico, the Superintendent of Insurance, who is selected by the members of the Public Regulation Commission, licenses and oversees the practices of private insurance companies who do business in New Mexico. The Superintendent of Insurance primarily regulates the individual and small employer health insurance market. Many insurance plans – those offered primarily by large companies – are regulated by the United States Department of Labor under a federal law known as the Employee Retirement Income Security Act (“ERISA” or Public Law 93-406). An analysis of ERISA or the impact of the Affordable Care Act on ERISA is beyond the scope of this paper. However, given that many New Mexicans work for large companies who offer health insurance regulated by the Department of Labor, future analysis of the impact of the ACA on ERISA plans and how employees in those companies can vindicate their rights could be included in Blueprint for Health New Mexico’s plans relating to private insurance reforms.

^{xiv} This applies to both insured and self-insured plans. See 76 FR 37209 (June 24, 2011).

^{xv} The Affordable Care Act adds section 2719 to the Public Health Service Act which states that health plans and issuers must initially incorporate the internal claims and appeals processes set forth in Department of Labor Regulations at 29 CFR 2560.503-1. See 76 FR 37209 (June 24, 2011).

^{xvi} See http://cciio.cms.gov/resources/files/external_appeals_preliminary_determinations_8_1_11.html

^{xvii} See Health Policy Brief: 'Unreasonable' Insurance Rate Increases, *Health Affairs*, March 31, 2011. Available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=43.

^{xviii} See ACA § 1003; adding a new section of the Public Health Service Act (Section 2794).

^{xix} See 76 FR 19964 (May 23, 2011). More information about the regulations can be found at <http://www.hhs.gov/news/press/2011pres/05/20110519a.html> (last accessed August 27, 2011).

^{xx} 76 FR at 29968.

^{xxi} 76 FR at 29971.

^{xxii} See http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html

^{xxiii} The New Mexico rate review legislation will be referred to by its senate bill number because that designation is familiar to many of those who participated in the 2011 legislative process. A copy of the final legislation may be found at <http://www.sos.state.nm.us/2011Bills/SB208.pdf>.


^{xxiv} The Southwest Women’s Law Center has prepared another policy brief for the Blueprint for Health New Mexico that addresses the Navigator Program. See CONSUMER NAVIGATORS UNDER THE AFFORDABLE CARE ACT: Building a Community-Based, Patient-Centered System in New Mexico to Support Greater Healthcare Access and Coverage (Southwest Women’s Law Center: August 31, 2011).

^{xxv} See Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit in New Mexico <http://www.familiesusa.org/assets/pdfs/health-reform/premium-tax-credits/New-Mexico.pdf>

Appendix A-1

Summary of Benefits and Coverage (SBC) Template

Summary of Coverage: What this Plan Covers & What it Costs Policy Period: _____ - _____
 Coverage for: _____ | Plan Type: _____

 **This is not a policy.** You can get the policy at www.insurancecompany.com/PLAN1500 or by calling 1-800-XXX-XXXX. A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why this Matters:
What is the premium?	\$	The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible?	\$	
Are there other deductibles for specific services?	\$	
Is there an out-of-pocket limit on my expenses?	\$	
What is not included in the out-of-pocket limit?		
Is there an overall annual limit on what the insurer pays?		
Does this plan use a network of providers?		
Do I need a referral to see a specialist?		
Are there services this plan doesn't cover?		

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
 If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

OMB Control Number XXXX-XXXX
 (expires XX/XX/XXXX) 1 of 6

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: _____ - _____
 Coverage for: _____ | Plan Type: _____



- Co-payments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your co-insurance payment of 20% would be \$200. If you haven't met any of the deductible and it's at least \$1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use _____ providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness			
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
More information about drug coverage is at www.insurancecompany.com/prescriptions	Specialty drugs (e.g., chemotherapy)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need	Emergency room services			

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: _____ - _____
 Coverage for: _____ | Plan Type: _____

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
immediate medical attention	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you become pregnant	Prenatal and postnatal care			
	Delivery and all inpatient services			
If you have a recovery or other special health need	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
If your child needs dental or eye care	Hospital service			
	Eye exam			
	Glasses			
	Dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)
•
•
•

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
 If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: _____ - _____
Coverage for: _____ | Plan Type: _____

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)
•

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

Your Grievance and Appeals Rights:


- A **grievance** is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit www.XXXXXXXXXXXXXX.com.
- An **appeal** is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit www.XXXXXXXXXXXXXX.gov.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*-----

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

About these Coverage Examples:

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much insurance protection you might get from different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$10,000
- Plan pays \$
- You pay \$

Sample care costs:

First office visit	\$100
Radiology	\$300
Laboratory tests	\$200
Routine obstetric care	\$2,000
Hospital charges (mother)	\$4,100
Hospital charges (baby)	\$1,900
Anesthesia	\$1,000
Circumcision	\$200
Vaccines, other preventive	\$200
Total	\$10,000

You pay:

Deductibles	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$

Treating breast cancer (lumpectomy, chemotherapy, radiation)

- Amount owed to providers: \$98,000
- Plan pays \$
- You pay \$

Sample care costs:

Office visits & procedures	\$4,000
Radiology	\$4,000
Laboratory tests	\$2,400
Hospital charges	\$3,300
Inpatient medical care	\$200
Outpatient surgery	\$3,400
Chemotherapy	\$64,000
Radiation therapy	\$13,000
Prostheses (wig)	\$500
Pharmacy	\$2,000
Mental health	\$1,200
Total	\$98,000

You pay:

Deductibles	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$

Managing diabetes (routine maintenance of existing condition)

- Amount owed to providers: \$7,800
- Plan pays \$
- You pay \$

Sample care costs:

Office visits & procedures	\$960
Laboratory tests	\$300
Medical equipment & supplies	\$40
Pharmacy	\$6,500
Total	\$7,800

You pay:

Deductibles	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy period.
- There are no other medical expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

* **No.** Treatments shown are just examples. The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

**Consumer Protection and Education in Federal Health Care Reform Implementation:
September 2, 2010**

For more information, contact Jane Wishner, Executive Director, Southwest Women's Law Center
jwishner@swwomenslaw.org

**Consumer Protection and Education in Health Care Reform
Implementation in New Mexico**

Recommendations to the Senate Joint Memorial 1 Work Group and the Governor's Health Care
Reform Leadership Team
September 2, 2010

The following recommendations were prepared by an ad hoc working group that met to address consumer issues in health care reform (HCR) implementation in New Mexico for the Senate Joint Memorial 1 Work Group and Governor Richardson's Health Care Reform Leadership Team. The ad hoc consumer advisory group met regularly over the summer and included representatives from the following agencies:

Insurance Division, Public Regulation Commission
Consumer Protection Division, Office of the New Mexico Attorney General
Health Action New Mexico
New Mexico Legal Aid
Senior Citizens Law Office
Southwest Women's Law Center

EARLIER RECOMMENDATIONS ADDRESSED THROUGH THE STATE'S STRATEGIC PLAN

In June, this working group submitted recommendations to the Governor's executive leadership team. We would like to publicly thank Human Services Department Secretary Katie Falls, Ruby Ann Esquibel and the Leadership Team for integrating consumer protection and education strategies into the State's strategic plan and for helping to facilitate communication between state agencies and consumer advocates. The Strategic Plan includes a recommendation that the New Mexico Office of Health Care Reform develop and oversee a coordinated plan to address consumer education and protection and adopted specific recommendations made by this working group:

6. Develop a comprehensive and cost-effective consumer protection and education plan that (1) promotes widespread consumer education as components of PPACA are rolled out, (2) creates an independent consumer protection system with procedures and resources available for every county and tribal community, and (3) obtains funding through the PPACA to coordinate and advance consumer protection and education throughout New Mexico.

Implementing Federal Health Care Reform – A Road map for New Mexico, Strategic Plan at 7 (July 12, 2010)(<http://www.hsd/state.nm.us/nhcr/nhcriao.htm>). See also Strategic Plan at 42-44. This report builds on that commitment.

SUMMARY OF KEY RECOMMENDATIONS

1. The New Mexico Office of Health Care Reform should establish a **State Consumer Coordinating Committee** consisting of consumer advocates and staff members from key agencies who will be responsible for coordinating statewide consumer education and protection efforts. (See pages 42-44 of NM Strategic Plan)
2. The State should incorporate consumer education and consumer protection planning into each

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element of health care reform implementation.

3. Consumer education planning should address the complexity of an outreach program that will help ensure the estimated 300,000 New Mexicans who are currently uninsured will receive the maximum benefits available to them under health care reform.
4. State entities that address consumer protection in the health care and health insurance context should plan and coordinate their consumer protection, appeal and ombudsman programs.
5. The Legislature should provide funding for consumer education and protection programs to ensure accountability and effective implementation of federal health care reform.
6. New Mexico should establish an independent Consumer Health Assistance Program (CHAP) for consumer education and assistance that utilizes community-based agencies, community health workers, health care and social service providers, and advocates.
7. Transparency is essential to an effective consumer protection system and therefore the public should have access to key data from state agencies overseeing different health programs, and state agencies should provide this information in accessible, consumer-friendly formats.

THE LEGISLATURE AND EXECUTIVE BRANCH SHOULD ADDRESS CONSUMER EDUCATION AND PROTECTION ISSUES EARLY IN THE IMPLEMENTATION PROCESS

The Patient Protection and Affordable Care Act and the related Healthcare and Education Affordability Reconciliation Act (“PPACA”) will reform the health care system, public health programs, and the private health insurance market throughout New Mexico. Some provisions have the potential for improving public health outcomes in communities that are pro-active and are able to develop collaborative partnerships to take advantage of some of the competitive grant and funding programs authorized by the Act.

Consumer education and protection are critical to ensure that New Mexicans obtain the maximum benefits and protections created by PPACA. Consumer education and protection are not addressed solely in a single section or set of provisions within the Act; rather they permeate almost every aspect of the new law, including those addressing Medicaid expansion, Medicare provisions, the new insurance exchanges, the new protections applicable to employer-sponsored health insurance, and the significant funding opportunities for workforce development, community health centers and specific projects that could be available to communities throughout New Mexico.

New Mexico needs a coordinated plan to address consumer education and protection to:

- ensure that the new benefits and protections created by PPACA are implemented efficiently and in a timely manner;
- create a system of accountability for government agencies and private insurance companies that are primarily responsible for implementation and operation of the new systems created by the Act;
- minimize the significant confusion among consumers, health care providers, insurers and employers as different provisions of the law go into effect, beginning in 2010;
- create opportunities for New Mexicans to obtain the maximum protections available under the Act;
- protect New Mexicans from fraudulent practices and scam artists who are already preying on the elderly and other vulnerable consumers under the guise of health care reform;
- ensure that members of tribal communities – both on and off tribal land – receive accurate information about unique choices and opportunities available under the Act;

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- ensure that New Mexicans with limited English proficiency are included in the Act's implementation and obtain comprehensive information and assistance to navigate the new system;
- ensure that technological requirements in the Act and technology and information systems created to implement the Act do not create barriers to New Mexicans who lack access to the internet; and
- ensure that implementation in New Mexico includes alternative (non-internet based) mechanisms for consumers/patients to obtain essential information, sign up for Medicaid and/or obtain subsidies for purchase of private insurance.

CONSUMER EDUCATION AND CONSUMER PROTECTION: RELATED BUT DISTINCT ISSUES AND CHALLENGES

To best serve the needs and interests of consumers/patients in New Mexico, consumer education and consumer protection strategies are necessary. But they are not the same thing. Consumer health assistance bridges both consumer education and consumer protection.

Numerous organizations, public, private and nonprofit, will engage in **consumer education** efforts around PPACA, most likely focusing on specific issues that affect those organizations or about which that organization has expert knowledge and information. There will also be misinformation, confusion, and potentially even fraud. Developing mechanisms for wide dissemination of accurate materials, targeting populations with particular needs or interests impacted by the new law, and sharing summaries and fact sheets prepared by national and local agencies are all among the strategies that should be explored.

Consumer protection refers to the specific systems established to enable consumers who are denied coverage, insurance, reimbursement or who are improperly charged for services to challenge such decisions and have some mechanism for redress of their grievances. There are two elements to an effective consumer protection system: (i) the system for considering and resolving consumer grievances and complaints; and (ii) an effective consumer assistance program independent of the agency that will resolve the complaints. A viable consumer protection system needs to address both the system for considering consumer complaints/appeals/inquiries as well as a system of information, education and representation that will inform consumers of their rights to bring a complaint or appeal and to know when they may have been denied access to services or coverage to which they are entitled. An effective **consumer protection** system requires sufficient **consumer education** regarding consumers' rights and responsibilities under the PPACA.

A **Consumer Health Assistance Program (CHAP)** addresses both areas by helping consumers navigate and access health coverage as well as pursue complaints when benefits are denied. Federal funding will be made available to support **consumer navigator** systems. This is a critical element of consumer health assistance. CHAPs can help families and communities perplexed by or unaware of the benefits provided to them under health care reform. They can also provide assistance and support if a consumer is denied coverage or benefits and wants to challenge such a decision. CHAPs can:

- help consumers enroll in Medicaid or with an appropriate insurance plan;
- educate health care consumers about how to use their health insurance to get the care they need;
- inform consumers of their rights;
- provide tools to help consumers resolve problems with their health plans; and

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- provide valuable feedback to policy makers.

One particularly important aspect of CHAPs is that they are grassroots, and their strength lies in the relationships they build with a given community. Meaningful consumer health assistance in New Mexico should be coordinated but not centralized and run from the top down. One size will not fit all. People who might not otherwise seek assistance for health issues from the Division of Insurance or the Human Services Department will seek help from a community agency.

One of the core recommendations of this work group is that New Mexico develop a ***Consumer Health Assistance Program*** that takes advantage of new federal funding opportunities and builds on a network of existing community programs throughout the State so that New Mexicans will be able to access meaningful assistance and support in the communities where they live.

Thus the strategies regarding consumer education and consumer protection are related but distinct. Attorneys and those trained to handle consumer complaints, both within state agencies (such as the Attorney General's Office) and in legal services agencies (such as New Mexico Legal Aid) are particularly equipped to handle consumer protection complaints. But a much wider array of individuals and organizations can provide invaluable help in: educating consumers about PPACA generally and specific benefits that apply to them; assisting consumers in navigating their choices and helping them sign up for coverage; and informing consumers about their rights and the consumer protection procedures available in the State.

RECOMMENDATIONS

1. **The New Mexico Office of Health Care Reform should establish a *State Consumer Coordinating Committee* consisting of consumer advocates, and staff members from key agencies who will be responsible for coordinating statewide consumer education and protection efforts. (See pages 42-44 of NM Strategic Plan)**
 - a. Without significant additional resources, no single state agency can develop the knowledge and expertise to effectively oversee and ensure consumer education to the myriad populations, communities and health systems impacted by HCR. Some new programs and benefits have already been implemented under HCR; many others will go into effect for new health plans created after September 23, 2010. A collaborative system utilizing the expertise of diverse agencies, consumer advocates and professionals can devise the best methods for informing New Mexicans of the new benefits and programs of HCR. Informal, ad hoc communication and networking – and the use of the internet – can help promote education and outreach with the use of limited resources in the short-term as longer-term plans are being developed. We recommend that the following agencies, at a minimum, be included in a Consumer Coordinating Committee: the Division of Insurance of the Public Regulation Commission (DOI), the Consumer Protection Division of the Office of the NM Attorney General (NMAG), the Human Services Department (HSD), the Department of Health (DOH), the Children Youth and Families Department (CYFD), the Department of Indian Affairs, and the Aging and Long-Term Services Department (ALTSD).
 - b. The NM Office of Health Care Reform should develop a listserv of interested individuals and agencies who are consumer advocates in NM and communicate with them about planning and specific educational efforts related to consumer education and protection.
 - c. Consumer representatives on the Coordinating Committee should include racially and ethnically diverse communities and advocates including but not limited to anti-poverty, legal services, aging, women's, immigrant, tribal, disability rights, and other organizations with

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experience working in communities of uninsured New Mexicans. The Southwest Women's Law Center and the Senior Citizens Law Office have prepared sample materials with information particularly relevant to the communities they serve. These sample materials are attached to this report as examples of the kinds of resources that can be developed by non-governmental entities and widely disseminated by the State.

- d. The Coordinating Committee should hold regular public meetings and convene ad hoc working groups on specific issues as implementation deadlines approach to maximize consumer education and protections under HCR.

2. The State should incorporate consumer education and consumer protection planning into each element of health care reform implementation.

- a. While the overall plan and specific elements of consumer education and protection need to be developed in a coherent and coordinated way, the State should not address consumer education and protection issues in isolation; rather it should integrate them into other major planning and implementation efforts.
- b. Planning and implementation grants from the federal government should include input and in-person meetings with consumer advocates. This may take a form similar to that of the Division of Insurance's Rate Review Grant.
- c. Consumer education and protection are core elements of the Insurance Exchanges authorized by PPACA, and New Mexico's planning and implementation of a State Insurance Exchange should incorporate strong consumer protection and consumer assistance provisions.
- d. The Legal Work Group of the Executive Leadership Team should seek out and incorporate input from consumer advocates regarding recommended changes in law that can strengthen consumer protections as HCR is implemented in New Mexico.

3. Consumer education planning should include the following key elements to ensure the estimated 300,000 New Mexicans who are currently uninsured will receive the maximum benefits available to them under health care reform:

- a. Identifying the numerous stakeholders who can provide information to consumers/patients, such as:
 - o Health care providers (e.g., hospitals, public health clinics, community health centers, family planning clinics, nursing homes, home health providers, pharmacies, private medical practices, oral health providers, vision providers, associations of health care providers, school-based health clinics, birthing centers, mental health centers);
 - o Health Insurance companies, brokers;
 - o Employers, chambers of commerce, and other business associations, including those that can address the needs of small business owners;
 - o Government agencies (state, federal, local), particularly agencies already working with low-income populations (e.g., ISD offices);
 - o Nonprofits that provide services and support at the community level (e.g., legal services providers, counseling, youth programs, services for domestic violence and

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- sexual assault survivors);
 - Other consumer and community-based advocacy and service organizations;
 - Housing agencies; and
 - Schools.
- b. Developing a timeline for key implementation dates and integrating community education campaigns to target those stakeholders most likely to reach the populations that will be affected at each stage of implementation – priority should be given to immediate changes going into effect in 2010 and 2011 and the most vulnerable populations who will be impacted by those changes;
 - c. Identifying the state agencies that have responsibility for different aspects of the new law and identifying the consumer/patient information relating to each and the constituencies that need to be informed about the new law, particularly with respect to Medicaid, Medicare, the new insurance exchange, and insurance regulation;
 - d. Developing State-wide strategies to implement the web-based health insurance information system required under the Act and to develop meaningful alternative means of communication to New Mexicans who do not have ready access to the internet and/or who have limited English proficiency;
 - e. Developing specific strategies and efforts to reach out to primary care providers and community health centers that currently serve indigent populations who will benefit from HCR and who will continue to need critical safety net services offered by community health clinics; and
 - f. Developing creative and diverse marketing strategies that will reach as many uninsured New Mexicans as possible and ensuring that all consumer materials include information regarding consumers’ rights along with the hotline number, street address and email address for consumers to use in seeking information and bringing complaints regarding benefits and coverage.
- 4. State entities that address consumer protection in the health care and health insurance context should plan and coordinate their consumer protection, appeal and ombudsman programs.**
- a. Whether through the Legal Work Group or a separate ad hoc group of agency experts that address consumer protection, complaints, appeals, due process and overall ombudsman programs, the State should develop recommendations on how best to coordinate such programs.
 - b. In addition to the executive branch agencies, the Division of Insurance and the Office of Attorney General should participate in this planning.
 - c. Legal services providers and other consumer advocates should be included in this planning process.
 - d. This coordination should be built into DOI’s consumer protection/ombudsman planning grant and program.

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5. **The Legislature should provide funding for consumer education and protection programs to ensure accountability and effective implementation of PPACA.**
 - a. Funding is needed to coordinate meaningful consumer education and dissemination of information to New Mexico's geographically diverse populations.
 - b. In the short run, using public websites to provide links to summaries, fact sheets and other materials available about health care reform is extremely valuable. But resources will be needed to create brochures and other written materials in different languages and for those who do not have easy access to the internet.
 - c. A commitment should be made to ensure that consumer assistance resources are not simply allocated to existing programs and used to move money around among existing programs. New Mexico needs a vibrant and meaningful consumer health assistance system to ensure New Mexicans in every part of the state realize the benefits provided under PPACA.
6. **New Mexico should establish an independent Consumer Health Assistance Program (CHAP) for consumer education and assistance that utilizes community-based agencies, community health workers, health care and social service providers, and advocates.**

As a preliminary matter, the following steps will assist in developing an effective consumer health assistance system in New Mexico:

- a. Evaluate current community resources to assist patients in signing up for and obtaining particular benefits under government-funded health programs and pursuing complaints and appeals if requests are denied.
- b. Analyze Consumer Health Assistance Programs operated in other states that provide consumer protection resources independent from the agencies that provide health care coverage and benefits.
- c. Prepare a summary of the existing consumer appeal, consumer protection, consumer ombudsman systems and procedures currently existing within various government agencies related to health programs, insurance, and other benefits, including HSD, DOH, ALTSD, CYFD, the Attorney General's Office, and the Division of Insurance.
- d. Analyze the different legal/procedural requirements needed for different agencies and benefits (e.g., entitlement programs which trigger due process protections versus other systems currently in effect) – recognize that some differences in procedures may be required by law.
- e. Evaluate the effectiveness of current systems in New Mexico to address insurance fraud and other scams that could harm New Mexicans during and after implementation.
- f. Review the timeline for implementation developed by the Executive Leadership Team to identify priority populations and communities for piloting effective consumer health assistance efforts.

Following a review of existing systems, the Consumer Coordinating Committee—in coordination with the DOI's consumer protection and rate review planning efforts and HSD's planning efforts around creation of a state insurance exchange—should:

- Make specific recommendations on how to **coordinate existing consumer protection, complaint and appeals systems within government agencies** consistent with current law while ensuring that such systems have an independent decision-maker to consider consumer complaints; and

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- Make specific recommendations on the creation and support of an ***independent non-governmental consumer health assistance program or system***, which will be a resource for local communities, legal service providers, advocates, and consumer “navigators” throughout New Mexico.

An effective consumer assistance program should:

- Provide consumer assistance for private employer-based insurance, subsidized insurance, individual plans, and public benefits programs including Medicaid and Medicare, including a guide to finding and obtaining health insurance coverage;
- Establish minimum standards for such assistance programs, including cultural and linguistic competency, experience working with vulnerable populations and capacity and training to respond to consumer concerns; and
- Provide sufficient resources to assist consumers throughout the state, including in every county and tribal community.

7. Transparency is essential to an effective consumer protection system and therefore the public should have access to key data from state agencies overseeing different health programs, and state agencies should provide this information in accessible consumer-friendly formats.

- a. Transparency is essential to help consumers make informed decisions about their own health care coverage and to enable the public to evaluate and make recommendations regarding public policies impacting availability of health care services and coverage.
- b. Many different types of data should be made public in ways that protect patient confidentiality but provide the public with information regarding insurance companies and public entities that provide health coverage, including:
 - quality assurance data;
 - benefits and pricing information;
 - multi-year data on premium increases;
 - financial statements about medical loss ratios;
 - rate review information;
 - data regarding complaints filed and how they were resolved; and
 - actuarial summaries.

PPACA requires states agencies to gather and submit much of this data to the federal government. State agencies should make all such information readily available to the public. Meaningful consumer protection cannot occur without transparency in the establishment and administration of insurance pricing.