STATE OF NEW MEXICO
OFFICE OF SUPERINTENDENT OF INSURANCE

SUPERINTENDENT OF INSURANCE
Russell Toal

DEPUTY SUPERINTENDENT
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BULLETIN 2021-023

November 5, 2021

TO: EVERY CURRENT AND PROSPECTIVE NEW MEXICO FULLY INSURED LARGE GROUP ISSUER

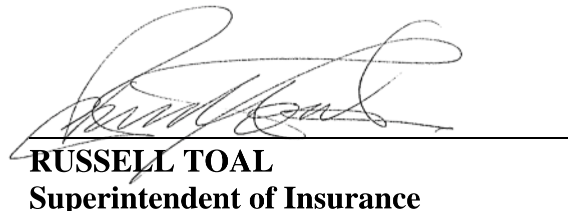
RE: ENDORSEMENTS REQUIRED FOR COVERAGE STARTING ON OR AFTER JANUARY 1, 2022

The Office of Superintendent of Insurance ("OSI") is committed to consumer protection which includes assuring that issuers supply accurate and understandable information that explains health insurance rights and benefits. In recent weeks, OSI has reviewed numerous large group plan submissions and found that the Evidence of Coverage (EOC) documents generally lack clear and accurate language pertaining to recently implemented statutes and regulations concerning surprise billing, prior authorization and no cost-sharing for behavioral health services and prescription drugs.

To ensure large group plan enrollees are fully and accurately informed about such rights and benefits, the OSI is issuing three (3) endorsements, which are attached to this bulletin. All issuers of fully-insured large group plans must include all 3 endorsements with the EOCs for plans that go into effect on or after January 1, 2022.

Questions concerning this Bulletin should be directed to viara.ianakieva@state.nm.us.

ISSUED this 5th day of November, 2021.



RUSSELL TOAL
Superintendent of Insurance

LARGE GROUPS ENDORSEMENT [NUMBER/IDENTIFIER]

THIS ENDORSEMENT CHANGES YOUR AGREEMENT WITH US

PLEASE READ CAREFULLY.

Effective January 1, 2022, this endorsement amends your insurance contract (including but not limited to the policy, certificate, SBCs and riders) to make the following changes:

NO COST SHARING FOR BEHAVIORAL HEALTH SERVICES

Cost sharing is eliminated for all professional and ancillary services for the treatment, rehabilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders. This includes cost sharing for inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable.

Cost sharing means any copayment, coinsurance, deductible or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations.

The terms of this endorsement replace and supersede any conflicting provision of your insurance contract and summary of benefits and coverage. All other requirements of the policy not in conflict with this endorsement still apply.

LARGE GROUPS ENDORSEMENT [NUMBER/IDENTIFIER]

THIS ENDORSEMENT CHANGES YOUR AGREEMENT WITH US.

PLEASE READ CAREFULLY.

Effective January 1, 2022, this endorsement amends your insurance contract (including but not limited to the policy and certificate) to make the following changes:

PRIOR AUTHORIZATION REQUIREMENT

Certain types of care require prior authorization by us.

This means that you or your provider must ask us to approve the care before you receive it.

A complete and current list of the services and prescription drugs that are subject to a prior authorization requirement can be found at [insert web link or identify location in EOC and drug formulary].

We may decline payment for unauthorized care. If your provider is [in network/contracted/participating], and you did not agree to receive unauthorized care, your provider cannot bill you for the care. If you received unauthorized care from a provider who is not [in network/contracted/participating] you may be fully responsible for the resulting bills.

We do not require prior authorization for:

- emergency services;
- contraception services that are not subject to any cost-sharing; or
- an obstetrical or gynecological ultrasound.

However, we require authorization for continued in-patient care if you are admitted to a hospital for emergency treatment, but your condition is stabilized. You or your provider must notify us within [insert notice time limit] from when you begin receiving emergency in-patient treatment, and within [insert notice time limit] after the emergency ends and your condition stabilizes.

PRIOR AUTHORIZATION PROCESS

Your [contracted/ in-network/ preferred] provider is responsible for knowing what care requires prior authorization, and for submitting a prior authorization request to us.

We will give any provider access to all necessary forms and instructions for making the request.

A [non-contracted/out-of-network/non-preferred] provider is not required to submit a prior authorization request for you. If you visit one of these providers, and that provider will not submit

a prior authorization request, you may submit a prior authorization request on your own behalf, or on behalf of a dependent. We will help you obtain required documents and show you the guidelines that apply to the request. However, because your provider should be able to gather required information and submit it sooner, we encourage you to have your provider request prior authorization whenever possible.

PRIOR AUTHORIZATION REVIEW TIMELINES

If we do not deny a complete prior authorization request within these time frames the request is automatically approved:

- Urgent Care or Prescription Drugs – If you require urgent medical care, behavioral health care or a prescription drug, we will resolve the request within 24 hours.
- Non-Urgent Medicine – if you do not have an urgent need for a prescription drug, we will resolve the request within three business days if your provider:
  - o Uses the prior authorization request form approved by the New Mexico Office of Superintendent of Insurance; o Requests an exception from an established step therapy process; or
  - o Requests to prescribe a drug that we do not usually cover.
- Other Requests – We will resolve all other requests within seven (7) business days.

Meeting these time frames depends on our receipt of sufficient information to evaluate the request. Our utilization management staff can answer questions your provider might have concerning required information or any aspect of the request submission process. If we require additional information to evaluate a request, we will request it from your provider. Your provider will have at least 4 hours to provide requested information in connection with an urgent prior authorization request, and at least two calendar days for any other type of request.

WHY WE REVIEW

Our review of a prior authorization request will determine if the proposed care involves a covered service, is medically necessary and whether an alternative type of care should be pursued instead of, or before, the requested care. Our decisions concerning medical necessity and care alternatives will be guided by current clinical care standards and will be made by an appropriate medical professional. Prior authorization does not guarantee payment. We are not required to pay for an authorized service if your coverage ends before you receive the service.

ENDORSEMENT [NUMBER/IDENTIFIER]

THIS ENDORSEMENT CHANGES YOUR AGREEMENT WITH US.

PLEASE READ CAREFULLY.

Effective January 1, 2022, this endorsement amends your insurance contract (including but not limited to the policy and certificate) to make the following changes: OUT-OF-NETWORK CARE AND BILLS

If you receive care under any of the circumstances below from a provider who is not in your network, these are your rights:

If you receive emergency care out-of-network, including air ambulance service:

- You are only responsible for paying what you would owe for the same care from an in-network provider or facility.
- You do NOT need to get prior authorization for emergency services.
- Your care can continue until your condition has stabilized. If you require additional care after stabilization, call us at [INSERT PHONE NUMBER] and we will help you receive that care from an in-network provider.
- You cannot be balance billed.

If you receive care from an out-of-network provider at an in-network facility, such as a hospital that is in your plan, you are only responsible for paying what you would owe for the same care from an in-network provider if:

- you did not consent to services from an out-of-network provider,
- were not offered the service from an in-network provider, or
- the service was not available from an in-network provider – as determined by your health care provider and your health insurance company.

If you get a bill from an out-of-network provider under any of the above circumstances that you do not believe is owed:

- Call us first at [INSERT PHONE NUMBER]. We will try to the resolve the issue with the provider on your behalf.
- Contact the New Mexico Office of Superintendent of Insurance if the problem has not been resolved by us – www.osi.state.nm.us or 1-855-4ASK-OSI (1-855-427-5674).

To help stop improper out-of-network bills, we will:

• Notify you if your provider leaves our network and allow you transitional care with that provider at the in-network benefit level for up to 90 days depending on your condition and course of treatment.

• Verify the accuracy of our provider directory information at least every 90 days.

• Confirm whether a provider is in-network if you contact us at [INSERT PHONE NUMBER]. If our representative provides inaccurate information that you rely on in choosing a provider, you will only be responsible for paying your in-network cost sharing amount for care received from that provider.

You have the right to receive notice of the following before you receive out-of-network care at an in-network facility:

• A good faith estimate of the charges for out-of-network care.

• At least five days to change your mind before you receive a scheduled out-of-network service. If you choose to receive out of network care you will be responsible for out-of-network charges that we do not cover.

• A list of [in-network/contracted/participating] providers and the option to be referred to any such provider who can provide necessary care.

If you pay an out-of-network provider more than we determine you owe:

• The provider will owe you a refund within 45 days of receipt of payment by us.

• If you do not receive a refund within that 45-day period, the provider will owe you the refund plus interest.

• You may contact the New Mexico Office of Superintendent of Insurance at www.osi.state.nm.us and 1-855-4ASK-OSI (1-855-427-5674) for assistance or to appeal the provider's failure to provide a refund. You need to file the appeal within 180 days of the 45- day refund period expiration.

The terms of this endorsement replace and supersede any conflicting provision of your insurance contract and Summary of Benefits and Coverage. All other requirements of the policy not in conflict with this endorsement still apply.

AFTER CARE REVIEW

If you received care without a required prior authorization, we may allow your provider to request authorization retrospectively. Our utilization management team will assist your provider in the submission of a retrospective authorization request. However, we do not routinely authorize care retrospectively. To avoid uncertainty, it is always best to request prior authorization.

BEHAVIORAL HEALTH CARE

Requests for behavioral health care and prescriptions are subject to the same prior and retroactive authorization processes and timelines as requests for medical care and prescriptions.

AUTHORIZATION DENIAL

We will inform you in writing if we deny a prior or retroactive authorization request. Our notice to you will explain why we denied the request and will provide you with instructions for disputing our decision if you disagree. A summary of the dispute resolution process begins on page [XX] of this document. You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

The terms of this endorsement replace and supersede any conflicting provision of your insurance contract and Summary of Benefits and Coverage. All other requirements of the policy not in conflict with this endorsement still apply.