F I S C A L I M P A C T R E P O R T

SPONSOR Thomson/ Armstrong, D/Pratt/ Trujillo CH/Cadena **ORIGINAL DATE** 2/12/19 **LAST UPDATED** 3/13/19 **HB** 436/aHHHC/aHSEIC/ aHFl#1/aSCORC

SHORT TITLE Align Health Insurance Law with Federal Law **SB**

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		NFI	NFI	NFI		

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Department of Health (DOH)
Human Services Department (HSD)
Albuquerque Public Schools (APS)
Public School Insurance Authority (PSIA)
Office of the Superintendent of Insurance (OSI)

SUMMARY

Synopsis of SCORC Amendment

The Senate Corporations and Transportation Committee amendment makes to House Bill 436, as thrice amended makes several changes:

1) It makes clear that Section 3 applies to "small group plans and multiple employer welfare arrangements,"
2) It adds a new paragraph to Section 3 which states that this act does not keep insurance carriers from using reasonable techniques to control health insurance costs, and
3) It exempts group retiree health plans, along with group health plans, under certain circumstances, from the need to comply with portions of Section 59A-23E NMSA 1978.

Synopsis of HFl #1 Amendment

The House Floor Amendment #1 makes several changes:

1) It inserts a hyphen into the term "coverage-only [accident or disability income insurance]"
2) Replaces the word "under [19 years of age]" to make clear that children under that age could have lower insurance rates,

3) Clarifies the language in Section 16-A of the bill to be certain that "restrictions, limitations or requirements" on mental health coverage are no greater than on other health conditions.

Synopsis of HSEIC Amendment

The House State Government, Elections and Indian Affairs Committee amendment to House Bill 436 adds another section to the bill and to the New Mexico Insurance Code, Section 59A NMSA 1978. It adds to the bill's protection of patients from pre-existing condition exclusions from coverage.

The new section 21, which is referred to in new language added to the long title of the bill, regards pre-existing conditions, prohibiting the exclusion in "excepted benefits policies or plans" from coverage of conditions for which medical care was provided more than six months before the date of coverage of a condition. "Excepted benefits plans and policies" are defined in Section 21 as the following:

1) Coverage-only accident or disability insurance
2) Supplemental liability insurance coverage
3) Liability insurance
4) Workers comp or similar insurance
5) Automobile medical payment insurance
6) Credit-only insurance
7) Coverage for on-site medical clinics
8) Similar insurance, as specified by the Office of the Superintendent of Insurance
9) Separate insurance plans that cover vision-only, dental-only, long-term care or the like-only policies
10) Disease-specific policies, hospital indemnity of other fixed indemnity insurance
11) Separate Medicare supplement health insurance or insurance for members of the military (Title 10, Section 55 USCA)

Synopsis of HHHC Amendment

The House Health and Human Services Committee amendment to House Bill 436 makes two changes in the bill,

1) Eliminating the words "Group Health Plan – Group Health Insurance" from a section of the Insurance Code entitled "Group and Blanket Health Insurance Contracts "and thus redundant, and
2) Inserting (in line 20, page 32) the word "not" where its inadvertent omission resulted in a provision the opposite of that intended, regarding imposition of pre-existing condition exclusions, which shall not be imposed.

Synopsis of Original Bill

House Bill 436 makes multiple changes to existing statute, all parts of Section 59A NMSA 1978, the Insurance Code, to bring New Mexico law into alignment with federal law, specifically the Patient Protection and Affordable Care Act (ACA). Provisions to be incorporated into state law include a package of essential health benefits, prohibition of exclusion of pre-existing conditions from coverage, prohibition of gender-based premium rates, and requirement of mental health coverage on an equal basis with physical health coverage. If HB 436 is passed, many protections incorporated into the ACA would be continued at the state level even if portions or the entirety of the ACA were repealed or struck down.

See "Significant Issues" below for a section by section breakdown of the bill's provisions.

FISCAL IMPLICATIONS

There is no appropriation in the bill.

OSI indicates that the bill only codifies what is being done now, and thus there would be no change in regulations or enforcement of those regulations.

SIGNIFICANT ISSUES

A summary of House Bill 436's provisions, organized by section, follows:

Section of HB 436	Section in Statute (NMSA 1978)	Provisions and Changes
1	59A-18-13.1	Removes outdated information regarding gender-based rate differences. Allows for difference in rates for children (if they are lower than would be the case for an older person), and difference by family composition only as it affects single coverage versus coverage of any number of family members.
2	59A-18-16	Removes an exception to convertibility or conversion of a policy.
3	59A 18-16.2	Policies must provide OSI-defined essential health benefits (EHB). Criteria for OSI to use include taking into account special groups such as women, children, persons with disabilities and not discriminate against coverage on the basis of age or expected life span. No annual or lifetime limits on essential health benefits can be applied. OSI must specify maximum cost-sharing for EHB. Rules would be required beginning July 1, 2019 and be revised annually. Insurers could not require cost-sharing on the following: • US Preventive Task Force items graded A or B • Immunizations recommended by Centers for Disease Control • Preventive care for children supported by the federal HRSA • Additional HRSA recommendations for women. Plans on the New Mexico health exchange must be offered to those up to age 21. Organ-specific, disease-specific or other limited plans would be excepted from these requirements.
4	59A-22-5	Removes language that permits and regulates the exclusion of pre-existing conditions from health care coverage.
5	59A23C-5.1	Insurance premiums could not be based on gender; the only factors that can be considered are age, place of employment, and smoking. Differences in rates must fall within a defined band. OSI would promulgate rules to effect these changes.
6	59A-23-7	With respect to small employers, disclosure must be made of

		insurers' rights to change premiums. Provision relative to premium setting by family status or class of business of a small employer have been removed.
7	59A-23E-2	Definitions basically unchanged, including that all group health plans would be under the authority of OSI
8	59A-23E-3	Regarding group health insurance, blanket health insurance, individual health insurance cannot impose a waiting period greater than 90 days.
9	59A-23E-8	Insurers must allow an eligible enrollee to enroll if their Medicaid benefit is stopped or becomes eligible for Medicaid.
10	59A-23E-11	Factors such as health status, medical experience, claims experience, health care use, genetic information, gender, national origin, sexual orientation may not be taken into account by an insurer in establishing eligibility for coverage.
11	59A-23E-12	Group health plan and health insurance issuers may not require an increased premium for employers or individuals based on the covered employee group's/person's health status or genetic information, but may provide incentives for those adopting healthy behaviors.
12	59A-23E-13	Regards individual and small group market coverage. Issuers must cover every individual or employer who applies during open or special enrollment periods regulated by OSI. Exception would be if a health plan declared that it did not have capacity or financial reserves necessary to take more enrollees. In the case of discontinuing taking more enrollees for these reasons, the insurer must not enroll additional members for at least 180 days.
13	59A-23E-14	Health care coverage must continue on all individual or group plans unless 1) the plan sponsor or individual has not paid premiums, 2) the plan sponsor or individual has committed fraud or misrepresented facts regarding the coverage, 3) the insurer has left the market, or 4) the enrollee and others in a group no longer lived in the insurer's service area. Any changes to coverage provisions under a given plan must be uniform across all individuals or groups, whichever is applicable.
14	59A-23E-15	Language removed regarding pre-existing condition exclusion.
15	59A-23E-16	Removes language exempting insurers from complying with requirements in the case of single-employee small employers.
16	59A-23E-18	Maintains parity for mental health care of all types, now to include individual health plans, removing language that limits the annual premium increase based on providing mental health coverage parity.
17	59A-46-2	Definitions: removes language excluding mental health care from "basic health services."
18	59A-46-32	Further limits pre-existing condition consideration when an insurance contract is continued or converted due to death or

		divorce.
19	59A-47-34	Removes language that limits conversion or continuation of a policy based on preexisting conditions.
20	New	Authorizes OSI to submit any necessary waivers under section 1332 of the ACA.
21	Multiple	Repeals multiple sections in statute: 59A-22-37. "Franchise" insurance. 59A-23B Minimum Healthcare Protection 59A-23C Small Group Rate and Renewability subsections entitled "Restrictions relating to premium rates" and "Preexisting conditions; limitations." 59A-23E-4 to 7: Regarding pre-existing health conditions and other restrictions.

OSI points out that the provisions in Section 9 allows employees moving up the economic ladder to enroll in a health plan offered by their employer at any time during the year.

HSD is in accord with certain provisions of the bill that pertain to Medicaid coverage:

> HSD agrees with the amended language of HB436 Section 9, Paragraph B (1) that would permit an eligible enrollee to enroll for coverage when Medicaid is terminated. This allows for the portability of health insurance coverage and eliminates gaps in health care. HSD believes that this comports with federal law regarding the termination of minimum essential coverage (MEC) as a condition for open enrollment into a group health plan
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> HSD also agrees with the amended language of HB436 Section 9, Paragraph B (2) that would allow an eligible enrollee to enroll for coverage under the terms of the plan when the eligible enrollee becomes eligible for medical assistance, "under such Medicaid plan" if the employee requests coverage under the group health plan or health insurance plan not later than sixty days after the date the employee or dependent is determined to be eligible for such assistance. This allows individuals to have employee sponsored health insurance in addition to Medicaid. In these instances, Medicaid is the payer of last resort. The only instance under which HSD does not allow employee sponsored health insurance to coexist with Medicaid is for a child covered through the Children's Health Insurance Program (CHIP). CHIP children, as a condition of eligibility, are not allowed to have other health insurance.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

In the words of OSI, "If the central tenets of the ACA are struck down in the pending federal case, Texas v. Azar, law regulating health insurance will revert to what is currently in state statute. State statute currently permits the denial of coverage for individuals with pre-existing conditions, health insurers to charge more for insurance premiums based on health status, and the denial of mental health coverage under individual insurance plans, among other major impacts on consumer rights. Enacting this legislation would prevent these issues should federal courts strike down the ACA."

LAC/gb/sb/gb