SENATE BILL

50TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2011

INTRODUCED BY

DISCUSSION DRAFT

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH INSURANCE; AMENDING AND ENACTING SECTIONS OF THE NEW MEXICO INSURANCE CODE TO PROVIDE GREATER TRANSPARENCY AND NEW STANDARDS IN REVIEW OF APPLICATIONS FOR HEALTH INSURANCE PREMIUM RATE INCREASES; PROVIDING FOR HEARINGS RELATED TO HEALTH INSURANCE PREMIUM RATE INCREASES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Public Regulation Commission Act is enacted to read:

"[NEW MATERIAL] HEALTH INSURANCE PREMIUM RATE REVIEW--HEARING EXAMINERS.--

A. The commission may appoint a hearing examiner to preside over matters pursuant to Chapter 59A, Article 18 NMSA 1978 before the commission, including rulemakings, adjudicatory hearings and administrative matters.

B. A hearing examiner shall provide the commission with a recommended decision on the matter assigned to the hearing examiner, including findings of fact and conclusions of law. The recommended decision shall be provided to the parties, and they may file exceptions to the decision prior to the final decision of the commission."

SECTION 2. A new section of Chapter 59A, Article 18 NMSA 1978 is enacted to read:

"[NEW MATERIAL] "BLOCK OF BUSINESS" DEFINED.--As used in this article, "block of business" means a particular policy or pool that provides health insurance, that an insurer issues to one or more individuals and that includes distinct benefits, services and terms."

SECTION 3. A new section of Chapter 59A, Article 18 NMSA 1978 is enacted to read:

"[NEW MATERIAL] "MEDICAL COST INDEX" DEFINED.--As used in this article, "medical cost index" means the annual average costs of medical care as indicated in the United States consumer price index for the western region."

SECTION 4. Section 59A-18-13 NMSA 1978 (being Laws 1984, Chapter 127, Section 343, as amended) is amended to read:

"59A-18-13. APPROVAL OR DISAPPROVAL OF HEALTH INSURANCE FORMS.--

A. With policy, endorsement, rider and application forms and classification of risks filed by the insurer with the

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superintendent under Section 59A-18-12 NMSA 1978 as to health insurance, the insurer shall also file with the superintendent its premium rates applicable to such health insurance forms. An insurer shall not use any such form or premium that has not been approved by the superintendent or that is not in effect in accordance with Section 59A-18-14 NMSA 1978.

B. An increase in a health insurance premium shall not be effective without sixty days' written notice to the policyholder. That notice shall include a plain-language summary of the form or classification of risks that the insurer files pursuant to Section 59A-18-12 NMSA 1978.

C. All filings submitted pursuant to this section shall be filed electronically. The superintendent may designate an entity to receive the electronic filings submitted pursuant to this section.

D. Within ten days of the filing, the superintendent shall make available on the division's web site and easily accessible to the general public all forms, classifications of risks, filings made pursuant to Subsections E, F and G of this section and the plain-language summary that an insurer files pursuant to Section 59A-18-12 NMSA 1978 and this section.

E. For each block of business included in the proposed premium rate increase, filings shall be accompanied by:

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(1) a summary in plain language, understandable to non-experts, that explains the rationale for the proposed rate increase;

(2) the rating history for the five years preceding the date of filing, including any premium increases for those blocks of business;

(3) an estimated percentage of the premium that the applicant expects to deposit in reserves;

(4) cost-containment and quality improvement efforts that the applicant has undertaken within the five years preceding the date of filing;

(5) the expected medical loss ratio and the medical loss ratio for the five years preceding the date of filing, accompanied by supporting information as to how the blocks of business will meet the requirements for medical loss ratio in state and federal law. Supporting information shall include, at a minimum, how the insurer applies the term "medical loss ratio" and the categories for administrative expenses such as marketing, advertising, salaries and commissions;

(6) actual provider compensation rates and the cost of medical care and utilization rates for medical care in the geographic area covered; and if medical costs, including utilization and compensation rates, are alleged to justify a premium rate increase, the filing shall identify the types of

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expenditures in these categories that support the premium rate increase;

(7) claims history and losses for the five years preceding the date of filing, accompanied by supporting documentation;

(8) in the aggregate, the ages, genders, tobacco use and geographic location of and claims history for individuals enrolled in the block of business potentially affected by a proposed rate increase; and

(9) whether the insurer has ceased to actively offer or sell to new applicants a block of business for which it seeks a rate increase.

F. For the five years preceding the date of filing for each block of business sold in the state, the filing shall be accompanied by the history of reserves or surplus, earnings on those reserves and the earnings reasonably expected from the surplus.

G. Regarding an insurer's overall operations for the five years preceding the date of filing, the insurer shall file:

(1) details regarding executive compensation;

(2) a list detailing which blocks of business are open and which are closed to new enrollment;

(3) an estimate of the insurer's profitability;

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(4) reserves and surpluses for product lines sold in the state, including earnings on the reserves during that period and a reasonable estimate of the expected earnings on any surplus; and

(5) innovations in health care quality and cost containment that the insurer has undertaken or promoted within the five years preceding the date of filing.

H. On the date that the superintendent posts a form, classification of risks or other filing pursuant to Subsection D of this section, the superintendent shall open a thirty-day public comment period for policy holders and the general public, during which the policy holders and the general public may make comments online or in writing. The superintendent shall post on the division's web site in a manner easily accessible to the public all comments made during the thirty-day public comment period."

SECTION 5. Section 59A-18-14 NMSA 1978 (being Laws 1984, Chapter 127, Section 344, as amended) is amended to read:

"59A-18-14. GROUNDS, PROCEDURE FOR DISAPPROVAL.--

A. The superintendent shall review any filing made pursuant to Section 59A-18-12 or 59A-18-13 NMSA 1978 within sixty days of the filing date. The superintendent shall approve any form or rate if [~~he~~] the superintendent finds that it complies with the Insurance Code and shall disapprove any form or rate only on [~~any~~] one or more of the following

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grounds:

(1) if the form is in any respect in violation of or does not comply with the Insurance Code;

(2) if the form contains, or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous or misleading clauses or exceptions and conditions [~~which~~] that deceptively affect the risk purported to be assumed in the general coverage of the contract, or [~~which encourages~~] that encourage misrepresentation of the policy or its benefits;

(3) if the [~~benefits offered are unreasonably restricted in relation to the premium charged~~] proposed rates are not actuarially sound;

(4) if the proposed rates are not reasonable or are excessive, inadequate or unfairly discriminatory;

(5) if the proposed rates are not based upon reasonable administrative expenses;

(6) if the proposed rates exceed by at least fifteen percentage points an increase in the medical cost index for the two calendar years preceding the date of filing;

[~~(4)~~] (7) if the form has [~~any~~] a title, heading or other indication of its provisions [~~which~~] that is misleading or if the form is printed in such type or manner of reproduction as to be difficult to read; or

[~~(5)~~] (8) if purchase of the form is being

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solicited by advertising, communication or dissemination of information [~~which~~] that is deceptive or misleading.

B. In order to determine whether the proposed rates are not reasonable, or are excessive, inadequate or unfairly discriminatory, the superintendent shall consider:

(1) the insurer's financial position, including but not limited to profitability, surplus, reserves, executive compensation and investment savings;

(2) historical and projected administrative costs, including market expenses, broker commissions and advertising and medical expenses;

(3) the historical and projected loss ratio between the amounts spent on direct services and earned premiums;

(4) any anticipated change in the number of enrollees if the proposed rate is approved;

(5) changes to covered benefits or health benefit plan design;

(6) innovations in health care quality and cost containment that the insurer has undertaken or promoted since the insurer's last rate filing for the same block of business;

(7) whether the proposed change in the rate is necessary to maintain the insurer's solvency or to maintain rate stability and prevent excessive rate increases in the

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future;

(8) any public comment received pursuant to Subsection H of Section 59A-18-13 NMSA 1978 that pertain to the standards set forth in this subsection;

(9) whether the insurer has ceased to actively offer or sell to new applicants a block of business for which it seeks a rate increase;

(10) premium affordability. The superintendent shall determine a proposed annual premium to be unaffordable if the premium would exceed eight percent of the per capita income in the state published in the most recent survey of current business that the United States department of commerce's bureau of economic analysis, or its successor agency, has published; and

(11) the insurer's statement of purpose or mission in its corporate charter or mission statement.

C. The insurer shall have the burden of proving by clear and convincing evidence that a rate increase is reasonable and is not excessive, inadequate or unfairly discriminatory.

D. The superintendent shall give notice approving or disapproving a rate filing or, with the written consent of the insurer, modifying a rate filing submitted pursuant to this section no later than thirty days after the close of the public comment period provided pursuant to Subsection H of Section

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59A-18-13 NMSA 1978. The notice shall address the considerations set forth in Subsection B of this section and be made in the following manner:

(1) in writing to the insurer; and

(2) on the web site of the insurance division in a manner easily accessible by policyholders and the general public.

[~~B.~~] E. If the superintendent disapproves any such form during the sixty-day review period [~~he~~] or after a hearing pursuant to Section 59A-4-15 NMSA 1978, the superintendent shall give the insurer written notice of the disapproval, stating the grounds [~~therefor~~] for the disapproval, specifically addressing the considerations set forth in Subsection B of this section.

[~~C.~~] F. After expiration of the sixty-day review period referred to in Subsection A of this section [~~59A-18-13 NMSA 1978~~] or at any time after having approved a form, the superintendent may, after a hearing thereon, disapprove a form or withdraw a previous approval on any of the grounds stated in Subsection A of this section. The superintendent's order issued on [~~such~~] the hearing shall state the grounds for disapproval or withdrawal of previous approval and the date, not less than twenty days after the date of the order, when disapproval or withdrawal of approval shall become effective.

G. In matters involving a minimum cumulative

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increase of seven percent over the current premium rates that existed during the five years preceding the date an insurer has filed a proposed rate increase, an aggrieved party or the attorney general may file a hearing request with the commission pursuant to the provisions of Section 6 of this 2011 act. The hearing request shall be filed within thirty days after the issuance of the superintendent's order approving, disapproving or modifying a rate filing pursuant to this section.

H. For the purposes of this section, "direct services" means services rendered to an individual by a health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of an assessment that covers services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act; provided, however, "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services."

SECTION 6. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] RATE REVIEW CASES--HEARING--EVIDENCE--HEARING OFFICER--BURDEN--FINDINGS.--

A. When appearing before the commission in appeals

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of the superintendent's decision in a rate review matter as provided in Subsection G of Section 59A-18-14 NMSA 1978, the attorney general shall represent the interests of covered individuals as a whole.

B. When the attorney general appears in a rate review case, the attorney general shall obtain an independent actuarial analysis of the proposed increase in premium rates. The actuarial analysis shall be performed by an actuary certified by the society of actuaries.

C. A hearing conducted pursuant to the provisions of this section shall be conducted by a hearing examiner that the commission appoints pursuant to Section 1 of this 2011 act and shall be a full evidentiary hearing.

D. The burden of proof to show that a premium increase is just, reasonable and actuarially sound shall be on the insurer, who shall prove this by clear and convincing evidence.

E. The commission shall give written notice of the hearing not less than thirty days in advance. The notice shall state the date, time and place of the hearing and specify the matters to be considered at the hearing.

F. On the division's web site in an easily accessible manner, in a newspaper of general circulation in this state and once in the New Mexico register, the commission shall give notice of the hearing by publishing the following

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information regarding the matter to be heard:

(1) the names of the person or persons requesting the hearing;

(2) the provisions of the Insurance Code at issue;

(3) the amount of the proposed rate increase; and

(4) the date, time and location of the hearing.

G. The commission shall mail the notice at least thirty days in advance of a hearing to all persons who had requested notice in writing.

H. If after a hearing the commission finds the proposed premium rates to be unjust, unreasonable, actuarially unsound or in any way in violation of law, the commission shall determine the just, reasonable and actuarially sound premium rates that the insurer may apply. The commission shall specify the rates by order to be served upon the insurer."