SENATE BILL

50TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2012

INTRODUCED BY

DISCUSSION DRAFT

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH COVERAGE; AMENDING THE PUBLIC ASSISTANCE ACT TO DIRECT THE HUMAN SERVICES DEPARTMENT TO ESTABLISH A BASIC HEALTH PROGRAM FOR CERTAIN INDIVIDUALS WHO ARE NOT ELIGIBLE FOR MEDICAID; PROVIDING FOR RULEMAKING; MAKING AN APPROPRIATION.

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

SECTION 1. Section 27-2-1 NMSA 1978 (being Laws 1973, Chapter 376, Section 1) is amended to read:

"27-2-1. SHORT TITLE.--Sections [~~1 through 20 of this act and Sections 13-1-9, 13-1-10, 13-1-12, 13-1-13, 13-1-17, 13-1-18, 13-1-18.1, 13-1-19, 13-1-20, 13-1-20.1, 13-1-21, 13-1-22, 13-1-27, 13-1-27.2, 13-1-27.3, 13-1-27.4, 13-1-28, 13-1-28.6, 13-1-29, 13-1-30, 13-1-34, 13-1-35, 13-1-37, 13-1-39, 13-1-40, 13-1-41 and 13-1-42 NMSA 1953~~] 27-2-1 through 27-2-34 NMSA 1978 and Section 2 of this 2012 act may be cited

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as the "Public Assistance Act"."

SECTION 2. A new section of the Public Assistance Act is enacted to read:

"[NEW MATERIAL] BASIC HEALTH PROGRAM--ESTABLISHMENT--PROGRAM REQUIREMENTS--ELIGIBILITY--NEGOTIATION WITH CARRIERS--RULEMAKING.--

A. By January 1, 2013 and consistent with federal law, the secretary shall establish a basic health program for eligible individuals that provides health coverage through standard health plans and that:

(1) provides benefits and services that are actuarially equivalent to ninety-eight percent or greater of the full actuarial value of the benefits provided under each participating standard health plan;

(2) has and maintains a medical loss ratio of at least eighty-five percent;

(3) provides a selection from which participants may choose, during enrollment periods, of at least three standard health plans offered by carriers;

(4) limits annual enrollee premiums to one hundred dollars ($100) per individual and cost-sharing of no more than two percent of expenses. The annual premiums shall not in any case exceed three thousand nine hundred sixty-seven dollars ($3,967) for families and one thousand nine hundred eighty-three dollars ($1,983) for individuals in fiscal year

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2013, adjusting in accordance with Section 223(c)(2)(A)(ii) of the federal Internal Revenue Code of 1986; and

(5) allows small employers to pay a portion or all of their employees' cost-sharing obligations under the basic health program on behalf of the small employers' employees.

B. The basic health program shall not require the following enrollees to pay premiums or be responsible for any cost-sharing in a standard health plan:

(1) enrollees who are Native American, Native Alaskan or Native Hawaiian and who are a member of a federally recognized nation, tribe or pueblo; and

(2) enrollees who have household incomes below one hundred thirty-three percent of the federal poverty level and who are not eligible to participate in the state's medicaid program.

C. In evaluating and negotiating with carriers regarding the health plans that carriers offer for participation in the basic health program as standard health plans, the secretary shall adopt a uniform procedure that includes a request for proposals that includes standards regarding:

(1) whether health benefits and services are substantially similar to those benefits provided to recipients under the state's medicaid program;

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(2) the quality of services to be provided under the standard health plan, which shall be at least as rigid as what is currently required of managed care health plans participating in the state medicaid program;

(3) the ability of the carrier to address the health care needs of, and provide quality health care services to, people with low incomes; and

(4) the minimum provider network development to ensure that the carrier's network for each service area within which it will participate has a sufficient number, mix of practice areas and geographic distribution to meet the target population's needs and to ensure adequate service availability.

D. A standard health plan shall include provisions for:

(1) coordinating and managing care for enrollees, especially enrollees living with chronic health conditions;

(2) providing incentives to enrollees for the use of preventive services;

(3) establishing relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for the appropriate utilization under the plan;

(4) providing quality of care and improved

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health outcomes; and

(5) reporting to the secretary on the provisions set forth in Paragraphs (1) through (4) of this subsection.

E. The secretary shall publish an annual report that sets forth:

(1) the average premiums and cost-sharing amounts for standard health plans;

(2) the disposition of any federal funds not expended during the previous federal fiscal year;

(3) enrollment statistics by county;

(4) an explanation of the procedures used to select standard health plans for participation in the basic health program; and

(5) the progress that participating standard health plans have made in implementing the provisions of Paragraphs (1) through (4) of Subsection D of this section.

F. The state shall establish a single application for participation in the state's medicaid program, children's health insurance program, basic health program and any health insurance exchange operating in the state.

G. In the event that a health insurance exchange is established in the state, any navigator or consumer outreach program established to serve consumers on the state health insurance exchange shall assist eligible individuals in

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enrolling in the state's basic health program.

H. The department shall coordinate the basic health program's benefits administration, enrollment and eligibility to maximize the continuity of coverage between the basic health program and the state's public coverage programs, including the state's medicaid program and children's health insurance program.

I. The secretary shall promulgate any necessary rules for the implementation and operation of the basic health program, including:

(1) rules to establish procedures and protocols for participant grievances and appeals;

(2) annual and special enrollment periods, including qualifications and procedures for annual and special enrollment periods; and

(3) rules to establish sources of non-state revenue for any shortfall in federal funding for the basic health program.

J. The secretary shall establish a trust fund for the deposit of federal funds for the establishment or operation of the basic health program. Amounts in the trust fund shall be used only to reduce the premiums or other cost-sharing or to provide additional benefits for enrollees. Amounts in, and expenditures from, the trust fund shall not be included in the state's determination of any nonfederal funds for purposes of

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meeting any matching or expenditure requirement of any federally funded program.

K. As used in this section:

(1) "carrier" means an insurer, a health maintenance organization, a nonprofit health care plan or other entity responsible for the payment of health benefits or provision of health care services;

(2) "eligible individual" means an individual:

(a) who is a resident of the state;

(b) who is not eligible to enroll in the state's medicaid program;

(c) whose household income exceeds one hundred thirty-three percent but does not exceed two hundred percent of the federal poverty level;

(d) who is not eligible for minimum essential coverage as defined in Section 5000A(f) of the federal Internal Revenue Code of 1986 or who is eligible for an employer-sponsored plan that is not affordable coverage as determined under Section 5000A(e)(2) of the federal Internal Revenue Code of 1986;

(e) who has not attained the age of sixty-five as of the beginning of the plan year; and

(f) who is not eligible to purchase health coverage on a state or federal health insurance or health benefits exchange;

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(3) "enrollee" means an eligible individual who has enrolled in a standard health plan under the basic health program;

(4) "medical loss ratio" means the amount of an assessment received under a health plan or policy that a health maintenance organization pays for services rendered to an enrollee by a health maintenance organization 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 a health maintenance organization does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act; provided, however, that "medical loss ratio" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services; and

(5) "standard health plan" means a health benefits plan offered by a health maintenance organization to eligible individuals pursuant to the state's basic health program as provided in this section."

SECTION 3. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] BASIC HEALTH PROGRAM--POOLING--RISK

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ADJUSTMENT.--

A. The risk in each standard health plan participating in the basic health program established pursuant to Section 2 of this 2012 act shall be pooled with all of the health plans in the individual and small group markets for purposes of risk adjustment.

B. Standard health plans shall be subject to assessment of risk adjustment fees and shall be eligible for provision of risk adjustment payments.

C. For purposes of this section, "risk adjustment" means the process by which the state assesses charges on qualified health plans that participate in a health insurance exchange operating in the state that incur lower-than-average risk and provides payments to qualified health plans that incur greater-than-average risk."

SECTION 4. APPROPRIATION.--One hundred thousand dollars ($100,000) is appropriated from the general fund to the human services department for expenditure in fiscal years 2013 and 2014 to hire employees for, establish and operate the basic health program pursuant to Section 2 of this 2012 act. Any unexpended or unencumbered balance remaining at the end of fiscal year 2014 shall revert to the general fund.

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