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

SPONSOR Komadina **ORIGINAL DATE** 2/19/07 **LAST UPDATED** **HB**

SHORT TITLE Health Insurance Exchange Act **SB** 976

ANALYST Earnest

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY07	FY08	FY09	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
PRC			$1,700	$1,700	Recurring	Insurance Operating Fund
HSD			$0.1	$0.1	Recurring	General Fund
DFA			$0.1	$0.1	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Public Regulation Commission (PRC)
Human Services Department (HSD)
Health Policy Council

SUMMARY

Synopsis of Bill

Senate Bill 976 would create a non-profit public corporation, separate from the state, to provide increased access, choice and portability of health insurance for New Mexicans. All eligible individuals would be permitted to obtain health insurance benefits through the exchange in accordance with provisions of this act, the New Mexico Insurance Code and other applicable state and federal law. The exchange would be governed by a board of directors, who would be considered a governmental entity for purposes of the Tort Claims Act, but neither the board nor the exchange would be considered a governmental entity for any other purpose.

This bill eliminates the existing Health Insurance Alliance (HIA); replaces some of its functions by ensuring guaranteed coverage based on certain requirements; and expands HIA functions to include consolidation of the individual and small group health insurance market through creation of an entity called the exchange which certifies and allows the purchase of health insurance benefit plans.

The bill includes a provision requiring individuals to carry health insurance or prove other means of financial responsibility and establishes a mechanism for the state to retain money due to the individual from the state for compliance.

HSD provided the following summary of the Exchange's organization and power provided by this bill:

> **Governance**: Board governed by 15 directors consisting of 5 elected by participating carriers and 9 appointed by the governor. The superintendent of insurance or designee is a non-voting member. A director of the exchange will be appointed by the board.
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> **Duties:** Publicize existence of the exchange and disseminate information on eligibility and enrollment. Establish and administer operation functions: enrollment procedures, election of coverage procedures including distribution of benefit information and billing and collection of premiums. Establish all financial accounting processes and procedures involved in billing and collection of premiums including distribution to carriers and other accompanying operational and accounting functions. Submit annual financial audit.
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> **Powers:** Contract with vendors to achieve functions specified in act; contract with private or public entities to administer enrollment, eligibility and premium billing and collections functions; contract with employer to act as plan administrator for participating employer plans subject to ERISA. Set and collect fees to cover cost of administration. Seek and receive grant funding. Establish operating procedures and service centers. Assume legal responsibility for its actions.
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> **Participation:** Any individual may apply to participate. Any public or private employer may apply on behalf of those persons who may be eligible. Participation is subject to open enrollment season with certain conditions for guaranteed coverage and specific qualifying events.
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> **Eligibility:** Resident of state and continued domicile; or employed at least 20 hours per week in state and employer does not offer health insurance coverage or individual is not eligible to participate; individual is not a resident but is eligible to participate in an employer plan; self employed individual who resides in another state but has principal place of business in state; full time student in state; dependant of state resident.
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> **Health benefit plans:** Health benefit plans offered through the exchange must be certified for up to a year by the superintendent of insurance as to good standing and licensure by offering plan and compliance with applicable state health insurance laws including this act. No competitive bidding process will be required except as pursuant to the Health Care Purchasing Act. Superintendent shall establish and administer regulations and procedures for certification.
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> **Plan Design:** Health benefit plans which are eligible for certification must include: Inpatient hospital benefits, ambulatory patient benefits, prescription drug benefits and mental health benefits.
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> **Rates:** Establishment of rates pursuant to existing statute 59A.18.13.1 NMSA 1978 and

includes provision for adjustment in subsequent years based on experience and modification to benefit design as long as the subsequent adjustments are consistent with general practice in the determination of the superintendent.

Underwriting: During designated open season: a participating individual who switches plans shall not be subject to any pre-existing condition provision and shall be charged the standard rate; a new participating individual with creditable coverage may enroll but may be subject to pre-existing condition periods not to exceed twelve months or charged a premium not to exceed 125% of the otherwise applicable standard rate. A new participating individual with two or less months of creditable coverage may enroll but may be subject to pre-existing condition periods not to exceed twelve months or charged a premium not to exceed 150% of the otherwise applicable standard rate. New participating individuals without creditable coverage are subject to carrier election to impose waivers or impose pre-existing condition periods or extend the surcharge for beyond the first year of coverage.

Continuation of Coverage: Any individual may continue to participate as long as they remain eligible subject to specific provisions regarding premium payment and shall not be canceled or non-renewed based on employer or employment status or other conditions as defined.

Dispute Resolution: Superintendent of Insurance shall establish procedures for resolving disputes with respect to eligibility, coverage surcharge, imposition of pre-existing conditions and other issues as defined.

Participating Employer Plans: Any employer may apply to participate and if participating must enter into a binding agreement with the exchange which designates certain specific requirements for coverage, benefits, administration and other circumstances as defined including provisions regarding record keeping, compliance and sponsorship of a "cafeteria plan".

Brokers: Commissions may be paid to licensed producers for individual or group enrollments as set by board. Provisions for membership organizations to obtain commission as specified.

Employer Responsibility: Employers (and self employed individuals) must annually file a form for each employee (including dependants) employed within the state which indicates health insurance coverage status and other specific information. HSD must file on behalf of all individuals receiving benefits under Medicaid or State Children's Health Insurance program or any other state coverage program. This reporting will be used in conjunction with individual reporting to establish compliance with personal responsibility requirements.

Market Consolidation: Carrier may not issue or renew individual health benefit plan other than through the exchange after first regular open season conducted by the exchange. Carrier may not issue or renew small group (50 or fewer employees) other than through the exchange after first regular open season conducted by the exchange.

Personal Responsibility: State residents over 18 and under 65 must offer proof of

ability to pay for medical care for themselves and dependents by indicating coverage under any exchange health benefit, their election to be considered under a state subsidy program or by demonstrating proof of financial security by posting a $10,000 bond as prescribed. Penalties for failure to comply include establishing an escrow account for that individual which will accrue all funds owed to that individual by the state including tax overpayment to be disbursed in the event of medical claims

FISCAL IMPLICATIONS

The bill allows the exchange to receive grants and establish fees sufficient to cover operating expenses. While the bill contains no appropriation to establish the exchange, there may significant administrative impact on several state agencies.

The bill requires the Human Services (HSD) to report status of recipients of Medicaid, State Children's Health Insurance Program and other state coverage programs to the superintendent of insurance. HSD does not provide an estimate of costs. According to HSD, HSD would have to develop the functionality to generate reports for the status of recipients of State Children's Health Insurance Program and other state coverage programs and this could have a moderate fiscal impact.

The secretary of finance and administration is charged with collecting proof of financial security by individuals who elect to do so through a $10,000 bond and establishing an escrow account in the name of the individual and/or retaining and depositing all funds owed to the individual by the state in that account. Money for health claims will also be disbursed through that account. This may have a significant impact on the Department of Finance and Administration.

SB 976 requires the superintendent of insurance to prepare and distribute forms for individual coverage for each of the state's residents and each non-resident employed in New Mexico. Employers and other individuals would be required to complete these forms and return them to the superintendent. According to PRC, the cost would be recurring and would come from the Insurance Operating Fund. The division estimates the cost for postage and preparation of these forms could approach $1.7 million annually.

SIGNIFICANT ISSUES

HSD notes that 21.1 percent, or about 400,000 individuals, in New Mexico are uninsured. Additionally 88 percent of small employers in New Mexico employ less than 20 employees with 41 percent not offering health insurance. Of the small employers not providing coverage, 81 percent cite cost as the primary reason and 67 percent of uninsured individuals say it is affordability.

SB 976 proposes a significant change to the health insurance market and consolidates the individual and small group markets under the exchange. The bill addresses universal coverage by mandating guaranteed issue at standard rates and mandating individuals to obtain insurance. This approach utilizes the private insurance market.

HSD indicates:

The *Insure New Mexico!* Council was established by executive order on October 14, 2004

to determine strategies to decrease the amount of uninsured in the state and increase the number of small employers offering health insurance. The current Health Insurance Alliance plays a critical role in the *Insure New Mexico! s*trategies to provide health insurance for New Mexicans. Health Insurance Alliance currently offers three types of health plans through at least 10 participating carriers and has the ability to coordinate with the State Coverage Insurance (SCI) plan. This bill proposes a transition period in which the HIA will transfer portability of health benefits and other functions to the Health Insurance Exchange but it is not clear operationally how or if the exchange would work with other Insure New Mexico programs including SCI and the Small Employers Insurance Program.

The existing health insurance strategies the state currently has in place are undergoing study. Under the auspices of the joint executive and legislative appointed Health Care Coverage for New Mexicans Committee, a vendor has been selected to study those existing programs and other independent proposals to cost out the most effective strategy to bring universal health insurance coverage to New Mexico. It is premature to substitute an integral part of the existing health insurance structure and initiate large scale changes in the insurance market while the study is ongoing.

ADMINISTRATIVE IMPLICATIONS

As noted in the Fiscal Implications section above, the bill would require several administrative changes at the Department of Finance and Administration, Human Services Department and the Insurance Division of the Public Regulation Commission.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

SB 976 duplicates HB 1045 and relates to SB 720 and SB 721.

TECHNICAL ISSUES

Health Policy Council offers the following amendment suggestions:

- There is no definition of "resident" in the bill though residency is a key part of Section 16, page 30, line7 dealing with residents of the state proving proof of insurance.
- Page 30, line 7- 9 notes that residents shall offer proof of their ability to pay for medical care. Since the bill is requiring proof of insurance, should not the word "insurance" be substituted for the word "care"?
- Page 31, lines 9-18 deal with the escrow account of $10,000. Should not this number be inflated annually to coincide with the medical care consumer price index increases just as premiums would increase?

OTHER SUBSTANTIVE ISSUES

The Health Policy Council:

SB 976 mandates the procurement of health insurance. Proposals for achieving universal health insurance coverage are receiving serious attention. Among the ideas attracting bipartisan support is an individual health insurance mandate, a legal requirement that

every resident obtain adequate private health insurance coverage. Under development in Massachusetts is a new purchasing pool—called the Commonwealth Health Insurance Connector, which will combine the small group (firms with fewer than 50 workers) and non-group insurance markets under one set of regulations. The Insurance Connector is as a result of the universal coverage law that passed last year in Massachusetts in which an individual has a mandate to procure insurance.

To discourage individuals who remain uninsured from unfairly passing their health care costs onto the rest of the population, starting in July 2007, residents in the state will have to confirm insurance coverage on state income tax returns. The Massachusetts Department of Revenue will penalize those who can pay the health care premium but remain uninsured by revoking their personal tax exemption in 2007, followed by a fine equaling 50 percent of the monthly cost of health insurance for each month they remain without coverage.

Proposals for an individual mandate respond to a legitimate concern about "free riders," the uninsured who nonetheless receive treatment and pass the costs on to taxpayers or individuals with insurance. When an individual without health insurance becomes sick or injured, he or she still receives medical treatment. Hospitals are legally required via Federal law since 1986 to provide screening examination at a minimum, much less any needed stabilization, to anyone who presents care regardless of ability to pay. Physicians do not face the same legal requirement, but few are willing to deny treatment because a patient lacks insurance. However, such treatment is not free. The cost is simply shifted to others—those with insurance or, more often, taxpayers. In fact, uncompensated care costs in New Mexico in 2005 were estimated at $363 million for New Mexico's hospitals alone (Source: *NMHHSA 2006 Annual Report*) with no estimate for the physicians or other medical professionals.

In addition, those most likely to go without health insurance are the young and relatively healthy. For example, although 18 to 24 year olds are only 10 percent of the U.S. population, they are 21 percent of the long-term uninsured. In New Mexico, the age group most likely to have no health insurance is adults between the ages of 18 to 24, followed by adults between the ages 25 to 34. Thirty-one percent of adults 18 to 24 years old and 29 percent of adults 25 to 34 years old do not have insurance. (Source: New Mexico State Planning Grant *Insure New Mexico!* Initiative Final Report Oct 2005).

For these young, healthy individuals, going without health insurance is often a logical decision. However, this becomes a form of adverse selection. Removing the young and healthy from the insurance pool means that those remaining in the pool will be older and sicker. That results in higher insurance premiums for those who are insured.

BE/mt