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

SPONSOR Komadina **ORIGINAL DATE** 1/25/08 **LAST UPDATED** 2/1/08 **HB**

SHORT TITLE Health Insurance Exchange Act **SB** 228/aSPAC

ANALYST Earnest

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY08	**FY09**		
NFI	NFI		

(Parenthesis ( ) Indicate Expenditure Decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Non-Rec	Fund Affected
FY08	**FY09**	**FY10**		
NFI	NFI	$7,000*	Recurring	General Fund

(Parenthesis ( ) Indicate Revenue Decreases)

*See revised fiscal implications section

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY08	FY09	FY10	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
PRC			$1,700	$1,700	Recurring	Insurance Operations 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
Human Services Department (HSD)
Department of Finance and Administration (DFA)
Public Regulation Commission (PRC)

Public Education Department (PED)
Higher Education Department (HED)
Health Policy Commission

SUMMARY

Synopsis of Senate Public Affairs Committee Amendment

The SPAC amendment adds a new item to the definition of "creditable coverage" to include "a plan designated by the superintendent as creditable coverage that includes spiritual care benefits for individuals that use prayer of spiritual means of healing."

Synopsis of Original Bill

Senate Bill 228 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 laws; 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.

Below is a section-by-section summary of the major provisions of the bill, adapted from a summary provided by HSD:

Section 4
Governance: Board governed by 13 directors consisting of 2 elected by participating carriers, 4 appointed by the governor; 1 director who is a licensed physician and is elected by the NM Medical Society; 1 director that is elected by and represents the NM Hospital Association; 1 director that is elected by the NM Association of Health Underwriters; 1 director that represents the Indian nations, tribes and pueblos; and the superintendent of insurance or designee, who is a non-voting member.

A director of the Exchange will be appointed by the board.

Section 5
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. Issue certification of creditable coverage as requested. 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. Submit by July 2010 to governor, legislature and superintendent of insurance a report on feasibility of expanding Exchange to employers with greater than 50 employees.

Section 6

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 employers to act as plan administrator for participating employer plans subject to ERISA. Assess each participating insurance plan for administrative and operating expenses 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. Enroll all eligible individuals through the Exchange.

Section 7

Enrollment and Coverage: 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. The Exchange shall verify eligibility for all applicants for private coverage. The state shall verify eligibility for all applicants for state sponsored or state-subsidized coverage unless the state enters into an agreement with the Exchange. The Exchange shall not decline, refuse to offer or restrict an offering to any participating individual of a participating plan that has been obtained in a timely fashion.

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. Open enrollment period and qualifying events are defined.

Section 8

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.

Plan Design: Health benefit plans which are eligible for certification must include: Inpatient hospital and medical benefits, surgical benefits, ambulatory patient benefits, prescription drug benefits and mental health benefits.

Rates: Carriers shall offer participating insurance plans at rates developed pursuant to 59A.18.13.1 NMSA 1978 and include 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.

Section 9

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 of eighteen months or more may enroll and shall not be subject to any pre-existing condition period and shall be charged the standard rates; a new participating individual with less than eighteen 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 an amount pursuant to Section 59A-18-13.1 NMSA 1978. New enrollees 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.

Section 10

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.

Section 11

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.

Section 12

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".

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 (see below).

Section 13

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. Brokers are not liable for actions associated with offerings for state funded programs which they receive training for through the Exchange as long as they are acting in good faith.

Section 14

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.

Section 15

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.

Sections 16 and 17

Mandatory Consolidated Purchasing: The publicly funded health care agencies will enter into a cooperative consolidated purchasing effort to provide health benefit plans for the benefit of agency eligible participants though an RFP process through participating insurance plans in the Exchange.

Section 18

Collection and Use of Enrollment Data: Superintendent of Insurance shall compile quarterly enrollment information as follows: all individuals currently enrolled though the Exchange; list from human services department of all individuals currently enrolled in health coverage programs though the department; individuals enrolled in each benefit plan they provide though insurance or administrative services. The information shall be used in order to ensure compliance with provisions of the act.

Section 19

Premium Rate Restrictions: Certain restrictions are enacted regarding premium rates for health benefit plans.

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.

Additionally, in a revised report on January 30, PRC estimated because the Health Insurance Alliance would be moved into the exchange, premium tax offsets could be reduced beginning in FY10. Assessments paid under the Alliance reduce general fund revenues by the amount of the offsets. These offsets are estimated to be $7 million for FY10.

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 228 requires under section 18 that the superintendent 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. The cost of this process is not currently included in PRC Insurance Division budget requests. The cost would be a recurring cost and would come from the Insurance Operating Fund. PRC estimates the cost for postage and preparation of these forms could approach $1.7 million annually.

SIGNIFICANT ISSUES

This bill proposes significant changes to the health insurance market and consolidates the individual and small group markets under the exchange. It imposes a personal responsibility mandate and an employer reporting function to ensure that requirement is fulfilled.

According to HSD

> The Legislative Health and Human Services Committee (LHHS) was charged with completing a health care costs study to determine the amount of public and private money expended on health care in the state, as well as the economic impact and the effect of health care reform efforts. The study was mandated by House Bill 955 (HB 955) during the 2003 regular legislative session (Laws 2003, Chapter 380).
> In 2002, the estimated cost of providing health care to New Mexicans was $7.9 billion. Approximately 75 percent of health care expenditures were publicly financed ($5.9 billion). Of the $6 billion that comes from public sources, the federal government pays for 64 percent ($5 billion) compared to 10 percent contributed by state government ($820 million). Counties cover about one percent of health care costs ($94 million) and only $3.4 million comes from out-of-state sources. Spending for hospital services, for medical and other professional services and supplies account for 28 percent of health care dollars, and spending on long-term care services accounts for another 12 percent. While categories were created based on comparable types of services utilized by the National Health Accounts (CMS, 1960-2002), some sources do not tend to collect or report data by types of services.
>
> It is difficult to analyze how the implementation of the Health Insurance Exchange Act would change this picture of the health care marketplace performed by the LHHS or contribute to getting more New Mexicans insured.
>
> Significant federal issues arise from a section of the SB 228 proposal that a new section of the Public Assistance Act is enacted to read: *"The department shall contract with participating insurance plans through the health insurance Exchange created pursuant to the Health Insurance Exchange Act to purchase health coverage for individuals eligible for programs that are funded in whole or in part by the state…."* Health benefit programs under Title 19 and 21 of the Social Security Act are tightly regulated especially in regard to contracting insurance plans. These plans receive significant federal matching dollars which may be jeopardized if federal regulatory process is not followed.
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> There are significant privacy and confidentiality issues involved in requiring that the human services department provide enrollment information to a non-state agency or any other entity for purposes of enforcing the personal responsibility aspect of the Health Exchange Act. Again federal regulation for programs funded with federal dollars has authority over this type of information.

The personal responsibly mandate section of SB 228 has language regarding failure to comply and penalty with the requirements of that section but contains no grievance or appeal process affording an individual the right to due process.

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

Senate bill 228 duplicates House Bill 205; relates to House Bill 62.

BE/mt:bb