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

SPONSOR Sanchez, M **ORIGINAL DATE / LAST UPDATED** 01/26/08 **HB**

SHORT TITLE Access to Quality Universal Health Insurance **SB** 377

ANALYST Weber, Hanika-Ortiz

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY08	FY09	FY10	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total			$47,000.0 (children < 300% FPL)	$0.1	Recurring	General Fund
Total			$115,000.0	$0.1	Recurring	Federal Medicaid
Total			Unknown/Signficant for TRD	$0.1	Recurring	General Fund
Total			Unknown/Minimal for PRC/HSD	$0.1	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to HB 62, HB 147, SB 225, SB 3

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
Department of Health (DOH)
NM Higher Education Department (NMHED)
Public Regulation Commission (PRC)

No Responses Received Yet From
Department of Finance and Administration (DFA)
Taxation and Revenue Department (TRD)

SUMMARY

Synopsis of Bill

Senate Bill 377 adds new sections of the insurance code and amends others to enact the Access to Quality Healthcare Act.

Section 2 is a new section that provides definitions of terms used throughout the act; such as "creditable coverage" to mean coverage of an individual pursuant to a group health plan, health insurance coverage, Medicare, the Medicaid Federal Tricare program, the Medical Insurance Pool Act, any Federal employees health benefits program, any Federal public health plan, any health benefit plan offered by a particular organization or group, automobile medical payment insurance or pursuant to benefits contained in any liability insurance policy; and, "preexisting condition" which excludes pregnancy within the definition.

Section 3 is new material that sets terms and conditions for guaranteed issue and renewability of coverage. Effective January 1, 2010 a health insurer shall issue health insurance coverage to any person who requests and offers to purchase the coverage without exclusion of preexisting conditions. The provisions of this section shall not apply to the following types of policies: (1) disability income; (2) long-term care; (3) Medicare supplement; (4) credit health; (5) short term; (6) accident-only; (7) fixed indemnity; (8) limited benefit; or (9) specified disease.

Section 4 relates to adjusted community rating. Every health insurer shall, in determining the initial year's premium charged, use only the rating factors of age, gender, geographic area of the placement of employment and smoking practices, except that for individual policies the rating factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment. In addition premium rate variations from index rates are addressed and limited. Certain policy types are excluded from the provisions.

Section 5 mandates reimbursement for direct services at not less than 90 percent of premiums collected across all health product lines in the preceding three years.

Section 6 outlines requirements of health care coverage.

- By January 1, 2010, every person having an income above four hundred percent of the federal poverty level and living in New Mexico for more than six months shall provide proof of creditable coverage or provide proof of financial responsibility for health care services.
- By July 1, 2009, the TRD shall identify individuals in the state who do not have creditable coverage. The agency may identify these individuals through coordination with appropriate governing bodies and state agencies, including licensure and renewal processes, public school and post-secondary institution enrollment processes, state income tax filing, employment and open enrollment periods. The agency shall provide assistance, education and outreach to individuals who do not have creditable coverage and promulgate guidelines defining affordability of health care coverage.
- By July 1, 2010, the secretary shall develop procedures to verify that the following individuals have creditable coverage: (1) individuals living in households with income greater than four hundred percent of the federal poverty level; and (2) children in households with income less than four hundred percent of the federal poverty level who are eligible for public programs pursuant to Medicaid or SCHIP programs.
- Individuals in households with incomes less than four hundred percent of the federal poverty level shall not be required to purchase or enroll in creditable coverage unless affordable coverage, pursuant to the established guidelines defining affordability, is offered through the individual's employer, available through a public program or otherwise.
- By October 1, 2010, the agency shall provide recommendations to the governor and the legislature on compliance and enforcement mechanisms that require all persons living in

New Mexico to obtain or enroll in a public or private health care coverage plan or program or provide proof of financial responsibility for health care services.

- As of July 1, 2010, the following individuals age eighteen and over shall obtain and maintain creditable coverage provided that the guidelines set by the secretary deem that the coverage available to the individual is affordable:(1) state residents meeting the income criteria set forth by the secretary; or (2) individuals who become residents of the state within sixty-three days in the aggregate. Residents who, within sixty-three days, have terminated any prior creditable coverage shall obtain and maintain creditable coverage within sixty-three days of termination.

Section 7 mandates HSD to recommend a sliding scale of subsidies for persons under 400 percent fpl for both individual policies and group sponsored policies.

Section 8 provides amendments to 59A-22-5 for time limits related to defenses of misrepresentation of policy provision.

Section 9 amends 59A-23B-3, the Minimum Healthcare Protection Act, regarding preexisting conditions and adds a new section community rating.

Section 10 amends 59A-23B-6 regarding forms and rates. Items C, D and E are eliminated that were inconsistent with the new preexisting condition and community rating changes.

Section 11 is new material that deals with the rate index for premiums.
Premium rates for health benefit plans subject to the Minimum Healthcare Protection Act shall be subject to the following provisions:

- the index rate for a rating period for an individual shall not exceed the index rate for any other individual by more than the following percentages for policies issued or delivered in the respective year: (a) twenty percent through December 31, 2008; (b) eighteen percent for calendar year 2009; (c) sixteen percent for calendar year 2010; (d) fourteen percent for calendar year 2011; (e) twelve percent for calendar year 2012; and (f) ten percent for every year thereafter;
- the premium rates charged during a rating period for an individual shall not vary from the index rate by more than the following percentages of the index rate for policies issued or delivered in the respective year: (a) twenty percent through December 31, 2008; (b) eighteen percent for calendar year 2009; (c) sixteen percent for calendar year 2010; (d) fourteen percent for calendar year 2011; (e) twelve percent for calendar year 2012; and (f) ten percent for every year thereafter; and

Section 12 makes premium rates for health benefit plans subject to the Small Group Rate and Renewability Act the same as in the previous section. Also, certain types of insurance are excluded from the provisions.

Section 13 amends 59A-23C-5.1 regarding adjusted community rating. Provisions inconsistent with community rating are eliminated.

Section 14 amends 59A-23C-7.1 regarding preexisting conditions. The amendment provides that a health benefit plan that is offered by a carrier to a small employer <u>shall not</u> include a preexisting clause.

Section 15 extends the elimination of preexisting clauses to any group health plan and a health insurance issuer offering group health insurance coverage.

Section 16 extends the preexisting condition ban to Medicare supplement policies.

Section 17 further extends the preexisting condition ban to 59A-56-14.

Section 18 is a temporary provision providing for a risk equalization study that will provide recommendation to the Legislative Health and Human Services Committee regarding the negative effects of adverse selection on an individual carrier that can result from guaranteed issue.

FISCAL IMPLICATIONS

Direct costs for enrolling children in house holds with income less than 400 percent fpl would have a fiscal impact. Recent HSD estimates approximate 48,000 children in households under 300 percent FPL (currently $61,956 annually for a family of 4). At an estimated managed care organization annual premium of $3,370 for this group a total $162 million requiring $47 million from the general fund is required. It is difficult to determine the pace at which this eligible population may enroll but as each year goes by the total cost will probably increase due to inflationary factors.

The bill has fiscal implications for TRD, PRC, & HSD in that several sections require them to perform work. In particular, section 6 places a substantial tracking and reporting mechanism on TRD as well as requirements to issue rules establishing "affordability" and making recommendations for enforcement. No appropriation is included to cover the cost of these efforts.

Section 7 has HSD recommend subsidies for person in house holds under 400 percent fpl (currently $82,608 annually for a family of 4). This adult population is considerably more expensive individually than the children with the annual premium for the State Coverage Insurance program currently at over $9,000. Also, continued federal participation in the coverage of adults is uncertain. However, this bill does not mandate coverage but only asks for subsidy recommendations making determination of a fiscal impact impossible.

HSD reports that 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, other medical and 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.

SIGNIFICANT ISSUES

SB 377 proposes to reform the underwriting of individual and group health insurance substantially.

PRC/INS has provided the following background:

- Currently these markets have the following characteristics. In the individual health insurance markets, insurers take applications which describe the applicants health status and then underwrite the policies to determine whether or not to: 1) issue the policy at standard rates, 2) issue the policy at substandard rates, 3) decline to issue coverage or 4) issue coverage with exceptions for certain health conditions (either temporarily or permanently). If the insurer chooses 3) or 4), the applicant is eligible for coverage in the Medical Insurance Pool. If the insurer chooses 2) and the substandard rate exceeds the medical insurance pool premiums by 25%, the applicant is eligible for coverage in the pool. Guaranteed issue in this market is accomplished in a two-tier system. Healthy individuals are underwritten and received coverage from insurers at low standard rates. Individuals with health problems or chronic conditions, who cannot qualify for these standard rates can apply to the Medical Insurance Pool, whose rates are set at approximately 135% of the commercial rates. Standard rates in the individual market are subject to adjusted community rating. Adjusted community rating permits insurers to vary rates by: 1) age, 2) gender, 3) geographical area and 4) whether or not an individual smokes. The variation is limited to 20% by gender (within age brackets) and to 250% by all combination of factors.

- In the small employer group market, we have guaranteed issue with premium rates that can vary based upon health status and claims history. In this market we define index rates and require those rates to meet adjusted community rating limits similar to adjusted community rating in the individual market (i.e., rates may vary by 1) age, 2) gender, 3) geographical area and 4) whether or not an individual smokes- with a 20% limit for variance by gender and a 250% limit for all factors). The resulting rate can be increased or decreased by 20% based on industry classification, health status or claims history. Again it is a two tiered system essentially based on health status. Healthy groups get the lowest rates and unhealthy groups pay higher rates (with limits).

PRC further notes that the bill proposes to eliminate this two-tier system by prohibiting the use of rates that vary by health status. Rate variation will be based on the adjusted community rating factors of age, gender, geographical are and smoking habits; however, the maximum variation in premium rates based on these factors will be limited to 20% beginning 12/31/2008 and ultimately will be limited to 10% beginning 12/31/2012. Health status will also be eliminated from coverage determination by prohibiting the use of preexisting condition exclusions. With the individual mandate contained in section 6, there will be no need for these exclusions or the use of waiting periods.

It is significant that this approach to access to quality universal health insurance does not create a new commission or collapse existing agencies into an "authority" but rather builds on current statute to achieve the goal. More study should be required to fully understand the implications from such insurance changes. Unfortunately, the response from TRD was not received prior to the first hearing on the bill but hopefully will be available soon for an amended FIR before the next hearing. Further response from the PRC regarding their technical analysis of the drafting of the bill should also help with a better understanding of the insurance changes.

Section 3 requires that beginning in January 1, 2010 health insurers are required to guarantee issue individual health insurance policies without preexisting condition exclusions and without

waiting periods. The provisions of the section do not apply to: 1) disability income, 2) long-term care, 3) medicare supplement, 4) credit health, 5) short term, 6) accident-only, 7) fixed indemnity, 8) limited benefit, or 9) specified disease policies.

Section 5 requires a health insurer to make reimbursement for direct services at a rate not less than ninety percent of premiums minus any activity designed to manage utilization or services. The 90 percent of premiums target for direct medical services may be considered appropriate for large groups or block purchases like Salud! However, it creates problems for insurers who only write individual or small employer groups. Economies of scale work against individual and small group coverage. Several insurers who currently offer only individual and small group coverage could be forced to leave the market. A more appropriate target could be developed for individual and small employer groups.

Section 6 imposes a personal responsibility mandate for persons with incomes over 400% of fpl to provide proof of creditable coverage as defined in the bill.

PERFORMANCE IMPLICATIONS

The TRD has a significant role in Sections 6 and 7 in that the Department must identify all individuals who do not have creditable coverage through licensure and renewal processes, public school and post-secondary institution enrollment processes, state income tax filing and employment open enrollment periods. In addition, the Department will be required to provide assistance, education and outreach to individuals who do not have creditable coverage and promulgate guidelines defining affordability of health care coverage. Again, there is no appropriation to help defer costs for this significant administrative impact.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

This bill attempts to create universal coverage with an individual mandate and insurance reforms. Other bills with individual mandates and insurance reforms include HB 62, HB 205 and SB 228. Additionally, other bills that address universal coverage include HB 147, HB 214, SB 3 and SB 225.

SUBSTANTIVE ISSUES

New Mexico has a high rate of uninsured at 21.1% or an estimated 401,000 individuals. Additionally, 88% of small employers in New Mexico employ less than 20 employees with 41% not offering health insurance. 81% of the small employers that do not currently provide coverage cite cost as the primary reason and 67% of uninsured individuals say it is affordability.

TECHNICAL ISSUES

Page 4, line 4, benefits could be further clarified by the addition of the word “health”.

AHO/sb