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

SPONSOR HJC **ORIGINAL DATE** 03/01/13 **LAST UPDATED** **HB** CS/CS/168/aHFl#1

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

ANALYST Geisler/Walker-Moran/Trowbridge

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY13	FY14	FY15	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	$0.0	$0.0	*Significant	$0.0	N/A	N/A

(Parenthesis ( ) Indicate Expenditure Decreases)

*See Fiscal Implications

Relates to: SB 221, HB 563, SB 589, SB 48

SOURCES OF INFORMATION
LFC Files

Responses Received From
Attorney General's Office (AGO)
Public Regulation Commission (PRC)
Human Services Department (HSD)
Department of Health (DOH)

SUMMARY

Synopsis of House Floor Amendment #1

The House Floor Amendment to CS/CS/HB 168//HFl#1 eliminates Section 10, which exempts the Health Insurance Exchange from payment of all fees and all taxes levied by this state or any of its political subdivisions. The amendment also renumbers succeeding sections accordingly and on page 2, line 6, strikes "11" and inserts in lieu thereof "10" to reflect the change made by the amendment.

Synopsis of Original Bill

The HJC substitute for the HHGIC substitute for House Bill 168 will amend, repeal, and enact sections of the Health Insurance Alliance Act. This will provide the statutory construct for the establishment of the New Mexico Health Insurance Exchange (HIX) that will offer qualified health plans in the individual, small employer, or large employer health insurance markets. The

bill provides that on June 15, 2013 all personnel, appropriations, money, records, equipment, supplies and other personal property of the New Mexico Health Insurance Alliance shall transfer to the HIX. Also included in the transfer are all contracts of the New Mexico Health Insurance Alliance. On the effective date of this act, the board of the New Mexico Health Insurance Alliance Board of Directors shall cease to exist. The bill directs the HIX to increase access to health plan coverage for small employer and eligible individuals with assistance in comparing and applying for qualified health plans. This bill also defines a qualified individual who may access the HIX, which includes all New Mexicans. This specifically defines a Native American due to specific regulations for Native Americans under the Affordable Care Act of 2010 (ACA). The HIX Board would consist of 13 members and shall be composed, as a whole, to assure representation of the state's Native American population and ethnic, cultural and geographic diversity. The Board is appointed as follows:

- One voting member is the Secretary of the New Mexico Human Services Department or his/her designee.
- The Superintendent of Insurance (SOI) or his/her designee who is a non-voting member. In the event of a tie the Superintendent's vote will be the determining vote. The Superintendent of Insurance will serve as Chair of the board unless the superintendent declines and shall appoint the chair.
- The Governor shall appoint one director who shall be an officer or employee of a carrier
- Five directors who shall be officers, general partners or proprietors of small employers, one of whom shall represent a nonprofit corporation. These five directors shall be appointed as follows:
  a. Two shall be appointed by the Governor, including the member representing a nonprofit.
  b. One appointed by the President Pro Tempore of the Senate.
  c. One appointed by the Speaker of the House of Representatives
  d. One Appointed by the New Mexico Legislative Council
- Four directors who shall be employees of small employers. These four will be appointed as follows:
  a. Two shall be appointed by the Governor.
  b. One shall be appointed by the Minority Floor Leader of the Senate.
  c. One shall be appointed by the Minority Floor Leader of the House of Representatives.
- One director shall be appointed by the Governor who is a consumer advocate.
- The Governor cannot appoint more than four directors of the same political party.

Plan of Operation

a. A Plan of Operation must be submitted 30 day after the effective date of this act.
b. The SOI shall approve the plan after notice and hearings provided that the plan is fair, reasonable and equitable.
c. The Plan shall include:
    a. Procedures for handling accounting of assets of the alliance
    b. Establish regular times and place for meetings
    c. Procedures for records on all financial transactions for annual and fiscal reporting to the SOI.
    d. Establish the amount of and the method for collecting assessments.
    e. Establish a program to publicize the existence of the alliance.

f. Establish penalties for nonpayment of assessments by members.
g. Procedures for alternative dispute resolutions between members and insured.

d. In regards to HIX
    a. By October 1, 2013 accept applications from qualified individuals and employers.
    b. By October 1, 2013 have available navigator services for person applying for Medicaid or to purchase qualified health plans.
    c. Eligibility determination for enrollment in Medicaid, along with eligibility determination for the exchange.
    d. Establish a program to publicize the existence of the HIX.

Qualified Health Plans (QHP)

a. QHP shall confirm to the federal and state law governing QHP's and the alliance's QHP design criteria.
    a. Must be licensed and in good standing.
    b. There must be at least one QHP in the HIX that must be silver level and one gold level of coverage.
    c. Charge the same premium for each health plan within each level of coverage without regard if the plan if offered through the alliance directly from the carrier or through the agent or broker.
    d. Follow compliance through both the Secretary of Health and Human Services and any other requirements that the board or SOI set forth.
    e. The following are items and services defined by both federal and state laws and must be a part of essential benefits:
        i. Ambulatory patient services.
        ii. Emergency Services.
        iii. Hospitalization
        iv. Maternity and newborn care
        v. Mental Health and substance abuse disorder services, including behavioral health treatment.
        vi. Prescription drugs.
        vii. Rehabilitative and rehabilitative services and devices.
        viii. Laboratory services
        ix. Preventative and wellness services and chronic disease management.
        x. Pediatric services including oral and vision care.

The legislation provides a delayed repeal of the Alliance Act. It also contains an emergency clause and a severability clause.

FISCAL IMPLICATIONS

The implementation of the health insurance exchange is likely to have a significant fiscal impact on the state, with additional federal revenue coming to New Mexico in the form of tax credits to subsidize the cost of health insurance for more than 73,000 exchange clients, as well as increased revenues from state premium taxes on the insurance plans offered by the exchange.

As reported in the consensus revenue estimates, the FY14 insurance premium tax estimate contains the first fiscal impacts from the expansion of Medicaid and creation of the health

insurance exchange under the federal ACA. Note that premiums taxed are paid quarterly and the impacts will only be reflected in the last quarterly payment for FY14; much larger impacts are anticipated for subsequent fiscal years. Analysts have been careful to include the impacts of existing law only.

The board will charge assessments or user fees to carriers, qualified employers or producers to generate funding to support exchange operations. The intent is to have revenues to the board be sufficed to operate without additional state funds.
Significant amounts of premium tax revenue are currently diverted to the New Mexico Medical Insurance Pool (NMMIP), which provides access to health insurance coverage to residents of New Mexico who are denied health insurance and considered uninsurable. For FY13, NMMIP has assessed health insurance companies $117 million to substantially fund the pool. Insurance carriers in turn are allowed a roughly 55 percent credit on assessments which are claimed against premium tax liability. This scheme will change under ACA, as the bulk of NMMIP pool participants should therefore receive insurance through the exchange, if not as an adult newly eligible for Medicaid. However, not all NMMIP participants are eligible to participate. Undocumented residents, currently estimated to be around 20 percent of the pool, will still participate in NMMIP. This leaves 80 percent of the pool eligible to enter the exchange on January 1, 2014. The consensus revenue estimate assumes about 40 percent of the pool transitions to the exchange or Medicaid. This transfer of clients is currently estimated to save the state between $10 million and $20 million per year.

SIGNIFICANT ISSUES

The Human Services Department (HSD) reports that New Mexico has been working for some time now to establish the HIX within the Health Insurance Alliance. Grant funding was received in September 2011 to help New Mexico establish a state-based exchange. Work has proceeded since then and New Mexico, according to the federal government, is further along than most other states at this point.

HSD indicates that the administration has been working towards the establishment of a free market exchange. Consumers should be offered the broadest possible array of plans with little structure of the marketplace beyond what is required by the ACA. This is more of an Amazon dot com style approach to shopping for insurance – a consumer can type in what they are looking to purchase, click, and buy. This legislation sets up an exchange that is closer to an active purchaser model, which would empower selective contracting with carriers, set criteria that are beyond the federal standard for participation, and offer fewer choices to consumers. Open markets and competition will always drive better choices for consumers, eventually crowding out ineffective and over priced plans.

HSD notes several examples of attempts to set-up an active purchaser exchange in this legislation include:

- The plan of operation section of the legislation allows for procedures to determine which qualified health plans may be offered on the exchange. This can act as a potential barrier to carriers who may wish to enter the exchange market. Certification of QHPs is acceptable, but the barrier of determination is not.
- The required offering of at least a gold level plan and a silver level plan on the exchange acts as a barrier to entry on the exchange to carriers. It should be the option of the carrier,

along with the Superintendent of Insurance, to decide what plans it can offer in a fiscally responsible manner. Requiring the offering of these higher tier medal plans will not be cost effective or affordable for most consumers.

- Carriers should be able to make decisions based on reasonable financial data on what plans they need to offer or discontinue and how long they should reasonable be able to do so. The number of years a plan can be offered being set in statute does not allow for appropriate financial flexibility on the part of the carrier.

HSD makes the following observations:

- Provisions are included in this legislation for people applying for Medicaid to receive eligibility determinations on the exchange. Additionally the legislation requires navigator services to be provided for people applying for Medicaid.
- Initial eligibility assessments may be made on the exchange, however HSD is in the process of building out the new Medicaid eligibility system called ASPEN. This new system will be used to make all final determinations for Medicaid eligibility and enrollment. Only the state Medicaid agency may make the actual determination of eligibility for Medicaid and enroll individuals in the program.
- Those people who are looking for insurance coverage through the exchange but may be eligible for Medicaid can be referred back to an Income Support Division (ISD). These offices form the backbone for Medicaid enrollment services in New Mexico. Navigators may be trained in where to direct these potentially eligible people and how to help provide their initial Medicaid eligibility assessment on the exchange, but cannot determine them eligible for the Medicaid program.
- This legislation also requires a dispute resolution process be established within the HIX. The process for doing so, like so many other exchange related items, is up in the air with the federal government. The state may have the option to opt for an entirely federally run dispute resolution process in order to save funds generated by the exchange for operation of the exchange, while helping to streamline the dispute resolution process. This provision is not needed in legislation.
- HSD also recommends that anywhere in this legislation that duplicates federal law and/or rule, the legislation should refer back to federal law and/or rule. This will help allow New Mexico's exchange to stay nimble in the future, rather than having to open the statutes any time a change needs to be made to comply with federal laws and/or rules.
- There could be an impact to the ASPEN interface programming that cannot be quantified with the information given at this time.

The New Mexico Department of Health (DOH) notes that the ACA requires all individuals to have health insurance. This legislation implements ACA requirements for states to offer health insurance exchanges for individuals and businesses that currently do not have or do not offer health insurance.

The health insurance exchange as created by HB 168/HJCS/HHGICS is a quasi-governmental entity that is exempt from the legislative appropriation and budgeting process, state procurement code, and the State Personnel Act. The exchange is likely to administer, accrue and account for substantial revenues and expenditures which will occur outside of the oversight of the executive branch and the Legislature. Although the "quasi-governmental" exchange model proposed in HB 168/HJCS/HHGICS is being considered by other states, some other states have also decided

to operate their exchanges within current executive branch agencies or have established independent state agencies, presumably with greater oversight and accountability by the Legislature and the public.

ADMINISTRATIVE IMPLICATIONS

HSD states that its Income Support Division (ISD) will need funding for staff to accommodate an increased workload generated from individuals potentially eligible for health care coverage through the HIX. The ACA requires that a determination for initial Medicaid eligibility be made for every application that is submitted through the Health Insurance Exchange. It is estimated that 50 percent of those who apply for services through the Exchange will be eligible for Medicaid coverage. HSD has requested funding for this activity and it is include in the Executive Recommendation.

DUPLICATION, RELATIONSHIP

HB 168/HJCS/HHGICS relates to:

- SB 221, which would create the New Mexico Health Insurance Exchange;
- HB 563, which would create the New Mexico Health Insurance Exchange;
- SB 589, which would create the New Mexico Health Insurance Exchange; and
- SB 48, which would enable the participation of large employers in a health insurance exchange.

DISPARITIES ISSUES

DOH notes that one of five New Mexicans is without health insurance. The 2012 Sate Health Improvement Plan discusses higher rates of individuals in New Mexico without health insurance, relative to the U.S. (New Mexico 21 percent, U.S. 16 percent).

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

DOH states that if HB 168/HJCS/HHGICS is not enacted, there would not be a substitute to HB168s and the New Mexico Health Insurance Exchange Act as “new material” would not be created, rather than amending the New Mexico Health Insurance Alliance Act. The New Mexico Health Insurance Alliance would not be governed by the New Mexico Health Insurance Exchange Board of Directors. HSD maintains that New Mexico will continue working to establish a free market, state-based health insurance exchange.

TT/blm:svb