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

SPONSOR Townsend **ORIGINAL DATE** 2/23/17 **LAST UPDATED** _____ **HB** 384

SHORT TITLE Medicaid Carrier Assessments Exemption **SB** _____

ANALYST Boerner

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Assessments Covered by Medicaid		($2,576.0)	($2,576.0)	($5,152.0)	Recurring	General Fund
		($9,174.3)	($9,174.3)	($18,348.6)	Recurring	Federal Medicaid Match

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
Office of Superintendent of Insurance (OSI)

SUMMARY

Synopsis of Bill

House Bill 384 (HB 384) amends Section 59A-23F-4 NMSA to exclude receipts of managed care Medicaid revenue from carriers' total revenue when calculating each carrier's New Mexico Health Insurance Exchange (NMHIX) assessment.

FISCAL IMPLICATIONS

This bill would remove the authority of the NMHIX to place assessments on insurers who administer the managed Medicaid program on behalf of HSD. These insurers are commonly referred to as Medicaid managed care organizations (MCOs). The assessment is based on revenue received by the MCOs' for Medicaid members.

The state's Medicaid program calculates the cost of the assessments levied by NMHIX on the MCOs attributable to their enrolled Medicaid members, and includes that amount when

determining the MCOs' per member/per month "capitation" payment rates. The assessments included in the MCOs' capitation rates typically account for approximately 80 percent of NMHIX's total funding. The estimated NMHIX assessment for calendar year 2017 is $14.7 million. The state's share of general fund is $2.6 million. The state's portion is calculated as described below.

NMHIX CY 2017 Assessment Funded By Medicaid	Assessment
CY 2017 Total Assessment	$14,688,045
Medicaid Portion of CY 2017 Assessment (approx 80%)	$11,750,436
Medicaid Portion of Premium Tax on Assessment $470,370	
Total Medicaid Portion of CY2017 Assessment $12,220,806	
General Fund Responsibility (state match = 21.1%)	$2,576,117

Source: HSD

As OSI points out, because the federal government matches state Medicaid spending by 70 to 80 percent (based on specific populations and services), reduced Medicaid spending on the Exchange would also reduce federal dollars brought into the state.

SIGNIFICANT ISSUES

Removing the NMHIX assessment from MCOs would reduce the net general fund need of the Medicaid program by approximately $2.6 million in FY18. Federal rules for actuarial rate setting for Medicaid require taxes and assessments to be built into MCO rates as a cost of doing business; therefore, the cost of the NMHIX assessment is primarily born by the state and federal government.

As HSD points out, these rules do not exist in the commercial market. Health insurance plans might insist that they would have to raise premiums for individual and small employer health insurance plans in order to maintain underwriting gains and meet certain OSI rules, but the health insurers would not be required to do so.

Indeed, OSI did raise such concerns, noting (paraphrased):

> While some insurance carriers with smaller market share may be able to absorb the costs of the new assessment burden without significantly affecting their rates, OSI projects the major medical carriers that underwrite the largest portions of individual and small group markets in the state will see a significant increase in the assessable magnitude of their market share. State and federal medical loss ratio law and risk-based capital law limits carrier' accounting for assessments. As a result of these laws and currently unfavorable risk pool structures, carriers will likely see a need to pass along these costs to consumers through increased premiums. OSI projects this premium increase would likely cause premiums for a single individual to increase approximately $47 year. While federal subsidies for coverage purchased through the Exchange will blunt the rise in premium costs for those who are eligible, ineligible individuals and small businesses may find these costs are increasing. Unaffordability of insurance premiums will likely increase uninsured rates, resulting in additional uncompensated care costs for the state.

BACKGROUND INFORMATION

The Exchange is a quasi-governmental entity organized pursuant to the New Mexico Health Insurance Exchange Act (the "Act") which replaces the New Mexico Health Insurance Alliance Act that was created by the State of New Mexico. The purpose of the Exchange is to provide qualified individuals and qualified employers with increased access to health insurance in the State

The federal Health and Human Services Department (HHS) issued grants to states under ACA Section 1311 to establish health insurance exchanges. By the end of federal fiscal year 2014, HHS had awarded nearly $21.4 billion in grants to agencies and organizations across all states and the District of Columbia. As of January 2014, the HHS Centers for Medicare and Medicaid Services (CMS) had awarded New Mexico $123.3 million. However, the federal grants phased out in 2016; since then, the NMHIX began relying on assessing carriers to cover ongoing operational costs. The ACA provides that an exchange may charge an assessment or user fee to participating issuers, but also allows an exchange to find other ways to generate funds to sustain its operations.

According to the Exchange's 2015 audited financial statements, beginning January 2015, maintenance and operation expenditures were paid from carrier assessments, as documented in the Exchange's Financial Sustainability Plan. The 2016 assessment, sufficient to cover the 2016 operating budget, was issued on January 2, 2016, in the amount of $11,790,605.

In early 2013, the Financial Sustainability Work Group made recommendations for the Exchange at the Advisory Task Force Meeting. (See *New Mexico Health Insurance Exchange Advisory Task Force Recommendations April 9, 2013.)* Recommendations specific to assessments are provided below.
http://www.hsd.state.nm.us/uploads/FileLinks/949558ccd4494e8496e01b61e71855c9/2013__4_9__Final_Advisory_Task_Force_Recommendations.pdf

> During deliberations, estimated exchange operating costs from other states were provided for comparison purposes, as were types of mechanisms considered in other states (flat fees to employers, percentage charges to insurers both on and off exchanges) to assist with reaching exchange viability by 2015. The Work Group determined a mechanism should be devised to assess self-insured plans to contribute to the operating costs of the Exchange and that assessments against insurance companies participating in the Exchange should be based on a percentage of lives covered by those companies. Other insurers offering products in New Mexico supervised by the Division of Insurance (health, life, dental, vision), but not offering products on the Exchange, should also pay an assessment to participate in the operational expenses of the Exchange. This global assessment will remove a potential disincentive for Exchange participants because if only those plans in the Exchange are assessed, it may make the Exchange a less attractive marketplace for plans to sell to consumers.

CB/jle/sb/jle