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

		ORIGINAL DATE	1/26/09		
SPONSOR	Heaton	**LAST UPDATED**	2/27/09	**HB**	111/aHHGAC/aHBIC
SHORT TITLE	Health Insurer Direct Services			**SB**	
				ANALYST	Hanika-Ortiz/Wilson

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY09	FY10		
	None		

(Parenthesis ( ) Indicate Expenditure Decreases)

Companion to HB 109 and HB 110

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
General Services Department/Risk Management Division (GSD/RMD)
Department of Health (DOH)

SUMMARY

Synopsis of HBIC Amendment

The House Business and Industry Committee amendment removes the House Health and Government Affairs Committee amendment and redefines the definition of "premium" to include all income received for health coverage less any premium taxes paid and less any fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance.

Synopsis of HHGAC Amendment

The House Health and Government Affairs Committee amendment removes the condition that an insurer may exclude premium taxes in its calculation of reimbursement of services at a rate not less than eight-five percent. The amendment further redefines the definition of "premium" to include all income received for health coverage less any premium taxes paid.

Synopsis of Original Bill

House Bill 111 proposes a requirement that health insurers reimburse for direct health care services at a rate no less than 85 percent of the amount insurers collect in premiums for health insurance coverage across all their health product lines, including fully insured, commercial, state and federal programs, over a three-year period.

FISCAL IMPLICATIONS

HB111 proposes to require that for every $10.00 individuals pay for health insurance premiums, insurance companies must spend $8.50 for direct health care services rather than on administration or profit.

The 85 percent of premiums target for direct medical services is considered appropriate for large groups or block purchases like Salud! However, it may create 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.

GSD/RMD reports that for the past three years, the division has expended in direct services more than 85 percent of premiums collected.

Provisions in the bill do not preclude a purchaser from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services for one or more products or for one or more years.

SIGNIFICANT ISSUES

HB 111 is part of Governor Richardson's 2009 Health Care Reform legislative package.

"Direct services" are services provided to an individual by a health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers or individuals, and any portion of an assessment that covers services rather than administration and for which a health insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act.

"Direct services" *do not* include care coordination, utilization review or management or any other activity designed to manage utilization or services. "Direct services" will be calculated over the preceding three calendar years, but not earlier than calendar year 2009, as determined by reports filed with the Public Regulation Commission's Division of Insurance.

COMPANIONSHIP

Companion to: HB 109, Employer Pre-Tax Health Coverage Options
Companion to: HB110, Health Insurance Guaranteed Issue

TECHNICAL ISSUES

The bill does not state what the penalty will be for a health insurer who fails to makes reimbursement for direct services at a rate less than 85 percent.

OTHER SUBSTANTIVE ISSUES

Several states limit or are considering legislation to limit the amount of money health insurance companies can spend on administration and/or profit, by requiring that a set percentage of funds paid by insured individuals be spent on direct services, sometimes called the "medical loss ratio" or MLR. A **minimum medical loss ratio** is a requirement that insurers spend, at least, a specified percentage of premium dollars on medical care rather than on administration, marketing, and profit. Without this requirement, insurers can charge very high premiums to individuals and small businesses, and spend a low proportion of these premium dollars on health care services.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Health insurers will not be required to reimburse for direct health care services at a rate no less than 85 percent of the amount insurers collect in premiums for health insurance coverage across all their health product lines over a three-year period.

AHO/mc:mt