SENATE BILL 745

47TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2005

INTRODUCED BY

Dede Feldman

AN ACT

RELATING TO HEALTH INSURANCE; PROVIDING FOR FINANCIAL INCENTIVES FOR HEALTH INSURANCE THAT INCLUDE A QUALIFIED WELLNESS OR DISEASE MANAGEMENT PROGRAM.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. Section 59A-18-13.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 26, as amended) is amended to read:

"59A-18-13.1. ADJUSTED COMMUNITY RATING--WELLNESS AND DISEASE MANAGEMENT PROGRAMS.--

A. Every insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan that provides primary health insurance or health care coverage insuring or covering major medical expenses shall, in determining the initial year's premium charged for an individual, use only the rating factors of age, gender,

underscored material = new
[bracketed material] = delete

geographic area of the place 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.

B. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan from offering rates that differ depending upon family composition.

C. An insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan that provides a qualified wellness or disease management program may use a rating factor that reflects the expected level of participation in the program and the anticipated effect the

underscored material = new
[~~bracketed material~~] = delete

program will have on utilization or medical claim costs. A qualified wellness or disease management program shall:

(1) meet the requirements of the federal Health Insurance Portability and Accountability Act of 1996 for bona fide wellness programs;

(2) provide financial incentives to covered employees or individuals for participating in the program; and

(3) provide to covered employees or individuals for whom it is unreasonably difficult to satisfy the program's applicable standards, reasonable alternative methods for achieving program participation.

D. The methodology proposed by the insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan for establishing rating factors for a qualified wellness or disease management program may take into consideration:

(1) the anticipated average percentage of employees or individuals eligible to participate in the program;

(2) the anticipated efficacy of the financial incentives in producing high levels of program participation;

(3) the level of program participation achieved in prior coverage periods;

(4) the expected success rate for program participants;

underscored material = new
[bracketed material] = delete

(5) clinical studies; and

(6) the insurer's experience in the use of the program.

[~~C.~~] E. The provisions of this section do not preclude an insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan from using health status or occupational or industry classification in establishing:

(1) rates for individual policies; or

(2) the amount an employer may be charged for coverage under the group health plan.

[~~D.~~] F. As used in Subsection [~~C~~] E of this section, "health status" does not include genetic information.

[~~E.~~] G. The superintendent shall adopt [~~regulations~~] rules to implement the provisions of this section.

Section 2. Section 59A-23B-6 NMSA 1978 (being Laws 1991, Chapter 111, Section 6, as amended) is amended to read:

"59A-23B-6. FORMS AND RATES--APPROVAL OF THE SUPERINTENDENT--ADJUSTED COMMUNITY RATING.--

A. All policy or plan forms, including applications, enrollment forms, policies, plans, certificates, evidences of coverage, riders, amendments, endorsements and disclosure forms, shall be submitted to the superintendent for approval prior to use.

underscored material = new
[~~bracketed material~~] = delete

B. No policy or plan may be issued in the state unless the rates have first been filed with and approved by the superintendent. This subsection shall not apply to policies or plans subject to the Small Group Rate and Renewability Act.

C. In determining the initial year's premium or rate charged for coverage under a policy or plan, the only rating factors that may be used are age, gender, geographic area of the place 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 determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rate in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan from offering rates that differ depending upon family composition.

underscored material = new
[~~bracketed material~~] = delete

D. An insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan that provides a qualified wellness or disease management program may use a rating factor that reflects the expected level of participation in the program and the anticipated effect the program will have on utilization or medical claim costs. A qualified wellness or disease management program shall:

(1) meet the requirements of the federal Health Insurance Portability and Accountability Act of 1996 for bona fide wellness programs;

(2) provide financial incentives to covered employees or individuals for participating in the program; and

(3) provide to covered employees or individuals for whom it is unreasonably difficult to satisfy the program's applicable standards, reasonable alternative methods for achieving program participation.

E. The methodology proposed by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan for establishing rating factors for a qualified wellness or disease management program may take into consideration:

(1) the anticipated average percentage of employees or individuals eligible to participate in the program;

(2) the anticipated efficacy of the financial

underscored material = new
[~~bracketed material~~] = delete

incentives in producing high levels of program participation;

(3) the level of program participation achieved in prior coverage periods;

(4) the expected success rate for program participants;

(5) clinical studies; and

(6) the insurer's experience in the use of the program.

[~~D.~~] F. The provisions of this section do not preclude an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan from using health status or occupational or industry classification in establishing:

(1) rates for individual policies; or

(2) the amount an employer may be charged for coverage under a group health plan.

[~~E.~~] G. As used in Subsection [~~D~~] F of this section, "health status" does not include genetic information.

[~~F.~~] H. The superintendent shall adopt regulations to implement the provisions of this section."

Section 3. Section 59A-23C-5.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 33, as amended) is amended to read:

"59A-23C-5.1. ADJUSTED COMMUNITY RATING.--

A. A health benefit plan that is offered by a carrier to a small employer shall be offered without regard to

underscored material = new
[~~bracketed material~~] = delete

the health status of any individual in the group, except as provided in the Small Group Rate and Renewability Act. The only rating factors that may be used to determine the initial year's premium charged a group, subject to the maximum rate variation provided in this section for all rating factors, are the group members':

(1) ages;

(2) genders;

(3) geographic areas of the place of employment; or

(4) smoking practices.

B. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rate in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit a carrier from offering rates that differ depending upon family composition.

C. A carrier that provides a qualified wellness or

underscored material = new
[~~bracketed material~~] = delete

disease management program may use a rating factor that reflects the expected level of participation in the program and the anticipated effect the program will have on utilization or medical claim costs. A qualified wellness or disease management program shall:

(1) meet the requirements of the federal Health Insurance Portability and Accountability Act of 1996 for bona fide wellness programs;

(2) provide financial incentives to covered employees or individuals for participating in the program; and

(3) provide to covered employees or individuals for whom it is unreasonably difficult to satisfy the program's applicable standards, reasonable alternative methods for achieving program participation.

D. The methodology proposed by the carrier for establishing rating factors for a qualified wellness or disease management program may take into consideration:

(1) the anticipated average percentage of employees or individuals eligible to participate in the program;

(2) the anticipated efficacy of the financial incentives in producing high levels of program participation;

(3) the level of program participation achieved in prior coverage periods;

(4) the expected success rate for program

underscored material = new
[bracketed material] = delete

participants;

(5) clinical studies; and

(6) the insurer's experience in the use of the program.

[~~C.~~] E. The provisions of this section do not preclude a carrier from using health status or occupational or industry classification in establishing the amount an employer may be charged for coverage under a group health plan.

[~~D.~~] F. As used in Subsection [~~C~~] E of this section, "health status" does not include genetic information.

[~~E.~~] G. The superintendent shall adopt regulations to implement the provisions of this section."

underscored material = new
[~~bracketed material~~] = delete