HOUSE BILL 587

**49TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2009**

INTRODUCED BY

Keith J. Gardner

AN ACT

RELATING TO HEALTH CARE; REQUIRING THE HUMAN SERVICES DEPARTMENT TO SUBMIT AN AMENDMENT TO THE PLANS FOR THE STATE MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.

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

Section 1. A new section of Chapter 27 NMSA 1978 is enacted to read:

"[NEW MATERIAL] SHORT TITLE.--This act may be cited as the "Premium Assistance Maximization Act"."

Section 2. A new section of Chapter 27 NMSA 1978 is enacted to read:

"[NEW MATERIAL] DEFINITIONS.--As used in the Premium Assistance Maximization Act:

A. "full-benefit-eligible person" means a person who is eligible to receive a standard full medicaid benefit

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package under the approved medicaid state plan and who meets the criteria established in accordance with the provisions of the federal Social Security Act, but "full-benefit-eligible person" does not mean a person who would otherwise be eligible based on medically needy populations as described by the federal government;

B. "insurer" means a person subject to the authority of the superintendent that offers or issues one or more health benefit plans or insurance in the state, including a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a nonprofit health care plan or a multiple-employer welfare arrangement;

C. "medicaid state plan" means the plan for the state established and maintained pursuant to Title 19 or Title 21 of the federal Social Security Act;

D. "qualified health benefit plan" means a health benefit plan that is defined by federal law or rule and that the secretary determines is either:

(1) a benchmark benefit package, such as:

(a) a federal employee health benefit plan for preferred provider option services benefits;

(b) the state employee benefits plan pursuant to the Group Benefits Act;

(c) a health maintenance organization plan that has the largest insured commercial, non-medicaid

enrollment; or

(d) secretary-approved coverage that the secretary determines, in consultation with the superintendent, provides appropriate coverage; or

(2) a benchmark equivalent plan designed or selected by the state that includes:

(a) a benefit package with an aggregate actuarial value equivalent to the actuarial value of one of the benchmark benefit packages;

(b) coverage meeting minimum requirements for inpatient and outpatient hospital services, physician surgical and medical services, laboratory and x-ray services and well-baby and well-child care, including immunizations and other preventive services;

(c) an equivalent to the state employee benefits plan that includes prescription drugs, mental health services, vision services and hearing services; or

(d) other coverage reported in detail in an actuarial report;

E. "secretary" means the secretary of human services;

F. "self-funded health benefit plan" means a health benefit plan not subject to regulation by the insurance division of the public regulation commission that is paid in whole or in part by the employer from the employer's own assets

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or from a funded welfare benefit plan, provided that such plan does not shift any risk or liability for benefit payments to an insurer, other than through re-insurance or stop-loss coverage; and

G. "superintendent" means the superintendent of the insurance division of the public regulation commission."

Section 3. A new section of Chapter 27 NMSA 1978 is enacted to read:

"[NEW MATERIAL] STATE PLAN AMENDMENTS.--The secretary shall amend the medicaid state plan to:

A. adopt each of the benchmark benefit packages and the benchmark equivalent benefit packages permitted under medicaid or under the state children's health insurance program, Title 19 and Title 21 of the federal Social Security Act, respectively; and

B. provide that in calculating the actuarial value of a benchmark equivalent plan, the actuary shall apply the maximum cost sharing allowable under Title 19 or Title 21 of the federal Social Security Act."

Section 4. A new section of Chapter 27 NMSA 1978 is enacted to read:

"[NEW MATERIAL] QUALIFIED PLANS.--The secretary shall determine in consultation with the superintendent which plans among all the health benefit plans offered or issued in the state meet the criteria of being a benchmark benefit or a

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benchmark equivalent plan and shall certify all such plans as qualified health benefit plans for purposes of Section 5 of the Premium Assistance Maximization Act. In cases where one or more eligible persons are also eligible to enroll in a self-funded health benefit plan, the secretary shall establish procedures to evaluate whether the plan meets the criteria of being a benchmark benefit or a benchmark equivalent benefit plan and shall certify all such plans that meet the criteria as qualified health benefit plans for purposes of Section 5 of the Premium Assistance Maximization Act."

Section 5. A new section of Chapter 27 NMSA 1978 is enacted to read:

"[NEW MATERIAL] ENROLLMENT.--

A. The secretary shall require all full-benefit-eligible persons to enroll in a qualified health benefit plan.

B. In a household or family where more than one person is eligible for benefits under the medicaid state plan, the secretary shall, when possible, enroll all eligible household or family members in the same qualified health benefit plan.

C. A person who is exempt from mandatory enrollment under the provisions of Tile 19 or Title 21 of the federal Social Security Act may opt out of enrollment in a qualified health benefit plan at any time."

Section 6. A new section of Chapter 27 NMSA 1978 is

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enacted to read:

"[NEW MATERIAL] PREMIUM ASSISTANCE.--

A. The secretary shall pay applicable individual or family premiums on behalf of those eligible to entities that provide or sponsor qualified health benefit plans, including plans that are:

(1) commercial health plans;

(2) managed care organizations; or

(3) employer-sponsored health insurance plans.

B. The secretary may direct that premium assistance payments be made on behalf of those eligible to:

(1) an insurer that issues a qualified health benefit plan;

(2) a plan administrator of a qualified self-funded health benefit plan; and

(3) an administrative agent on behalf of an eligible person.

C. For a child under nineteen years of age who is covered under the medicaid state plan and who is enrolled in a qualified health benefit plan that provides less than full coverage for early and periodic screening, diagnostic and treatment services, the secretary shall ensure that the child has access to full early and periodic screening, diagnostic and treatment services. The secretary may fulfill this requirement by:

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(1) contracting with the qualified health benefit plan to pay the premiums on behalf of the child for a coverage rider that provides coverage for early and periodic screening, diagnostic and treatment services not otherwise covered by the plan;

(2) contracting with the issuer or sponsor of one or more supplemental benefit plans that provide coverage for one or more early and periodic screening, diagnostic and treatment services to pay the premiums for such coverage on behalf of the child;

(3) paying the premiums for a separate supplemental policy on behalf of the child that is issued by a licensed health insurer that provides coverage for early and periodic screening, diagnostic and treatment services as a secondary payer to any qualified health benefit plan; or

(4) reimbursing a licensed health professional for providing early and periodic screening, diagnostic and treatment services, to the extent that such services are not otherwise reimbursed by a qualified health benefit plan."

Section 7. A new section of Chapter 27 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PREMIUMS AND COST SHARING.--

A. The secretary shall calculate the maximum allowable cost sharing under federal law for an eligible person based on the person's family or household gross income,

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including all earned and unearned income.

B. Income and expense disregards applied in determining program eligibility shall not be applied in determining the maximum allowable cost sharing under Subsection A of this section.

C. In the case of an eligible person enrolled in a qualified health benefit plan who incurs cost sharing during a plan year in excess of the maximum allowable cost sharing, the secretary shall pay to the plan or plan sponsor, on behalf of the person, cost sharing incurred by the person under the terms of the plan that is in excess of the maximum allowable amount."

Section 8. A new section of Chapter 27 NMSA 1978 is enacted to read:

"[NEW MATERIAL] INDIVIDUAL INCENTIVE PROGRAM.--

A. The secretary shall establish an incentive program in which cost-sharing obligations may be reduced for persons who participate in initiatives to improve health outcomes and lower health care costs.

B. Incentive program activities may include:

(1) appropriate immunizations;

(2) appropriate and cost-effective prescription drug utilization;

(3) self-management of chronic health conditions; and

(4) participation in quality improvement

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initiatives."

Section 9. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2009.



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