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

SPONSOR HBIC **ORIGINAL DATE** 02/11/10 **LAST UPDATED** 02/17/10 **HB** 12/HBICS

SHORT TITLE Health Insurer Service Reimbursement **SB**

ANALYST Lucero

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY10	**FY11**		
	None		

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Public Regulation Commission (PRC)
Retiree Health Care Authority (RHCA)
Human Services Department (HSD)
Health Policy Commission (HPC)

SUMMARY

Synopsis of Bill

House Business and Industry Committee Substitute for House Bill 12 proposes to enact new sections in the New Mexico Insurance Code's Small Group Rate and Renewability Act, the Health Maintenance Organization Law, and the Nonprofit Health Care Plan Law to require health insurers to reimburse for direct health care services at a rate no less than 85 percent of premiums across all health product lines over the previous three calendar years, but not earlier than calendar year 2010 as determined by reports filed with the Public Regulation Commission's Division of Insurance.

For individually underwritten policies, following notice and an informal hearing, the Superintendent of Insurance must establish the level of reimbursement for direct services as at least 75 percent of premiums, to be determined by the records filed with the Insurance Division. The superintendent must consider the costs associated with individual marketing and medical underwriting of the policies. The calculation will be made based on the level of the reimbursement for direct services over the three calendar years before the date on which that rate is established, but not earlier than 2010. The requirements establish a floor, and a purchaser of a policy of coverage may negotiate an agreement with an insurer that requires a

larger percentage of premiums paid be used for reimbursement for direct services.
However, the bill specifies that the new subsection shall not be construed to preclude a purchaser from negotiating an agreement with a health insurer that requires a higher amount of premium paid to be used for reimbursement for direct services for one or more products or for one or more years. For the purposes of the new section, the bill defines direct services, health insurer, and premium.

An insurer that does not comply with the reimbursement requirements must issue a dividend or credit against future premiums to all policyholders in an amount sufficient to assure that the benefits paid in the preceding three calendar years plus the amount of dividends or credits are equal to the required direct services reimbursement level. The superintendent may enforce compliance with this provision, in addition to any other penalties as provided by law.

FISCAL IMPLICATIONS

Although though there is no impact to state agencies, the PRC notes that the Risk Management Division of the General Services Department, as a self-insured entity, has been able to keep its administrative costs and those of contracting administrators far below the 85% requirement in this bill. Accordingly, the state should experience no fiscal impact.

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.

SIGNIFICANT ISSUES

The Health Policy Commission reports:

> The bill attempts 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, also referred to as a medical loss ratio (MLR). An MLR of 0.85 indicates that 85 percent of premiums are used to purchase medical services (as opposed to administrative costs and profits, in this case 15 percent). High MLR ratios can be achieved either through a large numerator (high medical expenditures) or through a small denominator (low insurance premiums).
>
> The components of the MLR are derived from internal accounting statistics developed by insurance companies to measure what fraction of premium revenues are paid out in claims (losses). State insurance departments gradually have required insurers to file loss ratios as part of their documentation of solvency and, in regulated contexts, for rate increases.
>
> The National Association of Insurance Commissioners (NAIC) has sought to standardize the often inconsistent accounting practices and definition of terms (for example, what counts as an administrative expense). The available data on MLRs, which are collected from state agencies, suffer from the inconsistent nature of the underlying insurer reports, the limits of auditing standards, and the incomplete adoption of NAIC guidelines. Public access is difficult and time-consuming as a result of the information not being centralized or available in an electronic format.

According to the PRC:

> Legislation that limits health insurers' administrative costs and provides a minimum level of health care services per premium dollar, commonly referred to as a "minimum loss ratio" law, is intended to ensure that the consumer has spent their premium dollars on health care coverage, with an appropriate amount set aside for the cost of administering the health care plan. A 2008 survey by Families USA found that only a few states have such laws, and that of those states with such laws, the typical minimum loss ratio for the small group market is 75%, while the individual market allows for more administrative costs per premium dollar.
>
> The ratio required by this proposal takes premium taxes off the top, so that the effective percentage spent on direct services is closer to eighty-one percent (81%) in the group market, with a floor closer to seventy-one percent (71%) in the individual market.
>
> In New Mexico, past performance for health maintenance organizations (HMOs) indicates that medical costs generally hover around the 85% requirement absent legislation. On the other hand, the ratio of direct services to premiums varies considerably in the individual market. In the current individual market, the administrative burden is greater, as the insurer undertakes marketing to individuals, and then performs medical underwriting of individuals to determine individual risk, eligibility for coverage, and premium rates. Insurers do not face equivalent administrative burdens when they write group coverage. In consideration of this difference, the substitute provides for separate percentage requirements for the group and individual markets.
>
> To give insurers the opportunity to prepare for the new requirements, the bill has included language that requires that the required ratios be determined by looking at the preceding three calendar years, but not earlier than calendar year 2010.
>
> The Managed Health Care Rule (MHCR), at 13.10.22.13 NMAC, already requires reporting of administrative costs and benefits. The definition of "direct services" in the proposed legislation is nearly identical to that which is contained in the MHCR, with a clarification/qualifier as what is not included in "direct services." This clarification is in accordance with the interpretation of direct services by the MHCR by the PRC.

The bill defines direct services as:

> "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 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. In addition the bill clarifies that "Direct services" *do not* include care coordination, utilization review or management or any other activity designed to manage utilization or services.

PERFORMANCE IMPLICATIONS

According to the PRC, the bill does not account for everything that is needed to determine whether the 85% of direct services has been met. See "Amendments" below.

ADMINISTRATIVE IMPLICATIONS

In addition to the proposed rulemaking and hearing on the issue of the percentage of direct services required in the individual market, the Superintendent may need to adopt additional rules to implement provisions of this section. For instance, it may be desirable to make allowances for plans that have been in existence for less than three years, as provided for in the reporting requirements for medical loss ratios, currently in effect at 13.10.22.13(B) 1-3 NMAC.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Companion to: HB96, "Guaranteed Issue of Health Insurance Coverage," HB31 "Health Insurer Guaranteed Issue," HB32 "Health Insurance Small Employer Definition," HB96 "Guaranteed Issue of Health Insurance Coverage," and HB106 "Limit Health Benefit Plan Index Rate"

OTHER SUBSTANTIVE ISSUES

HPC submits the following information:

Several states limit or are considering legislation to limit the amount of money heath insurance companies spend on administration and/or profit. In 2008, several state-based efforts that addressed health care reform incorporated proposals to regulate MLRs by insurers. Proposals in California, Pennsylvania, New Mexico, Michigan, Illinois, and Wisconsin have all discussed setting a minimum MLR, often at 85 percent. While some states currently do impose minimum MLRs, these are significantly lower than the proposed new standards.

State	Individual Market	Small Group Market	Other	Statutory Reference
California			Managed care plans: Administrative costs not to be "excessive," limited to 15% to 25% based on developmental phase of plan. Administrative costs do not include some factors such as salaries, stock options, etc.	California Health And Safety Code HSC Section 1378, enforced through Cal. Admin. Code tit. 28, § 1300.78
Delaware		75%		Title 18 Chapter 25 § 2506
Kentucky	65%	Groups of 2-10: 70% Groups of 11-50: 75%		KRS 304.17A-095(6)
Maine	65%	Insurers that file rates annually: 75% Insurers that file rates every three years: 78%		Individual: Title 24-A, Chapter 33, §2736-C Small group: Title 24-A Chapter 35, §2808-B 2-C
Maryland	60%	75%		Maryland Code § 15-605
Minnesota	65%	Groups of 2-9: 71% Groups of 10-50: 75%	Large group carriers: 82%	62A.021
Nevada			Nonprofit corporations: 75% Individual dental insurance: 75%	NRS 695B.170 NRS 686B.125
New Jersey	75%			17B:27A-25
New York	80%			§ 3231(3)(2)(A)
North Dakota	55%			26.1-36-37.2
Oklahoma		60%		36 O.S. 6515
South Dakota	65%			Individual: 58-17-64 Small group: 58-18-63
Vermont	70%		Safety net market: 80%	Title 8 Chapter 107 4080b(C)(m)

Washington	77%			SB 5261
Wyoming	60%			Individual: Chapter 33 Article 6C §33-6C-1 Small Group: §33-16D-5

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Health insurers will not be required to reimburse for direct health care services at prescribed rates, though they will continue to report to the Superintendent of Insurance their ratio of direct services to total premium. The Superintendent will continue to publish those ratios for those insurers that have managed health care plans subject to the MHCR.

DL/svb:mew