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

SPONSOR HHGAC **ORIGINAL DATE** 02/11/11 **LAST UPDATED** 03/09/11 **HB** 245/HHGACS

SHORT TITLE Health Insurance Purchasing Cooperative **SB**

ANALYST Esquibel

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Non-Rec	Fund Affected
FY11	FY12	FY13		
	N/A	N/A	N/A	N/A

(Parenthesis ( ) Indicate Revenue Decreases)

HB245 relates to SB370, Enact "New Mexico Health Insurance Exchange Act"; HB33/csHCPAC, New Mexico Health Insurance Exchange Act; SB38, New Mexico Health Insurance Exchange Act; HB257, LFC Perform FIR on Health Care Reform Designs; SB386, LFC to Conduct FIRS on Health Care Designs.

SOURCES OF INFORMATION

LFC Files
Responses Received From
Public Regulation Commission
Health Policy Commission
Human Services Department

SUMMARY

Synopsis of HHGAC Substitute

The House Health and Government Affairs Committee substitute for House Bill 245 amends the New Mexico Insurance Code to include in the definition of "group health insurance" a policy of coverage issued to a private health insurance cooperative, as defined in this bill. The cooperative is allowed to negotiate premium rates paid by its members.

Section 1 amends Article 23, Chapter 59A (the Insurance Code) to include a private health insurance cooperative, as defined in this bill, as an entity that may be issued a group health insurance plan or policy of coverage.

Section 2 includes the elements needed to establish a private health insurance cooperative, and the rights and responsibilities of the cooperative.

A private health insurance cooperative must:

- Organize as a nonprofit corporation, as provided by the Nonprofit Corporation Act, a

state law that is outside the purview of the Insurance Code.

- Consist of two (2) or more large or small employers, or any combination of large or small employers, with an aggregate of 50 or more FTEs.
- Not be formed by carriers or allow a carrier to be a member of a cooperative. "A cooperative is not a carrier or an insurer…."
- Arrange for group health benefit plan coverage for participating employer groups. (Carriers must contract abide by the requirements of Article 23 (regarding group health plans) of the Insurance Code.
- Collect premiums to cover the cost of group health benefit plan coverage, and administrative expenses.
- Establish administrative and accounting procedures for the operation of the cooperative, and grievance procedures for participants.
- Contract with carriers to provide services to employers covered through the cooperative.
- Publicize the cooperative's eligibility requirements and procedures for enrollment in the coverage offered by the cooperative.
- Issue coverage for the cooperative through a licensed agent marketing the coverage in accordance with Article 23.
- Not self-insure or self-fund any health benefit plan or portion of a plan.
- Must not restrict a small or large employer's access to health benefit plans pursuant to the Insurance Code.
- Must register with the Public Regulation Commission's Division of Insurance (DOI) as a cooperative, in accordance with insurance division rules, as promulgated by the superintendent, as specified and directed to do so under Section 3 of the bill.
- Must contract only with carriers that meet all of the following requirements:
    - Good standing with the DOI.
    - "Has the capacity to administer health benefit plans."
    - "Is able to monitor and evaluate quality and cost-effectiveness of care and applicable procedures."
    - "Is able to conduct utilization management and establishes applicable procedures and policies."
    - "Is able to ensure that enrollees have adequate access to health care providers, including adequate numbers and types of providers."
    - "Has a satisfactory grievance procedure and is able to respond to enrollees' calls, questions and complaints."
    - Has financial capacity by satisfying financial solvency standards set by the Superintendent of Insurance or through appropriate reinsurance or other risk-sharing mechanisms.

Rights of the private health insurance cooperative:

- To negotiate the premiums paid by its members.
- To restrict membership to employers within a single industry grouping.
- To be rated so that members of the cooperative are considered a single risk pool.
- To offer members more than one group health benefit plan, provided that all employees are eligible to participate in each plan offered.
- Employees of the cooperative may provide information about and solicit membership in the cooperative, without obtaining a license as an agent of broker, under the Insurance Code.

Carriers:

- Must cover diabetes equipment, supplies and services in any group health benefit plan provided to a cooperative.
- May elect not to participate in any cooperative, and may elect to participate in one or more cooperatives without participating in all cooperatives.

FISCAL IMPLICATIONS

The PRC indicates a cooperative is a purchasing group and not a carrier or an insurer. Therefore, premium taxes will be collected from the insurance carriers, and the policies issued will have all the requirements of New Mexico law and regulations currently imposed on insurance carriers. The additional cost of issuing regulations for the cooperatives is minor.

SIGNIFICANT ISSUES

The Human Services Department indicates formation of cooperatives between employers is not unlike the associations that are already allowed under Section 59A-34-3(a) (2) NMSA 1978. The general consensus is that associations under that law have not lowered premium costs for employers a healthy individuals leave association health plans to find coverage in the individual market at a lower cost. Unhealthy individuals remained in the association's health plans.

This bill does not attempt to create a Consumer Operated and Oriented Plan (CO-OP), authorized under the Patient Protection and Affordable Care Act (PPACA). CO-OPs will be eligible for federal establishment funds at a later time, and will be organized as non-profit, member-run health insurance companies.

ALTSD indicates in amending the current Insurance Code, HB245/HHGACS explicitly would include municipal or governmental entities in the definition of "employers".

PERFORMANCE IMPLICATIONS

The Superintendent of Insurance is required to promulgate rules pertaining to the governance and registration of health insurance cooperatives, and to administer and enforce those rules and the provisions of this proposed legislation.

The bill requires that the cooperative only contract with a carrier that is able to conduct utilization management. A health plan that has utilization management is subject to the Managed Health Care Rules, previously promulgated by the superintendent. Any plans offered to the proposed cooperatives would need to meet the requirements of these rules.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

HB245/HHGACS relates to:

- SB 38 & 370/SCORCS/aSFC (NM Health Insurance Exchange Act),
- HB33/HCPACS/HHGACS/aHFL (NM Health Insurance Exchange Act),
- HB245 (Health Insurance Purchasing Cooperative),
- HB246 (Amend Health Insurance Alliance Act),
- HB257 (LFC Perform FIR on Health Care Reform Designs),

- HB323 ("Interstate Health Care Freedom Compact"),
- HB584 (NM Health Benefit Exchange Act)
- SB5 (Health Security Act),
- SB89 (Private Health Insurance Purchasing Co-Op Act),
- SB90 (Health Insurance Access for Large Employers),
- SB208 (Health Insurance Rate Increase Review),
- SB227 (Benchmark Usual & Customary Rates),
- SB386 (LFC to Conduct FIRs on Health Care Designs),
- SJR5 (State Health Care System, CA).

TECHNICAL ISSUES

HSD indicates there is no need to have a separate statement in this legislation providing for diabetes equipment coverage, since the health insurance cooperatives are "group health insurance" for all purposes of Article 23, Chapter 59A. There is a long list of benefit mandates found in Article 23, including a reference at Section 59A-23-4 NMSA 1978 that incorporates the provisions of Section 59A-22-41, NMSA 1978, which contains a detailed description of mandated diabetes services and supplies.

OTHER SUBSTANTIVE ISSUES

The Health Policy Commission indicates the federal Patient Protection and Affordable Care Act (PPACA) creates state-based American Health Benefit Exchanges and small business health options program (SHOP) Exchanges, administered by a governmental agency or non-profit organization through which individuals and small businesses with up to 100 employees can purchase qualified coverage. The PPACA permits states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves as a distinct geographic area. Funding is available to states to establish within one year of enactment and until January 1, 2015.

In addition, federal funds will be made available to establish Consumer Operated and Oriented Plans (CO-OPs) to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members.

(Source: Henry J. Kaiser Family Foundation, www.kff.rg/healthreform/upload/8061.pdf)

It is important to note that the PPACA requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)

In addition, the PPACA requires that a process be established for reviewing increases in health plan premiums and requires plans to justify increases. The Act requires states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases. The PPACA also provides grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)

(Source: Henry J. Kaiser Family Foundation, www.kff.rg/healthreform/upload/8061.pdf)

According to *Cover the Uninsured*, a project of the Robert Wood Johnson Foundation, more than 50 million Americans are uninsured: More than 7 million of them are children; more than eight out of 10 are in working families.

New Mexico data highlights provided by *Cover the Uninsured* include:

- % of population w/ health insurance 79.9%
- % of employers offering health insurance to employees 51.2%
- % of population that could get medical care when needed 85.1%
- Patients served by FQHCs as a % of population under 200% FPL 30.2%

(Source: *Cover the Uninsured*. http://covertheuninsured.org/category/state/new-mexico)

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Employers will not be able to form cooperatives for the purpose of offering group health coverage with a single risk pool across employers.

RAE/bym