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

SPONSOR Papen **ORIGINAL DATE** 02/21/11 **LAST UPDATED** **HB**

SHORT TITLE Health Insurance Appeals **SB** 499

ANALYST Haug

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY11	FY12	FY13	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
		Minimal – $0 - $200.0	Minimal – $0 - $200.0	Minimal – $0 - $600.0	Recurring	General Fund
		Moderate – $0 - $500.0	Moderate – $0 - $500.0	Moderate – $0 - $1,500.0	Recurring	Insurance Operation Funds

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to SB 208

SOURCES OF INFORMATION
LFC Files

Responses Received From
Attorney General (AGO)
Health Policy Commission (HPC)
Administrative Office of the Courts (AOC)

SUMMARY

Synopsis of Bill

Senate Bill 499 amends various statutes to clarify the role of the Public Regulation Commission and the Superintendent of Insurance with respect to the review of health insurance rate filings.

FISCAL IMPLICATIONS

With respect to a similar bill, the Public Service Commission (PRC) noted that the proposal, as in Senate Bill 499, would impose a higher standard on the Superintendent for reviewing health insurance rate proposal from large health insurance corporations. Review of such filings requires expert, actuary analysis. Such professionals are costly. The benefit however, is likely to be more manageable health insurance costs statewide.

SIGNIFICANT ISSUES

The AGO states:

> **Section 1:** Amends the "Public Regulation Act" (NMSA 8-8-14). New language grants discretionary authority to the PRC to conduct an "administrative review of classification of risks and rates" which includes findings of fact and conclusions of law. A non-discretionary 30 day review period is also created.
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> **Section 2:** Amends NMSA 59A-4-15. New language creates a non-discretionary deadline for the Superintendent of Insurance and a right of interlocutory appeal; no postponement may last more than 90 days, and if the Superintendent refuses to grant a hearing suspension or postponement, a party has 20 days to appeal that decision to the district court in Santa Fe.
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> This section also has new languages granting authority to the Superintendent to appoint a hearing examiner to preside over hearings on reconsideration. In such a hearing the hearing examiner shall provide recommended findings of fact and conclusions of law.
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> **Section 3:** Amends NMSA 59A-18-12. (Filing of forms and classifications, review of effect upon insured.) Existing law is clarified so that "health care plan" is specifically made part of the existing law.
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> **Section 4:** Amends NMSA 59A-18-13. (Approval or disapproval of health insurance forms.) New language substitutes the word "premium" with the phrase "classification of risks and rates" and mandates that no change shall be effective unless it comports with Chapter 59A, Article 18 NMSA 1978.
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> **Section 5:** Amends 59A-18-14 NMSA. New language appears to eliminate the applicability of this section to "any filing by a health insurer" while a new Section 6 describes the grounds upon which the Superintendent shall approve or disapprove new classifications of risks and rates.
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> **Section 6:** Creates a new section of Title 59A, Chapter 18, specifically governing the Superintendent's review of health insurance classifications of risks and rates. Mandates 60 days written notice of the change before any change can be effective. Mandates compliance with the Policy Language Simplification Law. Mandates which types of general information must be included in any filing.
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> **Section 7:** Creates a new section of Title 59A, Chapter 18, and requires the Superintendent to approve any new rate filing on various grounds, *viz.*, (1) compliance with federal law, (2) no deceptive or misleading language in the filing, (3) actuarially soundness, (4) the proposed rates or classification of risks is reasonable, not excessive or inadequate and not discriminatory, and (5) administrative expenses comport with all applicable law. Also, parties in the proceeding are given a choice of appeal processes – they can appeal to the PRC or to the district court. PRC may also take an appeal on its own motion.

Section 8: Creates a new section of Title 59A, Chapter 18 to clarify which administrative rules govern the hearings mandated under this Act. Hearings are to be co0nducted pursuant to the procedures used by the PRC. (NMSA 8-8-14, 15, 16).

Section 9: Creates a new section of Title 59A, Chapter 18 to define the "finality" of a Superintendent's Order, for purposes of perfecting an appeal.

Section 10: Creates a new section of Title 59A, Chapter 18 mandating that the Superintendent adopt rules governing the filing of classifications of risks and rates and to otherwise assure compliance with all applicable law.

The HPC comments:

The federal Patient Protection and Affordable Care Act (PPACA) requires that a process be established for reviewing increases in health plan premiums and requires plans to justify increases.

The 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 with 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.

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.

RELATIONSHIP

Senate Bill 499 is related to Senate Bill 208.

GH/svb