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

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

SHORT TITLE Private Health Insurance Purchasing Co-Op Act **SB** 89/SPACS

ANALYST Lucero

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY11	FY12	FY13	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total		NFI	NFI			

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Health Policy Commission (HPC)
Public Regulation Commission (PRC)

SUMMARY

Synopsis of Bill

Senate Public Affairs Committee Substitute for Senate Bill 89 amends to the Insurance Code and enacts the Private Health Insurance Purchasing Cooperative Act, which would allow for the creation of health insurance purchasing cooperatives among employers. The bill would allow both large and small (or a combination of the two) employers to form health insurance cooperatives. These cooperatives would be regulated by the Superintendent of Insurance.

Section 1 amends Section 59A-23-3 NMSA 1978 of the Insurance Code to allow health insurance to be issued under a policy issued to a cooperative. A cooperative is defined as a private health insurance cooperative established pursuant to Section 2 of this 2011 act.

Section 2 enacts a new section of Chapter 59A, Article 23 NMSA 1978 to provide for the creation of private health insurance cooperatives such that:

- A person may form a cooperative to purchase employer health benefit plans. A cooperative shall be organized as a nonprofit corporation and has the rights and duties provided by the Nonprofit Corporation Act.
- Two or more large employers or small employers or any combination of large employers and small employers with an aggregate of 50 or more full-time-equivalent employees may purchase group health benefit plans pursuant to Chapter 59A, Article 23 NMSA

1978.

- A carrier shall not form, or be a member of, a cooperative. A carrier may associate with a sponsoring entity, such as a business association, chamber of commerce or other organization representing employers or serving an analogous function, to assist the sponsoring entity in forming a cooperative.

A cooperative would be required to:

- Arrange for group health benefit plan coverage for employer groups that participate in the cooperative by contracting with carriers pursuant to Chapter 59A, Article 23 NMSA 1978;
- Collect premiums to cover the cost of group health benefit plan coverage purchased through the cooperative and the cooperative's administrative expenses;
- Establish administrative and accounting procedures for the operation of the cooperative;
- Establish procedures under which an applicant for or participant in group health benefit plan coverage issued through the cooperative may have a grievance reviewed by an impartial person;
- Contract with carriers to provide services to employers covered through the cooperative; and
- Develop and implement a plan to maintain public awareness of the cooperative and publicize the eligibility requirements for, and the procedures for enrollment in, group health benefit plan coverage through the cooperative.

In addition:

- A carrier would be required to issue health benefit plan coverage for the cooperative through a licensed agent marketing the coverage in accordance with the provisions of Chapter 59A, Article 23 NMSA 1978.
- Members of a cooperative would be considered a single risk pool.
- A group health benefit plan provide through a cooperative would be required to provide coverage for diabetes equipment, supplies and services.
- A cooperative would be prohibited from self-insuring or self-funding any health benefit plan or portion of a plan.
- A cooperative may contract only with a carrier that meets seven criteria as specified in the bill.
- A cooperative is not a carrier or an insurer and would be exempt from licensure as such.
- A cooperative would be required to register as a cooperative with the Insurance Division of the Public Regulation Commission.

Section 3 enacts a new section of the New Mexico Insurance Code to require the Superintendent of Insurance to adopt rules to govern the registration of health insurance cooperatives, including the registration of cooperative employees, pursuant to Chapter 59A, Article 23 NMSA 1978.

FISCAL IMPLICATIONS

No fiscal impact

SIGNIFICANT ISSUES

The federal Affordable Care Act establishes health insurance exchanges which could supersede health care cooperatives.

ADMINISTRATIVE IMPLICATIONS

The bill requires the Superintendent of Insurance to adopt rules to govern the registration of cooperatives.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Duplicates HB245/HHGACs (Health Insurance Purchasing Cooperative).

SB89/SPACs may also relate to the following:

- HB33 (New Mexico Health Insurance Exchange Act),
- HB246 (Amend Health Insurance Alliance Act),
- HB257 (LFC Perform FIR on Health Care Reform Designs),
- HB323 ("Interstate Health Care Freedom Compact"),
- SB5 (Health Security Act),
- SB38 (New Mexico Health Insurance Exchange 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),
- SB370 (Enact "NM Health Insurance Exchange Act")and
- SJR5 (State Health Care System, CA).

TECHNICAL ISSUES

This bill requires that the members of a cooperative be treated as single risk pool. This should promote more homogeneous and stable rates.

OTHER SUBSTANTIVE ISSUES

Under this bill, a cooperative is not allowed to self-insure or self-fund any portion of their health care plans. Also, while insurance companies will provide the coverage, they are not allowed to be members of the cooperative. This bill exempts employees of a cooperative from having to obtain an insurance agent's license.

OTHER SUBSTANTIVE ISSUES

The Health Policy Commission reports:

> 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.

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)

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