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

SPONSOR SJC **ORIGINAL DATE** 03/08/11 **LAST UPDATED** **HB**

SHORT TITLE Health Insurance Rate Increase Review **SB** CS/208 & 499/SJCS

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)

SOURCES OF INFORMATION

LFC Files

SUMMARY

Synopsis of Bill

The Senate Judiciary Committee Substitute for Senate Bills 208 and 499 would amend and enact sections of the New Mexico Insurance Code to provide greater transparency and improve the health insurance rate review process by mandating specific factors the Superintendent of Insurance must consider when reviewing proposed rate increases from a health insurance company. It also clarifies the process for review and appeal of the Superintendent's decision with respect to particular rate decisions.

Section 1: 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.

This section also has new language 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.

Section 2: 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. A "beneficiary or, in the public interest of the state, the attorney general" are added to "an insured" as persons who may request the insurer to review the manner in which its filing has been applied as to insurance or health care plan afforded to the insured the beneficiary or the Attorney General.

Section 3: Amends NMSA 59A-18-13. (Approval or disapproval of health insurance forms.) New language removes the word “premium” as modifier of rates and mandates that no change shall be effective unless it comports with Chapter 59A, Article 18 NMSA 1978. The 60 written notice of a policyholder before an increase in health insurance premium is removed and replaced with language in Section 6.

Section 4: Amends 59A-18-14 NMSA. New language appears to eliminate the applicability of this section to “any filing by a health insurer for a change in rate” while a new Section 6 describes the grounds upon which the Superintendent shall approve or disapprove new classifications of risks and rates.

Section 5: Creates a new section of Title 59A, Chapter 18, specifically governing the Superintendent’s review of health care plan rates filings. Mandates compliance with the Policy Language Simplification Law. Mandates which types of general information must be included in any filing.

Section 6: 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) actuarial 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 can appeal to the PRC within 20 days of a final order of the Superintendent.

Section 7: 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 conducted pursuant to the procedures used by the PRC. (NMSA 8-8-14, 15, 16).

Section 8: Creates a new section of Title 59A, Chapter 18 to permit “an aggrieved party” to appeal to the Supreme Court a matter arising from an order of the Commission on appeal pursuant to Section 7.

Section 9: Creates a new section of the New Mexico Insurance Code to authorize the Superintendent to require insurers to pool the experience of a closed block of business with all appropriate blocks of business that are not closed and prohibits the imposition of surcharges or penalties on members of the closed block.

Section 10: Creates a new section of the New Mexico Insurance Code to define “closed block of business” as a policy or group of policies that an insurer no longer markets or sells, or that has less than 500 contracts in force in the state, or for which enrollment has decreased by more than 12 percent since the last rate filing relating to that block of business.

Section 11: Creates a new section of the New Mexico Insurance Code to define “block of business” as a particular policy or pool that provides health insurance that an insurer issues to one or more individuals and that includes distinct benefits, services and terms.

Section 12: Creates a new section of the New Mexico Insurance Code to require the Superintendent of Insurance to adopt rules to define terms used regarding forms, rates, reviews and blocks of business that an insurer or health care plan submits in filing matters; to govern any additional filing requirements the Superintendent deems appropriate; to provide notice of

hearings and the grounds on which the hearings have been requested; to meet criteria for review in accordance with federal law; and that the Superintendent deems appropriate to carry out the provisions of Article 18.

Section 13: Amends 59A-4-20 NMSA to removes matters arising from Sections 6 and 7 from matters that may be appealed from an order of the Superintendent after an informal hearing or an administrative hearing.

Section 14: Makes the effective date January 1, 2012.

FISCAL IMPLICATIONS

The Public Regulation Commission (PRC) has with respect to previous bills, noted that the proposed legislation in Senate Judiciary Committee Substitute for Senate Bills 208 and 499, would impose a higher standard on the Superintendent for reviewing health insurance rate proposals 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 statewide health insurance costs. The estimates above reflect the uncertainty of potential costs involved in reviewing these rate proposals.

SIGNIFICANT ISSUES

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 for individuals and small businesses with up to 100 employees to 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.

GH/svb