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

SPONSOR Leavell **ORIGINAL DATE** 03/07/09 **LAST UPDATED** **HB**

SHORT TITLE Health Insurance Preferred Provider Changes **SB** 656

ANALYST Lucero

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY09	FY10	FY11	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total		NFI				

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From

SUMMARY

Synopsis of Bill

Senate Bill 656 proposes to amend Section 59A-22A-1 NMSA 1978 to change the name of the act to "Preferred Provider and Exclusive Provider Arrangements Law."

The bill defines an "exclusive provider arrangement" as a contract between or on behalf of a health care insurer and a preferred provider that requires persons covered under a health care insurer's plan to use the services of preferred providers and that complies with all the requirements of the Preferred Provider and Exclusive Provider Arrangements Law.

Under the bill, health care insurers may issue exclusive provider arrangement health benefit plans that require covered persons to use the health care services of preferred providers. The policies shall contain a provision stating that in the event a covered person receives emergency care for services specified in the exclusive provider arrangement and cannot reasonably reach a preferred provider; emergency care rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider.

FISCAL IMPLICATIONS

Exclusive provider arrangements require patients to use preferred providers organizations (PPO) only. These providers are usually chosen through a contract bidding process. PPOs have been considered market-oriented solution for controlling health care costs. For employers, PPOs can reduce health care costs without restricting employees' freedom to choose their provider or

increasing patients' cost sharing liabilities. Providers interpret PPOs as a marketing tool to increase patient volume without accepting financial risk and other restrictions of practice associated with health maintenance organizations (HMOs). To insurers and third-party brokers PPOs present a quick inexpensive vehicle for organizing a vertically integrated delivery system. For patients the PPOs can reduce cost-sharing without loss of freedom of choice.

OTHER SUBSTANTIVE ISSUES

There have been several federal court challenges regarding preferred provider organizations (PPO) which may extend to exclusive provider arrangements under the antitrust laws. Federal antitrust laws may inhibit the growth of PPOs, particularly provider-sponsored ones. The crucial element in determining whether the antitrust laws are violated is the reimbursement arrangement between the PPO and the participating providers. For example, threatened antitrust challenges by the U.S. Department of Justice lead to the disbanding of the Stanislaus PPO in California. The Stanislaus PPO signed up half the practicing physicians in Modesto and 90 percent in nearby Turlock. Participating physicians were forbidden in their contract from contracting with other PPOs. This inhibited the development of other, competing PPOs in the same areas.

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