

1 AN ACT

2 RELATING TO HEALTH COVERAGE; INCREASING THE HEALTH INSURANCE  
3 PREMIUM SURTAX; DISTRIBUTING A PORTION OF THE REVENUE OF THE  
4 SURTAX TO A NEW HEALTH CARE AFFORDABILITY FUND; PROVIDING FOR  
5 A REDUCTION IN THE SURTAX IF THE ANNUAL FEE ON HEALTH  
6 INSURANCE PROVIDERS PURSUANT TO THE FEDERAL PATIENT  
7 PROTECTION AND AFFORDABLE CARE ACT IS IMPOSED; CREATING THE  
8 HEALTH CARE AFFORDABILITY FUND TO BE USED TO REDUCE THE COST  
9 OF HEALTH CARE COVERAGE FOR NEW MEXICO RESIDENTS AND SMALL  
10 BUSINESSES; REQUIRING THE SUPERINTENDENT OF INSURANCE TO  
11 REPORT ON EXPENDITURES FROM THE HEALTH CARE AFFORDABILITY  
12 FUND; REQUIRING THE SUPERINTENDENT OF INSURANCE TO ESTABLISH  
13 AND ANNUALLY UPDATE HEALTH INSURANCE AFFORDABILITY CRITERIA  
14 THAT DEFINE AFFORDABILITY STANDARDS; PROHIBITING IMPOSITION  
15 OF COST SHARING FOR BEHAVIORAL HEALTH SERVICES UNDER CERTAIN  
16 INSURANCE COVERAGE POLICIES OR PLANS; ALLOWING PLANS EXEMPT  
17 FROM REGULATION UNDER THE NEW MEXICO INSURANCE CODE TO  
18 ELIMINATE COST SHARING FOR BEHAVIORAL HEALTH SERVICES;  
19 ESTABLISHING REPORTING REQUIREMENTS.

20  
21 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

22 SECTION 1. A new section of the Tax Administration Act  
23 is enacted to read:

24 "DISTRIBUTION--HEALTH INSURANCE PREMIUM SURTAX--HEALTH  
25 CARE AFFORDABILITY FUND.--A distribution pursuant to

1 Section 7-1-6.1 NMSA 1978 shall be made to the health care  
2 affordability fund in an amount equal to the following  
3 amounts of the net receipts attributable to the health  
4 insurance premium surtax; provided that if the rate of the  
5 health insurance premium surtax is reduced pursuant to  
6 Subsection F of Section 7-40-3 NMSA 1978, no distribution  
7 pursuant to this section shall be made:

8 A. beginning January 1, 2022 and prior to  
9 July 1, 2022, fifty-two percent;

10 B. beginning July 1, 2022 and prior to  
11 July 1, 2024, fifty-five percent; and

12 C. beginning July 1, 2024, thirty percent."

13 SECTION 2. Section 7-40-3 NMSA 1978 (being Laws 2018,  
14 Chapter 57, Section 3) is amended to read:

15 "7-40-3. IMPOSITION AND RATE OF TAX--DENOMINATION OF  
16 "PREMIUM TAX" AND "HEALTH INSURANCE PREMIUM SURTAX".--

17 A. A tax is imposed at a rate of three and  
18 three-thousandths percent of the gross premiums and  
19 membership and policy fees received or written by a taxpayer,  
20 as reported by March 1 of each year to the department in the  
21 appropriate schedule, as determined by the department, of the  
22 taxpayer's annual financial statement on insurance or  
23 contracts covering risks within the state during the  
24 preceding calendar year. The tax shall not be imposed on  
25 return premiums, dividends paid or credited to policyholders

1 or contract holders and premiums received for reinsurance on  
2 New Mexico risks. The tax imposed pursuant to this section  
3 may be referred to as the "premium tax".

4 B. For a taxpayer that is an insurer lawfully  
5 organized pursuant to the laws of the Republic of Mexico, the  
6 premium tax shall apply solely to the taxpayer's gross  
7 premium receipts from insurance policies issued by the  
8 taxpayer in New Mexico that cover residents of New Mexico or  
9 property or risks principally domiciled or located in  
10 New Mexico.

11 C. With respect to a taxpayer that is a property  
12 bondsman, "gross premiums" shall be considered any  
13 consideration received as security or surety for a bail bond  
14 in connection with a judicial proceeding.

15 D. The premium tax provided in Subsection A of  
16 this section is imposed on the gross premiums received of a  
17 surplus lines broker, less return premiums, on surplus lines  
18 insurance where New Mexico is the home state of the insured  
19 transacted under the surplus lines broker's license, as  
20 reported by the surplus lines broker to the department on  
21 forms and in the manner prescribed by the department. For  
22 purposes of this subsection, "gross premiums" shall include  
23 any additional amount charged the insured, including policy  
24 fees, risk purchasing group fees and inspection fees; but  
25 "premiums" shall not include any additional amount charged

1 the insured for local, state or federal taxes; regulatory  
2 authority fees; or examination fees, if any. For a surplus  
3 lines policy issued to an insured whose home state is  
4 New Mexico and where only a portion of the risk is located in  
5 New Mexico, the entire premium tax shall be paid in  
6 accordance with this section.

7 E. In addition to the premium tax, except as  
8 provided in Subsection F of this section, a health insurance  
9 premium surtax is imposed at a rate of three and  
10 seventy-five hundredths percent of the gross health insurance  
11 premiums and membership and policy fees received by the  
12 taxpayer on hospital and medical expense incurred insurance  
13 or contracts; nonprofit health care plan contracts, excluding  
14 dental or vision only contracts; and health maintenance  
15 organization subscriber contracts covering health risks  
16 within this state during the preceding calendar year. The  
17 surtax shall not apply to return health insurance premiums,  
18 dividends paid or credited to policyholders or contract  
19 holders and health insurance premiums received for  
20 reinsurance on New Mexico risks. The surtax imposed pursuant  
21 to this section may be referred to as the "health insurance  
22 premium surtax".

23 F. If an act of the United States congress is  
24 signed into law that imposes the annual fee on health  
25 insurance providers pursuant to Section 9010 of the federal

1 Patient Protection and Affordable Care Act, or that imposes a  
2 substantially similar fee on the same class of taxpayers, the  
3 rate of the health insurance premium surtax shall be  
4 decreased at a rate equal to the rate of the annual fee  
5 imposed; provided that the rate of the health insurance  
6 premium surtax shall not be less than one percent. A  
7 reduction in the health insurance premium surtax pursuant to  
8 this subsection shall go into effect on the later of the  
9 effective date of the imposition of the federal annual fee or  
10 ninety days after the congressional act imposing the federal  
11 annual fee is signed into law."

12 SECTION 3. A new section of the Health Care Purchasing  
13 Act is enacted to read:

14 "BEHAVIORAL HEALTH SERVICES--ELIMINATION OF COST  
15 SHARING.--

16 A. Until January 1, 2027, group health coverage,  
17 including any form of self-insurance, offered, issued or  
18 renewed under the Health Care Purchasing Act that offers  
19 coverage of behavioral health services shall not impose cost  
20 sharing on those behavioral health services.

21 B. For the purposes of this section:

22 (1) "behavioral health services" means  
23 professional and ancillary services for the treatment,  
24 habilitation, prevention and identification of mental  
25 illnesses, substance abuse disorders and trauma spectrum

1 disorders, including inpatient, detoxification, residential  
2 treatment and partial hospitalization, intensive outpatient  
3 therapy, outpatient and all medications, including brand-name  
4 pharmacy drugs when generics are unavailable;

5 (2) "coinsurance" means a cost-sharing  
6 method that requires an enrollee to pay a stated percentage  
7 of medical expenses after any deductible amount is paid;  
8 provided that coinsurance rates may differ for different  
9 types of services under the same group health plan;

10 (3) "copayment" means a cost-sharing method  
11 that requires an enrollee to pay a fixed dollar amount when  
12 health care services are received, with the plan  
13 administrator paying the balance of the allowable amount;  
14 provided that there may be different copayment requirements  
15 for different types of services under the same group health  
16 plan; and

17 (4) "cost sharing" means a copayment,  
18 coinsurance, deductible or any other form of financial  
19 obligation of an enrollee other than a premium or a share of  
20 a premium, or any combination of any of these financial  
21 obligations, as defined by the terms of a group health plan."

22 SECTION 4. A new section of the New Mexico Insurance  
23 Code is enacted to read:

24 "HEALTH CARE AFFORDABILITY FUND.--

25 A. The "health care affordability fund" is created SB 317  
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1 in the state treasury. The fund consists of distributions,  
2 appropriations, gifts, grants and donations. Money in the  
3 fund at the end of a fiscal year shall not revert to any  
4 other fund. The office of superintendent of insurance shall  
5 administer the fund, and money in the fund is subject to  
6 appropriation by the legislature for purposes provided by  
7 this section. Disbursements from the fund shall be made by  
8 warrant of the secretary of finance and administration  
9 pursuant to vouchers signed by the superintendent or the  
10 superintendent's authorized representative.

11 B. The purpose of the fund is to:

12 (1) reduce health care premiums and cost  
13 sharing for New Mexico residents who purchase health care  
14 coverage on the New Mexico health insurance exchange;

15 (2) reduce premiums for small businesses and  
16 their employees purchasing health care coverage in the fully  
17 insured small group market;

18 (3) provide resources for planning, design  
19 and implementation of health care coverage initiatives for  
20 uninsured New Mexico residents; and

21 (4) provide resources for administration of  
22 state health care coverage initiatives for uninsured New  
23 Mexico residents.

24 C. If the federal Patient Protection and  
25 Affordable Care Act is repealed in full or in part by an act

1 of congress or invalidated by the United States supreme court  
2 and eliminates or reduces comprehensive health care coverage  
3 for New Mexico residents through medicaid or the New Mexico  
4 health insurance exchange, the fund may be used to maintain  
5 coverage through the New Mexico health insurance exchange or  
6 through medical assistance programs administered by the human  
7 services department, provided that coverage is prioritized  
8 for New Mexico residents with incomes below two hundred  
9 percent of the federal poverty level.

10 D. Prior to July 1, 2025, the staff of the  
11 legislative finance committee shall conduct a program  
12 evaluation to measure the impact of changes to the health  
13 insurance premium surtax and the creation of the health care  
14 affordability fund as it relates to the purpose of the fund.

15 E. Prior to July 1 of each year, the  
16 superintendent shall provide actuarial data from the health  
17 care affordability fund to the legislative finance committee.

18 F. Prior to July 1 of each year, the  
19 superintendent, in consultation with the secretary of human  
20 services, the secretary of taxation and revenue and the  
21 chief executive officer of the New Mexico health insurance  
22 exchange, shall work with the legislative finance committee  
23 and the department of finance and administration to develop  
24 and report on performance measures relating to the health  
25 care affordability fund and any programs or initiatives



1 funded by the fund."

2 SECTION 5. A new section of the New Mexico Insurance  
3 Code is enacted to read:

4 "HEALTH CARE AFFORDABILITY PLAN--RULEMAKING--REPORTING  
5 REQUIREMENTS.--

6 A. The superintendent, in consultation with the  
7 secretary of human services, the secretary of taxation and  
8 revenue and the chief executive officer of the New Mexico  
9 health insurance exchange, shall promulgate rules to:

10 (1) provide enhanced premium and  
11 cost-sharing assistance to individuals and families for the  
12 purchase of qualified health plans on the New Mexico health  
13 insurance exchange. In providing this assistance, the  
14 superintendent shall develop health care affordability  
15 criteria designed to reduce the amount that individuals pay  
16 in premiums and out-of-pocket medical expenses for qualified  
17 health plans offered on the New Mexico health insurance  
18 exchange; and

19 (2) establish income eligibility parameters  
20 for the health care affordability criteria for plan year 2023  
21 and each subsequent calendar year based on available funds.  
22 New Mexico residents who qualify shall have an income that is  
23 eligible for advanced premium tax credits under the federal  
24 Patient Protection and Affordable Care Act.

25 B. The superintendent, in consultation with the

1 human services department, the New Mexico medical insurance  
2 pool, the department of health and stakeholder groups,  
3 including health care providers that serve uninsured  
4 residents, health insurance carriers and consumer advocacy  
5 groups, shall develop a plan for extending health care  
6 coverage access to uninsured New Mexico residents who do not  
7 qualify for federal premium assistance or, except by reason  
8 of incarceration, qualified health plans, through the New  
9 Mexico health insurance exchange. No later than June 30,  
10 2022, the superintendent shall submit the plan to the  
11 legislative finance committee and the legislative health and  
12 human services committee that could offer health care  
13 coverage for eligible New Mexico residents beginning July 1,  
14 2023. The plan shall include:

15 (1) details about health care benefits;

16 (2) health care affordability criteria  
17 designed to reduce the amount that individuals pay in  
18 premiums and out-of-pocket medical expenses under the plan  
19 and that result in, to the greatest extent possible, health  
20 care costs comparable to costs for New Mexico residents for  
21 whom assistance is provided under Subsection A of this  
22 section; and

23 (3) income eligibility parameters that  
24 prioritize eligibility for New Mexico residents with incomes  
25 under two hundred percent of federal poverty level.

1 C. On or before October 31, 2023 and each October  
2 31 thereafter, the superintendent shall submit a report to  
3 the legislative finance committee and the legislative health  
4 and human services committee, which shall include:

5 (1) a summary of the affordability criteria  
6 implemented pursuant to Subsections A and B of this section;

7 (2) the estimated number of uninsured New  
8 Mexico residents who enrolled in coverage following  
9 implementation of the affordability criteria pursuant to  
10 Subsections A and B of this section; and

11 (3) the amount in reduced costs and coverage  
12 assistance the initiatives provided in the current and  
13 previous calendar years by income level, county and coverage  
14 source."

15 SECTION 6. A new section of Chapter 59A, Article 22  
16 NMSA 1978 is enacted to read:

17 "BEHAVIORAL HEALTH SERVICES--ELIMINATION OF COST  
18 SHARING.--

19 A. Until January 1, 2027, an individual or group  
20 health insurance policy, health care plan or certificate of  
21 health insurance that is delivered, issued for delivery or  
22 renewed in this state that offers coverage of behavioral  
23 health services shall not impose cost sharing on those  
24 behavioral health services.

25 B. For the purposes of this section:

1                   (1) "behavioral health services" means  
2 professional and ancillary services for the treatment,  
3 habilitation, prevention and identification of mental  
4 illnesses, substance abuse disorders and trauma spectrum  
5 disorders, including inpatient, detoxification, residential  
6 treatment and partial hospitalization, intensive outpatient  
7 therapy, outpatient and all medications, including brand-name  
8 pharmacy drugs when generics are unavailable;

9                   (2) "coinsurance" means a cost-sharing  
10 method that requires the insured to pay a stated percentage  
11 of medical expenses after any deductible amount is paid;  
12 provided that coinsurance rates may differ for different  
13 types of services under the same individual or group health  
14 insurance policy, health care plan or certificate of health  
15 insurance;

16                   (3) "copayment" means a cost-sharing method  
17 that requires the insured to pay a fixed dollar amount when  
18 health care services are received, with the insurer paying  
19 the balance of the allowable amount; provided that there may  
20 be different copayment requirements for different types of  
21 services under the same individual or group health insurance  
22 policy, health care plan or certificate of health insurance;  
23 and

24                   (4) "cost sharing" means a copayment,  
25 coinsurance, deductible or any other form of financial

1 obligation of the insured other than a premium or a share of  
2 a premium, or any combination of any of these financial  
3 obligations, as defined by the terms of an individual or  
4 group health insurance policy, health care plan or  
5 certificate of health insurance."

6 SECTION 7. A new section of Chapter 59A, Article 23  
7 NMSA 1978 is enacted to read:

8 "BEHAVIORAL HEALTH SERVICES--ELIMINATION OF COST  
9 SHARING.--

10 A. Until January 1, 2027, a group or blanket  
11 health insurance policy, health care plan or certificate of  
12 health insurance that is delivered, issued for delivery or  
13 renewed in this state that offers coverage of behavioral  
14 health services shall not impose cost sharing on those  
15 behavioral health services.

16 B. For the purposes of this section:

17 (1) "behavioral health services" means  
18 professional and ancillary services for the treatment,  
19 habilitation, prevention and identification of mental  
20 illnesses, substance abuse disorders and trauma spectrum  
21 disorders, including inpatient, detoxification, residential  
22 treatment and partial hospitalization, intensive outpatient  
23 therapy, outpatient and all medications, including brand-name  
24 pharmacy drugs when generics are unavailable;

25 (2) "coinsurance" means a cost-sharing

1 method that requires a covered person to pay a stated  
2 percentage of medical expenses after any deductible amount is  
3 paid; provided that coinsurance rates may differ for  
4 different types of services under the same group or blanket  
5 health insurance policy, health care plan or certificate of  
6 health insurance;

7 (3) "copayment" means a cost-sharing method  
8 that requires a covered person to pay a fixed dollar amount  
9 when health care services are received, with the insurer  
10 paying the balance of the allowable amount; provided that  
11 there may be different copayment requirements for different  
12 types of services under the same group or blanket health  
13 insurance policy, health care plan or certificate of health  
14 insurance; and

15 (4) "cost sharing" means a copayment,  
16 coinsurance, deductible or any other form of financial  
17 obligation of a covered person other than a premium or a  
18 share of a premium, or any combination of any of these  
19 financial obligations, as defined by the terms of a group or  
20 blanket health insurance policy, health care plan or  
21 certificate of health insurance."

22 SECTION 8. A new section of the Health Maintenance  
23 Organization Law is enacted to read:

24 "BEHAVIORAL HEALTH SERVICES--ELIMINATION OF COST  
25 SHARING.--

1           A. Until January 1, 2027, an individual or group  
2 health maintenance organization contract that is delivered,  
3 issued for delivery or renewed in this state that offers  
4 coverage of behavioral health services shall not impose cost  
5 sharing on those behavioral health services.

6           B. For the purposes of this section:

7                   (1) "behavioral health services" means  
8 professional and ancillary services for the treatment,  
9 habilitation, prevention and identification of mental  
10 illnesses, substance abuse disorders and trauma spectrum  
11 disorders, including inpatient, detoxification, residential  
12 treatment and partial hospitalization, intensive outpatient  
13 therapy, outpatient and all medications, including brand-name  
14 pharmacy drugs when generics are unavailable;

15                   (2) "coinsurance" means a cost-sharing  
16 method that requires an enrollee to pay a stated percentage  
17 of medical expenses after any deductible amount is paid;  
18 provided that coinsurance rates may differ for different  
19 types of services under the same individual or group health  
20 maintenance organization contract;

21                   (3) "copayment" means a cost-sharing method  
22 that requires an enrollee to pay a fixed dollar amount when  
23 health care services are received, with the carrier paying  
24 the balance of the allowable amount; provided that there may  
25 be different copayment requirements for different types of

1 services under the same individual or group health  
2 maintenance organization contract; and

3 (4) "cost sharing" means a copayment,  
4 coinsurance, deductible or any other form of financial  
5 obligation of an enrollee other than a premium or a share of  
6 a premium, or any combination of any of these financial  
7 obligations, as defined by the terms of an individual or  
8 group health maintenance organization contract."

9 SECTION 9. A new section of the Nonprofit Health Care  
10 Plan Law is enacted to read:

11 "BEHAVIORAL HEALTH SERVICES--ELIMINATION OF COST  
12 SHARING.--

13 A. Until January 1, 2027, an individual or group  
14 health care plan that is delivered, issued for delivery or  
15 renewed in this state that offers coverage of behavioral  
16 health services shall not impose cost sharing on those  
17 behavioral health services.

18 B. For the purposes of this section:

19 (1) "behavioral health services" means  
20 professional and ancillary services for the treatment,  
21 habilitation, prevention and identification of mental  
22 illnesses, substance abuse disorders and trauma spectrum  
23 disorders, including inpatient, detoxification, residential  
24 treatment and partial hospitalization, intensive outpatient  
25 therapy, outpatient and all medications, including brand-name



1 pharmacy drugs when generics are unavailable;

2 (2) "coinsurance" means a cost-sharing  
3 method that requires a subscriber to pay a stated percentage  
4 of medical expenses after any deductible amount is paid;  
5 provided that coinsurance rates may differ for different  
6 types of services under the same individual or group health  
7 care plan;

8 (3) "copayment" means a cost-sharing method  
9 that requires a subscriber to pay a fixed dollar amount when  
10 health care services are received, with the health care plan  
11 paying the balance of the allowable amount; provided that  
12 there may be different copayment requirements for different  
13 types of services under the same individual or group health  
14 care plan; and

15 (4) "cost sharing" means a copayment,  
16 coinsurance, deductible or any other form of financial  
17 obligation of a subscriber other than a premium or a share of  
18 a premium, or any combination of any of these financial  
19 obligations, as defined by the terms of an individual or  
20 group health care plan."

21 SECTION 10. REPORTING.--Until January 1, 2027:

22 A. the office of superintendent of insurance shall  
23 report by November 1 of each year to the governor, the  
24 legislative finance committee and the interim legislative  
25 health and human services committee data regarding the

1 elimination of cost sharing pursuant to the provisions of  
2 this 2021 act, including the effects on providers and  
3 patients with regard to costs for behavioral health services  
4 and the effects on health and social outcomes for patients,  
5 by using a set of performance measurement tools related to  
6 health care quality assurance, developed by a nationally  
7 recognized organization; and

8 B. the legislative finance committee shall report  
9 by November 1 of each year to the governor and the interim  
10 legislative health and human services committee data  
11 regarding the elimination of cost sharing pursuant to the  
12 provisions of this 2021 act, including the effects on  
13 providers and patients with regard to costs for behavioral  
14 health services and the effects on health and social outcomes  
15 for patients, by using a set of performance measurement tools  
16 related to health care quality assurance, developed by a  
17 nationally recognized organization.

18 SECTION 11. EFFECTIVE DATE.--The effective date of the  
19 provisions of this act is January 1, 2022. \_\_\_\_\_

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