AN ACT

RELATING TO HEALTH INSURANCE; AMENDING THE COMPREHENSIVE HEALTH INSURANCE POOL ACT; DEFINING CERTAIN ACTIONS AS UNFAIR TRADE PRACTICES.

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

Section 1. Section 59A-54-1 NMSA 1978 (being Laws 1987, Chapter 154, Section 1) is amended to read:

"59A-54-1. SHORT TITLE.--Chapter 59A, Article 54 NMSA 1978 may be cited as the "Medical Insurance Pool Act". Any reference in any law, rule, division bulletin or other legal document to the Comprehensive Health Insurance Pool Act shall be deemed to refer to the Medical Insurance Pool Act."

Section 2. Section 59A-54-2 NMSA 1978 (being Laws 1987, Chapter 154, Section 2) is amended to read:

"59A-54-2. PURPOSE.--The purpose of the Medical Insurance Pool Act is to provide access to health insurance coverage to all residents of New Mexico who are denied adequate health insurance and are considered uninsurable."

Section 3. Section 59A-54-3 NMSA 1978 (being Laws 1987, Chapter 154, Section 3, as amended) is amended to read:

"59A-54-3. DEFINITIONS.--As used in the Medical Insurance Pool Act:

A. "board" means the board of directors of the pool;

B. "creditable coverage" means, with respect to an individual, coverage of the individual pursuant to:

(1) a group health plan;

(2) health insurance coverage;

(3) Part A or Part B of Title 18 of the Social Security Act;

(4) Title 19 of the Social Security Act except coverage consisting solely of benefits pursuant to Section 1928 of that title;

(5) 10 USCA Chapter 55;

(6) a medical care program of the Indian health service or of an Indian nation, tribe or pueblo;

(7) the Medical Insurance Pool Act;

(8) a health plan offered pursuant to 5 USCA Chapter 89;

(9) a public health plan as defined in federal regulations; or

(10) a health benefit plan offered pursuant to Section 5(e) of the federal Peace Corps Act;

C. "health care facility" means any entity providing health care services that is licensed by the department of health;

D. "health care services" means any services or products included in the furnishing to any individual of medical care or hospitalization, or incidental to the furnishing of such care or hospitalization, as well as the

furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing or healing human illness or injury;

E. "health insurance" means any hospital and medical expense-incurred policy; nonprofit health care service plan contract; health maintenance organization subscriber contract; short-term, accident, fixed indemnity, specified disease policy or disability income contracts; limited benefit insurance; credit insurance; or as defined by Section 59A-7-3 NMSA 1978. "Health insurance" does not include insurance arising out of the Workers' Compensation Act or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is required by law to be contained in any liability insurance policy;

F. "health maintenance organization" means any person who provides, at a minimum, either directly or through contractual or other arrangements with others, basic health care services to enrollees on a fixed prepayment basis and who is responsible for the availability, accessibility and quality of the health care services provided or arranged, or as defined by Subsection M of Section 59A-46-2 NMSA 1978;

G. "health plan" means any arrangement by which persons, including dependents or spouses, covered or making application to be covered under the pool have access to

hospital and medical benefits or reimbursement, including group or individual insurance or subscriber contract; coverage through health maintenance organizations, preferred provider organizations or other alternate delivery systems; coverage under prepayment, group practice or individual practice plans; coverage under uninsured arrangements of group or group-type contracts, including employer self-insured, cost-plus or other benefits methodologies not involving insurance or not subject to New Mexico premium taxes; coverage under group-type contracts that are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by medicare or other governmental benefits. "Health plan" includes coverage through health insurance;

H. "insured" means an individual resident of this state who is eligible to receive benefits from any insurer or other health plan;

I. "insurer" means an insurance company authorized to transact health insurance business in this state, a nonprofit health care plan, a health maintenance organization and self-insurers not subject to federal preemption. "Insurer" does not include an insurance company that is licensed under the Prepaid Dental Plan Law or a company that is solely engaged in the sale of dental insurance and is licensed not under that act, but under

another provision of the Insurance Code;

J. "medicare" means coverage under Part A or Part B of Title 18 of the Social Security Act, as amended;

K. "pool" means the New Mexico medical insurance pool; and

L. "therapist" means a licensed physical, occupational, speech or respiratory therapist."

Section 4. Section 59A-54-4 NMSA 1978 (being Laws 1987, Chapter 154, Section 4, as amended) is amended to read:

"59A-54-4. POOL CREATED--BOARD.--

A. There is created a nonprofit entity to be known as the "New Mexico medical insurance pool". All insurers shall organize and remain members of the pool as a condition of their authority to transact insurance business in this state. The board is a governmental entity for purposes of the Tort Claims Act.

B. The superintendent shall, within sixty days after the effective date of the Medical Insurance Pool Act, give notice to all insurers of the time and place for the initial organizational meetings of the pool. Each member of the pool shall be entitled to one vote in person or by proxy at the organizational meetings.

C. The pool shall operate subject to the supervision and approval of the board. The board shall consist of the superintendent or his designee, who shall

serve as the chairman of the board, four members appointed by the members of the pool and five members appointed by the superintendent. The members appointed by the members of the pool shall consist of one representative of a nonprofit health care plan, one representative of a health maintenance organization and two representatives of other types of members of the pool. The members appointed by the superintendent shall consist of four citizens who are not professionally affiliated with an insurer, at least two of whom shall be individuals who are insured by the pool, who would qualify for pool coverage if they were not eligible for particular group coverage or who are a parent, guardian, relative or spouse of such an individual. The superintendent's fifth appointment shall be a representative of a statewide health planning agency or organization.

D. The members of the board appointed by the members of the pool shall be appointed for initial terms of four years or less, staggered so that the term of one member shall expire on June 30 of each year. The members of the board appointed by the superintendent shall be appointed for initial terms of five years or less, staggered so that the term of one member expires on June 30 of each year. Following the initial terms, members of the board shall be appointed for terms of three years. If the members of the pool fail to make the initial appointments required by this subsection within sixty days following the first

organizational meeting, the superintendent shall make those appointments. Whenever a vacancy on the board occurs, the superintendent shall fill the vacancy by appointing a person to serve the balance of the unexpired term. The person appointed shall meet the requirements for initial appointment to that position. Members of the board may be reimbursed from the pool subject to the limitations provided by the Per Diem and Mileage Act and shall receive no other compensation, perquisite or allowance.

E. The board shall submit a plan of operation to the superintendent and any amendments to it necessary or suitable to assure the fair, reasonable and equitable administration of the pool.

F. The superintendent shall, after notice and hearing, approve the plan of operation, provided it is determined to assure the fair, reasonable and equitable administration of the pool and provides for the sharing of pool losses on an equitable, proportionate basis among the members of the pool. The plan of operation shall become effective upon approval in writing by the superintendent consistent with the date on which coverage under the Medical Insurance Pool Act is made available. If the board fails to submit a plan of operation within one hundred eighty days after the appointment of the board, or any time thereafter fails to submit necessary amendments to the plan of operation, the superintendent shall, after notice and

hearing, adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of the Medical Insurance Pool Act. Rules promulgated by the superintendent shall continue in force until modified by him or superseded by a subsequent plan of operation submitted by the board and approved by the superintendent.

G. Any reference in law, rule, division bulletin, contract or other legal document to the New Mexico comprehensive health insurance pool shall be deemed to refer to the New Mexico medical insurance pool."

Section 5. Section 59A-54-7 NMSA 1978 (being Laws 1987, Chapter 154, Section 7, as amended) is amended to read:

"59A-54-7. BOARD--POWERS AND DUTIES.--The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health insurance business. In addition, the board shall have the specific authority to:

A. enter into contracts as are necessary or proper to carry out the provisions and purposes of the Medical Insurance Pool Act, including the authority, with the approval of the superintendent, to enter into contracts with similar pools of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions. The pool shall comply with the Procurement Code

except as otherwise provided in the Medical Insurance Pool Act;

B. sue or be sued, including taking any legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

C. establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices;

D. assess members of the pool in accordance with the provisions of the Medical Insurance Pool Act and make initial and interim assessments as may be reasonable and necessary for the organizational or interim operating expenses of the pool. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year. Interim assessments may include anticipated expenses of the next year that the board determines are reasonable and necessary for the operating expenses of the pool;

E. issue policies of insurance in accordance with the requirements of the Medical Insurance Pool Act;

F. appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design and any other function within the authority of the pool; and

G. conduct periodic audits to assure the general accuracy of the financial data submitted to the pool. The board shall cause the pool to have an annual audit of its operations by an independent certified public accountant."

Section 6. Section 59A-54-10 NMSA 1978 (being Laws 1987, Chapter 154, Section 10, as amended) is amended to read:

"59A-54-10. ASSESSMENTS.--

A. Following the close of each fiscal year, the pool administrator shall determine the net premium, being premiums less administrative expense allowances, the pool expenses and claim expense losses for the year, taking into account investment income and other appropriate gains and losses. The assessment for each insurer shall be determined by multiplying the total cost of pool operation by a fraction the numerator of which equals that insurer's premium and subscriber contract charges or their equivalent for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums and subscriber contract charges written in the state; provided that premium income shall include receipts of medicaid managed care premiums but shall

not include any payments by the secretary of health and human services pursuant to a contract issued under Section l876 of the Social Security Act, as amended. The board may adopt other or additional methods of adjusting the formula to achieve equity of assessments among pool members.

B. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

C. The proportion of participation of each member in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed with it by the member. Any deficit incurred by the pool shall be recouped by assessments apportioned among the members of the pool pursuant to the assessment formula provided by Subsection A of this section; provided that the assessment for any pool member shall be allowed as a thirty percent credit on the premium tax return for that member.

D. The board may abate or defer, in whole or in part, the assessment of a member of the pool if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligation. In the event an assessment against

a member of the pool is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in Subsection A of this section. The member receiving the abatement or deferment shall remain liable to the pool for the deficiency for four years."

Section 7. Section 59A-54-12 NMSA 1978 (being Laws 1987, Chapter 154, Section 12, as amended) is amended to read:

"59A-54-12. ELIGIBILITY--POLICY PROVISIONS.--

A. Except as provided in Subsection B of this section, a person is eligible for a pool policy only if on the effective date of coverage or renewal of coverage the person is a New Mexico resident, and:

(1) is not eligible as an insured or covered dependent for any health plan that provides coverage for comprehensive major medical or comprehensive physician and hospital services;

(2) is only eligible for a health plan that is offered at a rate higher than that available from the pool;

(3) has been rejected for coverage for comprehensive major medical or comprehensive physician and hospital services;

(4) is only eligible for a health plan with

a rider, waiver or restrictive provision for that particular individual based on a specific condition;

(5) has as of the date the individual seeks coverage from the pool an aggregate of eighteen or more months of creditable coverage, the most recent of which was under a group health plan, governmental plan or church plan as defined in Subsections P, N and D, respectively, of Section 59A-23E-2 NMSA 1978, except, for the purposes of aggregating creditable coverage, a period of creditable coverage shall not be counted with respect to enrollment of an individual for coverage under the pool if, after that period and before the enrollment date, there was a sixty-three-day or longer period during all of which the individual was not covered under any creditable coverage; or

(6) is entitled to continuation coverage pursuant to Section 59A-23E-19 NMSA 1978.

B. Notwithstanding the provisions of Subsection A of this section:

(1) a person's eligibility for a policy issued under the Health Insurance Alliance Act shall not preclude a person from remaining on a pool policy; provided that a self-employed person who qualifies for an approved health plan under the Health Insurance Alliance Act by using a dependent as the second employee may choose a pool policy in lieu of the health plan under that act;

(2) a pool policyholder shall be eligible

for renewal of pool coverage even though the policyholder became eligible for medicare or medicaid coverage while covered under a pool policy; and

(3) if a pool policyholder becomes eligible for any group health plan, the policyholder's pool coverage shall not be involuntarily terminated until any preexisting condition period imposed on the policyholder by the plan has been exhausted.

C. Coverage under a pool policy is in excess of and shall not duplicate coverage under any other form of health insurance.

D. A pool policy shall provide that coverage of a dependent unmarried person terminates when the person becomes nineteen years of age or, if the person is enrolled full time in an accredited educational institution, when he becomes twenty-five years of age. The policy shall also provide in substance that attainment of the limiting age does not operate to terminate coverage when the person is and continues to be:

(1) incapable of self-sustaining employment by reason of developmental disability or physical handicap; and

(2) primarily dependent for support and maintenance upon the person in whose name the contract is issued.

Proof of incapacity and dependency shall be furnished

to the insurer within one hundred twenty days of attainment of the limiting age and subsequently as required by the insurer but not more frequently than annually after the two-year period following attainment of the limiting age.

E. A pool policy that provides coverage for a family member of the person in whose name the contract is issued shall, as to the coverage of the family member or the individual in whose name the contract was issued, provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the family member or the person in whose name the contract is issued from the moment of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium shall be furnished to the carrier within thirty-one days after the date of birth in order to have the coverage continued beyond the thirty-one day period.

F. Except for a person eligible as provided in Paragraph (5) of Subsection A of this section, a pool policy may contain provisions under which coverage is excluded during a six-month period following the effective date of coverage as to a given individual for preexisting conditions, as long as either of the following exists:

(1) the condition has manifested itself within a period of six months before the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnoses or treatment; or

(2) medical advice or treatment was recommended or received within a period of six months before the effective date of coverage.

G. The preexisting condition exclusions described in Subsection F of this section shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage that was involuntarily terminated, if the application for pool coverage is made not later than thirty-one days following the involuntary termination. In that case, coverage in the pool shall be effective from the date on which the prior coverage was terminated. This subsection does not prohibit preexisting conditions coverage in a pool policy that is more favorable to the insured than that specified in this subsection.

H. An individual is not eligible for coverage by the pool if:

(1) except as provided in Subsection J of this section, the individual is, at the time of application, eligible for medicare or medicaid which would provide coverage for amounts in excess of limited policies such as dread disease, cancer policies or hospital indemnity policies;

(2) the individual has voluntarily terminated coverage by the pool within the past twelve months;

(3) the individual is an inmate of a public institution or is eligible for public programs for which medical care is provided;

(4) the individual is eligible for coverage under a group health plan;

(5) the individual has health insurance coverage as defined in Subsection R of Section 59A-23E-2 NMSA 1978;

(6) the most recent coverages within the coverage period described in Paragraph (5) of Subsection A of this section were terminated as a result of nonpayment of premium or fraud; or

(7) the individual has been offered the option of continuation coverage under a federal COBRA continuation provision as defined in Subsection F of Section 59A-23E-2 NMSA 1978 or under a similar state program and he has elected the coverage and did not exhaust the continuation coverage under the provision or program.

I. Any person whose health insurance coverage from a qualified state health policy with similar coverage is terminated because of nonresidency in another state may apply for coverage under the pool. If the coverage is applied for within thirty-one days after that termination

and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

J. The board may issue a pool policy for individuals who:

(1) are enrolled in both Part A and Part B of medicare because of a disability; and

(2) except for the eligibility for medicare, would otherwise be eligible for coverage pursuant to the criteria of this section."

Section 8. Section 59A-54-13 NMSA 1978 (being Laws 1987, Chapter 154, Section 13, as amended) is amended to read:

"59A-54-13. BENEFITS.--

A. The health insurance policy issued by the pool shall pay for medically necessary eligible health care services rendered or furnished for the diagnoses or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under Section 59A-54-14 NMSA 1978 and are not otherwise limited or excluded. Eligible expenses are the charges for the health care services and items for which benefits are extended under the pool policy. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations shall be established by the board and shall, at a minimum, reflect the levels of health insurance coverage generally available

in New Mexico for small group policies. The superintendent shall approve the benefit package developed by the board to ensure its compliance with the Medical Insurance Pool Act. The benefit package shall include therapy services and hearing aids.

B. The Medical Insurance Pool Act shall not be construed to prohibit the pool from issuing additional types of health insurance policies with different types of benefits which in the opinion of the board may be of benefit to the citizens of New Mexico.

C. The board may design and employ cost containment measures and requirements, including preadmission certification and concurrent inpatient review, for the purpose of making the pool more cost effective."

Section 9. Section 59A-54-14 NMSA 1978 (being Laws 1987, Chapter 154, Section 14, as amended) is amended to read:

"59A-54-14. DEDUCTIBLES--COINSURANCE--MAXIMUM OUT-OF-POCKET PAYMENTS.--

A. Subject to the limitation provided in Subsection C of this section, a pool policy offered in accordance with the Medical Insurance Pool Act shall impose a deductible on a per-person calendar-year basis. Deductible plans of five hundred dollars ($500) and one thousand dollars ($1,000) shall initially be offered. The board may authorize deductibles in other amounts. The

deductible shall be applied to the first five hundred dollars ($500) or one thousand dollars ($1,000) of eligible expenses incurred by the covered person.

B. Subject to the limitations provided in Subsection C of this section, a mandatory coinsurance requirement shall be imposed at the rate of twenty percent of eligible expenses in excess of the mandatory deductible.

C. The maximum aggregate out-of-pocket payments for eligible expenses by the insured shall be determined by the board."

Section 10. Section 59A-54-16 NMSA 1978 (being Laws 1987, Chapter 154, Section 16) is amended to read:

"59A-54-16. POOL POLICY.--

A. A pool policy offered under the Medical Insurance Pool Act shall contain provisions under which the pool is obligated to renew the contract until the day on which the individual in whose name the contract is issued first becomes eligible for medicare coverage, except that in a family policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the durational requirement of this subsection.

B. The pool shall not change the rates for pool policies except on a class basis with a clear disclosure in the policy of the right of the pool to do so.

C. A pool policy offered under the Medical Insurance Pool Act shall provide covered family members the

right to continue the policy as the named insured or through a conversion policy upon the death of the named insured or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the named insured by election to do so within a period of time specified in the contract subject to the requirements of Section 59A-54-l6 NMSA 1978."

Section 11. Section 59A-54-17 NMSA 1978 (being Laws 1987, Chapter 154, Section 17) is amended to read:

"59A-54-17. RULES.--The superintendent shall:

A. adopt rules that provide for disclosure by members of the pool of the availability of insurance coverage from the pool;

B. adopt rules that implement the provisions of the Medical Insurance Pool Act; and

C. adopt any other rules deemed necessary in order to carry out the provisions of the Medical Insurance Pool Act."

Section 12. Section 59A-54-18 NMSA 1978 (being Laws 1987, Chapter 154, Section 18) is amended to read:

"59A-54-18. COLLECTIVE ACTION.--Neither the participation by insurers in the pool, the establishment of rates, forms or procedures for coverages issued by the pool nor any other joint or collective action required by the Medical Insurance Pool Act shall be the basis of any legal action, civil or criminal liability or penalty against the

members of the pool either jointly or separately."

Section 13. Section 59A-54-19 NMSA 1978 (being Laws 1987, Chapter 154, Section 19, as amended) is amended to read:

"59A-54-19. RATES--STANDARD RISK RATE.--

A. The pool shall determine a standard risk rate by actuarially calculating the individual rate that an insurer would charge for an individual policy with the pool benefits issued to a person who was a standard risk. Separate schedules of standard risk rates based on age and other appropriate demographic characteristics may be used. In determining the standard risk rate, the pool shall consider the benefits provided, the standard risk experience and the anticipated expenses for a standard risk for the coverage provided. The rates charged for pool coverage shall be no more than one hundred fifty percent of the standard risk rate for each class of insureds.

B. The board shall adopt a low-income premium schedule that provides coverage at lower rates for those persons with an income less than an amount to be determined by the board. The board shall adopt as many income categories as it finds practical and shall determine income based on the preceding taxable year. No person shall be eligible for a low-income premium reduction if that person's premium is paid by a third party who is not a family member.

C. All rates and rate schedules shall be

submitted to the superintendent for approval."

Section 14. A new section of Chapter 59A, Article 16 NMSA 1978 is enacted to read:

"MEDICAL INSURANCE POOL ACT--UNFAIR REFERRAL.--It is an unfair trade practice for an insurer or other person to refer an individual employee or an employee's eligible dependent to the plan offered pursuant to the Medical Insurance Pool Act or to arrange for an individual employee or an employee's eligible dependent to apply to the plan, for the purpose of separating that employee or dependent from group health insurance coverage provided in connection with the employee's employment."

Section 15. TEMPORARY PROVISION--INTENT.--The intent of the amendment by this act to Subsection A of Section 59A-54-10 NMSA 1978 is to clarify that the calculation of assessments pursuant to Section 59A-54-10 NMSA 1978 includes medicaid managed care premiums. The specific inclusion of medicaid managed care premiums by this act shall not be interpreted to mean that medicaid managed care premiums were intended to be excluded from the calculation of assessments before the effective date of this act.