HOUSE BILL 1270

48TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2007

INTRODUCED BY

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AN ACT

RELATING TO HEALTH INSURANCE; PROVIDING FOR ADMINISTRATORS PURSUANT TO THE MEDICAL INSURANCE POOL ACT.

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

Section 1. 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

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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. "federally defined eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under the Medical Insurance Pool Act, the aggregate of the periods of creditable coverage is eighteen or more months;

(2) whose most recent prior creditable coverage was under a group health plan, government plan, church plan or health insurance coverage offered in connection with such a plan;

(3) who is not eligible for coverage under

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a group health plan, Part A or Part B of Title 18 of the Social Security Act or a state plan under Title 19 or Title 21 of the Social Security Act or a successor program and who does not have other health insurance coverage;

(4) with respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(5) who, if offered the option of continuation of coverage under a continuation provision pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or a similar state program elected this coverage; and

(6) who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in Paragraph (5) of this subsection;

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

E. "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

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healing human illness or injury;

F. "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;

G. "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;

H. "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

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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;

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

J. "insurer" means:

(1) 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; or

(2) a reinsurer or any insurer from whom a

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person providing health insurance procures insurance for itself or the insured, with respect to all or part of the health insurance risk of the person;

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

L. "pool" means the New Mexico medical insurance pool;

M. "preexisting condition" means a physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended for or received by an applicant within six months before the effective date of coverage, except that pregnancy is not considered a preexisting condition; [~~and~~]

N. "therapist" means a licensed physical, occupational, speech or respiratory therapist; and

O. "third party administrator" means a person paying or processing health coverage claims in the state."

Section 2. 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 and third party administrators 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

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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~~] the superintendent's designee, who shall serve as the [~~chairman~~] chair of the board, four members appointed by the members of the pool and six members appointed by the superintendent. 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. The superintendent's sixth appointment shall be a representative of the medical community.

D. The members of the board appointed by the members of the pool shall be appointed for initial terms of

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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

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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~~] the superintendent 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 3. Section 59A-54-10 NMSA 1978 (being Laws 1989, Chapter 154, Section 10, as amended by Laws 2005, Chapter 301, Section 5 and by Laws 2005, Chapter 305, Section 5) is amended to read:

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

A. Following the close of each fiscal year, the

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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 1876 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, including [~~assessment of health insurers and reinsurers~~] methods based upon the number of persons they cover [~~through primary, excess and stop-loss insurance in the state~~].

B. The board shall make a reasonable effort to ensure that each covered individual is counted only once with respect to any assessment. The board shall require each insurer that obtains excess or stop-loss insurance to include in its count of covered individuals all individuals whose

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coverage is insured, including through excess or stop-loss insurance, in whole or in part. The board shall allow a reinsurer to exclude from its count of covered individuals those individuals that have been counted by the primary insurer or by the primary reinsurer, primary excess reinsurer or stop-loss insurer to determine the assessment pursuant to this section.

[~~B.~~] C. 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.~~] D. 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 and a fifty-percent credit on the premium tax return for a member on the low-income premium schedule pursuant to Subsection B of Section 59A-54-19 NMSA 1978.

[~~D.~~] E. The board may abate or defer, in whole or

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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."