SENATE BILL 377

48TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2008

INTRODUCED BY

Michael S. Sanchez

AN ACT

RELATING TO HEALTH CARE REFORM; ENACTING THE ACCESS TO QUALITY UNIVERSAL HEALTH INSURANCE ACT; AMENDING AND ENACTING CERTAIN SECTIONS OF THE NEW MEXICO INSURANCE CODE; PROVIDING FOR UNIVERSAL HEALTH INSURANCE COVERAGE FOR NEW MEXICANS; MANDATING GUARANTEED ISSUE AND RENEWABILITY OF INSURANCE COVERAGE; REQUIRING NEW MEXICO RESIDENTS WITH INCOMES ABOVE FOUR HUNDRED PERCENT OF THE FEDERAL POVERTY LEVEL TO SHOW PROOF OF HEALTH COVERAGE; PROVIDING PREMIUM ASSISTANCE FOR HEALTH INSURANCE COVERAGE; ESTABLISHING MINIMUM REQUIREMENTS FOR MEDICAL LOSS RATIOS FOR INSURANCE COMPANIES; ESTABLISHING RISK EQUALIZATION MEASURES; ESTABLISHING COMMUNITY RATING FOR ALL HEALTH INSURANCE PRODUCTS.

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

Section 1. A new section of the New Mexico Insurance Code

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is enacted to read:

"[NEW MATERIAL] SHORT TITLE.--Sections 1 through 7 of this act may be cited as the "Access to Quality Universal Health Insurance Act"."

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

"[NEW MATERIAL] DEFINITIONS.--As used in the Access to Quality Universal Health Insurance Act:

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

(1) a group health plan;

(2) health insurance coverage;

(3) medicare pursuant to Part A or Part B of Title 18 of the federal Social Security Act;

(4) medicaid pursuant to Title 19 or Title 21 of the federal Social Security Act, except coverage consisting solely of benefits pursuant to Section 1928 of that title;

(5) the federal tricare program pursuant to 10 USCA Chapter 55;

(6) the Medical Insurance Pool Act;

(7) the federal employees health benefits program pursuant to 5 USCA Chapter 89;

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

(9) a health benefit plan offered pursuant to

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Section 5(e) of the federal Peace Corps Act;

B. "group health plan" means an employee welfare benefit plan to the extent the plan provides hospital, surgical or medical expenses benefits to employees or their dependents, as defined by the terms of the plan, directly through insurance, reimbursement or otherwise;

C. "health care services" means services rendered or products sold by a health care provider within the scope of the provider's license, including hospital, medical, surgical, dental, vision or pharmaceutical services or products;

D. "health insurance coverage" means any hospital and medical expense-incurred policy; nonprofit health care plan service contract or coverage of services; or health maintenance organization subscriber contract or coverage of services; but "health insurance coverage" does not include insurance issued pursuant to provisions of the Workers' Compensation Act or similar law; short-term, accident, fixed indemnity, specified disease policy or disability income insurance contracts and limited health benefit or credit health insurance; coverage for health care services under uninsured arrangements of group or group-type coverages, including employer self-insured, cost-plus or other benefits methodologies not involving insurance or not subject to New Mexico premium taxes; coverage for health care services under group-type contracts that are not available to the general public and can be obtained only

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because of connection with a particular organization or group; coverage by medicare or other governmental programs providing health care services; automobile medical payment insurance or provisions by which benefits are payable with or without regard to fault and are required by law to be contained in any liability insurance policy;

E. "health insurer" means an insurance company, insurance service or insurance organization, including a health maintenance organization, that is licensed to engage in the business of insurance in the state and that is subject to state law that regulates insurance within the meaning of Section 514(b)(2) of the federal Employee Retirement Income Security Act of 1974, but "health insurer" does not include a group health plan;

F. "insured" means an individual who has creditable coverage;

G. "medicare" means coverage under Part A or B of Title 18 of the federal Social Security Act;

H. "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 before the effective date of coverage, except that pregnancy is not considered a preexisting condition;

I. "premium" means all income received from individuals and private and public payers or sources for the

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procurement of health coverage, including capitated payments, recoveries from third parties or other insurers and interests; and

J. "secretary" means the secretary of taxation and revenue."

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

"[NEW MATERIAL] GUARANTEED ISSUE AND RENEWABILITY OF HEALTH INSURANCE COVERAGE.--

A. Effective January 1, 2010, a health insurer shall issue health insurance coverage to any person who requests and offers to purchase the coverage without exclusion of preexisting conditions.

B. A health insurer shall not impose a waiting period for any service related to a preexisting condition.

C. A health insurer shall ensure that an insured's privacy and confidentiality are protected and made applicable to individual and group policies.

D. The provisions of this section shall not apply to the following types of policies:

(1) disability income;

(2) long-term care;

(3) medicare supplement;

(4) credit health;

(5) short term;

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(6) accident-only;

(7) fixed indemnity;

(8) limited benefit; or

(9) specified disease."

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

"[NEW MATERIAL] ADJUSTED COMMUNITY RATING.--

A. Every health insurer shall, in determining the initial year's premium charged, use only the rating factors of age, gender, geographic area of the placement of employment and smoking practices, except that for individual policies the rating factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment.

B. Premium rates shall be subject to the following provisions:

(1) the index rate for a rating period for an individual shall not exceed the index rate for any other individual by more than the following percentages for policies issued or delivered in the respective year:

(a) twenty percent through December 31, 2008;

(b) eighteen percent for calendar year 2009;

(c) sixteen percent for calendar year

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2010;

(d) fourteen percent for calendar year 2011;

(e) twelve percent for calendar year 2012; and

(f) ten percent for every year thereafter;

(2) for an individual, the premium rates charged during a rating period to individuals shall not vary from the index rate by more than the following percentages of the index rate for policies issued or delivered in the respective year:

(a) twenty percent through December 31, 2008;

(b) eighteen percent for calendar year 2009;

(c) sixteen percent for calendar year 2010;

(d) fourteen percent for calendar year 2011;

(e) twelve percent for calendar year 2012; and

(f) ten percent for every year thereafter; and

(3) the percentage increase in the premium

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rate charged to an individual for a new rating period may not exceed the sum of the following:

(a) the percentage change in the new individual premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of individuals for which a health insurer is not issuing new policies, the health insurer shall use the percentage change in the base premium rate; and

(b) any adjustment due to change in coverage or change in the case characteristics of the individual as determined from the health insurer's rate manual for individuals.

C. Prior to usage, each health insurer shall file with the superintendent the rate manuals and any updates thereto for individuals. A rate filing fee is payable under Subsection U of Section 59A-6-1 NMSA 1978 for the filing of each update. The superintendent shall disapprove within sixty days of receipt of a complete filing or the filing is deemed approved. If the superintendent disapproves the form during the sixty-day review period, the superintendent shall give the carrier written notice of the disapproval stating the reasons for disapproval. At any time, the superintendent, after a hearing, may disapprove a form or withdraw a previous approval. The superintendent's order after the hearing shall state the grounds for disapproval or withdrawal of a previous approval

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and the date, not less than twenty days later, when disapproval or withdrawal becomes effective.

D. The provisions of this section shall not apply to the following types of policies:

(1) disability income;

(2) long-term care;

(3) medicare supplement;

(4) credit health;

(5) short term;

(6) accident-only;

(7) fixed indemnity;

(8) limited benefit; or

(9) specified disease.

E. The superintendent shall adopt rules to implement the provisions of this section."

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

"[NEW MATERIAL] HEALTH INSURERS--DIRECT SERVICES.--

A. A health insurer shall make reimbursement for direct services at a rate not less than ninety percent of premiums collected across all health product lines over the preceding three calendar years as determined by reports filed with the insurance division of the commission.

B. For the purposes of this section:

(1) "direct services" means medical and

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behavioral health services rendered to an individual by a health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services and any portion of an assessment for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act; provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services; and

(2) "premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, recoveries from third parties or other insurers and interests."

Section 6. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] REQUIREMENT FOR HEALTH CARE COVERAGE.--

A. By January 1, 2010, every person having an income above four hundred percent of the federal poverty level and living in New Mexico for more than six months shall provide proof of creditable coverage or provide proof of financial responsibility for health care services.

B. By July 1, 2009, the secretary shall identify individuals in the state who do not have creditable coverage. The secretary may identify these individuals through coordination with appropriate governing bodies and state

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agencies, including licensure and renewal processes, public school and post-secondary institution enrollment processes, state income tax filing, employment and open enrollment periods. The secretary shall provide assistance, education and outreach to individuals who do not have creditable coverage and promulgate guidelines defining affordability of health care coverage.

C. By July 1, 2010, the secretary shall develop procedures to verify that the following individuals have creditable coverage:

(1) individuals living in households with income greater than four hundred percent of the federal poverty level; and

(2) children in households with income less than four hundred percent of the federal poverty level who are eligible for public programs pursuant to Title 19 or Title 21 of the federal Social Security Act.

D. By October 1, 2010, the secretary shall provide recommendations to the governor and the legislature on compliance and enforcement mechanisms that require all persons living in New Mexico to obtain or enroll in a public or private health care coverage plan or program or provide proof of financial responsibility for health care services.

E. A health insurer may continue or renew an individual policy in existence on July 1, 2008 that has a

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permanent exclusion of payment for preexisting conditions until renewal or until the secretary promulgates rules about what constitutes creditable coverage pursuant to the Access to Quality Universal Health Insurance Act. An insured person may opt to continue an individual policy with the exclusion of payment for a preexisting condition.

F. Individuals in households with incomes less than four hundred percent of the federal poverty level shall not be required to purchase or enroll in creditable coverage unless affordable coverage, pursuant to the secretary's guidelines defining affordability, is offered through the individual's employer, available through a public program or otherwise.

G. As of July 1, 2010, the following individuals age eighteen and over shall obtain and maintain creditable coverage provided that the guidelines set by the secretary deem that the coverage available to the individual is affordable:

(1) state residents meeting the income criteria set forth by the secretary; or

(2) individuals who become residents of the state within sixty-three days in the aggregate. Residents who, within sixty-three days, have terminated any prior creditable coverage shall obtain and maintain creditable coverage within sixty-three days of termination."

Section 7. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] PREMIUM ASSISTANCE.--The human services department shall recommend to the legislature sliding-scale subsidies for the purchase of health insurance coverage paid by eligible individuals or employees whose income is under four hundred percent of the federal poverty level. The human services department shall also recommend sliding-scale subsidies for the purchase of employer-sponsored health insurance coverage paid by employees of businesses with more than six employees whose income is under four hundred percent of the federal poverty level."

Section 8. Section 59A-22-5 NMSA 1978 (being Laws 1984, Chapter 127, Section 426, as amended) is amended to read:

"59A-22-5. TIME LIMIT ON CERTAIN DEFENSES.--There shall be a provision for comprehensive major medical policies as follows:

A. [~~After two years from~~] As of the date of issue of this policy, no misstatements, except willfully fraudulent misstatements, made by the applicant in the application for [~~such~~] this policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy [~~commencing after the expiration of such two-year period~~].

B. The foregoing policy provision shall not be so construed as to [~~affect any initial two-year period nor to~~] limit the application of Sections 59A-22-17 through 59A-22-19,

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59A-22-21 and 59A-22-22 NMSA 1978 in the event of misstatement with respect to age or occupation or other insurance.

C. A policy [~~which~~] that the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age fifty or (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision, from which the clause in parentheses may be omitted at the insurance company's option, under the caption "Incontestable":

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled) it shall become incontestable as to the statements contained in the application.

D. For individual policies that do not reimburse or pay as a result of hospitalization, medical or surgical expenses, no claim for loss incurred or disability, as defined in the policy, shall be reduced or denied on the ground that a disease or physical condition disclosed on the application and not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy. [~~As an alternative, those policies may contain provisions under which coverage may be excluded for a period of six months following the effective~~

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~~date of coverage as to a given covered insured for a preexisting condition, provided that:~~

~~(1) the condition manifested itself within a period of six months prior to the effective date of coverage in such a manner as would cause a reasonably prudent person to seek diagnosis, care or treatment; or~~

~~(2) medical advice or treatment relating to the condition was recommended or received within a period of six months prior to the effective date of coverage.~~

~~C. Individual policies that reimburse or pay as a result of hospitalization, medical or surgical expenses may contain provisions under which coverage is excluded during a period of six months following the effective date of coverage as to a given covered insured for a preexisting condition, provided that:~~

~~(1) the condition manifested itself within a period of six months prior to the effective date of coverage in such a manner as would cause a reasonably prudent person to seek diagnosis, care or treatment; or~~

~~(2) medical advice or treatment relating to the condition was recommended or received within a period of six months prior to the effective date of coverage.~~

~~D. The preexisting condition exclusions authorized in Subsections B and C of this section shall be waived to the extent that similar conditions have been satisfied under any~~

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~~prior health insurance coverage if the application for new coverage is made not later than thirty-one days following the termination of prior coverage. In that case, the new coverage shall be effective from the date on which the prior coverage terminated.~~]

E. Nothing in this section shall be construed to require the use of preexisting conditions or prohibit the use of preexisting conditions that are more favorable to the insured than those specified in this section."

Section 9. Section 59A-23B-3 NMSA 1978 (being Laws 1991, Chapter 111, Section 3, as amended) is amended to read:

"59A-23B-3. POLICY OR PLAN--DEFINITION--CRITERIA.--

A. For purposes of the Minimum Healthcare Protection Act, "policy or plan" means a healthcare benefit policy or healthcare benefit plan that the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan chooses to offer to individuals, families or groups of fewer than twenty members formed for purposes other than obtaining insurance coverage and that meets the requirements of Subsection B of this section. For purposes of the Minimum Healthcare Protection Act, "policy or plan" shall not mean a healthcare policy or healthcare benefit plan that an insurer, health maintenance organization, fraternal benefit society or nonprofit healthcare plan chooses to offer outside the authority of the Minimum Healthcare Protection Act.

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B. A policy or plan shall meet the following criteria:

(1) the individual, family or group obtaining coverage under the policy or plan has been without healthcare insurance, a health services plan or employer-sponsored healthcare coverage for the six-month period immediately preceding the effective date of its coverage under a policy or plan, provided that the six-month period shall not apply to:

(a) a group that has been in existence for less than six months and has been without healthcare coverage since the formation of the group;

(b) an employee whose healthcare coverage has been terminated by an employer;

(c) a dependent who no longer qualifies as a dependent under the terms of the contract; or

(d) an individual and an individual's dependents who no longer have healthcare coverage as a result of termination or change in employment of the individual or by reason of death of a spouse or dissolution of a marriage, notwithstanding rights the individual or individual's dependents may have to continue healthcare coverage on a self-pay basis pursuant to the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985;

(2) the policy or plan includes the following managed care provisions to control costs:

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(a) an exclusion for services that are not medically necessary or are not covered by preventive health services; and

(b) a procedure for preauthorization of elective hospital admissions by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan; and

(3) subject to a maximum limit on the cost of healthcare services covered in any calendar year of not less than one hundred thousand dollars ($100,000), the policy or plan provides the following minimum healthcare services to covered individuals:

(a) inpatient hospitalization coverage or home care coverage in lieu of hospitalization or a combination of both, not to exceed twenty-five days of coverage inclusive of any deductibles, co-payments or co-insurance; provided that a period of inpatient hospitalization coverage shall precede any home care coverage;

(b) prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy and one office visit per week during the ninth month and until term; provided that coverage for each office visit shall also include prenatal counseling and education and necessary and appropriate

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screening, including history, physical examination and the laboratory and diagnostic procedures deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member;

(c) obstetrical care, including physicians' and certified nurse midwives' services, delivery room and other medically necessary services directly associated with delivery;

(d) well-baby and well-child care, including periodic evaluation of a child's physical and emotional status, a history, a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards; provided that such evaluation and care shall be covered when performed at approximately the age intervals of birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years and six years;

(e) coverage for low-dose screening mammograms for determining the presence of breast cancer; provided that the mammogram coverage shall include one baseline mammogram for persons age thirty-five through thirty-nine years, one biennial mammogram for persons age forty through forty-nine years and one annual mammogram for persons age fifty years and over; and further provided that the mammogram

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coverage shall only be subject to deductibles and co-insurance requirements consistent with those imposed on other benefits under the same policy or plan;

(f) coverage for cytologic screening, to include a Papanicolaou test and pelvic exam for asymptomatic as well as symptomatic women;

(g) a basic level of primary and preventive care, including no less than seven physician, nurse practitioner, nurse midwife or physician assistant office visits per calendar year, including any ancillary diagnostic or laboratory tests related to the office visit;

(h) coverage for childhood immunizations, in accordance with the current schedule of immunizations recommended by the American academy of pediatrics, including coverage for all medically necessary booster doses of all immunizing agents used in childhood immunizations; provided that coverage for childhood immunizations and necessary booster doses may be subject to deductibles and co-insurance consistent with those imposed on other benefits under the same policy or plan; and

(i) coverage for smoking cessation treatment.

C. A policy or plan may include the following managed care and cost control features to control costs:

(1) a panel of providers who have entered into

written agreements with the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan to provide covered healthcare services at specified levels of reimbursement; provided that such written agreement shall contain a provision relieving the individual, family or group covered by the policy or plan from an obligation to pay for a healthcare service performed by the provider that is determined by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan not to be medically necessary;

(2) a requirement for obtaining a second opinion before elective surgery is performed;

(3) a procedure for utilization review by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan; and

(4) a maximum limit on the cost of healthcare services covered in a calendar year of not less than one hundred thousand dollars ($100,000).

D. Nothing contained in Subsection C of this section shall prohibit an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan from including in the policy or plan additional managed care and cost control provisions that the superintendent determines to have the potential for controlling costs in a manner that does not cause discriminatory treatment of individuals,

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families or groups covered by the policy or plan.

E. Notwithstanding any other provisions of law, a policy or plan shall not exclude coverage for losses incurred for a preexisting condition [~~more than six months from the effective date of coverage. The policy or plan shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment recommended by or received from a physician within six months before the effective date of coverage~~].

F. A medical group, independent practice association or health professional employed by or contracting with an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan shall not maintain an action against an insured person, family or group member for sums owed by an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan that are higher than those agreed to pursuant to a policy or plan.

G. Every insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan that provides primary health insurance or healthcare coverage insuring or covering major medical expenses shall, in determining the initial year's premium charged for an individual, use only the rating factors of age, gender, geographic area of the place of employment and smoking practices, except that for individual policies the rating

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factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment."

Section 10. Section 59A-23B-6 NMSA 1978 (being Laws 1991, Chapter 111, Section 6, as amended) is amended to read:

"59A-23B-6. FORMS AND RATES--APPROVAL OF THE SUPERINTENDENT [~~ADJUSTED COMMUNITY RATING~~].--

A. All policy or plan forms, including applications, enrollment forms, policies, plans, certificates, evidences of coverage, riders, amendments, endorsements and disclosure forms, shall be submitted to the superintendent for approval prior to use.

B. No policy or plan may be issued in the state unless the rates have first been filed with and approved by the superintendent. This subsection shall not apply to policies or plans subject to the Small Group Rate and Renewability Act.

[~~C. In determining the initial year's premium or rate charged for coverage under a policy or plan, the only rating factors that may be used are age, gender, geographic area of the place of employment and smoking practices, except that for individual policies the rating factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on~~

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~~the basis of a person's gender shall not exceed another person's rate in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, society, organization or plan from offering rates that differ depending upon family composition.~~

~~D. The provisions of this section do not preclude an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan from using health status or occupational or industry classification in establishing:~~

~~(1) rates for individual policies; or~~

~~(2) the amount an employer may be charged for coverage under a group health plan.~~

~~E. As used in Subsection D of this section, "health status" does not include genetic information.~~

~~F.~~] C. The superintendent shall adopt regulations to implement the provisions of this section."

Section 11. A new section of the Minimum Healthcare Protection Act is enacted to read:

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"[NEW MATERIAL] RESTRICTIONS RELATING TO PREMIUM RATES.--

A. As used in this section, "rate manual" means a publication that lists insurance underwriting guidelines and premiums that a health insurer charges for its products.

B. Premium rates for health benefit plans subject to the Minimum Healthcare Protection Act shall be subject to the following provisions:

(1) the index rate for a rating period for an individual shall not exceed the index rate for any other individual by more than the following percentages for policies issued or delivered in the respective year:

(a) twenty percent through December 31, 2008;

(b) eighteen percent for calendar year 2009;

(c) sixteen percent for calendar year 2010;

(d) fourteen percent for calendar year 2011;

(e) twelve percent for calendar year 2012; and

(f) ten percent for every year thereafter;

(2) the premium rates charged during a rating

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period for an individual shall not vary from the index rate by more than the following percentages of the index rate for policies issued or delivered in the respective year:

(a) twenty percent through December 31, 2008;

(b) eighteen percent for calendar year 2009;

(c) sixteen percent for calendar year 2010;

(d) fourteen percent for calendar year 2011;

(e) twelve percent for calendar year 2012; and

(f) ten percent for every year thereafter; and

(3) the percentage increase in the premium rate charged to an individual for a new rating period shall not exceed the sum of the following:

(a) the percentage change in the new individual premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of individuals for which a health insurer is not issuing new policies, the health insurer shall use the percentage change in the base premium rate; and

(b) any adjustment due to change in

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coverage or change in the case characteristics of the individual as determined from the health insurer's rate manual for individuals.

C. Prior to usage, each health insurer shall file with the superintendent the rate manuals and any updates to the rate manuals for individuals. A rate filing fee is payable under Subsection U of Section 59A-6-1 NMSA 1978 for the filing of each update. The superintendent shall disapprove a rate manual within sixty days of receipt of a complete filing or the filing is deemed approved. If the superintendent disapproves a rate manual during the sixty-day review period, the superintendent shall give the carrier written notice of the disapproval stating the reasons for disapproval. At any time, the superintendent, after a hearing, may disapprove a rate manual or withdraw a previous approval. The superintendent's order after the hearing shall state the grounds for disapproval or withdrawal of a previous approval of a rate manual and the date not less than twenty days later, when disapproval or withdrawal becomes effective."

Section 12. Section 59A-23C-5 NMSA 1978 (being Laws 1991, Chapter 153, Section 5, as amended) is amended to read:

"59A-23C-5. RESTRICTIONS RELATING TO PREMIUM RATES.--

A. Premium rates for health benefit plans subject to the Small Group Rate and Renewability Act shall be subject to the following provisions:

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(1) the index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than [~~twenty percent~~] the following percentages of the index rate for policies issued or delivered in the respective year:

(a) twenty percent through December 31, 2008;

(b) eighteen percent for calendar year 2009;

(c) sixteen percent for calendar year 2010;

(d) fourteen percent for calendar year 2011;

(e) twelve percent for calendar year 2012; and

(f) ten percent for every year thereafter;

(2) for a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business, shall not vary from the index rate by more than [~~twenty percent of the index rate~~] the following percentages of the index rate for policies issued or delivered in the respective year:

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(a) twenty percent through December 31, 2008;

(b) eighteen percent for calendar year 2009;

(c) sixteen percent for calendar year 2010;

(d) fourteen percent for calendar year 2011;

(e) twelve percent for calendar year 2012; and

(f) ten percent for every year thereafter; and

(3) the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

(b) an adjustment, not to exceed ten percent annually and adjusted pro rata for rating periods of less than one year due to the claim experience, health status or duration of coverage of the employees or dependents of the

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small employer as determined from the carrier's rate manual for the class of business; and

(c) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business. [~~and~~

~~(4) in the case of health benefit plans issued prior to the effective date of the Small Group Rate and Renewability Act, a premium rate for a rating period may exceed the ranges described in Paragraph (1) or (2) of this subsection for a period of five years following the effective date of the Small Group Rate and Renewability Act. In that case, the percentage increase in the premium rate charged to a small employer in that class of business for a new rating period may not exceed the sum of the following:~~

~~(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and~~

~~(b) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.~~

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~~B. Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.~~

[~~C.~~] B. A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue.

[~~D.~~] C. Prior to usage, [~~and June 14, 1991~~] each carrier shall file with the superintendent the rate manuals and any updates to the rate manuals for each class of business. A rate filing fee is payable under Subsection U of Section 59A-6-1 NMSA 1978 for the filing of each update. The superintendent shall disapprove a rate manual within sixty days of receipt of a complete filing or the filing is deemed approved. If the superintendent disapproves a rate manual during the sixty-day review period, [~~he~~] the superintendent shall give the carrier written notice of the disapproval stating the reasons for disapproval. At any time, the

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superintendent, after a hearing, may disapprove a rate manual or withdraw a previous approval. The superintendent's order after the hearing shall state the grounds for disapproval or withdrawal of a previous approval of a rate manual and the date not less than twenty days later, when disapproval or withdrawal becomes effective.

D. The provisions of this section shall not apply to the following types of policies:

(1) disability income;

(2) long-term care;

(3) medicare supplement;

(4) credit health;

(5) short term;

(6) accident only;

(7) fixed indemnity;

(8) limited benefit; or

(9) specified disease."

Section 13. Section 59A-23C-5.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 33, as amended) is amended to read:

"59A-23C-5.1. ADJUSTED COMMUNITY RATING.--

A. A health benefit plan that is offered by a carrier to a small employer shall be offered without regard to the health status of any individual in the group, except as provided in the Small Group Rate and Renewability Act. The only rating factors that may be used to determine the initial

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year's premium charged a group, subject to the maximum rate variation provided in this section for all rating factors, are the group members':

(1) ages;

(2) genders;

(3) geographic areas of the place of employment; or

(4) smoking practices.

[~~B. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rate in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit a carrier from offering rates that differ depending upon family composition.~~

~~C. The provisions of this section do not preclude a carrier from using health status or occupational or industry classification in establishing the amount an employer may be charged for coverage under a group health plan.~~

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~~D. As used in Subsection C of this section, "health status" does not include genetic information.~~

~~E.~~] B. The superintendent shall adopt regulations to implement the provisions of this section."

Section 14. Section 59A-23C-7.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 32, as amended) is amended to read:

"59A-23C-7.1. PREEXISTING CONDITIONS [~~LIMITATIONS~~].--

A. A health benefit plan that is offered by a carrier to a small employer [~~may~~] shall not include a preexisting condition exclusion. [~~only if:~~

~~(1) the exclusion relates to a condition, physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date;~~

~~(2) the exclusion extends for a period of not more than six months, or eighteen months in the case of a late enrollee, after the enrollment date; and~~

~~(3) the period of the exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.~~]

B. As used in this section, "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage for the benefits

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whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date, but genetic information is not included as a preexisting condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the condition related to the genetic information.

[~~C. A carrier shall not impose a preexisting condition exclusion:~~

~~(1) in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;~~

~~(2) that excludes a child who is adopted or placed for adoption before his eighteenth birthday and who, as of the last day of the thirty-day period beginning on and following the date of the adoption or placement for adoption, is covered under creditable coverage; or~~

~~(3) that relates to or includes pregnancy as a preexisting condition.~~

~~D. The provisions of Paragraphs (1) and (2) of Subsection C of this section do not apply to any individual after the end of the first continuous sixty-three-day period during which the individual was not covered under any creditable coverage.~~

~~E. The preexisting condition exclusion authorized in this section shall be waived to the extent that similar conditions have been satisfied under a prior health benefit~~

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~~plan that was subject to the Small Group Rate and Renewability Act, provided the effective date of coverage under the new health benefit plan is made not later than sixty-three days after the individual ceases to be a member of the group insured or the group ceases to be insured under the prior health benefit plan, whichever occurs first. If the conditions authorized in this section have been previously satisfied, coverage under the new health benefit plan shall be effective from the date on which the prior coverage terminated.~~

~~F. Nothing in this section requires the use in a health benefit plan offered by a carrier of a preexisting condition exclusion. Nothing in this section prohibits the use of a preexisting condition exclusion that is less restrictive on small employers and insured persons than the exclusion authorized in this section.~~

~~G.~~] C. The superintendent shall adopt regulations to implement the provisions of this section."

Section 15. Section 59A-23E-3 NMSA 1978 (being Laws 1997, Chapter 243, Section 3, as amended) is amended to read:

"59A-23E-3. GROUP HEALTH PLAN--GROUP HEALTH INSURANCE--[~~LIMITATION ON~~] PREEXISTING CONDITION EXCLUSION [~~PERIOD--CREDITING FOR PERIODS OF PREVIOUS COVERAGE~~] BARRED.--Except as provided in Section 59A-23E-4 NMSA 1978, a group health plan and a health insurance issuer offering group health insurance coverage [~~may, with respect to a participant or~~

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~~beneficiary~~] shall not impose a preexisting condition exclusion [~~only if:~~

~~A. the exclusion relates to a condition, physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date;~~

~~B. the exclusion extends for a period of not more than six months, or eighteen months in the case of a late enrollee, after the enrollment date; and~~

~~C. the period of the exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date~~]."

Section 16. Section 59A-24A-4 NMSA 1978 (being Laws 1989, Chapter 28, Section 4, as amended) is amended to read:

"59A-24A-4. STANDARDS FOR POLICY PROVISIONS--AUTHORITY TO PROMULGATE REGULATIONS.--

A. No medicare supplement policy or certificate, in force in this state, shall contain benefits that duplicate benefits provided by medicare.

B. Notwithstanding any other provisions of law of this state, a medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred [~~more than six months from the effective date of coverage~~] because [~~it~~] the loss involved a preexisting condition. [~~The policy or~~

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~~certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.~~]

C. The superintendent shall adopt reasonable regulations to establish specific standards for policy provisions contained in medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this state, except as those laws are modified by the provisions of the Medicare Supplement Act. No requirement of the Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in the Medicare Supplement Act, shall apply to medicare supplement policies and certificates. The standards may cover, but are not limited to:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) probationary periods;

(5) benefit limitations, exceptions and reductions;

(6) elimination periods;

(7) requirements for replacement;

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(8) recurrent conditions; and

(9) definitions of terms.

D. The superintendent shall adopt reasonable regulations to establish minimum standards for benefits and claims payment, marketing practices, compensation arrangements and reporting practices for medicare supplement policies and certificates.

E. The superintendent may adopt reasonable regulations necessary to conform medicare supplement policies and certificates to the requirements of federal law. The regulations may, but are not limited to:

(1) require refunds or credits if policies or certificates do not meet loss ratio requirements;

(2) establish a uniform methodology for calculating and reporting loss ratios;

(3) assure public access to information in the possession of issuers concerning policies, premiums and loss ratios;

(4) establish an approval process for policy forms, certificate forms and proposed premium increases;

(5) establish procedures for conducting public hearings prior to granting approval to proposed premium increases; and

(6) establish standards for medicare select policies and certificates if the state is authorized to operate

as a medicare select state.

F. The superintendent may adopt reasonable regulations that specify prohibited policy or certificate provisions not otherwise specifically authorized by statute that, in the opinion of the superintendent, are unjust, unfair or unfairly discriminatory to any person insured or proposed to be insured under a medicare supplement policy or certificate."

Section 17. Section 59A-56-14 NMSA 1978 (being Laws 1994, Chapter 75, Section 14, as amended) is amended to read:

"59A-56-14. ELIGIBILITY--GUARANTEED ISSUE--PLAN PROVISIONS.--

A. A small employer is eligible for an approved health plan if on the effective date of coverage or renewal:

(1) at least fifty percent of its employees not otherwise insured elect to be covered under the approved health plan;

(2) the small employer has not terminated coverage with an approved health plan within three years of the date of application for coverage except to change to another approved health plan; and

(3) the small employer does not offer other general group health insurance coverage to its employees. For the purposes of this paragraph, general group health insurance coverage excludes coverage that:

(a) is offered by a state or federal

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agency to a small employer's employee whose eligibility for alternative coverage is based on the employee's income; or

(b) provides only a specific limited form of health insurance such as accident or disability income insurance coverage or a specific health care service such as dental care.

B. An individual is eligible for an approved health plan if on the effective date of coverage or renewal the individual meets the definition of an eligible individual under Section 59A-56-3 NMSA 1978.

C. An approved health plan shall provide in substance that attainment of the limiting age by an unmarried dependent individual does not operate to terminate coverage when the individual continues to be incapable of self-sustaining employment by reason of developmental disability or physical handicap and the individual is primarily dependent for support and maintenance upon the employee. Proof of incapacity and dependency shall be furnished to the alliance and the member that offered the approved health plan within one hundred twenty days of attainment of the limiting age. The board may require subsequent proof annually after a two-year period following attainment of the limiting age.

D. An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable with respect to a newly born child of the family

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member or the individual in whose name the contract is issued from the moment of birth, 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 member within thirty-one days after the date of birth in order to have the coverage from birth. An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable for an adopted child in accordance with the provisions of Section 59A-22-34.1 NMSA 1978.

E. [~~Except as provided in Subsections G, H and I of this section~~] An approved health plan offered to a small employer [~~may~~] shall not contain a preexisting condition exclusion. [~~only if:~~

~~(1) the exclusion relates to a condition, physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date;~~

~~(2) the exclusion extends for a period of not more than six months after the enrollment date; and~~

~~(3) the period of the exclusion is reduced by the aggregate of the periods of creditable coverage applicable~~

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~~to the participant or beneficiary as of the enrollment date.~~]

F. As used in this section, "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage for the benefits whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date, but genetic information is not included as a preexisting condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the condition related to the genetic information.

G. [~~An~~] A health insurer shall not impose a preexisting condition exclusion.

[~~(1) in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;~~

~~(2) that excludes a child who is adopted or placed for adoption before the child's eighteenth birthday and who, as of the last day of the thirty-day period beginning on and following the date of the adoption or placement for adoption, is covered under creditable coverage; or~~

~~(3) that relates to or includes pregnancy as a preexisting condition.~~

~~H. The provisions of Paragraphs (1) and (2) of Subsection G of this section do not apply to any individual after the end of the first continuous sixty-three-day period~~

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~~during which the individual was not covered under any reditable coverage.~~

~~I. The preexisting condition exclusions described in Subsection E of this section shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the effective date of coverage for health insurance through the alliance is made not later than sixty-three days following the termination of the prior coverage. In that case, coverage through the alliance shall be effective from the date on which the prior coverage was terminated. This subsection does not prohibit preexisting conditions coverage in an approved health plan that is more favorable to the covered individual than that specified in this subsection.~~

~~J.~~] H. An approved health plan issued to an [~~eligible~~] individual shall not contain [~~any~~] a preexisting condition exclusion.

[~~K. An individual is not eligible for coverage by the alliance under an approved health plan issued to a small employer if the individual:~~

~~(1) is eligible for medicare; provided, however, if an individual has health insurance coverage from an employer whose group includes twenty or more individuals, an individual eligible for medicare who continues to be employed may choose to be covered through an approved health plan;~~

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~~(2) has voluntarily terminated health insurance issued through the alliance within the past twelve months unless it was due to a change in employment; or~~

~~(3) is an inmate of a public institution.~~

~~L. The alliance shall provide for an open enrollment period of sixty days from the initial offering of an approved health plan. Individuals enrolled during the open enrollment period shall not be subject to the preexisting conditions limitation.~~

~~M. If an insured covered by an approved health plan switches to another approved health plan that provides increased or additional benefits such as lower deductible or co-payment requirements, the member offering the approved health plan with increased or additional benefits may require the six-month period for preexisting conditions provided in Subsection E of this section to be satisfied prior to receipt of the additional benefits.~~]"

Section 18. TEMPORARY PROVISION--RISK EQUALIZATION STUDY.--By September 1, 2008, the insurance division of the public regulation commission, in consultation or in conjunction with the department of health, the human services department, the higher education department or other appropriate state agency or governing body, shall make recommendations to the legislative health and human services committee regarding the feasibility and options for implementation of risk equalization

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processes that can spread risk among health insurers to minimize adverse selection that can result from guaranteed issues of coverage products.

Section 19. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2008.