SENATE BILL 778

46TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2003

INTRODUCED BY

John Arthur Smith

AN ACT

RELATING TO HEALTH INSURANCE; REVISING BOARD MEMBERSHIP AND ELIGIBILITY CRITERIA FOR THE MEDICAL INSURANCE POOL; AMENDING SECTIONS OF THE NMSA 1978.

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;

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(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. "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;

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(3) who is not eligible for coverage under 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;

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

[~~D.~~] 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

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the purpose of preventing, alleviating, curing or healing human illness or injury;

[~~E.~~] 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;

[~~F.~~] 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;

[~~G.~~] 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

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

[~~I.~~] J. "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.~~] K. "medicare" means coverage under Part A or

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Part B of Title 18 of the Social Security Act, as amended;

[~~K.~~] L. "pool" means the New Mexico medical insurance pool; [~~and~~]

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

[~~L.~~] N. "therapist" means a licensed physical, occupational, speech or respiratory therapist."

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 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

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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~~] six 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~~] three 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. 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 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

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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

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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 3. 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

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

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

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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 4. 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

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hospital services;

(2) [~~is only eligible for a health plan that is offered at a rate higher than that available from the pool~~] is currently paying a rate for a health plan that is higher than one hundred twenty-five percent of the pool's standard rate;

(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 a medical condition that is listed on the pool's pre-qualifying conditions;

[~~(5)~~] (6) 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

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creditable coverage; or

[~~(6)~~] (7) 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 or purchasing 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~~

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~~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~~

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~~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.~~]

D. A policyholder's newborn child or newly adopted child is automatically eligible for thirty-one consecutive calendar days of coverage for an additional premium.

[~~F.~~] E. Except for a person eligible as provided in Paragraph [~~(5)~~] (6) 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.~~] F. The preexisting condition exclusions

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described in Subsection [~~F~~] E 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.~~] G. An individual is not eligible for coverage by the pool if:

(1) except as provided in Subsection [~~J~~] I of this section, the individual is, at the time of application, eligible for medicare or medicaid [~~which~~] that 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 and did not have other continuous coverage during that time, except that this paragraph shall not apply to an applicant who is a federally defined eligible individual;

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

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(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)~~] (6) 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.~~] H. 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.~~] I. The board may issue a pool policy for individuals who:

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(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."

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