HOUSE BILL 110

49TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2009

INTRODUCED BY

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AN ACT

RELATING TO HEALTH INSURANCE; PROVIDING FOR GUARANTEED ISSUE BY HEALTH INSURERS; ELIMINATING GENDER AS A HEALTH INSURANCE RATING FACTOR; REVISING THE DEFINITION OF "SMALL EMPLOYER".

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

Section 1. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] HEALTH INSURERS--GUARANTEED ISSUE--PREEXISTING CONDITIONS.--

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

B. A health insurer may impose a waiting period not to exceed six months before payment for any service related to

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a preexisting condition.

C. A health insurer may continue an individual policy in existence on July 1, 2009 that has a permanent exclusion of payment for a preexisting condition until renewal. Upon renewal of such a policy, an insured, at the sole discretion of the insured, may opt to continue the existing individual policy with the exclusion of payment for the preexisting condition.

D. A health insurer shall ensure that an insured's privacy and confidentiality are protected and made applicable to individual policies, similar to privacy requirements pursuant to the federal Health Insurance Portability and Accountability Act of 1996 for other policies.

E. For the purposes of this section:

(1) "coverage" does not include short-term, accident, fixed indemnity, specified disease policy or disability income, limited-benefit, credit, workers' compensation, automobile, medical or other 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;

(2) "health insurer" means a person duly authorized to transact the business of health insurance in the state pursuant to the Insurance Code but does not include a person that only issues a limited-benefit policy intended to

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supplement major medical coverage, including medicare supplement, long-term care, disability income, disease-specific, accident-only or hospital-indemnity-only insurance policies; and

(3) "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 for health insurance within six months before the effective date of coverage, except that pregnancy is not considered a preexisting condition for federally defined individuals."

Section 2. Section 59A-18-13.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 26, as amended) is amended to read:

"59A-18-13.1. ADJUSTED COMMUNITY RATING.--

A. Every insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan that provides primary health insurance or health care 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 factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment.

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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 rates 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, fraternal benefit society, health maintenance organization or nonprofit health care plan from offering rates that differ depending upon family composition.

C. The provisions of this section do not preclude an insurer, fraternal benefit society, health maintenance organization or nonprofit health care 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 the group health plan.

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

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

Section 3. 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 the basis of a person's gender shall not exceed another~~

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

Section 4. Section 59A-23C-3 NMSA 1978 (being Laws 1991, Chapter 153, Section 3, as amended) is amended to read:

"59A-23C-3. DEFINITIONS.--As used in the Small Group Rate

and Renewability Act:

A. "actuarial certification" means a written statement by a member of the American academy of actuaries or another individual acceptable to the superintendent that a small employer carrier is in compliance with the provisions of Section 59A-23C-5 NMSA 1978, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans;

B. "base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

C. "carrier" means any person who provides health insurance in this state. For the purposes of the Small Group Rate and Renewability Act, "carrier" or "insurer" includes a licensed insurance company, a licensed fraternal benefit society, a prepaid hospital or medical service plan, a health maintenance organization, a nonprofit health care organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation;

D. "case characteristics" means demographic or

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other relevant characteristics of a small employer, as determined by a small employer carrier, that are considered by the carrier in the determination of premium rates for the small employer, but "case characteristics" does not include claim experience, health status and duration of coverage since issue;

E. "class of business" means all small employers as shown on the records of the small employer carrier. A separate class of business may be established by the small employer carrier on the basis that the applicable health benefit plans have been acquired from another small employer carrier as a distinct grouping of plans;

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

(1) a group health plan;

(2) health insurance coverage;

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

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

(5) 10 USCA Chapter 55;

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

(7) the Comprehensive Health Insurance Pool Act;

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(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;

G. "department" means the department of insurance;

H. "group health plan" means an employee welfare benefit plan as defined Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise;

I. "health benefit plan" or "plan" means any hospital or medical expense-incurred policy or certificate, hospital or medical service plan contract or health maintenance organization subscriber contract. "Health benefit plan" does not include accident-only, credit, dental or disability income insurance, medicare supplement coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance or automobile medical-payment insurance;

J. "index rate" means, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the

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corresponding highest premium rate;

K. "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(1) the first period in which the individual is eligible to enroll under the plan; or

(2) a special enrollment period pursuant to Sections [~~8 and 9 of the Health Insurance Portability Act~~] 59A-23E-8 and 59A-23E-9 NMSA 1978;

L. "new business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

M. "rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier;

N. "small employer" means any person, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent of its working days during either of the two preceding years, employed no [~~less~~] fewer than [~~two~~] one and no more than fifty eligible employees; provided that:

(1) in determining the number of eligible

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employees, the spouse or dependent of an employee may, at the employer's discretion, be counted as a separate employee;

(2) companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state income taxation shall be considered one employer; and

(3) in the case of an employer that was not in existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year;

O. "small employer carrier" means any insurer that offers health benefit plans covering the employees of a small employer; and

P. "superintendent" means the superintendent of insurance."

Section 5. 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 year's premium charged a group, subject to the maximum rate

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variation provided in this section for all rating factors, are the group members':

(1) ages;

[~~(2) genders;~~

~~(3)~~] (2) geographic areas of the place of employment; or

[~~(4)~~] (3) 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.

D. As used in Subsection C of this section, "health

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status" does not include genetic information.

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

Section 6. Section 59A-56-6 NMSA 1978 (being Laws 1994, Chapter 75, Section 6, as amended) is amended to read:

"59A-56-6. BOARD--POWERS AND DUTIES.--

A. The board shall have the general powers and authority granted to insurance companies licensed to transact health insurance business under the laws of this state.

B. The board:

(1) may enter into contracts to carry out the provisions of the Health Insurance Alliance Act, including, with the approval of the superintendent, contracting with similar alliances of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions;

(2) may sue and be sued;

(3) may conduct periodic audits of the members to assure the general accuracy of the financial data submitted to the alliance;

(4) shall establish maximum rate schedules, allowable rate adjustments, administrative allowances, reinsurance premiums and agent referral, servicing fees or commissions subject to applicable provisions in the Insurance Code. In determining the initial year's rate for health

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insurance, the only rating factors that may be used are age, [~~gender~~] geographic area of the place of employment and smoking practices. In any 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 rates 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 may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit a member from offering rates that differ depending upon family composition;

(5) may direct a member to issue policies or certificates of coverage of health insurance in accordance with the requirements of the Health Insurance Alliance Act;

(6) shall establish procedures for alternative dispute resolution of disputes between members and insureds;

(7) shall cause the alliance to have an annual audit of its operations by an independent certified public accountant;

(8) shall conduct all board meetings as if it were subject to the provisions of the Open Meetings Act;

(9) shall draft one or more sample health insurance policies that are the prototype documents for the

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members;

(10) shall determine the design criteria to be met for an approved health plan;

(11) shall review each proposed approved health plan to determine if it meets the alliance-designed criteria and, if it does meet the criteria, approve the plan; provided that the board shall not permit more than one approved health plan per member for each set of plan design criteria;

(12) shall review annually each approved health plan to determine if it still qualifies as an approved health plan based on the alliance-designed criteria and, if the plan is no longer approved, arrange for the transfer of the insureds covered under the formerly approved plan to an approved health plan;

(13) may terminate an approved health plan not operating as required by the board;

(14) shall terminate an approved health plan if timely claim payments are not made pursuant to the plan; and

(15) shall engage in significant marketing activities, including a program of media advertising, to inform small employers and eligible individuals of the existence of the alliance, its purpose and the health insurance available or potentially available through the alliance.

C. The alliance is subject to and responsible for examination by the superintendent. No later than March 1 of

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each year, the board shall submit to the superintendent an audited financial report for the preceding calendar year in a form approved by the superintendent."