AN ACT

RELATING TO INSURANCE; REQUIRING GROUP HEALTH CARE COVERAGE OF UNMARRIED DEPENDENTS UNTIL THEIR TWENTY-FIFTH BIRTHDAY.

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

Section 1. Section 13-7-1 NMSA 1978 (being Laws 1997, Chapter 74, Section 1) is amended to read:

"13-7-1. SHORT TITLE.--Chapter 13, Article 7 NMSA 1978 may be cited as the "Health Care Purchasing Act"."

Section 2. A new section of the Health Care Purchasing Act is enacted to read:

"MAXIMUM AGE OF DEPENDENT.--Any group health care coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act on or after July 1, 2003 that offers coverage of an insured's dependent shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's twenty-fifth birthday, regardless of whether the dependent is enrolled in an educational institution."

Section 3. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"MAXIMUM AGE OF DEPENDENT.--Each blanket or group health policy or certificate of insurance delivered, issued for delivery or renewed in New Mexico on or after July 1, 2003 that provides coverage for an insured's dependent shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's twenty-fifth birthday, regardless of whether the dependent is enrolled in an educational institution."

Section 4. Section 59A-23D-2 NMSA 1978 (being Laws 1995, Chapter 93, Section 2, as amended by Laws 1997, Chapter 243, Section 27 and also by Laws 1997, Chapter 254, Section 2) is amended to read:

"59A-23D-2. DEFINITIONS.--As used in the Medical Care Savings Account

Act:

A. "account administrator" means any of the following that administers medical care savings accounts:

(1) a national or state chartered bank, savings and loan association, savings bank or credit union;

(2) a trust company authorized to act as a fiduciary in this state;

(3) an insurance company or health maintenance organization authorized to do business in this state pursuant to the New Mexico Insurance Code; or

(4) a person approved by the federal secretary of health and human services;

B. "deductible" means the total covered medical expense an employee or his dependents must pay prior to any payment by a qualified higher deductible health plan for a calendar year;

C. "department" means the insurance division of the public regulation commission;

D. "dependent" means:

(1) a spouse;

(2) an unmarried or unemancipated child of the employee who is a minor and who is:

(a) a natural child;

(b) a legally adopted child;

(c) a stepchild living in the same household who is primarily dependent on the employee for maintenance and support;

(d) a child for whom the employee is the legal guardian and who is primarily dependent on the employee for maintenance and support, as long as evidence of the guardianship is evidenced in a court order or decree; or

(e) a foster child living in the same household, if the child is not otherwise provided with health care or health insurance coverage;

(3) an unmarried child described in Subparagraphs (a) through (e) of Paragraph (2) of this subsection who is between the ages of eighteen and twenty-five; or

(4) a child over the age of eighteen who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who is chiefly dependent on the employee for support and maintenance;

E. "eligible individual" means an individual who with respect to any month:

(1) is covered under a qualified higher deductible health plan as of the first day of that month;

(2) is not, while covered under a qualified higher deductible health plan, covered under any health plan that:

(a) is not a qualified higher deductible health plan; and

(b) provides coverage for any benefit that is covered under the qualified higher deductible health plan; and

(3) is covered by a qualified higher deductible health plan that is established and maintained by the employer of the individual or of the spouse of the individual;

F. "eligible medical expense" means an expense paid by the employee for medical care described in Section 213(d) of the Internal Revenue Code of 1986 that is deductible for federal income tax purposes to the extent that those amounts are not compensated for by insurance or otherwise;

G. "employee" includes a self-employed individual;

H. "employer" includes a self-employed individual;

I. "medical care savings account" or "savings account" means an account established by an employer in the United States exclusively for the purpose of paying the eligible medical expenses of the employee or dependent, but only if the written governing instrument creating the trust meets the following requirements:

(1) except in the case of a rollover contribution, no contribution

will be accepted:

(a) unless it is in cash; or

(b) to the extent the contribution, when added to previous contributions to the trust for the calendar year, exceeds seventy-five percent of the highest annual limit deductible permitted pursuant to the Medical Care Savings Account Act;

(2) no part of the trust assets will be invested in life insurance contracts;

(3) the assets of the trust will not be commingled with other property except in a common trust fund or common investment fund; and

(4) the interest of an individual in the balance in his account is nonforfeitable;

J. "program" means the medical care savings account program established by an employer for his employees; and

K. "qualified higher deductible health plan" means a health coverage policy, certificate or contract that provides for payments for covered health care benefits that exceed the policy, certificate or contract deductible, that is purchased by an employer for the benefit of an employee and that has the following deductible provisions:

(1) self-only coverage with an annual deductible of not less than one thousand five hundred dollars ($1,500) or more than two thousand two hundred fifty dollars ($2,250) and a maximum annual out-of-pocket expense requirement of three thousand dollars ($3,000), not including premiums;

(2) family coverage with an annual deductible of not less than three thousand dollars ($3,000) or more than four thousand five hundred dollars ($4,500) and a maximum annual out-of-pocket expense requirement of five thousand five hundred dollars ($5,500), not including premiums; and

(3) preventive care coverage may be provided within the policies without the preventive care being subjected to the qualified higher

deductibles."

Section 5. A new section of the Health Maintenance Organization Law is enacted to read:

"MAXIMUM AGE OF DEPENDENT.--Each group health maintenance organization contract delivered or issued for delivery in New Mexico on or after July 1, 2003 that provides coverage for an enrollee's dependents shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's twenty-fifth birthday, regardless of whether the dependent is enrolled in an educational institution; provided that this requirement does not apply to the medicaid managed care system."

Section 6. Section 59A-47-1 NMSA 1978 (being Laws 1984, Chapter 127, Section 878) is amended to read:

"59A-47-1. SHORT TITLE.--Chapter 59A, Article 47 NMSA 1978 may be cited as the "Nonprofit Health Care Plan Law"."

Section 7. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"MAXIMUM AGE OF DEPENDENT.--Any group subscriber contract offered, issued or renewed in New Mexico on or after July 1, 2003 that provides coverage of a subscriber's dependents shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's twenty-fifth birthday, regardless of whether the dependent is enrolled in an educational institution."

Section 8. Section 59A-56-3 NMSA 1978 (being Laws 1994, Chapter 75, Section 3, as amended) is amended to read:

"59A-56-3. DEFINITIONS.--As used in the Health Insurance Alliance Act:

A. "alliance" means the New Mexico health insurance alliance;

B. "approved health plan" means any arrangement for the provisions of health insurance offered through and approved by the alliance;

C. "board" means the board of directors of the alliance;

D. "child" means a dependent unmarried individual who is less than

twenty-five years of age;

E. "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 federal Social Security Act;

(4) Title 19 of the federal 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;

F. "department" means the insurance division of the commission;

G. "director" means an individual who serves on the board;

H. "earned premiums" means premiums paid or due during a calendar year for coverage under an approved health plan less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year;

I. "eligible expenses" means the allowable charges for a health care service covered under an approved health plan;

J. "eligible individual":

(1) means an individual who:

(a) as of the date of the individual's application for

coverage under an approved health plan, has 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 those plans are defined in Subsections P, N and D of Section 59A-23E-2 NMSA 1978, respectively, or health insurance offered in connection with any of those plans, but 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 an approved health plan if, after that period and before the enrollment date, there was a sixty-three-day or longer period during all of which the individual was not covered under any creditable coverage; or

(b) is entitled to continuation coverage pursuant to Section 59A-56-20 or 59A-23E-19 NMSA 1978; and

(2) does not include an individual who:

(a) has or is eligible for coverage under a group health plan;

(b) is eligible for coverage under medicare or a state plan under Title 19 of the federal Social Security Act or any successor program;

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

(d) during the most recent coverage within the coverage period described in Subparagraph (a) of Paragraph (1) of this subsection was terminated from coverage as a result of nonpayment of premium or fraud; or

(e) has been offered the option of coverage under a COBRA continuation provision as that term is defined in Subsection F of Section 59A-23E-2 NMSA 1978, or under a similar state program, except for continuation coverage under Section 59A-56-20 NMSA 1978, and did not exhaust the coverage available under the offered program;

K. "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for

that enrollment;

L. "gross earned premiums" means premiums paid or due during a calendar year for all health insurance written in the state less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year;

M. "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;

N. "health care service" means a service or product furnished an individual for the purpose of preventing, alleviating, curing or healing human illness or injury and includes services and products incidental to furnishing the described services or products;

O. "health insurance" means "health" insurance as defined in Section 59A-7-3 NMSA 1978; any hospital and medical expense-incurred policy; nonprofit health care plan service contract; health maintenance organization subscriber contract; 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 contracts, 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 because of connection with a particular organization or group; coverage by medicare or other governmental programs providing health care services; but "health insurance" does not include insurance issued pursuant to provisions of the Workers' Compensation Act or similar law, 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;

P. "health maintenance organization" means a health maintenance organization as defined by Subsection M of Section 59A-46-2 NMSA 1978;

Q. "incurred claims" means claims paid during a calendar year plus claims incurred in the calendar year and paid prior to April 1 of the succeeding year, less claims incurred previous to the current calendar year and paid prior to April 1 of the current year;

R. "insured" means a small employer or its employee and an individual covered by an approved health plan, a former employee of a small employer who is covered by an approved health plan through conversion or an individual covered by an approved health plan that allows individual enrollment;

S. "medicare" means coverage under both Parts A and B of Title 18 of the federal Social Security Act;

T. "member" means a member of the alliance;

U. "nonprofit health care plan" means a "health care plan" as defined in Subsection K of Section 59A-47-3 NMSA 1978;

V. "premiums" means the premiums received for coverage under an approved health plan during a calendar year;

W. "small employer" means a person that is a resident of this state, has employees at least fifty percent of whom are residents of this state, is actively engaged in business and that on at least fifty percent of its working days during either of the two preceding calendar years, employed no fewer than two and no more than fifty eligible employees; provided that:

(1) in determining the number of eligible 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;

X. "superintendent" means the superintendent of insurance;

Y. "total premiums" means the total premiums for business written in the state received during a calendar year; and

Z. "unearned premiums" means the portion of a premium previously paid for which the coverage period is in the future."