SENATE BILL 754

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

INTRODUCED BY

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AN ACT

RELATING TO PRESCRIPTION DRUGS; ALLOWING THE MEDICAL INSURANCE POOL TO CREATE A PRESCRIPTION DRUG PROGRAM.

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

Section 1. A new section of the Medical Insurance Pool Act is enacted to read:

"[NEW MATERIAL] PRESCRIPTION DRUG PROGRAM--COST-SHARING.--

A. The board may establish a prescription drug program, in whole or in part, including a pilot or phase-in program, to offer selected eligible persons the ability to purchase prescription drugs. The board may establish varying levels of eligibility and cost-sharing criteria as needed for selected eligible persons.

B. The board may establish the cost-sharing amounts payable by a person enrolled in the prescription drug program,

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including the premium, deductible, coinsurance, co-payment and other out-of-pocket expenses.

C. If the board establishes a prescription drug program, the board shall establish the assessments pursuant to Section 59A-54-10 NMSA 1978."

Section 2. 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 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

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to achieve equity of assessments among pool members.

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~~] A deficit incurred by the pool shall be recouped by assessments apportioned among the members of the pool pursuant to the assessment formula provided by Subsection A of this section; provided that the assessment for any pool member shall be allowed as a thirty percent credit on the premium tax return for that member.

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

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member receiving the abatement or deferment shall remain liable to the pool for the deficiency for four years.

E. If the board establishes a prescription drug program, the assessment for a pool member shall be determined in the same manner as provided in this section provided that a pool member shall be allowed a fifty percent credit on the premium tax return for that member."

Section 3. 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 hospital services;

(2) is only eligible for a health plan that is offered at a rate higher than that available from the pool;

(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

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individual based on a specific condition;

(5) 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 creditable coverage; or

(6) 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 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

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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 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

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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 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.

F. Except for a person eligible as provided in Paragraph (5) 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:

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(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. The preexisting condition exclusions described in Subsection F 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. An individual is not eligible for coverage by the pool if:

(1) except as provided in Subsection J 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;

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(2) the individual has voluntarily terminated coverage by the pool within the past twelve months;

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

(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) 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. [~~Any~~] A 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

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are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

J. The board may issue a pool policy for [~~individuals~~] an individual who:

(1) [~~are~~] is 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.

K. The board may issue a pool prescription drug program benefit policy for a person who is over the age of sixty-five and unable to purchase or is ineligible for a similar prescription drug program. The board may issue a pool prescription drug program benefit policy for a person who is eligible for a state-funded or state-operated low-income pharmacy benefit program."

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