SENATE BILL 22

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

INTRODUCED BY

Mary Jane M. Garcia

AN ACT

PROVIDING PREMIUM ASSISTANCE FOR CERTAIN INDIVIDUALS; PROVIDING PREMIUM RATE RESTRICTIONS; PROVIDING GUARANTEED ISSUE OF HEALTH INSURANCE FOR INDIVIDUALS; REQUIRING HEALTH CARE COVERAGE FOR CERTAIN INDIVIDUALS; REQUIRING A CERTAIN REIMBURSEMENT LEVEL FOR DIRECT SERVICES; PROVIDING FOR INCLUSION OF INDIAN HEALTH SERVICE PROVIDERS IN INSURERS' PROVIDER NETWORKS; REQUIRING EMPLOYERS TO OFFER A PRETAX HEALTH COVERAGE OPTION; MAKING AN APPROPRIATION.

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

Section 1. Section 27-2-12 NMSA 1978 (being Laws 1973, Chapter 376, Section 16, as amended) is amended to read:

"27-2-12. MEDICAL ASSISTANCE PROGRAMS.--

A. Consistent with the federal act and subject to the appropriation and availability of federal and state funds,

the medical assistance division of the department may by rule provide medical assistance, including the services of licensed doctors of oriental medicine, licensed chiropractic physicians and licensed dental hygienists in collaborating practice, to persons eligible for public assistance programs under the federal act.

B. Subject to appropriation and availability of federal, state or other funds received by the state from public or private grants or donations, the medical assistance division of the department may by rule provide medical assistance, including assistance in the payment of premiums for medical or long-term care insurance, to children up to the age of [~~twelve if not part of a sibling group; children up to the age of~~] eighteen [~~if part of a sibling group that includes a child up to the age of twelve~~] and pregnant women who are residents of the state of New Mexico and who are ineligible for public assistance under the federal act. The department, in implementing the provisions of this subsection, shall:

(1) establish rules that encourage pregnant women to participate in prenatal care; and

(2) not provide a benefit package that exceeds the benefit package provided to state employees."

Section 2. 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.--

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

(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 calendar year:

(a) twenty percent in 2009;

(b) eighteen percent in 2010;

(c) sixteen percent in 2011;

(d) fourteen percent in 2012;

(e) twelve percent in 2013; and

(f) ten percent in 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 calendar year:

(a) twenty percent in 2009;

(b) eighteen percent in 2010;

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(c) sixteen percent in year 2011;

(d) fourteen percent in 2012;

(e) twelve percent in 2013; and

(f) ten percent in every year thereafter;

(3) the percentage increase in the premium rate charged to a small employer for a new rating period shall 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 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

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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 shall 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.

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.

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C. 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. Prior to usage and June 14, 1991, each carrier shall file with the superintendent the rate manuals and any updates thereto for each class of business. A rate filing fee is payable under Subsection [~~H~~] V 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, [~~he~~] 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 and the date not less than twenty days later when disapproval or withdrawal becomes effective."

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

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"[NEW MATERIAL] HEALTH INSURERS--DIRECT SERVICES--GUARANTEED ISSUE FOR INDIVIDUALS--PREEXISTING CONDITIONS.--

A. A health insurer shall make reimbursement for direct services at a rate not less than eighty-five percent of premiums across all health product lines, including fully insured, commercial, state and federal programs, over the preceding three calendar years, but not earlier than calendar year 2009, as determined by reports filed with and in a format required by the insurance division of the commission. Nothing in this subsection shall be construed to preclude a purchaser from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services for one or more products or for one or more years.

B. If a health insurer makes reimbursement for direct services at a rate less than eighty-five percent of premiums pursuant to Subsection A of this section, based on reports filed with or an audit conducted by the insurance division of the commission, the difference between the amount reimbursed for direct services and eighty-five percent of premiums received shall be paid into the healthy New Mexico fund, as provided in the Health Care Benefits Act, if enacted, or other fund designated by the department of finance and administration to provide premium assistance for health care coverage. Notwithstanding the provisions of Section 59A-2-11

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NMSA 1978, the amount paid into the healthy New Mexico fund or other fund designated by the department of finance and administration shall satisfy any fee, administrative fine or other penalty that may be assessed for making reimbursement at a rate less than eighty-five percent of premiums.

C. 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.

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

E. A health insurer shall offer or make a referral to a transition product to provide coverage during the waiting period due to a preexisting condition.

F. A health insurer may continue an individual policy in existence on July 1, 2009 that has a permanent exclusion of payment for preexisting conditions 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 a preexisting condition.

G. A health insurer shall ensure that an insured's privacy and confidentiality are protected and made applicable to individual policies, similar to privacy requirements

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pursuant to the federal Health Insurance Portability and Accountability Act of 1996 for other policies.

H. An individual is eligible for a pool policy pursuant to the Medical Insurance Pool Act if the individual is a New Mexico resident and is quoted a rate for another health plan at one hundred twenty-five percent or more of the medical insurance pool's standard rate.

I. For the purposes of this section:

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

(2) "direct services" means 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, quality incentive payments to providers or individuals and any portion of an assessment that covers services rather than administration and for which a health insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act; provided, however, that "direct services" does not include

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health care coordination, utilization review or management or any other activity designed to manage utilization or services;

(3) "health insurer" means a person duly authorized to transact the business of health insurance in the state, including a nonprofit health care plan, a health maintenance organization and self-insured entities not subject to federal preemption, but does not include a person that only issues a limited benefit policy intended to supplement major medical coverage, including medicare supplement, long-term care, disability income, disease-specific, accident only or hospital indemnity only insurance policies;

(4) "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; and

(5) "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 4. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] HEALTH INSURER--INDIAN HEALTH SERVICE.--A health insurer shall allow an Indian health service provider or other provider pursuant to the federal Indian Self-

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Determination and Education Assistance Act that meets quality and credentialing standards to participate in the insurer's provider network; provided, however, that participation in a provider network shall not require the provider to reduce, expand or alter the eligibility requirements for the provider."

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

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

A. Beginning July 1, 2009, every individual through age eighteen shall have:

(1) health coverage through a public or private health care coverage plan or program; or

(2) proof of financial responsibility for health care services.

B. Proof of coverage shall be provided upon enrollment in any child care, head start or pre-kindergarten program that is certified, licensed or authorized to operate in the state and upon enrollment in any school, college or university. Proof of health coverage or financial responsibility shall meet guidelines for coverage set by the health care benefits administration pursuant to the Health Care Benefits Act, if enacted, or, in its absence, by the human services department.

C. Information about individuals unable to provide the proof required pursuant to Subsection A of this section

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shall be reported by child care, head start and pre-kindergarten programs and schools, colleges and universities in the state to the health care benefits administration or the human services department in a format required by the administration or the department and shall be used only for purposes of outreach, data reporting and connection to health coverage options for those individuals unable to show proof of coverage.

D. The health care benefits administration or the human services department shall provide assistance, education and outreach to families of children identified as not having proof of health care coverage and shall report annually about the number of such children unable to provide proof of health coverage and, if available, the reason for the inability to provide proof.

E. Nothing in this section shall require adults who object to obtaining health coverage for religious reasons to obtain or provide proof of such coverage. Such adults may sign a declaration of religious objection with any entity requiring proof of coverage. A parent shall not refuse to provide proof of coverage for the parent's children, regardless of the parent's religious belief."

Section 6. [NEW MATERIAL] EMPLOYERS REQUIRED TO OFFER PRETAX HEALTH COVERAGE OPTION.--An employer, except a federally recognized Indian nation, tribe or pueblo acting as an

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employer, shall offer to its employees for whom the employer does not offer a health insurance plan a pretax health coverage option pursuant to Section 125 or successor provision of the federal Internal Revenue Code of 1986, whether or not the employer chooses to pay any portion of the health coverage premium or costs.

Section 7. APPROPRIATION.--

A. Five hundred thirteen thousand five hundred dollars ($513,500) is appropriated from the general fund to the human services department for expenditure in fiscal year 2009 for operations and systems changes to provide coverage pursuant to Subsection B of this section. Any unexpected or unencumbered balance remaining at the end of fiscal year 2009 shall revert to the general fund.

B. Fifty-seven million five hundred twenty-nine thousand dollars ($57,529,000) is appropriated from the general fund to the human services department for expenditure in fiscal year 2010 to provide health care coverage for individuals through age eighteen in medicaid, premium assistance programs pursuant to Section 27-2-12 NMSA 1978 or other health coverage programs designed to reduce the number of children without coverage. Any unexpended or unencumbered balance remaining at the end of fiscal year 2010 shall revert to the general fund.

Section 8. EFFECTIVE DATE.--The effective date of the provisions of this act is January 1, 2009.

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