SENATE JUDICIARY COMMITTEE SUBSTITUTE FOR
SENATE CORPORATIONS AND TRANSPORTATION COMMITTEE SUBSTITUTE FOR
SENATE BILL 577

**52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015**

AN ACT

RELATING TO INSURANCE; AMENDING SECTIONS OF THE NEW MEXICO INSURANCE CODE TO CHANGE PENALTY ENFORCEMENT PROVISIONS AND TO INCLUDE STUDENT POLICIES WITHIN PROVISIONS RELATING TO INDIVIDUAL HEALTH INSURANCE; AMENDING SECTIONS OF THE NEW MEXICO INSURANCE CODE AND THE MEDICAL INSURANCE POOL ACT TO ENACT CHANGES IN PROVISIONS RELATING TO PREMIUM TAXES; AMENDING THE INSURANCE FRAUD ACT TO ESTABLISH A FEE PAYMENT DEADLINE AND LATE PAYMENT PENALTY; REMOVING HIGHER EDUCATION INSTITUTIONAL POLICIES AND CONTRACTS FROM NEW MEXICO INSURANCE CODE PROVISIONS RELATING TO BLANKET HEALTH INSURANCE; AMENDING A SECTION OF THE MINIMUM HEALTHCARE PROTECTION ACT TO PROVIDE THE SUPERINTENDENT OF INSURANCE WITH EXTENDED TIME TO REVIEW INSURER MARKETING PROPOSALS; AMENDING A SECTION OF THE LAW FOR REGULATION OF CREDIT LIFE INSURANCE AND CREDIT HEALTH INSURANCE TO PROVIDE THE SUPERINTENDENT OF INSURANCE WITH EXTENDED TIME

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TO REVIEW INSURER FORMS.

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

**SECTION 1.** Section 59A-5-30 NMSA 1978 (being Laws 1984, Chapter 127, Section 97) is amended to read:

"59A-5-30. PENALTIES FOR LATE, FALSE ANNUAL STATEMENTS.--

A. Any insurer failing without just cause reasonably beyond control of the insurer, to file its annual statement as required in Section [~~96 of this article~~] 59A-5-29 NMSA 1978, shall be required to pay a penalty of one hundred dollars ($100) for each day's delay, but not to exceed five thousand dollars ($5,000) in aggregate amount [~~to be recovered in a civil action brought against the insurer in the name of the State of New Mexico by the attorney general~~]. Such penalty may be in addition to any refusal to continue, or suspension or revocation of, the insurer's certificate of authority for such failure.

B. Any director, officer, agent or employee of any insurer who subscribes to, makes or concurs in making or publishing, any annual or other statement of the insurer required by law, knowing the same to contain any material statement [~~which~~] that is false, shall upon conviction thereof be guilty of a misdemeanor and upon conviction shall be sentenced to a fine of not more than one thousand dollars ($1,000), unless by its extent and nature the offense is

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punishable under other statutes as a felony."

**SECTION 2.** Section 59A-6-2 NMSA 1978 (being Laws 1984, Chapter 127, Section 102, as amended) is amended to read:

"59A-6-2. PREMIUM TAX--HEALTH INSURANCE PREMIUM SURTAX.--

A. The premium tax provided for in this section shall apply as to the following taxpayers:

(1) each insurer authorized to transact insurance in New Mexico;

(2) each insurer formerly authorized to transact insurance in New Mexico and receiving premiums on policies remaining in force in New Mexico, except that this provision shall not apply as to an insurer that withdrew from New Mexico prior to March 26, 1955;

(3) each plan operating under provisions of Chapter 59A, Articles 46 through 49 NMSA 1978;

(4) each property bondsman, as that person is defined in Section 59A-51-2 NMSA 1978, as to any consideration received as security or surety for a bail bond in connection with a judicial proceeding, which consideration shall be considered "gross premiums" for the purposes of this section; and

(5) each unauthorized insurer that has assumed a contract or policy of insurance directly or indirectly from an authorized or formerly authorized insurer and is receiving premiums on such policies remaining in force in New Mexico,

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except that this provision shall not apply if a ceding insurer continues to pay the tax provided in this section as to such policy or contract.

B. Each such taxpayer shall pay in accordance with this subsection a premium tax of three and three-thousandths percent of the gross premiums and membership and policy fees [~~received or~~] written by it, as reported in Schedule T and supporting schedules of its annual financial statement on insurance or contracts covering risks within this state during the preceding calendar year, less [~~all return premiums, including~~] dividends paid or credited to policyholders or contract holders and premiums received for reinsurance on New Mexico risks.

C. In addition to the premium tax imposed pursuant to Subsection B of this section, each taxpayer described in Subsection A of this section that transacts health insurance in New Mexico or is a plan described in Chapter 59A, Article 46 or 47 NMSA 1978 shall pay a health insurance premium surtax of one percent of the gross health insurance premiums and membership and policy fees [~~received by it~~] written by it, as reported in Schedule T and supporting schedules of its annual financial statement on hospital and medical expense incurred insurance or contracts; on nonprofit health care service plan contracts, excluding dental or vision only contracts; and on health maintenance organization subscriber contracts covering health

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risks within this state during the preceding calendar year, less [~~all return health insurance premiums, including~~] dividends paid or credited to health insurance policyholders or contract holders and health insurance premiums received for reinsurance on New Mexico risks. Except as provided in this section, all references in the Insurance Code to the premium tax shall include both the premium tax and the health insurance premium surtax.

D. For each calendar quarter, [~~an estimated~~] a payment of the premium tax and the health insurance premium surtax shall be made on April 15, July 15, October 15 and the following January 15. The [~~estimated~~] payments shall be equal to [~~at least one-fourth of the payment made during the previous calendar year or one-fifth of the actual payment due for the current calendar year, whichever is greater~~] the current year-to-date actual tax due for the calendar quarter preceding the premium tax due date for the current calendar year. The premium tax paid for each calendar quarter shall be based on all premiums written during that calendar quarter and shall not include any New Mexico medical insurance pool credits. The New Mexico medical insurance pool credits shall only be granted on the final annual premium tax return and shall only be granted after the New Mexico medical insurance pool final assessments have been issued for the prior calendar year. The credits granted for the New Mexico medical insurance pool shall not

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exceed the annual premium tax due on the final annual premium tax return. The final adjustment for payments due for the prior year shall be made with the return, which shall be filed on April 15 of each year, at which time all taxes for that year are due. Dividends paid or credited to policyholders or contract holders and refunds, savings, savings coupons and similar returns or credits applied or credited to payment of premiums for existing, new or additional insurance shall, in the amount so used, constitute premiums subject to tax under this section for the year in which so applied or credited.

E. Exempted from the taxes imposed by this section are:

(1) premiums attributable to insurance or contracts purchased by the state or a political subdivision for the state's or political subdivision's active or retired employees; and

(2) payments received by a health maintenance organization from the federal secretary of health and human services pursuant to a contract issued under the provisions of 42 U.S.C. Section 1395 mm(g)."

**SECTION 3.** Section 59A-16C-14 NMSA 1978 (being Laws 1998, Chapter 115, Section 14, as amended) is amended to read:

"59A-16C-14. INSURANCE FRAUD FUND CREATED--APPROPRIATION.--

A. There is created an "insurance fraud fund" in

the state treasury. All fees collected [~~under~~] pursuant to the provisions of the Insurance Fraud Act shall be deposited in the fund and are subject to appropriation for use in paying the expenses incurred by the superintendent in carrying out the provisions of the Insurance Fraud Act. Interest on the fund shall be credited to the fund. The fund is a continuing, nonreverting fund.

B. To implement the provisions of the Insurance Fraud Act, the superintendent shall determine a rate of assessment and collect a fee from authorized insurers in an amount not less than two hundred dollars ($200) and not exceeding one-tenth of one percent of the correctly reported direct written premiums on policies written in New Mexico by the authorized insurers. The fee shall be due on October 1, 2015 and each October 1 thereafter. The failure of an insurer to pay this fee when due shall subject the insurer to a penalty of one thousand dollars ($1,000) per month or part thereof, after notice and demand therefor. The superintendent, after taking into account unexpended money produced by collection of the fee, shall adjust the rate of assessment each year to produce the amount of money that [~~he~~] the superintendent estimates will be necessary to pay expenses incurred by the superintendent in carrying out the provisions of the Insurance Fraud Act. The assessment for a title insurer, as defined in Section 59A-30-3 NMSA 1978, shall be determined by the

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superintendent at the annual hearing conducted pursuant to Section 59A-30-8 NMSA 1978.

C. In calculating the direct written premiums for an insurer pursuant to the provisions of this section, all direct written premiums for workers' compensation insurance shall be excluded from the calculation.

D. The fees required by this section are in addition to all other taxes and fees now imposed or that may be subsequently imposed."

**SECTION 4.** Section 59A-22-1 NMSA 1978 (being Laws 1984, Chapter 127, Section 422) is amended to read:

"59A-22-1. SCOPE OF ARTICLE.--[~~This article~~] Chapter 59A, Article 22 NMSA 1978 applies generally to policies of individual health insurance, including student policies. Nothing in [~~this~~] that article shall apply to or affect:

A. any policy of [~~workmen's~~] workers' compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein; [~~or~~]

B. life insurance, endowment or annuity contracts or contracts supplemental thereto [~~which~~] that contain only such provisions relating to health insurance as:

(1) provide additional benefits in case of death by accident; and

(2) operate to safeguard such contracts against lapse or to give a special surrender value or special

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benefit or annuity in event the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract;

C. group or blanket health insurance, except as stated in Chapter 59A, Article 23 [~~of the Insurance Code~~] NMSA 1978; or

D. reinsurance."

**SECTION 5.** Section 59A-23-2 NMSA 1978 (being Laws 1984, Chapter 127, Section 461) is amended to read:

"59A-23-2. BLANKET HEALTH INSURANCE.--

A. Blanket health insurance is [~~hereby~~] declared to be that form of health insurance covering special groups of not less than ten [~~(10)~~] persons as enumerated in one of the following paragraphs [~~(1) to (5) inclusive~~]:

(1) under a policy or contract issued to [~~any~~] a common carrier, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on [~~such~~] the common carrier;

(2) under a policy or contract issued to an employer, who shall be deemed the policyholder, covering [~~any~~] a group of employees defined by reference to exceptional hazards incident to [~~such~~] employment;

[~~(3) under a policy or contract issued to a college, school or other institution of learning or to the head or principal thereof, who or which shall be deemed the~~

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~~policyholder, covering students and teachers;~~

~~(4)~~] (3) under a policy or contract issued in the name of [~~any~~] a volunteer fire department, first aid or other such volunteer group, which shall be deemed the policyholder, covering all of the members of [~~such~~] the department or group; or

[~~(5)~~] (4) under a policy or contract issued to any other substantially similar group [~~which~~] that, in the discretion of the superintendent, may be subject to the issuance of a blanket health policy or contract.

B. An individual application shall not be required from a person covered under a blanket sickness or accident policy or contract.

C. All benefits under any blanket sickness and accident policy shall be payable to the person insured or [~~his~~] the person's agent, or to [~~his~~] the person's designated beneficiary or beneficiaries, or to [~~his~~] the person's estate, except that if the person insured be a minor, such benefits may be made payable to [~~his~~] the minor's parent, guardian or other person actually supporting [~~him~~] the minor."

**SECTION 6.** Section 59A-23B-5 NMSA 1978 (being Laws 1991, Chapter 111, Section 5) is amended to read:

"59A-23B-5. POLICY OR PLAN DISCLOSURE REQUIREMENTS.--

A. Upon offering coverage under a policy or plan for any individual, family or group member, an insurer,

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fraternal benefit society, health maintenance organization or nonprofit healthcare plan shall provide the individual, family or group member with a written disclosure statement containing at least the following:

(1) a general explanation of those mandated benefits and providers not covered by the policy or plan;

(2) an explanation of the managed care and cost control features of the policy or plan, along with all appropriate mailing addresses and telephone numbers to be utilized by the insured or enrollees seeking information or authorization; and

(3) an explanation of the primary and preventive care features of the policy or plan.

B. Any disclosure statement provided pursuant to Subsection A of this section shall be written in a clear and understandable form and format and shall be separate from the insurance policy or certificate or other evidence of coverage provided to the individual, family and group member.

C. Before any insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan issues a policy or plan contract, the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan shall obtain from the prospective policyholder, contract holder or member a signed written statement in which the prospective policyholder, contract holder or member:

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(1) certifies as to the eligibility of the individual, family or group for coverage under the policy or plan;

(2) acknowledges the limited nature of the coverage, including the managed care and cost control features of the policy or plan;

(3) acknowledges that if misrepresentations are made regarding eligibility for coverage under a policy or plan, the person making such misrepresentations shall forfeit coverage provided by the policy or plan if the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan relied upon the misrepresentation to its detriment; and

(4) acknowledges that the prospective policyholder, contract holder or member had at the time of application for the policy or plan, been offered the opportunity to purchase coverage that included all applicable mandated benefits and the prospective policyholder, contract holder or member rejected such coverage.

D. A copy of the written statement required by Subsection C of this section shall be provided to the prospective policyholder, contract holder or member no later than at the time of delivery of the policy or plan and the original signed written statement shall be retained in the files of the insurer, fraternal benefit society, health

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maintenance organization or nonprofit healthcare plan while the policy or plan remains in effect or for three years, whichever is less.

E. Any material statement made by an applicant for coverage under a policy or plan that falsely certifies to the applicant's eligibility for coverage shall serve as the basis for termination of coverage under the policy or plan if the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan detrimentally relied upon the misrepresentation.

F. All printed, radio or television communication intended to be used for marketing a policy or plan in the state and the disclosures required by Subsection A of this section shall be submitted for review and approval by the superintendent of insurance prior to use. The superintendent of insurance shall complete the review within [~~thirty~~] sixty days or else the materials submitted shall be deemed approved for use."

**SECTION 7.** Section 59A-25-8 NMSA 1978 (being Laws 1984, Chapter 127, Section 479) is amended to read:

"59A-25-8. FILING, APPROVAL AND WITHDRAWAL OF FORMS.--

A. All policies, certificates of insurance, notice of proposed insurance, applications for insurance, endorsements and riders delivered or issued for delivery in this state and the schedules of premium rates pertaining [~~thereto~~] to them

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shall be filed by the insurer with the superintendent.

B. The superintendent shall within [~~thirty (30)~~] sixty days after the filing of any such policies, certificates of insurance, notice of proposed insurance, applications for insurance, endorsements and riders, disapprove any [~~such~~] form if the benefits provided therein are not reasonable in relation to the premium charge, or if it contains provisions [~~which~~] that are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage, or are contrary to [~~any~~] a provision of the Insurance Code or of [~~any~~] a rule or regulation promulgated thereunder.

C. If the superintendent notifies the insurer that the form is disapproved, it is unlawful thereafter for the insurer to issue or use [~~such~~] the form. In [~~such~~] the notice, the superintendent shall specify the reason for disapproval and state that a hearing will be granted within twenty [~~(20)~~] days after request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider shall be issued or used until the expiration of thirty [~~(30)~~] days after it has been [~~so~~] filed, unless the superintendent gives [~~his~~] prior written approval thereto.

D. The superintendent may, at any time after a hearing held not less than twenty [~~(20)~~] days after written notice to the insurer, withdraw [~~his~~] approval of [~~any such~~] a

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form on [~~any~~] a ground set forth in Subsection B [~~above~~] of this section. The written notice of hearing shall state the reason for the proposed withdrawal.

E. The insurer shall not issue [~~such~~] the forms or use them after the effective date of [~~such~~] withdrawal.

F. If a group policy of credit life insurance or credit health insurance has been or is delivered in another state, the insurer shall be required to file only the group certificate and notice of proposed insurance delivered or issued for delivery in this state as specified in Subsections B and D of Section [~~478 of this article~~] 59A-25-7 NMSA 1978, and [~~such~~] the forms shall be approved by the superintendent if they conform with the requirements specified in such subsections and if the schedules of premium rates applicable to the insurance evidenced by [~~such~~] the certificate or notice are not in excess of the insurer's schedules of premium rates filed with the superintendent."

**SECTION 8.** 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

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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 1876 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

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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 fifty-percent credit on the premium tax return for that member and a seventy-five-percent credit on the premium tax return for that member for the assessments attributable to pool policy holders that receive premiums, in whole or in part, through the federal Ryan White CARE Act, the Ted R. Montoya hemophilia program at the university of New Mexico health sciences center, the children's medical services bureau of the public health division of the department of health or other program receiving state funding or assistance. The New Mexico medical insurance pool credits shall only be granted on the final annual premium tax return and shall only be granted after the New Mexico medical insurance pool final assessments have been issued for the prior calendar year. The credits granted for the New Mexico medical insurance pool shall not exceed the annual premium tax due on the final annual premium tax return.

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

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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 9.** Section 59A-57-3 NMSA 1978 (being Laws 1998, Chapter 107, Section 3) is amended to read:

"59A-57-3. DEFINITIONS.--As used in the Patient Protection Act:

A. "continuous quality improvement" means an ongoing and systematic effort to measure, evaluate and improve a managed health care plan's process in order to improve continually the quality of health care services provided to enrollees;

B. "covered person", "enrollee", "patient" or "consumer" means an individual who is entitled to receive health care benefits provided by a managed health care plan;

C. "department" means the office of superintendent of insurance [~~department~~];

D. "emergency care" means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable

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layperson to result in jeopardy to a person's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to a person;

E. "health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting;

F. "health care insurer" means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan;

G. "health care professional" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law;

H. "health care provider" or "provider" means a person that is licensed or otherwise authorized by the state to furnish health care services and includes health care professionals and health care facilities;

I. "health care services" includes, to the extent offered by the plan, physical health or community-based mental

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health or developmental disability services, including services for developmental delay;

J. "managed health care plan" or "plan" means a health care insurer or a provider service network when offering a benefit that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers managed, owned, under contract with or employed by the health care insurer or provider service network. "Managed health care plan" or "plan" does not include a health care insurer or provider service network offering a traditional fee-for-service indemnity benefit or a benefit that covers only short-term travel, accident-only, limited benefit [~~student health plan~~] or specified disease policies;

K. "person" means an individual or other legal entity;

L. "point-of-service plan" or "open plan" means a managed health care plan that allows enrollees to use health care providers other than providers under direct contract with or employed by the plan, even if the plan provides incentives, including financial incentives, for covered persons to use the plan's designated participating providers;

M. "provider service network" means two or more health care providers affiliated for the purpose of providing health care services to covered persons on a capitated or

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similar prepaid flat-rate basis that hold a certificate of authority pursuant to the Provider Service Network Act;

N. "superintendent" means the superintendent of insurance; and

O. "utilization review" means a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients."



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