ARTICLE 54
Medical Insurance Pool

59A-54-1. Short title.

Chapter 59A, Article 54 NMSA 1978 may be cited as the "Medical Insurance Pool Act". Any reference in any law, rule, division bulletin or other legal document to the Comprehensive Health Insurance Pool Act shall be deemed to refer to the Medical Insurance Pool Act.

History: 1978 Comp., § 59A-54-1, enacted by Laws 1987, ch. 154, § 1; 2001, ch. 352, § 1.

59A-54-2. Purpose.

The purpose of the Medical Insurance Pool Act is to provide access to health insurance coverage to all residents of New Mexico who are denied adequate health insurance and are considered uninsurable.

History: 1978 Comp., § 59A-54-2, enacted by Laws 1987, ch. 154, § 2; 2001, ch. 352, § 2.

59A-54-3. Definitions.

As used in the Medical Insurance Pool Act:

A. "board" means the board of directors of the pool;

B. "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) the Medical Insurance Pool Act;

(7) a health plan offered pursuant to 5 USCA Chapter 89;

(8) a public health plan as defined in federal regulations; or

(9) a health benefit plan offered pursuant to Section 5(e) of the federal Peace Corps Act;

C. "federally defined eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under the Medical Insurance Pool Act, the aggregate of the periods of creditable coverage is eighteen or more months;

(2) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage, as those plans or coverage are defined in Section 59A-23E-2 NMSA 1978, offered in connection with that plan;

(3) who is not eligible for coverage under a group health plan, Part A or Part B of Title 18 of the Social Security Act or a state plan under Title 19 or Title 21 of the Social Security Act or a successor program and who does not have other health insurance coverage;

(4) with respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(5) who, if offered the option of continuation of coverage under a continuation provision pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or a similar state program, elected this coverage; and

(6) who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in Paragraph (5) of this subsection;

D. "health care facility" means an entity providing health care services that is licensed by the department of health;

E. "health care services" means services or products included in the furnishing to an individual of medical care or hospitalization, or incidental to the furnishing of that care or hospitalization, as well as the furnishing to a person of other services or products for the purpose of preventing, alleviating, curing or healing human illness or injury;

F. "health insurance" means a hospital and medical expense-incurred policy; nonprofit health care service plan contract; health maintenance organization subscriber contract; short-term, accident, fixed indemnity or specified disease policy; disability income contracts; limited benefit insurance; credit insurance or as defined by Section 59A-7-3 NMSA 1978. "Health insurance" does not include insurance arising out of the Workers' Compensation Act [Chapter 52, Article 1 NMSA 1978] or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is required by law to be contained in a liability insurance policy;

G. "health maintenance organization" means a person who provides, at a minimum, either directly or through contractual or other arrangements with others, basic health care services to enrollees on a fixed prepayment basis and who is responsible for the availability, accessibility and quality of the health care services provided or arranged, or as defined by Subsection M of Section 59A-46-2 NMSA 1978;

H. "health plan" means an arrangement by which persons, including dependents or spouses, covered o making application to be covered under the pool have access to hospital and medical benefits or reimbursement, including group or individual insurance or subscriber contract; coverage through health maintenance organizations, preferred provider organizations or other alternate delivery systems; coverage under prepayment, group practice or individual practice plans; coverage 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 under group-type contracts that are not available to the general public and can be obtained only because of connection with a particulai organization or group; and coverage by medicare or other governmental benefits. "Health plan" includes coverage through health insurance;

I. "insured" means an individual resident of this state who is eligible to receive benefits from an insurer or other health plan;

J. "insurer" means an insurance company authorized to transact health insurance business in this state, a nonprofit health care plan, a health maintenance organization and self-insurers not subject to federal preemption. "Insurer" does not include an insurance company that is licensed under the Prepaid Dental Plan Law [Chapter 59A, Article 48 NMSA 1978] or a company that is solely engaged in the sale of dental insurance and is licensed not under that act, but under another provision of the Insurance Code [Chapter 59A NMSA 1978];

K. "medicare" means coverage under Part A or Part B of Title 18 of the Social Security Act, as amended;

L. "pool" means the New Mexico medical insurance pool;

M. "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 within six months before the effective date of coverage, except that pregnancy is not considered a preexisting condition for a federally defined eligible individual; and

N. "therapist" means a licensed physical, occupational, speech or respiratory therapist.

History: 1978 Comp., § 59A-54-3, enacted by Laws 1987, ch. 154, § 3; 1991, ch. 200, § 1; 1993, ch. 118, § 1; 1997, ch. 243, § 32; 1998, ch. 41, § 25; 2001, ch. 352, § 3; 2003, ch. 395, § 1; 2008, ch. 88, § 1.

59A-54-4. Pool created; board.

A. There is created a nonprofit entity to be known as the "New Mexico medical insurance pool". All insurers shall organize and remain members of the pool as a condition of their authority to transact insurance business in this state. The board is a governmental entity for purposes of the Tort Claims Act [41-4-1 to 41-4-27 NMSA 1978].

B. The superintendent shall, within sixty days after the effective date of the Medical Insurance Pool Act, give notice to all insurers of the time and place for the initial organizational meetings of the pool. Each member of the pool shall be entitled to one vote in person or by proxy at the organizational meetings.

C. The pool shall operate subject to the supervision and approval of the board. The board shall consist of the superintendent or his designee, who shall serve as the chairman of the board, four members appointed by the members of the pool and six members appointed by the superintendent. The members appointed by the superintendent shall consist of four citizens who are not professionally affiliated with an insurer, at least two of whom shall be individuals who are insured by the pool, who would qualify for pool coverage if they were not eligible for particular group coverage or who are a parent, guardian, relative or spouse of such an individual. The superintendent's fifth appointment shall be a representative of a statewide health planning agency or organization. The superintendent's sixth appointment shall be a representative of the medical community.

D. The members of the board appointed by the members of the pool shall be appointed for initial terms of four years or less, staggered so that the term of one member shall expire on June 30 of each year. The members of the board appointed by the superintendent shall be appointed for initial terms of five years or less, staggered so that the term of one member expires on June 30 of each year. Following the initial terms

members of the board shall be appointed for terms of three years. If the members of the pool fail to make the initial appointments required by this subsection within sixty days following the first organizational meeting, the superintendent shall make those appointments. Whenever a vacancy on the board occurs, the superintendent shall fill the vacancy by appointing a person to serve the balance of the unexpired term. The person appointed shall meet the requirements for initial appointment to that position. Members of the board may be reimbursed from the pool subject to the limitations provided by the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978] and shall receive no other compensation, perquisite or allowance.

E. The board shall submit a plan of operation to the superintendent and any amendments to it necessary or suitable to assure the fair, reasonable and equitable administration of the pool.

F. The superintendent shall, after notice and hearing, approve the plan of operation, provided it is determined to assure the fair, reasonable and equitable administration of the pool and provides for the sharing of pool losses on an equitable, proportionate basis among the members of the pool. The plan of operation shall become effective upon approval in writing by the superintendent consistent with the date on which coverage under the Medical Insurance Pool Act is made available. If the board fails to submit a plan of operation within one hundred eighty days after the appointment of the board, or any time thereafter fails to submit necessary amendments to the plan of operation, the superintendent shall, after notice and hearing, adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of the Medical Insurance Pool Act. Rules promulgated by the superintendent shall continue in force until modified by him or superseded by a subsequent plan of operation submitted by the board and approved by the superintendent.

G. Any reference in law, rule, division bulletin, contract or other legal document to the New Mexico comprehensive health insurance pool shall be deemed to refer to the New Mexico medical insurance pool.

History: 1978 Comp., § 59A-54-4, enacted by Laws 1987, ch. 154, § 4; 1991, ch. 200, § 2; 2001, ch. 352, § 4; 2003, ch. 395, § 2.

59A-54-5. Plan of operation.

The plan of operation submitted by the board to the superintendent shall:

A. establish procedures for the handling and accounting of assets and money of the pool;

B. establish regular times and places for meetings of the board;

C. establish procedures for records to be kept of all financial transactions and for annual fiscal reporting to the superintendent;

D. contain additional provisions necessary and proper for the execution of the powers and duties of the pool;

E. establish procedures for the collection of assessments from all members of the pool to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

F. establish the amount of assessment pursuant to Section 59A-54-10 NMSA 1978 that shall be imposed annually at the end of each calendar year and that shall be due and payable within thirty days of the receipt of the assessment notice;

G. establish procedures for the selection of an administrator in accordance with Section 59A-54-11 NMSA 1978;

H. develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment in the plan and to maintain public awareness of the plan; and

I. establish penalties for noncollection of assessments from pool members.

History: 1978 Comp., § 59A-54-5, enacted by Laws 1987, ch. 154, § 5; 1991, ch. 200, § 3.

59A-54-6. Notice of pool.

A. Every insurer shall provide a notice and an application for coverage by the pool to any person who receives:

(1) a rejection of coverage for health insurance or health care services;

(2) a notice that the rate for health insurance or coverage for health care services provided will exceed the rates of a pool policy;

(3) a notice of reduction or limitation of coverage, including a restrictive rider, from an insurer if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan; or

(4) a termination of coverage for health insurance or health care services by either the carrier or the covered individual.

B. The notice required by Subsection A of this section shall state that the person is eligible to apply for health insurance provided by the pool. Application for the health insurance shall be on forms prescribed by the board and made available to all insurers.

History: 1978 Comp., § 59A-54-6, enacted by Laws 1987, ch. 154, § 6; 1991, ch. 200, § 4; 2021, ch. 108, § 31.

59A-54-7. Board; powers and duties.

The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health insurance business. In addition, the board shall have the specific authority to:

A. enter into contracts as are necessary or proper to carry out the provisions and purposes of the Medical Insurance Pool Act, including the authority, with the approval of the superintendent, to enter into contracts with similar pools of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions. The pool shall comply with the Procurement Code [13-1-28 to 13-1-199 NMSA 1978], except as otherwise provided in the Medical Insurance Pool Act;

B. sue or be sued, including taking any legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

C. establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices;

D. assess members of the pool in accordance with the provisions of the Medical Insurance Pool Act and make initial and interim assessments as may be reasonable and necessary for the organizational or interim operating expenses of the pool. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year. Interim assessments may include anticipated expenses of the next year that the board determines are reasonable and necessary for the operating expenses of the pool;

E. issue policies of insurance in accordance with the requirements of the Medical Insurance Pool Act;

F. issue a policy of insurance, in accordance with the requirements of the Medical Insurance Pool Act, for a small group that is formed voluntarily through an employer, association, cooperative, mutual alliance o other organization; provided, however, that an employer group may not have more than fifty persons;

G. appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design and any other function within the authority of the pool; and

H. conduct periodic audits to assure the general accuracy of the financial data submitted to the pool. The board shall cause the pool to have an annual audit of its operations by an independent certified public accountant.

History: 1978 Comp., § 59A-54-7, enacted by Laws 1987, ch. 154, § 7; 1991, ch. 200, § 5; 2001, ch. 352, § 5; 2005, ch. 294, § 1.

59A-54-7.1. 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 and, if established, shall ensure that cost-containment mechanisms are included in the program.

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

D. 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 for the prescription drug program assessment on the premium tax return for that member

E. 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.

F. If the board establishes a prescription drug program, the board shall cooperate with other state and federal prescription drug initiatives.

History: Laws 2003, ch. 396, § 1.

59A-54-7.2. Expansion of programs pursuant to federal law.

The board may:

A. establish a health plan to offer selected eligible individuals the ability to purchase or enroll in a program pursuant to federal law that provides expanded coverage for state high-risk pools;

B. establish eligibility and coverage criteria as needed for selected eligible individuals;

C. establish the cost-sharing amounts payable by a selected eligible individual enrolled in the health plan, including the premium, deductible, coinsurance, co-payment or other out-of-pocket expenses; and

D. participate with and receive funding from any federal agency designated to administer expanded coverage programs for state high-risk pools.

History: Laws 2010, ch. 92, § 1.

59A-54-8. Examination.

The pool shall be subject to and responsible for examination by the superintendent. Not later than June 1 of 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.

History: 1978 Comp., § 59A-54-8, enacted by Laws 1987, ch. 154, § 8; 2021, ch. 108, § 32.

59A-54-9. Policy forms.

All policy forms issued by the pool shall conform in substance to prototype forms developed by the pool and shall be filed with and approved by the superintendent before they are issued.

History: 1978 Comp., § 59A-54-9, enacted by Laws 1987, ch. 154, § 9; 1991, ch. 200, § 6.

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 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 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.

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

History: 1978 Comp., § 59A-54-10, enacted by Laws 1987, ch. 154, § 10; 1991, ch. 200, § 7; 1994, ch. 58, § 1; 2001, ch. 352, § 6; 2003, ch. 395, § 3; 2005, ch. 301, § 5; 2005, ch. 305, § 5; 2007, ch. 361, § 9; 2018, ch. 57, § 28.

59A-54-11. Pool administrator; selection; duties.

A. The board shall select a pool administrator through a competitive bidding process. The board shall evaluate bids based on criteria established by the board, which shall include:

(1) proven ability to handle accident and health insurance;

(2) efficiency of claim paying procedures;

(3) an estimate of total charges for administering the plan; and

(4) ability to administer the pool in a cost-efficient manner.

B. The pool administrator shall serve for a period not to exceed that provided in Subsection B of Section 13-1-150 NMSA 1978, subject to removal for cause. At least one year prior to the expiration of the pool administrator's contract, the board shall invite all interested parties, including the current administrator, to submit bids to serve as the pool administrator for the succeeding contract period. Selection of the administrator for a succeeding period shall be made at least six months prior to the expiration of the pool administrator's current contract.

C. The pool administrator shall:

(1) perform all eligibility and administrative claim payment functions relating to the pool;

(2) establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis, not less than monthly, as determined by the board;

(3) perform all necessary functions to assure timely payment of benefits to persons covered under the pool, including:

(a) making information available relating to the proper manner of submitting a claim for benefits tc the pool and distributing forms upon which submission shall be made; and

(b) evaluating the eligibility of each claim for payment by the pool;

(4) submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be as determined by the board; and

(5) following the close of each fiscal year, determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report this information to the board and the superintendent on a form prescribed by the superintendent.

D. The administrator shall be paid as provided in the contract negotiated pursuant to the process for selection of the administrator established by the board.

History: 1978 Comp., § 59A-54-11, enacted by Laws 1987, ch. 154, § 11; 1991, ch. 200, § 8; 2021, ch. 108, § 33.

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 a health plan that provides coverage foı comprehensive major medical or comprehensive physician and hospital services;

(2) is currently paying a rate for a health plan that is higher than one hundred twenty-five percent of the pool's standard rate;

(3) has a mental health diagnosis and has individual health insurance coverage that does not include coverage for mental health services;

(4) has been rejected for coverage for comprehensive major medical or comprehensive physiciar and hospital services;

(5) is only eligible for a health plan with a rider, waiver or restrictive provision for that particular individual based on a specific condition;

(6) has a medical condition that is listed on the pool's prequalifying conditions;

(7) 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, governmenta 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 ninety-five day or longer period during all of which the individual was not covered under any creditable coverage; or

(8) 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 [repealed] shall not preclude a person from remaining on or purchasing a pool policy; provided that a self-employed person who qualifies for an approved health plan under the Health Insurance Alliance Act [repealed] by using a dependent as the second employee may choose a pool policy in lieu of the health plan under that act; and

(2) 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 policyholder's newborn child or newly adopted child is automatically eligible for thirty-one consecutive calendar days of coverage for an additional premium.

E. Except for a person eligible as provided in Paragraph (7) 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.

F. The preexisting condition exclusions described in Subsection E 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 ninety-five 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.

G. An individual is not eligible for coverage by the pool if:

(1) except as provided in Subsection I of this section, the individual is, at the time of application, eligible for medicare or medicaid that would provide coverage for amounts in excess of limited policies such as dread disease, cancer policies or hospital indemnity policies;

(2) the individual has voluntarily terminated coverage by the pool within the past twelve months and did not have other continuous coverage during that time, except that this paragraph shall not apply to an applicant who is a federally defined eligible individual;

(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 (7) 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 the individual has elected the coverage and did not exhaust the continuation coverage under the provision or program, provided, however, that an unemployed former employee who has not exhausted COBRA coverage shall be eligible.

H. A person whose health insurance coverage from a qualified state high risk pool health policy is terminated because of nonresidency in another state may apply for coverage under the pool. If the coverage is applied for within ninety-five days after that termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

I. The board may issue a pool policy for individuals who:

(1) are 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.

History: 1978 Comp., § 59A-54-12, enacted by Laws 1987, ch. 154, § 12; 1991, ch. 200, § 9; 1997, ch. 243, § 33; 1998, ch. 41, § 26; 2001, ch. 352, § 7; 2003, ch. 395, § 4; 2005, ch. 301, § 6; 2005, ch. 305, § 6 2007, ch. 211, § 1; 2008, ch. 88, § 2.

59A-54-13. Benefits.

A. The health insurance policy issued by the pool shall pay for medically necessary eligible health care services rendered or furnished for the diagnoses or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under Section 59A-54-14 NMSA 1978 and are not otherwise limited or excluded. Eligible expenses are the charges for the health care services and items for which benefits are extended under the pool policy. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations shall be established by the board and shall, at a minimum, reflect the levels of health insurance coverage generally available in New Mexico for small group policies; provided that a health insurance policy issued by the pool shall not include a lifetime maximum benefit. The superintendent shall approve the benefit package developed by the board to ensure its compliance with the Medical Insurance Pool Act. The benefit package shall include therapy services and hearing aids.

B. The Medical Insurance Pool Act shall not be construed to prohibit the pool from issuing additional types of health insurance policies with different types of benefits that, in the opinion of the board, may be of benefit to the citizens of New Mexico.

C. The board may design and employ cost containment measures and requirements, including preadmission certification and concurrent inpatient review, for the purpose of making the pool more cost effective.

History: 1978 Comp., § 59A-54-13, enacted by Laws 1987, ch. 154, § 13; 1991, ch. 200, § 10; 2001, ch. 352, § 8; 2008, ch. 88, § 3.

59A-54-14. Deductibles; coinsurance; maximum out-of-pocket payments.

A. Subject to the limitation provided in Subsection C of this section, a pool policy offered in accordance with the Medical Insurance Pool Act shall impose a deductible on a per-person calendar-year basis. Deductible plans of five hundred dollars ($500) and one thousand dollars ($1,000) shall initially be offered. The board may authorize deductibles in other amounts. The deductible shall be applied to the first five hundred dollars ($500) or one thousand dollars ($1,000) of eligible expenses incurred by the covered person.

B. Subject to the limitations provided in Subsection C of this section, a mandatory coinsurance requirement shall be imposed at the rate determined by the board.

C. The maximum aggregate out-of-pocket payments for eligible expenses by the insured shall be determined by the board.

History: 1978 Comp., § 59A-54-14, enacted by Laws 1987, ch. 154, § 14; 1991, ch. 200, § 11; 2001, ch. 352, § 9; 2021, ch. 108, § 34.

59A-54-15. Dependent family member required coverage; employer responsibilities.

A. An employer is authorized to make a payroll deduction from the compensation of an employee for the portion of the pool policy premium the employee is responsible for, and an employer shall contribute the same dollar amount of the cost of that policy on behalf of the employee that the employer contributes for other similar employees for health insurance.

B. An employer shall offer and make available to dependent family members of an employee covered by the pool the same group plan offered to other employees of the group. The employer shall charge a dependent family member a premium equal to that amount charged to other employees and shall contribute the difference between the amount the employer would pay for the employee under its group family coverage and the amount the employer has paid to the pool on behalf of the employee pursuant to Subsection A of this section. In no event shall an employer be required to pay more for a family with the employee being a high risk than for a standard family in the employer's group plan.

History: 1978 Comp., § 59A-54-15, enacted by Laws 1987, ch. 154, § 15.

59A-54-16. Pool policy.

A. A pool policy offered under the Medical Insurance Pool Act shall contain provisions under which the pool is obligated to renew the contract until the day on which the individual in whose name the contract is issued first becomes eligible for medicare coverage, except that in a family policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the durational requirement of this subsection.

B. The pool shall not change the rates for pool policies except on a class basis with a clear disclosure in the policy of the right of the pool to do so.

C. In the case of a small group policy, a pool policy offered under the Medical Insurance Pool Act shall provide covered family members the right to continue the policy as the named insured or through a conversion policy upon the death of the named insured or upon the divorce, annulment or dissolution of

marriage or legal separation of the spouse from the named insured by election to do so within a period of time specified in the contract subject to the requirements of this section.

History: 1978 Comp., § 59A-54-16, enacted by Laws 1987, ch. 154, § 16; 2001, ch. 352, § 10; 2008, ch. 88, § 4.

59A-54-17. Rules.

The superintendent shall:

A. adopt rules that provide for disclosure by members of the pool of the availability of insurance coverage from the pool;

B. adopt rules that implement the provisions of the Medical Insurance Pool Act; and

C. adopt any other rules deemed necessary in order to carry out the provisions of the Medical Insurance Pool Act.

History: 1978 Comp., § 59A-54-17, enacted by Laws 1987, ch. 154, § 17; 2001, ch. 352, § 11.

59A-54-18. Collective action.

Neither the participation by insurers in the pool, the establishment of rates, forms or procedures for coverages issued by the pool nor any other joint or collective action required by the Medical Insurance Pool Act shall be the basis of any legal action, civil or criminal liability or penalty against the members of the pool either jointly or separately.

History: 1978 Comp., § 59A-54-18, enacted by Laws 1987, ch. 154, § 18; 2001, ch. 352, § 12.

59A-54-19. Rates; standard risk rate.

A. The pool shall determine a standard risk rate by actuarially calculating the individual rate that an insurer would charge for an individual policy with the pool benefits issued to a person who was a standard risk. Separate schedules of standard risk rates based on age and other appropriate demographic characteristics may be used. In determining the standard risk rate, the pool shall consider the benefits provided, the standard risk experience and the anticipated expenses for a standard risk for the coverage provided. The rates charged for pool coverage shall be no more than one hundred fifty percent of the standard risk rate for each class of insureds.

B. The board shall adopt a low-income premium schedule that provides coverage at lower rates for those persons with an income less than four hundred percent of the current federal poverty level guidelines applicable to New Mexico, published by the United States department of health and human services. For individuals with household incomes of one hundred ninety-nine percent of the federal poverty level or lower, the premium reduction shall be seventy-five percent. For individuals with household incomes of two hundred percent to two hundred ninety-nine percent of the federal poverty level, the premium reduction shall be fifty percent. For individuals with household incomes of three hundred percent to three hundred

ninety-nine percent of the federal poverty level, the premium reduction shall be twenty-five percent. The board shall determine income based on the preceding taxable year. No person shall be eligible for a low-income premium reduction if that person's premium is paid by a third party who is not a family member.

C. All rates and rate schedules shall be submitted to the superintendent for approval.

History: 1978 Comp., § 59A-54-19, enacted by Laws 1987, ch. 154, § 19; 1991, ch. 200, § 12; 1994, ch. 58, § 2; 2001, ch. 352, § 13; 2009, ch. 190, § 1; 2021, ch. 108, § 35.

59A-54-20. Benefit payments reduction.

A. The pool shall be the last payer of benefits whenever any other benefit is available. Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance or health benefit plan, including a self-insured plan and by all hospital and medical expense benefits paid or payable under any workmen's compensation coverage, automobile medical payment or liability insurance, whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law program.

B. The administrator or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this subsection.

History: 1978 Comp., § 59A-54-20, enacted by Laws 1987, ch. 154, § 20.

59A-54-21. Exemption.

The pool is exempt from payment of all fees and all taxes levied by this state or any of its political subdivisions.

History: 1978 Comp., § 59A-54-21, enacted by Laws 1987, ch. 154, § 21.