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Chapter No. 136

SB 317

AN ACT

RELATING TO HEALTH COVERAGE; INCREASING THE HEALTH INSURANCE PREMIUM SURTAX; DISTRIBUTING A PORTION OF THE REVENUE OF THE SURTAX TO A NEW HEALTH CARE AFFORDABILITY FUND; PROVIDING FOR A REDUCTION IN THE SURTAX IF THE ANNUAL FEE ON HEALTH INSURANCE PROVIDERS PURSUANT TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT IS IMPOSED; CREATING THE HEALTH CARE AFFORDABILITY FUND TO BE USED TO REDUCE THE COST OF HEALTH CARE COVERAGE FOR NEW MEXICO RESIDENTS AND SMALL BUSINESSES; REQUIRING THE SUPERINTENDENT OF INSURANCE TO REPORT ON EXPENDITURES FROM THE HEALTH CARE AFFORDABILITY FUND; REQUIRING THE SUPERINTENDENT OF INSURANCE TO ESTABLISH AND ANNUALLY UPDATE HEALTH INSURANCE AFFORDABILITY CRITERIA THAT DEFINE AFFORDABILITY STANDARDS; PROHIBITING IMPOSITION OF COST SHARING FOR BEHAVIORAL HEALTH SERVICES UNDER CERTAIN INSURANCE COVERAGE POLICIES OR PLANS; ALLOWING PLANS EXEMPT FROM REGULATION UNDER THE NEW MEXICO INSURANCE CODE TO ELIMINATE COST SHARING FOR BEHAVIORAL HEALTH SERVICES; ESTABLISHING REPORTING REQUIREMENTS.

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

SECTION 1. A new section of the Tax Administration Act is enacted to read:

"DISTRIBUTION--HEALTH INSURANCE PREMIUM SURTAX--HEALTH CARE AFFORDABILITY FUND. -- A distribution pursuant to Section 7-1-6.1 NMSA 1978 shall be made to the health care affordability fund in an amount equal to the following amounts of the net receipts attributable to the health insurance premium surtax; provided that if the rate of the health insurance premium surtax is reduced pursuant to Subsection F of Section 7-40-3 NMSA 1978, no distribution pursuant to this section shall be made:

A. beginning January 1, 2022 and prior to July 1, 2022, fifty-two percent;

B. beginning July 1, 2022 and prior to July 1, 2024, fifty-five percent; and

C. beginning July 1, 2024, thirty percent."

SECTION 2. Section 7-40-3 NMSA 1978 (being Laws 2018, Chapter 57, Section 3) is amended to read:

"7-40-3. IMPOSITION AND RATE OF TAX--DENOMINATION OF "PREMIUM TAX" AND "HEALTH INSURANCE PREMIUM SURTAX". --

A. A tax is imposed at a rate of three and three-thousandths percent of the gross premiums and membership and policy fees received or written by a taxpayer, as reported by March 1 of each year to the department in the appropriate schedule, as determined by the department, of the taxpayer's annual financial statement on insurance or contracts covering risks within the state during the preceding calendar year. The tax shall not be imposed on return premiums, dividends paid or credited to policyholders or contract holders and premiums received for reinsurance on New Mexico risks. The tax imposed pursuant to this section may be referred to as the "premium tax".

B. For a taxpayer that is an insurer lawfully organized pursuant to the laws of the Republic of Mexico, the premium tax shall apply solely to the taxpayer's gross premium receipts from insurance policies issued by the taxpayer in New Mexico that cover residents of New Mexico or property or risks principally domiciled or located in New Mexico.

C. With respect to a taxpayer that is a property bondsman, "gross premiums" shall be considered any consideration received as security or surety for a bail bond in connection with a judicial proceeding.

D. The premium tax provided in Subsection A of this section is imposed on the gross premiums received of a surplus lines broker, less return premiums, on surplus lines insurance where New Mexico is the home state of the insured transacted under the surplus lines broker's license, as reported by the surplus lines broker to the department on forms and in the manner prescribed by the department. For purposes of this subsection, "gross premiums" shall include any additional amount charged the insured, including policy fees, risk purchasing group fees and inspection fees; but "premiums" shall not include any additional amount charged the insured for local, state or federal taxes; regulatory authority fees; or examination fees, if any. For a surplus lines policy issued to an insured whose home state is New Mexico and where only a portion of the risk is located in New Mexico, the entire premium tax shall be paid in accordance with this section.

E. In addition to the premium tax, except as provided in Subsection F of this section, a health insurance premium surtax is

imposed at a rate of three and seventy-five hundredths percent of the gross health insurance premiums and membership and policy fees received by the taxpayer on hospital and medical expense incurred insurance or contracts; nonprofit health care plan contracts, excluding dental or vision only contracts; and health maintenance organization subscriber contracts covering health risks within this state during the preceding calendar year. The surtax shall not apply to return health insurance premiums, dividends paid or credited to policyholders or contract holders and health insurance premiums received for reinsurance on New Mexico risks. The surtax imposed pursuant to this section may be referred to as the "health insurance premium surtax".

F. If an act of the United States congress is signed into law that imposes the annual fee on health insurance providers pursuant to Section 9010 of the federal Patient Protection and Affordable Care Act, or that imposes a substantially similar fee on the same class of taxpayers, the rate of the health insurance premium surtax shall be decreased at a rate equal to the rate of the annual fee imposed; provided that the rate of the health insurance premium surtax shall not be less than one percent. A reduction in the health insurance premium surtax pursuant to this subsection shall go into effect on the later of the effective date of the imposition of the federal annual fee or ninety days after the congressional act imposing the federal annual fee is signed into law."

SECTION 3. A new section of the Health Care Purchasing Act is enacted to read:

"BEHAVIORAL HEALTH SERVICES--ELIMINATION OF COST SHARING. --

A. Until January 1, 2027, group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act that offers coverage of behavioral health services shall not impose cost sharing on those behavioral health services.

B. For the purposes of this section:

(1) "behavioral health services" means professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable;

(2) "coinsurance" means a cost-sharing method that requires an enrollee to pay a stated percentage of medical expenses after any deductible amount is paid; provided that coinsurance rates may differ for different types of services under the same group health plan;

(3) "copayment" means a cost-sharing method that requires an enrollee to pay a fixed dollar amount when health care services are received, with the plan administrator paying the balance of the allowable amount; provided that there may be different copayment requirements for different types of services under the same group health plan; and

(4) "cost sharing" means a copayment, coinsurance, deductible or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations, as defined by the terms of a group health plan."

SECTION 4. A new section of the New Mexico Insurance Code is enacted to read:

"HEALTH CARE AFFORDABILITY FUND. --

A. The "health care affordability fund" is created in the state treasury. The fund consists of distributions, appropriations, gifts, grants and donations. Money in the fund at the end of a fiscal year shall not revert to any other fund. The office of superintendent of insurance shall administer the fund, and money in the fund is subject to appropriation by the legislature for purposes provided by this section. Disbursements from the fund shall be made by warrant of the secretary of finance and administration pursuant to vouchers signed by the superintendent or the superintendent's authorized representative.

B. The purpose of the fund is to:

(1) reduce health care premiums and cost sharing for New Mexico residents who purchase health care coverage on the New Mexico health insurance exchange;

(2) reduce premiums for small businesses and their employees purchasing health care coverage in the fully insured small group market;

(3) provide resources for planning, design and implementation of health care coverage initiatives for uninsured New Mexico residents; and

(4) provide resources for administration of state health care coverage initiatives for uninsured New Mexico residents.

C. If the federal Patient Protection and Affordable Care Act is repealed in full or in part by an act of congress or invalidated by the United States supreme court and eliminates or reduces comprehensive health care coverage for New Mexico residents through medicaid or the New Mexico health insurance exchange, the fund may be used to maintain coverage through the New Mexico health insurance exchange or through medical assistance programs administered by the human services department, provided that coverage is prioritized for New Mexico residents with incomes below two hundred percent of the federal poverty level.

D. Prior to July 1, 2025, the staff of the legislative finance committee shall conduct a program evaluation to measure the

impact of changes to the health insurance premium surtax and the creation of the health care affordability fund as it relates to the purpose of the fund.

E. Prior to July 1 of each year, the superintendent shall provide actuarial data from the health care affordability fund to the legislative finance committee.

F. Prior to July 1 of each year, the superintendent, in consultation with the secretary of human services, the secretary of taxation and revenue and the chief executive officer of the New Mexico health insurance exchange, shall work with the legislative finance committee and the department of finance and administration to develop and report on performance measures relating to the health care affordability fund and any programs or initiatives funded by the fund."

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

"HEALTH CARE AFFORDABILITY PLAN--RULEMAKING--REPORTING REQUIREMENTS.--

A. The superintendent, in consultation with the secretary of human services, the secretary of taxation and revenue and the chief executive officer of the New Mexico health insurance exchange, shall promulgate rules to:

(1) provide enhanced premium and cost-sharing assistance to individuals and families for the purchase of qualified health plans on the New Mexico health insurance exchange. In providing this assistance, the superintendent shall develop health care affordability criteria designed to reduce the amount that individuals pay in premiums and out-of-pocket medical expenses for qualified health plans offered on the New Mexico health insurance exchange; and

(2) establish income eligibility parameters for the health care affordability criteria for plan year 2023 and each subsequent calendar year based on available funds.

New Mexico residents who qualify shall have an income that is eligible for advanced premium tax credits under the federal Patient Protection and Affordable Care Act.

B. The superintendent, in consultation with the human services department, the New Mexico medical insurance pool, the department of health and stakeholder groups, including health care providers that serve uninsured residents, health insurance carriers and consumer advocacy groups, shall develop a plan for extending health care coverage access to uninsured New Mexico residents who do not qualify for federal premium assistance or, except by reason of incarceration, qualified health plans, through the New Mexico health insurance exchange. No later than June 30, 2022, the superintendent shall submit the plan to the legislative finance committee and the legislative health and human services committee that could offer health care coverage for eligible New Mexico residents beginning July 1, 2023. The plan shall include:

(1) details about health care benefits;

(2) health care affordability criteria designed to reduce the amount that individuals pay in premiums and out-of-pocket medical expenses under the plan and that result in, to the greatest extent possible, health care costs comparable to costs for New Mexico residents for whom assistance is provided under Subsection A of this section; and

(3) income eligibility parameters that prioritize eligibility for New Mexico residents with incomes under two hundred percent of federal poverty level.

C. On or before October 31, 2023 and each October 31 thereafter, the superintendent shall submit a report to the legislative finance committee and the legislative health and human services committee, which shall include:

(1) a summary of the affordability criteria implemented pursuant to Subsections A and B of this section;

(2) the estimated number of uninsured New Mexico residents who enrolled in coverage following implementation of the affordability criteria pursuant to Subsections A and B of this section; and

(3) the amount in reduced costs and coverage assistance the initiatives provided in the current and previous calendar years by income level, county and coverage source."

SECTION 6. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"BEHAVIORAL HEALTH SERVICES--ELIMINATION OF COST SHARING.--

A. Until January 1, 2027, an individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state that offers coverage of behavioral health services shall not impose cost sharing on those behavioral health services.

B. For the purposes of this section:

(1) "behavioral health services" means professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable;

(2) "coinsurance" means a cost-sharing method that requires the insured to pay a stated percentage of medical expenses after any deductible amount is paid; provided that coinsurance rates may differ for different types of services under the same individual or group health insurance policy, health care plan or certificate of health insurance;

(3) "copayment" means a cost-sharing method that requires the insured to pay a fixed dollar amount when health care services are received, with the insurer paying the balance of the allowable amount; provided that there may be different copayment requirements for different types of services under the same individual or group health insurance policy, health care plan or certificate of health insurance; and

(4) "cost sharing" means a copayment, coinsurance, deductible or any other form of financial obligation of the insured other than a premium or a share of a premium, or any combination of any of these financial obligations, as defined by the terms of an individual or group health insurance policy, health care plan or certificate of health insurance."

SECTION 7. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"BEHAVIORAL HEALTH SERVICES--ELIMINATION OF COST SHARING.--

A. Until January 1, 2027, a group or blanket health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state that offers coverage of behavioral health services shall not impose cost sharing on those behavioral health services.

B. For the purposes of this section:

(1) "behavioral health services" means professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable;

(2) "coinsurance" means a cost-sharing

25 method that requires a covered person to pay a stated percentage of medical expenses after any deductible amount is paid; provided that coinsurance rates may differ for different types of services under the same group or blanket health insurance policy, health care plan or certificate of health insurance;

(3) "copayment" means a cost-sharing method that requires a covered person to pay a fixed dollar amount when health care services are received, with the insurer paying the balance of the allowable amount; provided that there may be different copayment requirements for different types of services under the same group or blanket health insurance policy, health care plan or certificate of health insurance; and

(4) "cost sharing" means a copayment, coinsurance, deductible or any other form of financial obligation of a covered person other than a premium or a share of a premium, or any combination of any of these financial obligations, as defined by the terms of a group or blanket health insurance policy, health care plan or certificate of health insurance."

SECTION 8. A new section of the Health Maintenance Organization Law is enacted to read:

"BEHAVIORAL HEALTH SERVICES--ELIMINATION OF COST SHARING.--

A. Until January 1, 2027, an individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state that offers coverage of behavioral health services shall not impose cost sharing on those behavioral health services.

B. For the purposes of this section:

(1) "behavioral health services" means professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable;

(2) "coinsurance" means a cost-sharing method that requires an enrollee to pay a stated percentage of medical expenses after any deductible amount is paid; provided that coinsurance rates may differ for different types of services under the same individual or group health maintenance organization contract;

(3) "copayment" means a cost-sharing method that requires an enrollee to pay a fixed dollar amount when health care services are received, with the carrier paying the balance of the allowable amount; provided that there may be different copayment requirements for different types of services under the same individual or group health maintenance organization contract; and

(4) "cost sharing" means a copayment, coinsurance, deductible or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations, as defined by the terms of an individual or group health maintenance organization contract."

SECTION 9. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"BEHAVIORAL HEALTH SERVICES--ELIMINATION OF COST SHARING.--

A. Until January 1, 2027, an individual or group health care plan that is delivered, issued for delivery or renewed in this state that offers coverage of behavioral health services shall not impose cost sharing on those behavioral health services.

B. For the purposes of thissection:

(1) "behavioral health services" means professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable;

(2) "coinsurance" means a cost-sharing method that requires a subscriber to pay a stated percentage of medical expenses after any deductible amount is paid; provided that coinsurance rates may differ for different types of services under the same individual or group health care plan;

(3) "copayment" means a cost-sharing method that requires a subscriber to pay a fixed dollar amount when health care services are received, with the health care plan paying the balance of the allowable amount; provided that there may be different copayment requirements for different types of services under the same individual or group health care plan; and

(4) "cost sharing" means a copayment, coinsurance, deductible or any other form of financial obligation of a subscriber other than a premium or a share of a premium, or any combination of any of these financial obligations, as defined by the terms of an individual or group health care plan."

SECTION 10. REPORTING.--Until January 1, 2027:

A. the office of superintendent of insurance shall report by November 1 of each year to the governor, the legislative finance committee and the interim legislative health and human services committee data regarding the elimination of cost sharing pursuant to the provisions of this 2021 act, including the effects on providers and patients with regard to costs for behavioral health services and the effects on health and social outcomes for patients, by using a set of performance measurement tools related to health care quality assurance, developed by a nationally recognized organization; and

B. the legislative finance committee shall report by November 1 of each year to the governor and the interim legislative health and human services committee data regarding the elimination of cost sharing pursuant to the provisions of this 2021 act, including the effects on providers and patients with regard to costs for behavioral health services and the effects on health and social outcomes for patients, by using a set of performance measurement tools related to health care quality assurance, developed by a nationally recognized organization.

SECTION 11. EFFECTIVE DATE.--The effective date of the provisions of this act is January 1, 2022.