SENATE BILL 577

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

INTRODUCED BY

Carroll H. Leavell

AN ACT

RELATING TO INSURANCE; AMENDING SECTIONS OF THE NEW MEXICO INSURANCE CODE AND THE MEDICAL INSURANCE POOL ACT TO ENACT CHANGES IN PROVISIONS RELATING TO PREMIUM TAXES AND ESTABLISH INCREASES FOR CERTAIN FEES; AMENDING THE INSURANCE FRAUD ACT, THE MINIMUM HEALTHCARE PROTECTION ACT, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO MAKE TECHNICAL CHANGES; AMENDING A SECTION OF THE SMALL GROUP RATE AND RENEWABILITY ACT TO CHANGE THE DEFINITION OF "SMALL EMPLOYER"; 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

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THE SUPERINTENDENT OF INSURANCE WITH EXTENDED TIME 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

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($1,000), unless by its extent and nature the offense is punishable under other statutes as a felony."

SECTION 2. Section 59A-6-1 NMSA 1978 (being Laws 1984, Chapter 127, Section 101, as amended) is amended to read:

"59A-6-1. FEE SCHEDULE.--The superintendent shall collect the following fees:

A. insurer's certificate of authority -

(1) filing application for certificate of authority, and issuance of certificate of authority, if issued, including filing of all charter documents, financial statements, service of process, power of attorney, examination reports and other documents included with and part of the application $1,000.00

(2) annual continuation of certificate of authority, per kind of insurance . . . . . [~~200.00~~] 300.00

(3) reinstatement of certificate of authority (Section 59A-5-23 NMSA 1978) 150.00

(4) amendment to certificate of authority 200.00

B. charter documents - filing amendment to any charter document (as defined in Section 59A-5-3 NMSA 1978). 10.00

C. annual statement of insurer, filing . . 200.00

D. service of process, acceptance by superintendent and issuance of certificate of service, where issued . . 10.00

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E. agents' licenses and appointments -

(1) filing application for original agent license and issuance of license, if issued 30.00

(2) appointment of agent -

(a) filing appointment, per kind of insurance, each insurer . . . . . [~~20.00~~] 30.00

(b) annual continuation of appointment, each insurer 20.00

(3) variable annuity agent's license -

(a) filing application for license and issuance of license, if issued 30.00

(b) annual continuation of appointment 20.00

(4) temporary license -

(a) as to life and health insurance or both 30.00

(b) as to property insurance . . . 30.00

(c) as to casualty/surety insurance 30.00

(d) as to vehicle insurance . . . 30.00

F. agency license and affiliations -

(1) filing application for original agency business entity license and issuance of license, if issued 30.00

(2) filing of individual affiliation, per kind

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of insurance . . . . . [~~20.00~~] 30.00

(3) annual continuation of individual affiliation 20.00

G. solicitor license -

(1) filing application for original license and issuance of license, if issued 30.00

(2) annual continuation of appointment, per kind of insurance . . . . . [~~20.00~~] 30.00

H. broker license -

(1) filing application for license and issuance of original license, if issued 30.00

(2) annual continuation of license . . 30.00

I. insurance vending machine license -

(1) filing application for original license and issuance of license, if issued, each machine 25.00

(2) annual continuation of license, each machine 25.00

J. examination for license, application for examination conducted directly by the superintendent, each grouping of kinds of insurance to be covered by the examination as provided by the superintendent's rules, and payable as to each instance of examination 50.00

K. surplus lines insurer - filing application for qualification as eligible surplus lines insurer . . . 1,000.00

L. surplus lines broker license -

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(1) filing application for original license and issuance of license, if issued 100.00

(2) annual continuation of license . . 100.00

M. surplus lines broker license and affiliations -

(1) filing application for original surplus lines brokerage business entity license and issuance of license, if issued 100.00

(2) filing of individual affiliation per kind of insurance . . . . . [~~20.00~~] 30.00

(3) annual continuation of individual affiliation 20.00

N. adjuster license -

(1) filing application for original license and issuance of license, if issued 30.00

(2) annual continuation of license 30.00

O. insurance consultant license -

(1) filing application for original license and issuance of license, if issued 50.00

(2) application examination 10.00

(3) biennial continuation of license 100.00

P. viatical settlements license -

(1) providers -

(a) filing application for original

license and issuance of license, if issued 1,000.00

(b) annual continuation of license 200.00

(2) brokers -

(a) filing application for original license and issuance of license, if issued 100.00

(b) annual continuation of license 100.00

(3) brokerages -

(a) filing application for original license and issuance of license, if issued 100.00

(b) annual continuation of license 20.00

(c) filing of individual affiliation, per kind of insurance . . . . . [~~20.00~~] 30.00

(d) annual continuation of individual affiliation 20.00

Q. rating organization or rating advisory organization license -

(1) filing application for license and issuance of license, if issued 100.00

(2) annual continuation of license 100.00

R. nonprofit health care plans -

(1) filing application for preliminary permit

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and issuance of permit, if issued 100.00

(2) certificate of authority, application, issuance, continuation, reinstatement, charter documents - same as for insurers

(3) annual statement, filing 200.00

(4) agents and solicitors -

(a) filing application for original license and issuance of license, if issued 30.00

(b) examination for license conducted directly by the superintendent, each instance of examination 50.00

(c) annual continuation of appointment 20.00

S. prepaid dental plans -

(1) certificate of authority, application, issuance, continuation, reinstatement, charter documents - same as for insurers

(2) annual report, filing 200.00

(3) agents and solicitors -

(a) filing application for original license and issuance of license, if issued 30.00

(b) examination for license conducted directly by superintendent, each instance of examination 50.00

(c) annual continuation of

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license 20.00

T. prearranged funeral insurance - application for certificate of authority, issuance, continuation, reinstatement, charter documents, filing annual statement, licensing of sales representatives - same as for insurers

U. premium finance companies -

(1) filing application for original license and issuance of license, if issued 100.00

(2) annual renewal of license 100.00

V. motor clubs -

(1) certificate of authority -

(a) filing application for original certificate of authority and issuance of certificate of authority, if issued 200.00

(b) annual continuation of certificate of authority 100.00

(2) sales representatives -

(a) filing application for registration or license and issuance of registration or license, if issued, each representative 20.00

(b) annual continuation of registration or license, each representative 20.00

W. bail bondsmen -

(1) filing application for original license as bail bondsman or solicitor, and issuance of license, if

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issued 30.00

(2) examination for license conducted directly by superintendent, each instance of examination 50.00

(3) annual continuation of appointment 20.00

X. securities salesperson license -

(1) filing application for license and issuance of license, if issued 25.00

(2) annual renewal of license 25.00

Y. required filing of forms or rates - by all lines of business other than property or casualty -

(1) rates 50.00

(2) major form - each new policy and each package submission, which can include multiple policy forms, application forms, rider forms, endorsement forms or amendment forms 30.00

(3) incidental forms and rates - forms filed for informational purposes; riders, applications, endorsements and amendments filed individually; rate service organization reference filings; rates filed for informational purposes 15.00

Z. health maintenance organizations -

(1) filing an application for a certificate of authority 1,000.00

(2) annual continuation of certificate of

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authority 200.00

(3) filing each annual report 200.00

(4) filing an amendment to organizational documents requiring approval 200.00

(5) filing informational amendments . . 50.00

(6) agents and solicitors -

(a) filing application for original license and issuance of license, if issued 30.00

(b) examination for license, each instance of examination 50.00

(c) annual continuation of appointment 20.00

AA. purchasing groups and foreign risk retention groups -

(1) original registration 500.00

(2) annual continuation of registration 200.00

(3) agent or broker fees - same as for authorized insurers

BB. third party administrators -

(1) filing application for original individual insurance administrator license 30.00

(2) filing application for original officer, manager or partner insurance administrator license 30.00

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(3) annual continuation or renewal of license 30.00

(4) examination for license conducted directly by the superintendent, each examination 75.00

(5) filing of annual report 50.00

CC. miscellaneous fees -

(1) duplicate license 30.00

(2) name change 30.00

(3) for each signature and seal of superintendent affixed to any instrument 10.00

DD. pharmacy benefits managers -

(1) filing an application for a license 1,000.00

(2) annual continuation of license, each year continued 500.00

(3) filing each annual report 200.00

(4) filing an amendment to organizational documents requiring approval 200.00

(5) filing informational amendments . 100.00

(6) agents -

(a) filing application for original license and issuance of license, if issued 100.00

(b) annual continuation of license . . . . . 100.00.

An insurer shall be subject to additional fees or charges,

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termed retaliatory or reciprocal requirements, whenever form or rate-filing fees in excess of those imposed by state law are charged to insurers in New Mexico doing business in another state or whenever a condition precedent to the right to issue policies in another state is imposed by the laws of that state over and above the conditions imposed upon insurers by the laws of New Mexico; in those cases, the same form or rate-filing fees may be imposed upon an insurer from another state transacting or applying to transact business in New Mexico so long as the higher fees remain in force in the other state. If an insurer does not comply with the additional retaliatory or reciprocal requirement charges imposed under this subsection, the superintendent may refuse to grant or may withdraw approval of the tendered form or rate filing.

All fees are earned when paid and are not refundable."

SECTION 3. 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

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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, 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

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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~~] reported on the Schedule T and supporting schedules of its annual financial statement on hospital and medical expense incurred insurance or contracts; nonprofit health care service 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, [~~less~~] all return health insurance premiums, including dividends paid or credited to 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

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to [~~at least one-fourth~~] one hundred percent 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~~] current year-to-date actual tax due for the quarter preceding the premium tax due date for the current calendar year. The premium tax paid for each quarter shall be based on all premiums written for the prior 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 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 premium tax due on the final 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:

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(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 4. Section 59A-6-4 NMSA 1978 (being Laws 1984, Chapter 127, Section 104, as amended) is amended to read:

"59A-6-4. PENALTY FOR FAILURE TO REPORT OR PAY TAX OR FEES.--Every insurer, nonprofit health care plan, health maintenance organization, prepaid dental plan or prearranged funeral plan transacting business in New Mexico that fails to file when due any report for taxation, regardless of whether tax is due, or to pay when due any tax or fees as required in this article shall be liable to the state for the amount thereof and for penalty of one thousand dollars ($1,000) for each month or part thereof it has failed to file the report or pay the tax or fees after demand therefor, after the due date of the applicable premium tax payment. Services of process in any action against a person to recover the tax, fee or penalty may be made upon the superintendent as attorney for service of process as provided in Section 59A-5-32 NMSA 1978."

SECTION 5. Section 59A-6-5 NMSA 1978 (being Laws 1984,

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Chapter 127, Section 105, as amended) is amended to read:

"59A-6-5. DISTRIBUTION OF DIVISION COLLECTIONS.--

A. All money received by the division for fees, licenses, penalties and taxes shall be paid daily by the superintendent to the state treasurer and credited to the "insurance department suspense fund" except as provided by:

(1) the Law Enforcement Protection Fund Act; and

(2) Section 59A-6-1.1 NMSA 1978.

B. The superintendent may authorize refund of money [~~erroneously paid~~] overpaid as fees, licenses, penalties or taxes from the insurance department suspense fund under request for refund made within [~~three years~~] one year after the [~~erroneous payment~~] overpayment. In the case of premium taxes [~~erroneously paid or~~] overpaid in accordance with law, refund may also be requested as a credit against premium taxes due in any annual or quarterly premium tax return filed within [~~three years~~] one year of the [~~erroneous or excess payment~~] overpayment.

C. If required by a compact to which New Mexico has joined pursuant to law, the superintendent shall authorize the allocation of premiums collected pursuant to Section 59A-14-12 NMSA 1978 to other states that have joined the compact pursuant to an allocation formula agreed upon by the compacting states.

D. The "insurance operations fund" is created in

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the state treasury. The fund shall consist of the distributions made to it pursuant to Subsection E of this section. The legislature shall annually appropriate from the fund to the division those amounts necessary for the division to carry out its responsibilities pursuant to the Insurance Code and other laws. Any balance in the fund at the end of a fiscal year greater than one-half of that fiscal year's appropriation shall revert to the general fund.

E. At the end of every month, after applicable refunds are made pursuant to Subsection B of this section and after any allocations have been made pursuant to Subsection C of this section, the treasurer shall make the following transfers from the balance remaining in the insurance department suspense fund:

(1) to the "fire protection fund", that part of the balance derived from property and vehicle insurance business;

(2) to the insurance operations fund, that part of the balance derived from the fees imposed pursuant to Subsections A and E of Section 59A-6-1 NMSA 1978 other than fees derived from property and vehicle insurance business; and

(3) to the general fund, the balance remaining in the insurance department suspense fund derived from all other kinds of insurance business."

SECTION 6. Section 59A-12A-3 NMSA 1978 (being Laws 1989,

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Chapter 374, Section 3) is amended to read:

"59A-12A-3. LICENSE REQUIRED--PENALTY.--

A. No administrator shall perform or provide any service, function, duty or activity respecting any insurance, plan, self-insurance or alternatives to insurance in [~~any~~] an administrative or management capacity in this state or with respect to risks located or partially located in this state or on behalf of persons in this state unless licensed as an administrator under the Insurance Code.

B. Licensing [~~and examination procedures~~] for administrators shall be in accordance with Chapter 59A, Article 11 NMSA 1978 [~~except that the superintendent may, in his discretion, waive the examination requirements for administrators who are operating in New Mexico prior to the effective date of Chapter 59A, Article 12A NMSA 1978~~].

C. [~~Every corporation or partnership to be licensed under Chapter 59A, Article 12A NMSA 1978 shall have every officer and manager of that corporation and every partner of that partnership licensed as an administrator.~~] No person shall act as a third party administrator in this state unless that person is licensed as a third party administrator pursuant to Chapter 59A, Article 12A NMSA 1978 or unless that person works under the supervision and control of a licensed third party administrator.

D. In addition to any applicable denial, suspension

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or revocation of a license, refusal to continue license or administrative fine, violation of this section shall be a misdemeanor punishable by a fine not to exceed one thousand dollars ($1,000) and by forfeiture to the state of an amount equal to all compensation for services as administrator received or to be received by the violator by reason of the prohibited transactions."

SECTION 7. 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

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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 may 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 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 8. 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

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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 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 9. Section 59A-22-49 NMSA 1978 (being Laws 2009, Chapter 74, Section 1) is amended to read:

"59A-22-49. COVERAGE FOR AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT.--

A. An individual or group health insurance policy, health care plan or certificate of health insurance that is

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delivered, issued for delivery or renewed in this state shall provide coverage to an eligible individual who is nineteen years of age or younger, or an eligible individual who is twenty-two years of age or younger and is enrolled in high school, for:

(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and

(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.

B. Coverage required pursuant to Subsection A of this section:

(1) shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan;

(2) shall be limited to thirty-six thousand dollars ($36,000) annually and shall not exceed two hundred thousand dollars ($200,000) in total lifetime benefits. Beginning January 1, 2011, the maximum benefit shall be adjusted annually on January 1 to reflect any change from the previous year in the medical component of the then-current consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor;

(3) shall not be denied on the basis that the

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services are habilitative or rehabilitative in nature;

(4) may be subject to other general exclusions and limitations of the insurer's policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and

(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

C. The coverage required pursuant to Subsection A of this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the individual or group health insurance policy, health care plan or certificate of health insurance, except as otherwise provided in Subsection B of this section.

D. An insurer shall not deny or refuse to issue

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health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

E. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health insurance plan to pay claims appropriately. These elements include, but are not limited to:

(1) the diagnosis;

(2) the proposed treatment by types;

(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

F. This section shall not be construed as limiting benefits and coverage otherwise available to an insured under a health insurance plan.

G. The provisions of this section shall not apply to policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident only, hospital indemnity or other limited-benefit health insurance policies.

H. As used in this section:

(1) "autism spectrum disorder" means a

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condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, [~~fourth~~] current edition, text revision, also known as DSM-IV-TR, published by the American psychiatric association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder;

(2) "habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual; and

(3) "high school" means a school providing instruction for any of the grades nine through twelve."

SECTION 10. 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;

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(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 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

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be made payable to [~~his~~] the minor's parent, guardian or other person actually supporting [~~him~~] the minor."

SECTION 11. Section 59A-23-7.9 NMSA 1978 (being Laws 2009, Chapter 74, Section 2) is amended to read:

"59A-23-7.9. COVERAGE FOR AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT.--

A. A blanket or group health insurance policy or contract that is delivered, issued for delivery or renewed in this state shall provide coverage to an eligible individual who is nineteen years of age or younger, or an eligible individual who is twenty-two years of age or younger and is enrolled in high school, for:

(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and

(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.

B. Coverage required pursuant to Subsection A of this section:

(1) shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan;

(2) shall be limited to thirty-six thousand dollars ($36,000) annually and shall not exceed two hundred thousand dollars ($200,000) in total lifetime benefits.

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Beginning January 1, 2011, the maximum benefit shall be adjusted annually on January 1 to reflect any change from the previous year in the medical component of the then-current consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor;

(3) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;

(4) may be subject to other general exclusions and limitations of the insurer's policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and

(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

C. The coverage required pursuant to Subsection A of this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable

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to an insured than the dollar limits, deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the blanket or group health insurance policy or contract, except as otherwise provided in Subsection B of this section.

D. An insurer shall not deny or refuse to issue health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

E. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health insurance plan to pay claims appropriately. These elements include, but are not limited to:

(1) the diagnosis;

(2) the proposed treatment by types;

(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

F. This section shall not be construed as limiting benefits and coverage otherwise available to an insured under a health insurance plan.

G. The provisions of this section shall not apply

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to policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident only, hospital indemnity or other limited-benefit health insurance policies.

H. As used in this section:

(1) "autism spectrum disorder" means a condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, [~~fourth~~] current edition, text revision, also known as DSM-IV-TR, published by the American psychiatric association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder;

(2) "habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual; and

(3) "high school" means a school providing instruction for any of the grades nine through twelve."

SECTION 12. 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 13. Section 59A-23C-3 NMSA 1978 (being Laws 1991, Chapter 153, Section 3, as amended) is amended to read:

"59A-23C-3. DEFINITIONS.--As used in the Small Group Rate and Renewability Act:

A. "actuarial certification" means a written statement by a member of the American academy of actuaries or another individual acceptable to the superintendent that a

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small employer carrier is in compliance with the provisions of Section 59A-23C-5 NMSA 1978, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans;

B. "base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

C. "carrier" means any person who provides health insurance in this state. For the purposes of the Small Group Rate and Renewability Act, "carrier" or "insurer" includes a licensed insurance company, a licensed fraternal benefit society, a prepaid hospital or medical service plan, a health maintenance organization, a nonprofit health care organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation;

D. "case characteristics" means demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, that are considered by the carrier in the determination of premium rates for the small employer, but "case characteristics" does not include claim

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experience, health status and duration of coverage since issue;

E. "class of business" means all small employers as shown on the records of the small employer carrier. A separate class of business may be established by the small employer carrier on the basis that the applicable health benefit plans have been acquired from another small employer carrier as a distinct grouping of plans;

F. "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) a medical care program of the Indian health service or of an Indian nation, tribe or pueblo;

(7) the [~~Comprehensive Health~~] Medical Insurance Pool Act;

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

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

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

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

H. "group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise;

I. "health benefit plan" or "plan" means any hospital or medical expense-incurred policy or certificate, hospital or medical service plan contract or health maintenance organization subscriber contract. "Health benefit plan" does not include accident-only, credit, dental or disability income insurance, medicare supplement coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance or automobile medical-payment insurance;

J. "index rate" means, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

K. "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who

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enrolls under the plan other than during:

(1) the first period in which the individual is eligible to enroll under the plan; or

(2) a special enrollment period pursuant to Sections [~~8 and 9 of the Health Insurance Portability Act~~] 59A-23E-8 and 59A-23E-9 NMSA 1978;

L. "new business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

M. "rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier;

N. "small employer" means any person, firm, corporation, partnership or association actively engaged in business [~~who~~] that, on at least fifty percent of its working days during either of the two preceding years, employed no [~~less~~] fewer than two and no more than [~~fifty~~] one hundred eligible employees; provided that:

(1) in determining the number of eligible employees, the spouse or dependent of an employee may, at the employer's discretion, be counted as a separate employee;

(2) companies that are affiliated companies or

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that are eligible to file a combined tax return for purposes of state income taxation shall be considered one employer; and

(3) in the case of an employer that was not in existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year;

O. "small employer carrier" means any insurer that offers health benefit plans covering the employees of a small employer; and

P. "superintendent" means the superintendent of insurance."

SECTION 14. 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 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

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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 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.

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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 15. Section 59A-46-50 NMSA 1978 (being Laws 2009, Chapter 74, Section 3) is amended to read:

"59A-46-50. COVERAGE FOR AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT.--

A. An individual or group health maintenance contract that is delivered, issued for delivery or renewed in this state shall provide coverage to an eligible individual who is nineteen years of age or younger, or an eligible individual who is twenty-two years of age or younger and is enrolled in high school, for:

(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and

(2) treatment of autism spectrum disorder

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through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.

B. Coverage required pursuant to Subsection A of this section:

(1) shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan;

(2) shall be limited to thirty-six thousand dollars ($36,000) annually and shall not exceed two hundred thousand dollars ($200,000) in total lifetime benefits. Beginning January 1, 2011, the maximum benefit shall be adjusted annually on January 1 to reflect any change from the previous year in the medical component of the then-current consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor;

(3) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;

(4) may be subject to other general exclusions and limitations of the insurer's policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and

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(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

C. The coverage required pursuant to Subsection A of this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the individual or group health maintenance contract, except as otherwise provided in Subsection B of this section.

D. An insurer shall not deny or refuse to issue health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

E. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health insurance plan to pay claims appropriately. These elements include, but are not limited to:

(1) the diagnosis;

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(2) the proposed treatment by types;

(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

F. This section shall not be construed as limiting benefits and coverage otherwise available to an insured under a health insurance plan.

G. The provisions of this section shall not apply to policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident only, hospital indemnity or other limited-benefit health insurance policies.

H. As used in this section:

(1) "autism spectrum disorder" means a condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, [~~fourth~~] current edition, text revision, also known as DSM-IV-TR, published by the American psychiatric association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder;

(2) "habilitative or rehabilitative services"

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means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual; and

(3) "high school" means a school providing instruction for any of the grades nine through twelve."

SECTION 16. Section 59A-47-45 NMSA 1978 (being Laws 2009, Chapter 74, Section 4) is amended to read:

"59A-47-45. COVERAGE FOR AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT.--

A. An individual or group health insurance policy, health care plan or certificate of health insurance delivered or issued for delivery in this state shall provide coverage to an eligible individual who is twenty-two years of age or younger and is enrolled in high school, for:

(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and

(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.

B. Coverage required pursuant to Subsection A of this section:

(1) shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan;

(2) shall be limited to thirty-six thousand

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dollars ($36,000) annually and shall not exceed two hundred thousand dollars ($200,000) in total lifetime benefits. Beginning January 1, 2011, the maximum benefit shall be adjusted annually on January 1 to reflect any change from the previous year in the medical component of the then-current consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor;

(3) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;

(4) may be subject to other general exclusions and limitations of the insurer's policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and

(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

C. The coverage required pursuant to Subsection A

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of this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the individual or group health maintenance contract, except as otherwise provided in Subsection B of this section.

D. An insurer shall not deny or refuse to issue health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

E. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health insurance plan to pay claims appropriately. These elements include, but are not limited to:

(1) the diagnosis;

(2) the proposed treatment by types;

(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

F. This section shall not be construed as limiting benefits and coverage otherwise available to an insured under a

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health insurance plan.

G. The provisions of this section shall not apply to policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident only, hospital indemnity or other limited-benefit health insurance policies.

H. As used in this section:

(1) "autism spectrum disorder" means a condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, [~~fourth~~] current edition, text revision, also known as DSM-IV-TR, published by the American psychiatric association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder;

(2) "habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual; and

(3) "high school" means a school providing instruction for any of the grades nine through twelve."

SECTION 17. Section 59A-54-10 NMSA 1978 (being Laws 1987, Chapter 154, Section 10, as amended) is amended to read:

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"59A-54-10. ASSESSMENTS.--

A. Following the close of each fiscal year, the pool administrator shall determine the net premium, being premiums less administrative expense allowances, the pool expenses and claim expense losses for the year, taking into account investment income and other appropriate gains and losses. The assessment for each insurer shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges or their equivalent for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums and subscriber contract charges written in the state; provided that premium income shall include receipts of medicaid managed care premiums but shall not include any payments by the secretary of [~~health and~~] human services pursuant to a contract issued under Section 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

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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; 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 premium tax return and shall only be granted after the New Mexico medical insurance pool final assessments have been issued for the prior

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calendar year. The credits granted for the New Mexico medical insurance pool shall not exceed the premium tax due on the final 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 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."

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