SENATE BILL 538

46TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2004

INTRODUCED BY

Dede Feldman

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH CARE; PROVIDING FOR THE CONSOLIDATED PURCHASE OF CERTAIN PUBLIC HEALTH CARE PROGRAMS; CREATING THE HEALTH CARE PURCHASING AUTHORITY; AMENDING, REPEALING, ENACTING AND RECOMPILING SECTIONS OF THE NMSA 1978; MAKING AN APPROPRIATION.

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

Section 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] HEALTH CARE PURCHASING AUTHORITY CREATED.--

A. The "health care purchasing authority" is created. The authority shall consist of twenty-nine members, as follows:

(1) a school business official selected by the

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superintendent of a school district with enrollment greater than sixty thousand students, with the advice and consent of the senate;

(2) a public school superintendent of a school district with enrollment less than sixty thousand students selected by the New Mexico school superintendents association, with the advice and consent of the senate;

(3) a public school board member selected by the New Mexico school boards association, with the advice and consent of the senate;

(4) a teacher who is licensed and teaching in elementary or secondary education selected by the statewide organization of the national education association, with the advice and consent of the senate;

(5) a teacher who is licensed and teaching in elementary or secondary education or other public school employee selected by the New Mexico federation of educational employees, with the advice and consent of the senate;

(6) a teacher who is licensed and teaching in elementary or secondary education selected by the Albuquerque teachers federation, with the advice and consent of the senate;

(7) a member of the public education commission selected by the commission, with the advice and consent of the senate;

(8) a retired person selected by the statewide

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organization of the American association of retired persons, with the advice and consent of the senate;

(9) a retiree who is a representative of the educators retirement board selected by the board, in consultation with the New Mexico association of educational retirees, with the advice and consent of the senate;

(10) a retiree who is a representative of the retired public employees of New Mexico selected by that organization, with the advice and consent of the senate;

(11) a retiree who is a representative of the public employees retirement association selected by the association, with the advice and consent of the senate;

(12) the secretary of human services or the secretary's designee;

(13) the secretary of health or the secretary's designee;

(14) the secretary of general services or the secretary's designee;

(15) a classified state employee, appointed by the governor, with the advice and consent of the senate;

(16) a public school employee of a school district with enrollment greater than sixty thousand students, appointed by the governor, with the advice and consent of the senate;

(17) a public school employee of a school

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district with enrollment less than sixty thousand students, appointed by the governor, with the advice and consent of the senate;

(18) an employee of a public post-secondary educational institution, appointed by the governor, with the advice and consent of the senate;

(19) a state employee, appointed by the governor, with the advice and consent of the senate;

(20) an elected official or employee of a municipality, appointed by the governor, with the advice and consent of the senate;

(21) an elected official or employee of a county, appointed by the governor, with the advice and consent of the senate;

(22) a person that advocates for persons without health care coverage, appointed by the governor, with the advice and consent of the senate;

(23) a retired person from the public at large, appointed by the governor, with the advice and consent of the senate;

(24) a retired person with at least five years' experience in the private business sector, appointed by the governor, with the advice and consent of the senate;

(25) a person who has at least five years' experience as a health care practitioner or administrator,

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appointed by the governor, with the advice and consent of the senate; and

(26) the superintendent of insurance, the executive director of the New Mexico health policy commission, the director of the state agency on aging and the secretary of public education, as nonvoting, ex-officio members.

B. The governor, the senate and the recommending organizations, to the extent practicable, shall take into consideration and give preference to persons who have experience in health care delivery, administration or financing.

C. The members shall be appointed so as to give geographic representation to all parts of the state. The members shall be residents of the state. The initial appointed members shall be appointed to staggered terms of four years or less, so that the terms of at least three members expire on January 1 of each year; thereafter, the terms shall be for four years. A vacancy shall be filled by appointment by the appropriate appointing authority for the remainder of the unexpired term. An appointed member of the authority shall be eligible for reappointment.

D. A member of the authority shall not have a pecuniary or fiduciary interest with an entity with which the authority contracts pursuant to this 2004 act. Each member shall provide, within thirty days of appointment and annually

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thereafter, a conflict-of-interest disclosure statement as developed by the authority.

E. The authority shall elect annually one of its members to serve as chair and one of its members to serve as vice chair. The authority may delegate to the director and the secretary of general services such powers and duties as it may deem proper and consistent with the Health Care Purchasing Act.

F. Meetings of the authority shall be held at the call of the chair or whenever six members shall so request in writing; provided that the authority shall meet at least four times per year. A majority of voting members constitutes a quorum for the transaction of any business and for the exercise of any power or duty of the authority. The affirmative vote of at least a majority of a quorum present shall be necessary for any action to be taken by the authority. An ex-officio member may designate in writing another person to attend meetings of the authority and, to the same extent and with the same effect, act in the ex-officio member's stead.

G. The authority is not created or organized, and its operations shall not be conducted, for the purpose of making a profit. Revenues or assets of the authority shall not inure to the benefit of its members or officers. The members of the authority shall not receive compensation for their services, but shall be reimbursed for actual and necessary expenses at the same rate and on the same basis as provided for

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public officers in the Per Diem and Mileage Act.

H. The authority is a policy-making body and shall not be subject to the supervision or control of any other authority, bureau, department or agency of the state except as specifically provided in the Health Care Purchasing Act. The use of the term "state agency" or "instrumentality" in any other law of the state shall not be deemed to refer to the authority unless the authority is specifically referenced in that law or in this 2004 act.

I. The authority is subject to the provisions of the Open Meetings Act.

J. The authority is a governmental instrumentality for purposes of the Tort Claims Act."

Section 2. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] POWERS OF THE AUTHORITY.--The authority may:

A. sue or be sued;

B. adopt and alter an official seal;

C. adopt rules, pursuant to the Administrative Procedures Act, as are necessary and appropriate to implement the provisions of the Health Care Purchasing Act;

D. make and execute contracts, agreements and other instruments necessary and appropriate in the exercise of the authority's powers and functions to carry out the provisions of

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the Health Care Purchasing Act;

E. apply for and accept gifts or grants of property, funds, services or aid in any form from the United States, any unit of government or any person and to comply, subject to the provisions of the Health Care Purchasing Act, with the terms and conditions of the gifts or grants;

F. provide for the services of two or more entities licensed in the state that are insurance companies, health maintenance organizations or professional claims administrators in accordance with the Procurement Code;

G. provide for services that oversee quality of and access to health care; and

H. provide, at its discretion, different plans for eligible participants covered by Title 18 of the federal Social Security Act than the plans provided for eligible participants who are not covered by Title 18 of the federal Social Security Act."

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

"[NEW MATERIAL] DUTIES OF THE AUTHORITY.--The authority shall:

A. fix, revise from time to time, charge and collect fees and other charges in connection with the procurement of health care benefits and other services rendered by the authority;

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B. accept, administer, hold and use all funds made available to the authority from any sources;

C. collect and disburse funds and provide for the investment of the fund;

D. collect all current and historical claims and financial information necessary for effective procurement of health care benefits;

E. make claims and financial information available, while protecting proprietary and individually identifiable information, to the New Mexico health policy commission, the insurance division of the public regulation commission, the human services department and the department of health for policy and planning purposes;

F. negotiate health care benefit policies covering additional or lesser benefits as determined appropriate by the authority, but the authority shall maintain all coverage as required by federal or state law for each participant;

G. procure health care benefits and other coverages authorized by the Health Care Purchasing Act in accordance with the Procurement Code; provided that health care benefits coverage afforded by the authority shall include at least one option that is not a health maintenance organization benefits plan;

H. establish the procedures for contributions and deductions if not already provided;

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I. establish subcommittees that shall hold regional and quarterly meetings for participant groups eligible pursuant to the Retiree Health Care Act, the Group Benefits Act, a school district with a student enrollment greater than sixty thousand students and, prior to the effective date of this 2004 act, the Public School Insurance Authority Act;

J. in conjunction with the human services department and the department of health, provide for initiatives and outcome measurements that address public health and safety issues and improve the health education and health status of participants;

K. in conjunction with the human services department and the department of health, provide for intervention and treatment programs designed to address the state's most prevalent diseases and injuries and improve the health education and health status of participants;

L. report to the governor and the legislature, five years from the effective date of this 2004 act and every three years thereafter, the impact that consolidation and procurement pursuant to the Health Care Purchasing Act has had on the state's uninsured, health insurance costs, business community and private group and individual insurance market; and

M. do any and all things necessary and appropriate to carry out its purposes and exercise the powers given and granted in the Health Care Purchasing Act."

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Section 4. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] PURCHASE OF HEALTH CARE BENEFITS.--

A. The general services department is designated the group policyholder for health care benefits plans established pursuant to the Health Care Purchasing Act.

B. To the extent practicable or as required by law, a health care benefits plan shall cover preexisting conditions.

C. Participants eligible for health care benefits plan coverage shall not be grouped unless an actuarial analysis demonstrates that each group of participants to be grouped would receive a more favorable premium rate. The local superintendent, or the superintendent's designee, of a school district with student enrollment greater than sixty thousand students may review the actuarial analysis for concurrence before the authority determines if the participants will be grouped; provided that the participants of that school district shall not be grouped with other participants unless the school district participants would receive a more favorable premium rate by grouping.

D. Health care benefits plans offered pursuant to the Health Care Purchasing Act shall include appropriate coverage as described in the following sections:

(1) Section 59A-22-33 NMSA 1978;

(2) Section 59A-22-34 NMSA 1978;

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(3) Section 59A-22-34.1 NMSA 1978;

(4) Section 59A-22-34.2 NMSA 1978;

(5) Section 59A-22-34.3 NMSA 1978;

(6) Section 59A-22-35 NMSA 1978;

(7) Section 59A-22-36 NMSA 1978;

(8) Section 59A-22-39 NMSA 1978;

(9) Section 59A-22-39.1 NMSA 1978;

(10) Section 59A-22-40 NMSA 1978;

(11) Section 59A-22-41 NMSA 1978;

(12) Section 59A-22-42 NMSA 1978;

(13) Section 59A-22-43 NMSA 1978;

(14) Section 59A-22-44 NMSA 1978;

(15) Section 59A-23-6 NMSA 1978; and

(16) Section 59A-23E-18 NMSA 1978.

E. Health care benefits plans offered pursuant to the Health Care Purchasing Act shall include effective cost-containment measures, including prevention, intervention and treatment programs, to control the growth of health care costs. The authority shall report annually by October 1 to the governor, the insurance division of the public regulation commission, the legislative finance committee and the legislative health and human services committee on the effectiveness of the cost-containment measures required by this subsection and the initiatives required by Subsections J and K

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of Section 3 of this 2004 act."

Section 5. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] EXPULSION FROM PROGRAM FOR FALSIFICATION.--

A. After written notice to the participant and hearing with a fair opportunity to appear and present the case personally or by counsel, the authority may expel from participation pursuant to the Health Care Purchasing Act a participant who knowingly submits a false claim or eligibility request or knowingly has falsified or attempted to falsify a claim or eligibility request for health care benefits offered by the authority.

B. On its motion or on the receipt of a complaint, the authority may call and hold a hearing to determine whether a participant has knowingly submitted a false claim or eligibility request or has knowingly falsified or attempted to falsify a claim or eligibility request for health care benefits offered pursuant to the Health Care Purchasing Act.

C. If the authority, at the conclusion of the hearing, issues a decision finding that a participant knowingly submitted a false claim or eligibility request or has knowingly falsified or attempted to falsify a claim or eligibility request for health care benefits offered pursuant to the Health Care Purchasing Act, the authority shall expel the participant

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from participation in any coverage plans or impose conditions upon continued or future participation."

Section 6. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] EXEMPTION FROM LEGAL PROCESS.--All health care benefit payments, participant and employer contributions, optional benefits payments and rights, benefits or payments accruing to a person pursuant to the Health Care Purchasing Act, as well as all money in the fund, are exempt from execution, attachment, garnishment or other legal process and shall not be assigned except as specifically provided by that act; provided that a participant may assign benefit payment to a health care provider."

Section 7. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] HEALTH CARE BENEFITS PLAN CONTRIBUTIONS.--

A. Health care benefits plan contributions by retirees and participating employers and employees pursuant to the Retiree Health Care Act shall be made pursuant to that act.

B. Health care benefits plan contributions for the state or any of its departments or institutions, including institutions of higher education and the public schools and charter schools, shall be made pursuant to Section 10-7-4 NMSA 1978.

C. Health care benefits plan contributions by or on

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behalf of participants shall be made to the separate subaccounts in the health care purchasing fund to ensure sole and separate accounting and funding for coverage of participants through:

(1) the Retiree Health Care Act;

(2) the Group Benefits Act, including other participants pursuant to Section 13-7-5 NMSA 1978;

(3) a school district with student enrollment greater than sixty thousand students; or

(4) prior to the effective date of this 2004 act, the Public School Insurance Authority Act."

Section 8. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] HEALTH CARE PURCHASING FUND CREATED.--

A. The "health care purchasing fund" is created in the state treasury. The fund and income produced by the fund shall be held in trust for the benefit of participating state agencies, participants and political subdivisions and their employees, deposited in a segregated account and invested by the state investment officer in consultation with the authority. Money in the fund shall be used solely for the purposes of the fund and shall not be used to pay general or special obligations or debts of the state. Balances in the fund in excess of amounts needed for the purposes of the fund shall not be used to pay dividends or refunds, however described, to participants but may be used, in the authority's discretion, to reduce future

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contributions, to provide additional health care benefits or as a reserve to stabilize premiums. Money remaining in the fund at the end of a fiscal year shall not revert to the general fund.

B. The fund consists of money appropriated to the fund, income from investment of the fund, employers' contributions, participants' contributions, insurance or reinsurance proceeds and other funds received by gift, grant, bequest or otherwise for deposit in the fund, including refunds of amounts from prior group life, vision, dental, health and disability insurance plans.

C. Money appropriated to the fund from the retiree health care fund, the group self-insurance fund, the public school insurance fund or a school district with student enrollment greater than sixty thousand students shall be maintained in separate subaccounts to provide sole and separate accounting and funding for coverage of participants eligible through:

(1) the Retiree Health Care Act;

(2) the Group Benefits Act, including other participants pursuant to Section 13-7-5 NMSA 1978;

(3) a school district with student enrollment greater than sixty thousand students; or

(4) prior to the effective date of this 2004 act, the Public School Insurance Authority Act.

The separate subaccounts shall not be commingled to ensure

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that each subaccount is maintained solely and separately for the respective participants. A separate subaccount shall be maintained for other public or private participants and participating employers that voluntarily elect to purchase coverage afforded by or through the authority; provided that sole and separate accounting and funding is provided for each distinct participant group.

D. Disbursements from the fund shall be made by warrant signed by the secretary of finance and administration upon vouchers signed by the director or the director's authorized representative.

E. Money in the fund is appropriated to the general services department:

(1) to purchase, at the direction of the authority, health care benefits or any combination of these benefits, for participants in the health care benefits plan, from or through two or more entities licensed in the state that are insurance companies, health maintenance organizations or professional claims administrators determined to be the best responsible bidders, as defined in the Procurement Code, after requesting sealed proposals in accordance with the provisions of the Procurement Code;

(2) to contract with and pay two or more professional claims administrators, health maintenance organizations or insurance companies;

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(3) to contract with and pay private attorneys or law firms for advice and for defense of contested claims determinations;

(4) to contract with and pay qualified independent actuaries, financial auditors and claims management and procedures auditors;

(5) to contract with and pay consultants, financial advisers and investment advisers for independent consulting and advice;

(6) to pay reasonable investment commissions and expenses;

(7) to pay any other costs and expenses incurred in carrying out the provisions of this section; and

(8) as otherwise provided by law.

F. Any money or appropriations savings realized as a result of this 2004 act shall be used for the benefit of participant groups.

G. The fund and its subaccounts shall be maintained in actuarially sound condition as evidenced by written certification of an actuary qualified for such work that as of June 30 of the current year the fund and its subaccounts were actuarially sound. The written certification shall be completed by October 1 of the current year.

H. Annually on or before January 15, the authority shall submit to the legislature a report on a health care

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benefits plan established pursuant to the Health Care Purchasing Act, a financial audit of the fund and its subaccounts and a claims management and procedures audit by a qualified claims auditor for the one-year period ending on June 30 immediately preceding the report. With respect to claims files, the claims audit may, in the authority's discretion, be limited to a financial stratified sample."

Section 9. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] HEALTH CARE PURCHASING FUND--INVESTMENT.--

A. In making investments of the fund, the state investment officer shall consider the relative safety of the investment and the need for liquidity in the fund, as well as the income to be produced. No investment of the fund shall have a maturity date, or similar date before which it may not be liquidated for cash without penalty, premium, deduction, surcharge or interest rate decrease, later than one year from the date of purchase.

B. Investment of the fund shall be made with the exercise of that degree of judgment and care, under the circumstances then prevailing, that a person of prudence, discretion and intelligence exercises in the management of his own affairs, not for speculation but for investment, considering the probable safety of his capital as well as the probable income to be derived."

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Section 10. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] ADMINISTRATION.--

A. The authority is administratively attached to the general services department.

B. The general services department shall provide administrative services to the authority, including:

(1) keeping all official records of the authority;

(2) providing personnel administration, financial management, procurement and budget preparation services;

(3) providing clerical, record-keeping and administrative support to the authority; and

(4) executing contracts, agreements and other instruments necessary and appropriate to carry out the provisions of the Health Care Purchasing Act pursuant to Subsection D of Section 2 of this 2004 act.

C. The authority shall receive support staff from the general services department. The powers, duties and responsibilities of the authority pursuant to the Health Care Purchasing Act are explicitly exempt from the authority of the secretary of general services under the provisions of Subsection B of Section 9-17-5 NMSA 1978.

D. The director, with the prior approval of the

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authority, may apportion the costs of administering and operating health care benefits to participating employers and their participants, whether the plan is insured or self-insured."

Section 11. Section 7-1-6.30 NMSA 1978 (being Laws 1990, Chapter 6, Section 20, as amended) is amended to read:

"7-1-6.30. DISTRIBUTION--RETIREE HEALTH CARE FUND--HEALTH CARE PURCHASING FUND.--For the period ending June 30, 2002, a distribution pursuant to Section 7-1-6.1 NMSA 1978 shall be made to the retiree health care fund in an amount equal to one-twelfth of one hundred six percent of the total amount distributed to the retiree health care fund in the previous fiscal year. For the fiscal [~~year~~] years beginning July 1, 2002 and [~~subsequent fiscal years~~] July 1, 2003, a distribution pursuant to Section 7-1-6.1 NMSA 1978 shall be made to the retiree health care fund in an amount equal to one-twelfth of one hundred twelve percent of the total amount distributed to the retiree health care fund in the previous fiscal year. For the fiscal year beginning July 1, 2004, a distribution pursuant to Section 7-1-6.1 NMSA 1978 shall be made to the health care purchasing fund in an amount equal to one-twelfth of one hundred twelve percent of the total amount distributed to the retiree health care fund in the previous fiscal year; provided that the distribution is made to the subaccount in the health care purchasing fund that is solely and separately for coverage of

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participants eligible pursuant to the Retiree Health Care Act. For the fiscal year beginning July 1, 2005 and subsequent fiscal years, a distribution pursuant to Section 7-1-6.1 NMSA 1978 shall be made to the health care purchasing fund in an amount equal to one-twelfth of one hundred twelve percent of the total amount distributed to the health care purchasing fund in the previous fiscal year; provided that the distribution is made to the subaccount in the health care purchasing fund that is solely and separately for coverage of participants eligible pursuant to the Retiree Health Care Act."

Section 12. Section 9-17-6 NMSA 1978 (being Laws 1983, Chapter 301, Section 6, as amended) is amended to read:

"9-17-6. GENERAL SERVICES DEPARTMENT--ADMINISTRATIVELY ATTACHED AGENCIES.--

A. The personnel board and office are administratively attached to the general services department, as provided in Section 10-9-11 NMSA 1978.

[~~B. The information systems council is administratively attached to the general services department as provided in Section 15-1-5 NMSA 1978.~~]

B. The health care purchasing authority is administratively attached to the general services department as provided in the Health Care Purchasing Act.

C. A division shall be created, pursuant to Subsection C of Section 9-17-3 NMSA 1978, by July 1, 2004 to

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carry out the provisions of the Health Care Purchasing Act. The director of the division created pursuant to this subsection shall have qualifications that include five years' experience in health care administration, experience with public institutions and their employees and knowledge of health care benefits or insurance."

Section 13. Section 10-7B-1 NMSA 1978 (being Laws 1989, Chapter 231, Section 1) is amended to read:

"10-7B-1. SHORT TITLE.--[~~Sections 1 through 7 of this act~~] Chapter 10, Article 7B NMSA 1978 may be cited as the "Group Benefits Act"."

Section 14. Section 10-7B-2 NMSA 1978 (being Laws 1989, Chapter 231, Section 2, as amended) is amended to read:

"10-7B-2. DEFINITIONS.--As used in the Group Benefits Act:

[~~A. "committee" means the group benefits committee~~]

A. "authority" means the health care purchasing authority created pursuant to the Health Care Purchasing Act;

B. "director" means the director of [~~the risk management~~] a separate division of the general services department newly created to carry out the provisions of the Health Care Purchasing Act;

C. "employee" means a salaried officer, employee or legislator of the state or a salaried officer or employee of a local public body;

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D. "local public body" means any New Mexico incorporated municipality, county or [~~school district~~] post-secondary educational institution;

E. "professional claims administrator" means any person or legal entity that has at least five years of experience handling group benefits claims, as well as such other qualifications as the director may determine from time to time with the [~~committee's~~] authority's advice; and

F. "state" or "state agency" means the state of New Mexico or any of its branches, agencies, departments, boards, instrumentalities or institutions."

Section 15. Section 10-7B-5 NMSA 1978 (being Laws 1989, Chapter 231, Section 5) is amended to read:

"10-7B-5. ADMINISTRATIVE COSTS.--The director, with the prior approval of the [~~group benefits committee~~] authority, may apportion the costs of administering and operating employee benefits [~~administration and other employee benefit costs~~] to all participating state agencies and their employees and participating local public bodies and their employees, whether the plan is insured or self-insured."

Section 16. Section 10-7B-6 NMSA 1978 (being Laws 1989, Chapter 231, Section 6, as amended) is amended to read:

"10-7B-6. STATE EMPLOYEES GROUP BENEFITS SELF-INSURANCE PLAN--AUTHORIZATION--LOCAL PUBLIC BODY PARTICIPATION.--

A. The [~~risk management division of~~] authority may

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direct the general services department [~~may, with the prior advice of the committee~~] to establish and administer a group benefits self-insurance plan, providing life, vision, health, dental and disability coverages, or any combination of such coverages, for employees of the state and of participating local public bodies. Any such group benefits self-insurance plan shall afford coverage for employees' dependents at each employee's option. Any such group benefits self-insurance plan may consist of self-insurance or a combination of self-insurance and insurance; provided that particular coverages or risks may be fully insured, fully self-insured or partially insured and partially self-insured.

B. The [~~director, with the advice of the committee~~] authority shall establish by [~~regulation or letter of administration~~] rule the types, extent, nature and description of coverages, the eligibility rules for participation, the [~~deductibles~~] out-of-pocket payments, rates and all other matters reasonably necessary to carry on or administer a group benefits self-insurance plan established pursuant to Subsection A of this section.

C. The contribution of each participating state agency to the cost of any such group benefits self-insurance plan shall not exceed that percentage provided for state group benefits insurance plans as provided by law. The contribution of a participating local public body to the cost of any such

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group benefits self-insurance plan shall not exceed that percentage provided for local public body group benefits insurance plans as provided by law.

D. Except as provided in Subsection E of this section, public employees' contributions to the cost of any group benefits self-insurance plan may be deducted from their salaries and paid directly to the [~~group self-insurance~~] health care purchasing fund; provided that where risks are insured or reinsured, the director may authorize payment of the costs of such insurance or reinsurance directly to the insurer or reinsurer.

E. A legislator and the legislator's covered dependents are eligible to participate in and receive benefits from the group benefits self-insurance plan if the legislator pays monthly premiums in amounts that equal one hundred percent of the cost of the insurance. The premiums shall be paid directly to the [~~group self-insurance~~] health care purchasing fund; provided that where risks are insured or reinsured, the director may authorize payment of the premiums directly to the insurer or reinsurer.

F. Local public bodies [~~and state agencies~~] that are not participating in the state group benefits insurance plan or self-insurance plan may elect to participate in any group benefits self-insurance plan established pursuant to Subsection A of this section by giving written notice to the director on a

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date set by the director, which date shall not be later than ninety days prior to the date participation is to begin. The director shall determine an initial rate for the electing entity in accordance with a letter of administration setting forth written guidelines established by the director with the [~~committee's~~] authority's advice. The initial rate shall be based on the claims experience of the electing entity's group for the three immediately preceding continuous years. If three years of continuous experience is not available, a rate fixed for the entity by the director with the [~~committee's~~] authority's advice shall apply, and the electing entity's group shall be rerated on the first premium anniversary following the date one full year of experience for the group becomes available. Any such election may be terminated effective not earlier than June 30 of the third calendar year succeeding the year in which the election became effective or on any June 30 thereafter. Notice of termination shall be made in writing to the director not later than April 1 immediately preceding the June 30 on which participation will terminate. Any accumulated deficit shall be paid upon termination. A reelection to participate in the plan following a termination may not be made effective for at least three full years following the effective date of termination.

G. As soon as practicable, the director with the [~~committee's~~] authority's advice shall establish an experience

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rating plan for state agencies and local public bodies participating in any group benefits self-insurance plan created pursuant to Subsection A of this section. Rates applicable to state agencies and participating local public bodies shall be based on such experience rating plan. Any such experience rating plan may provide separate rates for individual state agencies and individual local public bodies or for such other experience centers as the director may determine."

Section 17. Section 10-7C-1 NMSA 1978 (being Laws 1990, Chapter 6, Section 1) is amended to read:

"10-7C-1. SHORT TITLE.--[~~Sections 1 through 16 of this act~~] Chapter 10, Article 7C NMSA 1978 may be cited as the "Retiree Health Care Act"."

Section 18. Section 10-7C-2 NMSA 1978 (being Laws 1990, Chapter 6, Section 2) is amended to read:

"10-7C-2. PURPOSE OF ACT.--The purpose of the Retiree Health Care Act is to provide comprehensive core group health insurance for persons who have retired from certain public service in New Mexico. The purpose is to provide eligible retirees, their spouses, dependents and surviving spouses and dependents with health insurance consisting of a plan or optional plans of benefits that can be purchased by funds flowing into the [~~retiree~~] health care purchasing fund and by co-payments or out-of-pocket payments of insureds."

Section 19. Section 10-7C-4 NMSA 1978 (being Laws 1990,

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Chapter 6, Section 4, as amended) is amended to read:

"10-7C-4. DEFINITIONS.--As used in the Retiree Health Care Act:

A. "active employee" means an employee of a public institution or any other public employer participating in either the Educational Retirement Act, the Public Employees Retirement Act, the Judicial Retirement Act, the Magistrate Retirement Act or the Public Employees Retirement Reciprocity Act or an employee of an independent public employer;

B. "authority" means the [~~retiree~~] health care purchasing authority created pursuant to the [~~Retiree~~] Health Care Purchasing Act;

C. "basic plan of benefits" means only those coverages generally associated with a medical plan of benefits;

[~~D. "board" means the board of the retiree health care authority;~~

~~E.~~] D. "current retiree" means an eligible retiree who is receiving a disability or normal retirement benefit under the Educational Retirement Act, the Public Employees Retirement Act, the Judicial Retirement Act, the Magistrate Retirement Act, the Public Employees Retirement Reciprocity Act or the retirement program of an independent public employer on or before July 1, 1990;

E. "director" means the director of a separate division of the general services department newly created to

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carry out the provisions of the Health Care Purchasing Act;

F. "eligible dependent" means a person obtaining retiree health care coverage based upon that person's relationship to an eligible retiree as follows:

(1) a spouse;

(2) an unmarried child under the age of [~~nineteen~~] twenty-five who is:

(a) a natural child;

(b) a legally adopted child;

(c) a stepchild living in the same household who is primarily dependent on the eligible retiree for maintenance and support;

(d) a child for whom the eligible retiree is the legal guardian and who is primarily dependent on the eligible retiree for maintenance and support, as long as evidence of the guardianship is evidenced in a court order or decree; or

(e) a foster child living in the same household;

[~~(3) a child described in Subparagraphs (a) through (e) of Paragraph (2) of this subsection who is between the ages of nineteen and twenty-five and is a full-time student at an accredited educational institution; provided that "full-time student" shall be a student enrolled in and taking twelve or more semester hours or its equivalent contact hours in~~

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~~primary, secondary, undergraduate or vocational school or a student enrolled in and taking nine or more semester hours or its equivalent contact hours in graduate school;~~

~~(4)~~] (3) a dependent child over [~~nineteen~~] twenty-five who is wholly dependent on the eligible retiree for maintenance and support and who is incapable of self-sustaining employment by reason of mental retardation, [~~or~~] physical handicap or serious mental illness; provided that proof of incapacity and dependency shall be provided within thirty-one days after the child reaches the limiting age and at such times thereafter as may be required by the [~~board~~] authority;

[~~(5)~~] (4) a surviving spouse defined as follows:

(a) "surviving spouse" means the spouse to whom a retiree was married at the time of death; or

(b) "surviving spouse" means the spouse to whom a deceased vested active employee was married at the time of death; or

[~~(6)~~] (5) a surviving dependent child who is the dependent child of a deceased eligible retiree whose other parent is also deceased;

G. "eligible employer" means either:

(1) a "retirement system employer", which means an institution of higher education, a school district or other entity participating [~~in the public school insurance~~

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~~authority~~] pursuant to the Health Care Purchasing Act, a state agency, state court, magistrate court, municipality, county or public entity, each of which is affiliated under or covered by the Educational Retirement Act, the Public Employees Retirement Act, the Judicial Retirement Act, the Magistrate Retirement Act or the Public Employees Retirement Reciprocity Act; or

(2) an "independent public employer", which means a municipality, county or public entity that is not a retirement system employer;

H. "eligible retiree" means:

(1) a "nonsalaried eligible participating entity governing [~~authority~~] body member" who is a person who is not a retiree and who:

(a) has served without salary as a member of the governing [~~authority~~] body of an employer eligible to participate in the benefits of the Retiree Health Care Act and is certified to be such by the [~~executive director of the public school insurance authority~~] superintendent of the respective school district;

(b) has maintained group health insurance coverage through that member's governing [~~authority~~] body if such group health insurance coverage was available and offered to the member during the member's service as a member of the governing [~~authority~~] body; and

(c) was participating in the group health

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insurance program under the Retiree Health Care Act prior to July 1, 1993; or

(d) notwithstanding the provisions of Subparagraphs (b) and (c) of this paragraph, is eligible under Subparagraph (a) of this paragraph and has applied before August 1, 1993 to the retiree health care authority to participate in the program;

(2) a "salaried eligible participating entity governing [~~authority~~] body member" [~~who is~~] which means a person who is not a retiree and who:

(a) has served with salary as a member of the governing [~~authority~~] body of an employer eligible to participate in the benefits of the Retiree Health Care Act;

(b) has maintained group health insurance through that member's governing [~~authority~~] body, if such group health insurance was available and offered to the member during the member's service as a member of the governing [~~authority~~] body; and

(c) was participating in the group health insurance program under the Retiree Health Care Act prior to July 1, 1993; or

(d) notwithstanding the provisions of Subparagraphs (b) and (c) of this paragraph, is eligible under Subparagraph (a) of this paragraph and has applied before August 1, 1993 to the retiree health care authority to participate in

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the program;

(3) an "eligible participating retiree", [~~who is~~] which means a person who:

(a) falls within the definition of a retiree, has made contributions to the fund or the retiree health care fund for at least five years prior to retirement and whose eligible employer during that period of time made contributions as a participant in the Retiree Health Care Act on the person's behalf, unless that person retires on or before July 1, 1995, in which event the time period required for employee and employer contributions shall become the period of time between July 1, 1990 and the date of retirement, and who is certified to be a retiree by the educational retirement director, the executive secretary of the public employees retirement board or the governing [~~authority~~] body of an independent public employer;

(b) falls within the definition of a retiree, retired prior to July 1, 1990 and is certified to be a retiree by the educational retirement director, the executive secretary of the public employees retirement association or the governing [~~authority~~] body of an independent public employer; but this paragraph does not include a retiree who was an employee of an eligible employer who exercised the option not to be a participating employer pursuant to the Retiree Health Care Act and did not after January 1, 1993 elect to become a

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participating employer; unless the retiree: 1) retired on or before June 30, 1990; and 2) at the time of retirement did not have a retirement health plan or retirement health insurance coverage available from his employer; or

(c) is a retiree who: 1) was at the time of retirement an employee of an eligible employer who exercised the option not to be a participating employer pursuant to the Retiree Health Care Act, but which eligible employer subsequently elected after January 1, 1993 to become a participating employer; 2) has made contributions to the fund or the retiree health care fund for at least five years prior to retirement and whose eligible employer during that period of time made contributions as a participant in the Retiree Health Care Act on the person's behalf, unless that person retires less than five years after the date participation begins, in which event the time period required for employee and employer contributions shall become the period of time between the date participation begins and the date of retirement; and 3) is certified to be a retiree by the educational retirement director, the executive director of the public employees retirement board or the governing [~~authority~~] body of an independent public employer; [~~or~~]

(4) a "legislative member", which means a person who is not a retiree and who served as a member of the New Mexico legislature for at least two years, but is no longer

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a member of the legislature and is certified to be such by the legislative council service; or

(5) a "former participating employer governing body member", which means a person, other than a nonsalaried eligible participating entity governing body member or a salaried eligible participating entity governing body member, who is not a retiree and who served as a member of the governing body of a participating employer for at least four years but is no longer a member of the governing body and is certified to be such by the chief executive officer of the participating employer;

I. "fund" means the [~~retiree~~] health care purchasing fund;

J. "group health insurance" means coverage that includes but is not limited to life insurance, accidental death and dismemberment, hospital care and benefits, surgical care and treatment, medical care and treatment, dental care, eye care, obstetrical benefits, prescribed drugs, medicines and prosthetic devices, medicare supplement, medicare carveout, medicare coordination and other benefits, supplies and services through the vehicles of indemnity coverages, health maintenance organizations, preferred provider organizations and other health care delivery systems as provided by the Retiree Health Care Act and other coverages considered by the [~~board~~] authority to be advisable;

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K. "ineligible dependents" include:

(1) those dependents created by common law relationships;

(2) dependents while in active military service;

(3) parents, aunts, uncles, brothers, sisters, grandchildren and other family members left in the care of an eligible retiree without evidence of legal guardianship; and

(4) anyone not specifically referred to as an eligible dependent pursuant to the rules and regulations adopted by the [~~board~~] authority;

L. "participating employee" means an employee of a participating employer, which employee has not been expelled from participation in the Retiree Health Care Act [~~pursuant to Section 10-7C-10 NMSA 1978~~];

M. "participating employer" means an eligible employer who has satisfied the conditions for participating in the benefits of the Retiree Health Care Act, including the requirements of [~~Subsection M of Section 10-7C-7 NMSA 1978 and~~] Subsection D or E of Section 10-7C-9 NMSA 1978, as applicable;

N. "public entity" means a flood control authority, economic development district, council of governments, regional housing authority, conservancy district or other special district or special purpose government; and

O. "retiree" means a person who:

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(1) is receiving:

(a) a disability or normal retirement benefit or survivor's benefit pursuant to the Educational Retirement Act;

(b) a disability or normal retirement benefit or survivor's benefit pursuant to the Public Employees Retirement Act, the Judicial Retirement Act, the Magistrate Retirement Act or the Public Employees Retirement Reciprocity Act; or

(c) a disability or normal retirement benefit or survivor's benefit pursuant to the retirement program of an independent public employer to which that employer has made periodic contributions; or

(2) is not receiving a survivor's benefit but is the eligible dependent of a person who received a disability or normal retirement benefit pursuant to the Educational Retirement Act, the Public Employees Retirement Act, the Judicial Retirement Act, the Magistrate Retirement Act or the Public Employees Retirement Reciprocity Act."

Section 20. Section 10-7C-9 NMSA 1978 (being Laws 1990, Chapter 6, Section 9, as amended) is amended to read:

"10-7C-9. PARTICIPATION.--

A. All eligible employers shall participate in the Retiree Health Care Act except as provided in Subsection D or [~~Subsection~~] E of this section. Participating employers are

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required to continue existing group health insurance coverages until such time as similar coverages are offered by the [~~board~~] authority.

B. Participation in the basic health insurance coverages provided by the authority shall be conditioned upon receipt by the [~~board~~] director of a certificate of eligibility from the educational retirement director, the executive secretary of the public employees retirement association, the executive director of the public school insurance authority or the governing body of an independent public employer. Once eligibility is established for each eligible retiree, the [~~board~~] authority shall contribute from money in the fund the authority's portion of the premium for the basic plan of benefits commencing no earlier than January 1, 1991 plus the balance of the premium, which shall be collected from the retiree.

C. Each eligible retiree shall accept or reject enrollment in the basic plan of benefits on an enrollment form provided by the [~~board~~] director. An eligible retiree who rejects enrollment or fails to return a properly executed enrollment form within the open enrollment period as established by the [~~board~~] authority forfeits all entitlement and eligibility for benefits under the Retiree Health Care Act until the next open enrollment period as established by the [~~board~~] authority.

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D. On or before January 1, 1991, municipalities, counties and institutions of higher education that are retirement system employers may at their option determine by ordinance, or for institutions of higher education, by resolution, to be excluded from coverage under the Retiree Health Care Act; that determination shall be subject to the following conditions:

(1) any contributions paid into the fund by a municipality, county or institution of higher education that exercises timely an irrevocable option not to participate in the Retiree Health Care Act under this subsection shall be returned without interest to that municipality, county or institution of higher education for return of the employee contributions to the employees and for crediting of the employer contributions to the appropriate fund of the municipality, county or institution of higher education. If the determination to be excluded from coverage is exercised by a municipality, county or institution of higher education prior to July 1, 1990, then that municipality, county or institution of higher education shall not be required to make the contributions that would otherwise be required by Section 10-7C-15 NMSA 1978; and

(2) any municipality, county or institution of higher education, in addition to complying with all other required notice and public hearing or meeting requirements, shall, no less than thirty days prior to the public hearing or

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public meeting on a proposed ordinance or proposed resolution, notify the authority of the public hearing or public meeting by certified mail. [~~and~~

~~(3) in the event that:~~

~~(a) the number of active employees employed by municipalities contributing to the fund reaches a number equaling sixty percent or more of all active employees employed by all municipalities that are retirement system employers, the municipal position on the board of the authority shall be restored within sixty days of the date that percentage is reached; provided, however, that if a municipality with a population greater than one hundred thousand that is located in a class A county exercises this option, then the sixty-percent requirement shall be applied to the remaining municipalities only;~~

~~(b) the number of active employees employed by counties contributing to the fund reaches a number equaling sixty percent or more of all active employees employed by all counties that are retirement system employers, the county position on the board of the authority shall be restored within sixty days of the date that percentage is reached; provided, however, that if a class A county exercises this option, then the eighty-percent requirement shall be applied to the remaining counties only; or~~

~~(c) the number of active employees~~

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~~employed by institutions of higher learning contributing to the fund reaches a number equaling seventy percent or more of all active employees employed by an institution of higher education contributing to the educational retirement fund, the institution of higher education position on the board shall be restored within sixty days of the date that percentage is reached.~~]

E. An independent public employer may become a participating employer if that employer satisfies the requirements [~~imposed pursuant to Subsection M of Section 10-7C-7 NMSA 1978 and if that employer also files with the authority on or prior to January 1, 1991 or prior to July 1, 1993 or~~] of the authority and files with the authority prior to July 1 of any year a written irrevocable election by the governing body of that employer to participate in the Retiree Health Care Act. Any such independent public employer or retirement system employer, as defined in Subsection G of Section 10-7C-4 NMSA 1978 that chooses to become a participating employer after January 1, 1998 shall begin making the appropriate employer and employee contributions to the fund on the July 1 immediately following the adoption of the ordinance or resolution. On the following January 1, eligible retirees of those participating employers and their eligible dependents shall be eligible to receive group health insurance coverage pursuant to the provisions of the Retiree Health Care Act.

F. A municipality or county that enacted an

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ordinance or an institution of higher education that enacted a resolution prior to January 1, 1991 pursuant to Subsection D of this section to be excluded from coverage under the Retiree Health Care Act may become a participating employer if that employer satisfies the requirements [~~imposed pursuant to Subsection M of Section 10-7C-7 NMSA 1978~~] of the authority and if that employer also enacts an ordinance or resolution, as applicable, after a public hearing and published notice of the hearing, prior to July 1, 1993 or July 1 of any year to choose to become a participating employer under the Retiree Health Care Act. Any such municipality, county or institution of higher education that chooses to become a participating employer after January 1, 1998 shall begin making the appropriate employer and employee contributions determined by the [~~board~~] authority to the fund on the July 1 immediately following the adoption of the ordinance or resolution. On the following January 1, eligible retirees of those participating employers and their eligible dependents shall be eligible to receive group health insurance coverage pursuant to the provisions of the Retiree Health Care Act."

Section 21. Section 10-7C-13 NMSA 1978 (being Laws 1990, Chapter 6, Section 13, as amended) is amended to read:

"10-7C-13. PAYMENT OF PREMIUMS ON HEALTH CARE PLANS.--

A. Except as otherwise provided in this section,

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each eligible retiree shall pay a monthly premium for the basic plan in an amount set by the [~~board~~] authority not to exceed fifty dollars ($50.00) plus the amount, if any, of the compounded annual increases authorized by the [~~board~~] authority, which increases shall not exceed nine percent until fiscal year 2008 after which the increases shall not exceed the authority's group health care trend. In addition to the monthly premium for the basic plan, each current retiree and nonsalaried eligible participating entity governing [~~authority~~] body member who becomes an eligible retiree shall also pay monthly an additional participation fee set by the [~~board~~] authority. That fee shall be five dollars ($5.00) plus the amount, if any, of the compounded annual increases authorized by the [~~board~~] authority, which increases shall not exceed nine percent until fiscal year 2008 after which the increases shall not exceed the authority's group health care trend. The additional monthly participation fee paid by the current retirees and nonsalaried eligible participating entity governing [~~authority~~] body members who become eligible retirees shall be a consideration and a condition for being permitted to participate in the Retiree Health Care Act. A legislative member or a former participating employer governing body member shall pay a monthly premium for any selected plan equal to one-twelfth of the annual cost of the claims and administrative costs of that plan allocated to the member by the [~~board~~] authority. In addition, a legislative

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member or a former participating employer governing body member shall pay the additional monthly participation fee set by the [~~board~~] authority pursuant to this subsection as a consideration and condition for participation in the Retiree Health Care Act. Eligible dependents shall pay monthly premiums in amounts that with other money appropriated to the fund shall cover the cost of the basic plan for the eligible dependents.

B. Eligible retirees and eligible dependents shall pay monthly premiums to cover the cost of the optional plans that they elect to receive, and the [~~board~~] authority shall adopt rules for the collection of additional premiums from eligible retirees and eligible dependents participating in the optional plans. An eligible retiree or eligible dependent may authorize the authority in writing to deduct the amount of these premiums from the monthly annuity payments, if applicable.

C. The participating employers, active employees and retirees are responsible for the financial viability of the program. The overall financial viability is not an additional financial obligation of the state.

D. For eligible retirees who become eligible for participation on or after July 1, 2001, the [~~board~~] authority may determine monthly premiums based on the retirees' years of credited service with participating employers."

Section 22. Section 13-7-2 NMSA 1978 (being Laws 1997, Chapter 74, Section 2) is amended to read:

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"13-7-2. PURPOSE OF ACT.--

A. The purpose of the Health Care Purchasing Act is to ensure public employees, public school employees and retirees of public employment and the public schools access to more affordable and enhanced quality of health insurance through cost containment and savings effected by procedures for consolidating the purchasing of publicly financed health insurance.

B. Further, the purpose of the Health Care Purchasing Act is to positively affect efforts to:

(1) improve the health status of all participants;

(2) contain or minimize the rise in health care costs;

(3) lower the number of uninsured New Mexicans; and

(4) promote cost containment through consumer choice and selective contracting with insurance companies, health maintenance organizations and professional claims administrators."

Section 23. Section 13-7-3 NMSA 1978 (being Laws 1997, Chapter 74, Section 3) is amended to read:

"13-7-3. DEFINITIONS.--As used in the Health Care Purchasing Act:

[~~A. "consolidated purchasing" means a single process for the procurement of all health care benefits by the publicly~~

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~~funded insurance agencies in compliance with the Procurement Code and includes associated activities related to the procurement such as actuarial, cost containment, benefits consultation and analysis; and~~

~~B. "publicly funded health care agency" means the:~~

~~(1) risk management division and the group benefits committee of the general services department;~~

~~(2) retiree health care authority;~~

~~(3) public school insurance authority; and~~

~~(4) publicly funded health care program of any public school district with a student enrollment in excess of sixty thousand students~~]

A. "authority" means the health care purchasing authority created pursuant to the Health Care Purchasing Act;

B. "director" means the director of a separate division of the general services department newly created to carry out the provisions of the Health Care Purchasing Act;

C. "fund" means the health care purchasing fund;

D. "health care benefits" means:

(1) benefits consisting of medical and behavioral health care provided through insurance or other reimbursement, including items and services paid for as medical or behavioral health care;

(2) group benefits as provided in the Group Benefits Act; or

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(3) group health insurance as provided in the Retiree Health Care Act;

E. "participant" means a person eligible and covered pursuant to the Group Benefits Act or the Retiree Health Care Act, an employee of a school district or charter school, a person eligible and covered pursuant to the Health Care Purchasing Act or a dependent as permitted by those acts or other governing bodies;

F. "political subdivision" means:

(1) a county, municipality, school district, charter school, state educational institution or other public body;

(2) a local public body as defined in the Group Benefits Act; or

(3) a public entity as defined in the Retiree Health Care Act; and

G. "professional claims administrator" means a person or legal entity that has at least five years of experience handling group benefits claims, as well as such other qualifications as the director may determine from time to time with the authority's advice."

Section 24. Section 13-7-4 NMSA 1978 (being Laws 1997, Chapter 74, Section 4) is amended to read:

"13-7-4. MANDATORY CONSOLIDATED PURCHASING.--

A. The [~~agencies shall enter into a cooperative~~

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~~consolidated purchasing effort to provide~~] authority shall provide for the purchase of plans of health care benefits for the benefit of eligible participants [~~of the respective agencies~~]. The request for [~~proposal~~] proposals shall set forth one or more plans of health care benefits [~~and shall include accommodation of fully funded arrangements as well as varying degrees of self-funded pool options.~~

~~B. A consolidated purchasing request for proposals for all health care benefits by the publicly funded health care agencies shall be issued on or before July 1, 1999 and any contracts for health care benefits renewed or issued on or after July 1, 2000 shall be the result of consolidated purchasing.~~

~~C. All requests for proposals issued as part of the consolidated purchasing shall include at least one distinct service area consisting of the Albuquerque metropolitan area. Proposals on a distinct service area shall be evaluated separately~~] and contracts shall be awarded to two or more entities licensed in the state that are insurance companies, health maintenance organizations or professional claims administrators.

B. Plans of health care benefits may consist of self-insurance and insurance; provided that particular coverages or risks may be fully insured, fully self-insured or partially insured and partially self-insured.

C. Contracts for the consolidated purchase of health

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care benefits renewed or issued on or after July 1, 2004 shall be the result of a consolidated purchase."

Section 25. Section 13-7-5 NMSA 1978 (being Laws 2001, Chapter 351, Section 1) is amended to read:

"13-7-5. CONSOLIDATED PURCHASING FOR OTHER PERSONS.--

A. Counties, municipalities, state educational institutions and other political subdivisions that wish to use [~~the~~] a consolidated [~~purchasing single process for the procurement~~] purchase of health care benefits shall create or enter into an existing association, cooperative or other mutual alliance to create larger pools of eligible participants.

B. Counties, municipalities, state educational institutions and other political subdivisions that wish to use the consolidated [~~purchasing single process~~] purchase of health care benefits shall, through their respective association, cooperative or mutual alliance, participate in the subsequent consolidated [~~purchasing single process with the publicly funded health care agencies~~] purchase."

Section 26. Section 13-7-6 NMSA 1978 (being Laws 2001, Chapter 351, Section 2) is amended to read:

"13-7-6. USE OF SOCIAL SECURITY NUMBERS.--The [~~publicly funded health care agencies~~] authority, political subdivisions and other persons providing health care benefits through [~~the~~] a consolidated [~~purchasing single process~~] purchase of health care benefits, in compliance with state and federal law, shall not

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require the use of participants' social security numbers as health care benefit plan identification numbers."

Section 27. Section 22-29-1 NMSA 1978 (being Laws 1986, Chapter 94, Section 1) is amended to read:

"22-29-1. SHORT TITLE.--[~~This act~~] Chapter 22, Article 29 NMSA 1978 may be cited as the "Public School Insurance Authority Act"."

Section 28. Section 22-29-2 NMSA 1978 (being Laws 1986, Chapter 94, Section 2) is amended to read:

"22-29-2. PURPOSE OF ACT.--The purpose of the Public School Insurance Authority Act is to provide [~~comprehensive core insurance~~] risk-related coverage programs for all participating public schools, school board members, school board retirees and public school employees and retirees by expanding the pool of subscribers to maximize cost containment opportunities for required insurance coverage."

Section 29. Section 22-29-3 NMSA 1978 (being Laws 1986, Chapter 94, Section 3, as amended) is amended to read:

"22-29-3. DEFINITIONS.--As used in the Public School Insurance Authority Act:

A. "authority" means the public school insurance authority;

B. "board" means the board of directors of the public school insurance authority;

C. "charter school" means a school organized as a

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charter school pursuant to the provisions of the 1999 Charter Schools Act;

D. "director" means the director of the public school insurance authority;

E. "educational entities" means state educational institutions as enumerated in Article 12, Section 11 of the constitution of New Mexico and other state diploma, degree-granting and certificate-granting post-secondary educational institutions and regional education cooperatives;

F. "fund" means the public school insurance fund;

[~~G. "group health insurance" means coverage that includes life insurance, accidental death and dismemberment, medical care and treatment, dental care, eye care and other coverages as determined by the authority;~~

~~H.~~] G. "risk-related coverage" means coverage that includes property and casualty, general liability, auto and fleet, workers' compensation and other casualty insurance; and

[~~I.~~] H. "school district" means a school district as defined in Subsection K of Section 22-1-2 NMSA 1978, excluding any school district with a student enrollment in excess of sixty thousand students."

Section 30. Section 22-29-4 NMSA 1978 (being Laws 1986, Chapter 94, Section 4) is amended to read:

"22-29-4. AUTHORITY CREATED.--

A. There is created the "public school insurance

authority" which is established to provide for [~~group health insurance and other~~] risk-related coverage with the exception of the mandatory coverage provided by the risk management division on the effective date of the Public School Insurance Authority Act.

B. Health care benefits coverage shall be purchased for all school districts, regardless of student enrollment, pursuant to the Health Care Purchasing Act."

Section 31. Section 22-29-5 NMSA 1978 (being Laws 1986, Chapter 94, Section 5, as amended) is amended to read:

"22-29-5. BOARD CREATED--MEMBERSHIP--DUTIES.--

A. There is created the "board of directors of the public school insurance authority". The board shall be composed of [~~nine~~] eleven members, consisting of the following:

(1) one member to be selected by the [~~state board of~~] public education department;

(2) one school business official to be selected by the New Mexico school administrators;

(3) one board member of the New Mexico school boards association to be selected by the association;

(4) one superintendent to be selected by the New Mexico superintendents' association;

(5) three members to be selected by the New Mexico national education association and the New Mexico federation of teachers with the intent that representation be

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proportional to their respective membership; provided that each of these three members be currently employed as public school teachers employed by participating entities;

(6) one member to be selected by the board from lists submitted by the participating educational entities; and

(7) three members to be appointed by and serve at the pleasure of the governor. Such members shall not be employed by or on behalf of or be contracting with an employer participating in or eligible to participate in the public school insurance authority.

B. Each member of the board shall serve at the pleasure of the party by which he has been appointed for a term not to exceed three years. Any board member who has been appointed and who misses four meetings of the board during a fiscal year shall be replaced and shall forfeit his position on the board, and his replacement shall be made by the organization affected. The board shall set minimum terms of appointment and shall elect from its membership a president, vice president and secretary.

C. The board has the authority to hire a director and appoint such other officers and employees as it may deem necessary and has the authority to contract with consultants or other professional persons or firms as may be necessary to carry out the provisions of the Public School Insurance Authority Act.

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[~~The board has the authority to provide for its full- and part-time employees, as it deems necessary, employee benefits insurance on the same basis as a member public school district may provide such employee benefits. In addition~~] The board has the authority to provide to members of the board and the employees risk coverages of the same scope and limitations as are allowed its member school districts to be provided to their local school boards. The board has the authority to provide employees an irrevocable option of qualifying for coverage under either the Educational Retirement Act or the Public Employees Retirement Act.

D. The members of the board shall receive per diem and mileage as provided in the Per Diem and Mileage Act, but shall receive no other compensation, perquisite or allowance."

Section 32. Section 22-29-6 NMSA 1978 (being Laws 1986, Chapter 94, Section 6, as amended) is amended to read:

"22-29-6. FUND CREATED--BUDGET REVIEW--PREMIUMS.--

A. There is created the "public school insurance fund". All income earned on the fund shall be credited to the fund. The fund is appropriated to the authority to carry out the provisions of the Public School Insurance Authority Act. Any money remaining in the fund at the end of each fiscal year shall not revert to the general fund.

B. The board shall determine which money in the fund constitutes the long-term reserves of the authority. The state

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investment officer shall invest the long-term reserves of the authority in accordance with the provisions of Sections 6-8-1 through 6-8-16 NMSA 1978. The state treasurer shall invest the money in the fund that does not constitute the long-term reserves of the fund in accordance with the applicable provisions of Chapter 6, Article 10 NMSA 1978.

C. All appropriations shall be subject to budget review through the [~~department of~~] public education department, the state budget division of the department of finance and administration and the legislative finance committee.

D. The authority shall provide that premiums are collected from school districts and charter schools participating in the authority sufficient to provide the required [~~insurance~~] risk-related coverage and to pay the expenses of the authority. All premiums shall be credited to the fund.

E. Any reserves remaining at the termination of [~~an insurance~~] a contract for risk-related coverage shall be disbursed to the individual school districts, charter schools and other participating entities on a pro rata basis.

F. Disbursements from the fund for purposes other than procuring and paying for [~~insurance or insurance-related~~] risk-related coverage services, including [~~but not limited to~~] third-party administration, premiums, claims and cost containment activities, shall be made only upon warrant drawn by

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the secretary of finance and administration pursuant to vouchers signed by the director or his designee; provided that the chairman of the board may sign vouchers if the position of director is vacant."

Section 33. Section 22-29-7 NMSA 1978 (being Laws 1986, Chapter 94, Section 7, as amended) is amended to read:

"22-29-7. AUTHORITY--DUTIES.--In order to effectuate the purposes of the Public School Insurance Authority Act, the authority has the power to:

A. enter into professional services and consulting contracts or agreements as necessary;

B. collect money and provide for the investment of the fund;

C. collect all current and historical claims and financial information necessary for effective procurement of lines of [~~insurance~~] risk-related coverage;

D. promulgate necessary rules, regulations and procedures for implementation of the Public School Insurance Authority Act;

E. negotiate new insurance policies covering additional or lesser benefits as determined appropriate by the authority, but the authority shall maintain all coverage levels required by federal and state law for each participating member. In the event it is practical to wholly self-insure a particular line of coverage, the authority may do so;

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F. procure lines of [~~insurance~~] risk-related coverage in compliance with the [~~provisions of the Health Care Purchasing Act and the~~] competitive sealed proposal process of the Procurement Code provided that any [~~group medical insurance~~] risk-related coverage plan offered pursuant to this section shall include effective cost-containment measures to control the growth of health care costs. The board shall report annually by September 1 to appropriate interim legislative committees on the effectiveness of the cost-containment measures required by this subsection; and

G. purchase, renovate, equip and furnish a building for the board."

Section 34. Section 22-29-9 NMSA 1978 (being Laws 1986, Chapter 94, Section 9, as amended) is amended to read:

"22-29-9. PARTICIPATION--WAIVERS.--

A. School districts and charter schools shall participate in the authority, unless the school district or charter school is granted a waiver by the board.

B. In determining whether a waiver should be granted, the board shall establish minimum benefit and financial standards for the desired line of risk-related coverage. These minimum benefit and financial standards and the proposed time schedule for responsive offers shall be sent to all school districts and charter schools at the time the request for proposals for the desired line of coverage is issued. Any

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school district or charter school seeking a waiver of risk-related coverage shall match the minimum benefit and financial standards set forth in the request for proposals for the desired line of risk-related coverage. School districts and charter schools shall submit documentation of their proposals matching the board's minimum benefit and financial requirements prior to the deadline established by the board. The authority has the power to approve or disapprove a waiver of participation based on the documentation submitted by the school district or charter school regarding the benefit and financial standards established by the board. The board shall grant a waiver to a school district or charter school that requests a waiver and that has met the minimum benefit and financial standards within the time schedule established by the board. Once the board awards the [~~insurance~~] contract for risk-related coverage, no school district or charter school shall be granted a waiver for the entire term of the contract.

C. [~~Any school district or charter school granted a waiver of participation for health insurance shall be required to petition for participation in other kinds of group insurance coverage and shall be required to meet the requirements established by the authority prior to participation in other kinds of group insurance coverage.~~] A school district or charter school [~~which has been~~] that was granted a waiver prior to July 1, 2004 shall be prohibited from participating in the risk-

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related coverage for which a waiver was granted for the entire term of the authority's [~~insurance~~] contract for risk-related coverage. If the authority contracts for a line or lines of risk-related coverage for a period of eight years, the board may establish procedures and preconditions for authorizing a school district or charter school [~~which has been~~] that was granted a waiver prior to July 1, 2004 to again participate in the risk-related coverage after the expiration of the first four years of risk-related coverage.

D. Any school district or charter school granted a waiver of participation for workers' compensation shall be required to petition for participation in other risk-related coverages and shall be required to meet the requirements established by the authority prior to participation in other kinds of risk-related coverages. A school district or charter school [~~which~~] that has been granted a waiver shall be prohibited from participating in the risk-related coverage for which a waiver was granted for the entire term of the authority's [~~insurance~~] contract for risk-related coverage.

E. Educational entities may petition the authority for permission to participate in the [~~insurance~~] risk-related coverage provided by the authority. To protect the stability of the fund, the authority shall establish reasonable terms and conditions for participation by educational entities.

F. A participating school district or charter school

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may separately provide for coverage additional to that offered by the authority.

G. The local school districts, charter schools or the authority, as appropriate, may provide for marketing and servicing to be done by licensed insurance agents or brokers who should receive reasonable compensation for their services."

Section 35. TEMPORARY PROVISION--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--

A. On the effective date of this 2004 act, all appropriations, money, records, equipment, supplies and other property of the retiree health care authority and its board shall be transferred to the general services department.

B. On the effective date of this 2004 act, all appropriations, money, records, equipment, supplies and other property of the public school insurance authority relating to group insurance shall be transferred to the general services department; provided that the real property occupied by the public school insurance authority and the appropriations, money, records, equipment, supplies and other property of the public school insurance authority relating to risk-related coverage shall not be transferred.

C. On the effective date of this 2004 act, all appropriations, money, records, equipment, supplies and other property of a school district with enrollment greater than sixty thousand students relating to health care benefits as defined in

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the Health Care Purchasing Act shall be transferred to the general services department.

D. On the effective date of this 2004 act, all appropriations, money, records, equipment, supplies and other property of the group benefits committee shall be transferred to the general services department.

E. On the effective date of this 2004 act, the following personnel shall be transferred to the general services department, as needed for transition and ongoing operation and administration:

(1) classified personnel of the retiree health care authority;

(2) classified personnel of the public school insurance authority, relating to group insurance; and

(3) classified personnel of the group benefits committee.

F. On the effective date of this 2004 act, the general services department and a school district with enrollment greater than sixty thousand students shall enter into a joint powers agreement to transfer the classified personnel of the affected school district to the general services department.

G. The state personnel office shall work with state agencies to assist those public employees displaced by the consolidation provisions of the Health Care Purchasing Act in obtaining comparable employment.

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H. On the effective date of this 2004 act, all contracts of the retiree health care authority, the group benefits committee, the public school insurance authority as they pertain to group insurance and any school district with enrollment greater than sixty thousand students as they pertain to health care benefits as defined in the Health Care Purchasing Act shall be binding and effective on the general services department. The health care purchasing authority shall not renegotiate contracts in existence as of June 30, 2004 that, as a result of this 2004 act, would increase the premium rates for participants.

I. On the effective date of this 2004 act, all references in law to the retiree health care authority, the group benefits committee, the public school insurance authority as they pertain to group insurance and any school district with enrollment greater than sixty thousand students as they pertain to health care benefits as defined in the Health Care Purchasing Act shall be deemed to be references to the general services department or the health care purchasing authority, as appropriate.

Section 36. TEMPORARY PROVISION--TRANSITION PERIOD.--On the effective date of this 2004 act, appropriate steps shall be taken to ensure a transition that provides uninterrupted health care access, delivery, financing and customer service, including:

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A. a separate joint powers agreement shall be in effect no later than June 1, 2004 between the general services department and each public body affected by the consolidation pursuant to this 2004 act;

B. continued applicability of existing rules of each public body affected by the consolidation pursuant to this 2004 act until the health care purchasing authority has adopted new, replacement or revised rules;

C. a transition plan between the general services department and each public body affected by the consolidation pursuant to this act shall be in effect no later than June 1, 2004 that includes communications to affected employees and participants, an implementation schedule, methods for transition and transfer of property, personnel, contracts and other programs and services. Each plan shall provide for transition and planning meetings between and among the general services department, the group benefits committee, the board of the retiree health care authority, the retiree health care authority, the board of directors of the public school insurance authority, the public school insurance authority and the governing body and the administrative organization relating to health care benefits of a school district with student enrollment greater than sixty thousand students to ensure the appropriate transfer of property, personnel, contracts and other items or services to be consolidated pursuant to the Health Care

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Purchasing Act; provided that the transition plan may include actions to be taken before or after June 30, 2004 but no later than June 30, 2005; provided further that the appropriations and money shall be transferred and under the control of the general services department on July 1, 2004;

D. allowing the general services department to assess and assume responsibility for the information technology systems and resources of the retiree health care authority, the public school insurance authority, the group benefits committee and a school district with enrollment greater than sixty thousand students; provided that, notwithstanding the provisions of Section 15-1C-7 NMSA 1978, the general services department may proceed with transition and set-up of information technology systems and resources in consultation and collaboration with the office of the chief information officer; and

E. ensuring that the level of customer service for public employees, retirees and dependents is maintained or exceeded during the transition period.

Section 37. TEMPORARY PROVISION--VOLUNTARY PURCHASE BY PRIVATE EMPLOYERS OR INDIVIDUALS.--

A. The health care purchasing authority shall determine, by December 31, 2005, methods to permit private employers or individuals to voluntarily purchase, as established through actuarially based rates, health care benefits coverage afforded by the authority, taking into consideration the results

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of studies and recommendations of the legislative health and human services committee and the study conducted by the human services department and the New Mexico health policy commission, with the cooperation of the insurance division of the public regulation commission and the general services department, and assessing the potential effects and methods of authorizing businesses and individuals to join a public health insurance purchasing collaborative.

B. The health care purchasing authority shall only permit voluntary purchase of health care benefits by private employers or individuals if:

(1) the employer has not offered health care benefits coverage to its employees for a period of at least twelve months prior to enrollment in the coverage afforded by the authority; or

(2) the individual has not had health care benefits coverage for at least six months and has lived in the state for at least twelve months prior to enrollment in the coverage afforded by the authority; provided that the individual is ineligible if he has declined similar coverage under a plan or policy offered through or by his employer or through a government-sponsored program other than one developed pursuant to the Health Care Purchasing Act.

C. The health care purchasing authority shall adopt rules pursuant to the Administrative Procedures Act to determine

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and establish eligibility and enrollment for private employers and individuals as described in Subsections A and B of this section.

Section 38. TEMPORARY PROVISION--RECOMPILATION INSTRUCTIONS.--Sections 10-7C-17 through 10-7C-19 NMSA 1978 (being Laws 2002, Chapter 75, Sections 2 through 4 and Laws 2002, Chapter 80, Sections 2 through 4, as amended) are recompiled as part of the Health Care Purchasing Act.

Section 39. REPEAL.--Sections 10-7B-3, 10-7B-4, 10-7B-7, 10-7B-8, 10-7C-5 through 10-7C-8, 10-7C-10, 10-7C-11, 10-7C-14, 10-7C-16, 13-7-7 and 22-29-10 NMSA 1978 (being Laws 1989, Chapter 231, Sections 3, 4, 7 and 8, Laws 1990, Chapter 6, Sections 5, 6 and 7, Laws 2000, Chapter 79, Sections 1 and 2, Laws 1990, Chapter 6, Sections 8, 10, 11, 14 and 16, Laws 2001, Chapter 351, Section 3 and Laws 1989, Chapter 373, Section 5, as amended) are repealed.

Section 40. SEVERABILITY.--If any part or application of this act is held invalid, the remainder or its application to other situations or persons shall not be affected.

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