AN ACT

RELATING TO HEALTH CARE; PROVIDING OPTIONS FOR SMALL EMPLOYERS TO INCREASE ACCESS TO VOLUNTARY HEALTH CARE COVERAGE.

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

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

"10-7B-1. SHORT TITLE.--Chapter 10, Article 7B NMSA 1978 may be cited as the "Group Benefits Act"."

Section 2. 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;

B. "director" means the director of the risk management division of the general services department;

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

D. "local public body" means any New Mexico incorporated municipality, county or school district;

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 advice;

F. "small employer" means a person having for-profit or nonprofit status that employs an average of fifty or fewer persons over a twelve-month period; and

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

Section 3. 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 committee, may apportion the costs of employee benefits administration and other employee benefit costs to all participating state agencies and their employees, participating local public bodies and their employees and participating small employers and persons and dependents eligible through the small employer, whether the plan is insured or self-insured."

Section 4. A new section of the Group Benefits Act is enacted to read:

"SMALL EMPLOYER HEALTH CARE COVERAGE.--

A. The director may enter into an agreement with a small employer to voluntarily purchase health care coverage offered pursuant to the Group Benefits Act for persons and dependents eligible through the small employer.

B. The director may enter into agreements with an

association, cooperative or mutual alliance representing small employers to provide outreach and assistance for small employers to voluntarily purchase health care coverage offered pursuant to the Group Benefits Act for persons and dependents eligible through the small employer.

C. The director shall only permit voluntary purchase of health care coverage by small employers if the small employer has not offered health care coverage to persons and dependents eligible through a small employer for a period of at least twelve months prior to enrollment in the coverage offered pursuant to the Group Benefits Act.

D. A separate account shall be maintained for small employers that voluntarily elect to purchase health care coverage offered pursuant to the Group Benefits Act to provide separate accounting, payment and private funding of health care coverage for small employers. The funds in the small employers account shall be maintained separately in actuarially sound condition as evidenced by an annual written certification of a qualified actuary."

Section 5. Section 59A-54-10 NMSA 1978 (being Laws 1987, Chapter 154, Section 10, as amended) is amended to read:

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

A. Following the close of each fiscal year, the pool administrator shall determine the net premium, being premiums less administrative expense allowances, the pool

expenses and claim expense losses for the year, taking into account investment income and other appropriate gains and losses. The assessment for each insurer shall be determined by multiplying the total cost of pool operation by a fraction the numerator of which equals that insurer's premium and subscriber contract charges or their equivalent for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums and subscriber contract charges written in the state; provided that premium income shall include receipts of medicaid managed care premiums but shall not include any payments by the secretary of health and human services pursuant to a contract issued under Section 1876 of the Social Security Act, as amended. The board may adopt other or additional methods of adjusting the formula to achieve equity of assessments among pool members, including assessment of health insurers and reinsurers based upon the number of persons they cover through primary, excess and stop-loss insurance in the state.

B. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

C. The proportion of participation of each member in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed with it by the member. Any deficit incurred by 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 thirty-percent credit on the premium tax return for that member and a fifty percent credit on the premium tax return for a member on the low-income premium schedule pursuant to Subsection B of Section 59A-54-19 NMSA 1978.

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."

Section 6. Section 59A-54-12 NMSA 1978 (being Laws

1987, Chapter 154, Section 12, as amended) is amended to read:

"59A-54-12. ELIGIBILITY--POLICY PROVISIONS.--

A. Except as provided in Subsection B of this section, a person is eligible for a pool policy only if on the effective date of coverage or renewal of coverage the person is a New Mexico resident, and:

(1) is not eligible as an insured or covered dependent for any health plan that provides coverage for comprehensive major medical or comprehensive physician and hospital services;

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

(3) has been rejected for coverage for comprehensive major medical or comprehensive physician and hospital services;

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

(5) has a medical condition that is listed on the pool's pre-qualifying conditions;

(6) has as of the date the individual seeks coverage from the pool an aggregate of eighteen or more months of creditable coverage, the most recent of which was under a group health plan, governmental plan or church plan as defined

in Subsections P, N and D, respectively, of Section 59A-23E-2 NMSA 1978, except, for the purposes of aggregating creditable coverage, a period of creditable coverage shall not be counted with respect to enrollment of an individual for coverage under the pool if, after that period and before the enrollment date, there was a sixty-three-day or longer period during all of which the individual was not covered under any creditable coverage; or

(7) is entitled to continuation coverage pursuant to Section 59A-23E-19 NMSA 1978.

B. Notwithstanding the provisions of Subsection A of this section:

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

(2) if a pool policyholder becomes eligible for any group health plan, the policyholder's pool coverage shall not be involuntarily terminated until any preexisting condition period imposed on the policyholder by the plan has been exhausted.

C. Coverage under a pool policy is in excess of

and shall not duplicate coverage under any other form of health insurance.

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

E. Except for a person eligible as provided in Paragraph (6) of Subsection A of this section, a pool policy may contain provisions under which coverage is excluded during a six-month period following the effective date of coverage as to a given individual for preexisting conditions.

F. The preexisting condition exclusions described in Subsection E of this section shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage that was involuntarily terminated, if the application for pool coverage is made not later than thirty-one days following the involuntary termination. In that case, coverage in the pool shall be effective from the date on which the prior coverage was terminated. This subsection does not prohibit preexisting conditions coverage in a pool policy that is more favorable to the insured than that specified in this subsection.

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

(1) except as provided in Subsection I of this section, the individual is, at the time of application,

eligible for medicare or medicaid that would provide coverage for amounts in excess of limited policies such as dread disease, cancer policies or hospital indemnity policies;

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

(3) the individual is an inmate of a public institution or is eligible for public programs for which medical care is provided;

(4) the individual is eligible for coverage under a group health plan;

(5) the individual has health insurance coverage as defined in Subsection R of Section 59A-23E-2 NMSA 1978;

(6) the most recent coverages within the coverage period described in Paragraph (6) of Subsection A of this section were terminated as a result of nonpayment of premium or fraud; or

(7) the individual has been offered the option of continuation coverage under a federal COBRA continuation provision as defined in Subsection F of Section 59A-23E-2 NMSA 1978 or under a similar state program and he has elected the coverage and did not exhaust the continuation

coverage under the provision or program, provided, however, that an unemployed former employee who has not exhausted COBRA coverage shall be eligible.

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

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

(1) are enrolled in both Part A and Part B of medicare because of a disability; and

(2) except for the eligibility for medicare, would otherwise be eligible for coverage pursuant to the criteria of this section."

Section 7. TEMPORARY PROVISION.--By January 1, 2010, the superintendent of insurance shall:

A. promulgate rules to allow participating small employers and persons and dependents eligible pursuant to this act to participate in the coverage afforded pursuant to the Health Insurance Alliance Act; and

B. recommend statutory changes to the Health

Insurance Alliance Act as may be needed.

Section 8. DELAYED REPEAL.--Section 4 of this act is repealed effective July 1, 2010.

Section 9. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2005.