HOUSE BILL 62

48TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2008

INTRODUCED BY

John A. Heaton

AN ACT

RELATING TO HEALTH CARE REFORM; ENACTING THE HEALTH SOLUTIONS NEW MEXICO ACT; CREATING THE HEALTH COVERAGE AUTHORITY; PROVIDING FOR CONTRIBUTIONS TO THE HEALTHY NEW MEXICO WORK FORCE FUND; REQUIRING NEW MEXICO RESIDENTS TO SHOW PROOF OF HEALTH COVERAGE; REQUIRING EMPLOYERS TO CONTRIBUTE TO THE HEALTHY NEW MEXICO WORK FORCE FUND; PROVIDING INSURANCE REFORM INITIATIVES; TRANSFERRING ADMINISTRATIVE AUTHORITY OF CERTAIN HEALTH COVERAGE PROGRAMS TO THE HEALTH COVERAGE AUTHORITY; PROVIDING FOR TRANSITION OF ADMINISTRATIVE AUTHORITY OF CERTAIN HEALTH COVERAGE PROGRAMS; MAKING AN APPROPRIATION.

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

Section 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 12 of this act may be cited as the "Health Solutions New Mexico Act".

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Section 2. [NEW MATERIAL] PURPOSE.--The purpose of the Health Solutions New Mexico Act is to achieve universal health coverage, contain health care costs and improve health care access and quality for New Mexicans. Initiatives for health care and health coverage should:

A. recognize the unique racial, ethnic, cultural and linguistic diversity in the state;

B. be transparent and accountable;

C. be financially viable, taking into account costs, impact on the state's economy, the health of its people and rising costs of health care;

D. consider the quality of health care, including health outcomes and individual wellness;

E. improve access to health care and improve health status and outcomes in the state;

F. consider the needs of individuals and families with low incomes, chronic illnesses, high-risk or other high-need health care situations that may require assistance in purchasing, accessing or enrolling in available health coverage programs; and

G. provide high-quality health care that offers choice of providers, plans and treatment options for consumers to improve individual and systemic health outcomes and contain rising health care costs.

Section 3. [NEW MATERIAL] DEFINITIONS.--As used in the

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Health Solutions New Mexico Act:

A. "advocacy" means the act of promoting or supporting efforts to provide health coverage or services for individuals;

B. "affordability" means the designation of the percentage or amount of income that a household should reasonably be expected to devote to health care while still having sufficient income to access other necessities;

C. "authority" means the health coverage authority;

D. "board" means the board of directors of the authority;

E. "consumer" means an individual that obtains or receives health care services from or through a provider;

F. "fund" means the healthy New Mexico work force fund;

G. "health insurer" means a person duly authorized to transact the business of health insurance in the state, including a nonprofit health care plan, a health maintenance organization and self-insurers not subject to federal preemption;

H. "payer" means a person that purchases health care services directly from a provider or through a health insurer or other third party;

I. "preexisting condition" means a physical or mental condition for which medical advice, medication,

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diagnosis, care or treatment was recommended for or received by an applicant for health insurance within six months before the effective date of coverage, except that pregnancy is not considered a preexisting condition for a federally defined eligible individual;

J. "provider" means an individual practitioner, a practitioner group, a facility or an institution duly licensed or permitted by the state to provide health care services or supplies; and

K. "purchaser" means a person that determines what health services and benefits will be paid directly by or through an arrangement with a payer.

Section 4. [NEW MATERIAL] HEALTH COVERAGE AUTHORITY--CREATION--BOARD OF DIRECTORS--POWERS--DUTIES.--

A. The "health coverage authority" is created as an adjunct agency pursuant to Section 9-1-6 NMSA 1978.

B. The board of directors of the authority shall consist of eleven voting members as follows:

(1) four members appointed by the governor and confirmed by the senate;

(2) two members appointed by the governor from a list of nominations submitted jointly by the president pro tempore, the majority leader and the minority leader of the senate;

(3) two members appointed by the governor from

a list of nominations submitted jointly by the speaker, the majority leader and the minority leader of the house of representatives;

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

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

(6) the chair of the public regulation commission or the chair's designee.

C. The members appointed to the board shall have terms chosen by lot as follows: three members shall serve two-year terms; three members shall serve three-year terms; and two members shall serve four-year terms. Thereafter, members shall serve four-year terms. An appointed member shall serve until the member's successor is appointed, but in no case shall the appointed member serve longer than an additional twelve months. An appointed member shall not serve more than two consecutive four-year terms. An appointed member subject to senate confirmation shall serve on the board as a member-designee until the senate acts to confirm or not to confirm the appointee.

D. A vacancy shall be filled by appointment by the original appointing authority for the remainder of the unexpired term. The governor may request additional nominations from the legislature to ensure compliance with

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board qualifications pursuant to Subsection F, G or H of this section.

E. A majority of the eleven board members shall constitute a quorum. The board may allow members' participation in meetings by telephone or other electronic medium that allows full participation. Every even-numbered year, the board shall elect its chair and vice chair in open session from any of the appointed members. A chair or vice chair shall serve no more than two consecutive two-year terms.

F. No more than three of the appointed board members shall have an interest in the health care delivery, financing, coverage or advocacy sector that provides twenty-five percent or more of the board member's income or the board member's immediate-family or same-household income while serving and for twelve months preceding appointment to or service on the board.

G. Each appointed board member shall have at least three years' experience in at least one of the following areas; provided, however, that all areas are represented on the board:

(1) health care management, delivery or finance;

(2) medical or behavioral health practice;

(3) health care policy development or implementation;

(4) business management or finance;

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(5) actuarial analysis or economics;

(6) labor organization and advocacy;

(7) Native American health care issues; and

(8) health care consumer advocacy.

H. Board members shall represent the ethnic, economic, geographic and political diversity of the state, including the interests of public and private employers and employees and purchasers and consumers of health care goods and services. At least one board member shall be a Native American.

I. A member may be removed from the board by a majority vote of the members present at a meeting where a quorum is duly constituted. The board shall set standards for attendance and may remove a member only for lack of attendance, neglect of duty or malfeasance in office. A member shall not be removed without proceedings consisting of at least one notice of hearing and an opportunity to be heard. Removal proceedings shall be before the board and in accordance with rules adopted by the board.

J. A board member may receive per diem and mileage in accordance with the Per Diem and Mileage Act, subject to appropriation by the legislature and as travel policy is set by the board; provided, however, that the travel policy shall not allow travel reimbursement at a rate greater than the Per Diem and Mileage Act.

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K. The board shall meet as needed, but no less often than once per calendar quarter. Unless otherwise indicated in the Health Solutions New Mexico Act, the board is subject to and shall comply with statutes and rules applicable to state agencies, including the Administrative Procedures Act.

L. The board shall create the following advisory councils to provide the board with analyses and expert policy and program recommendations. At least once each year or as requested by the board, each council shall present its findings and make recommendations to the board on issues described below or those requested by the board. The councils shall include:

(1) a delivery system policy council consisting of representatives from health care providers, consumers and payers on issues regarding the delivery of health care, including access, quality, standardization, credentialing, health professional supply, prevention, public health, evidence-based and best practices, physician-directed and consumer-directed care, interdisciplinary team-based care directed by any licensed health professional, formulary or preferred drug list standardization, Native American health care delivery systems, community-based models, culturally specific health delivery, primary care, health information technology, public reporting of data and other elements necessary for the delivery of comprehensive quality care;

(2) a cost containment and finance council

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consisting of representatives from health insurers, employers, payers, providers, consumers and other health care financing managers or administrators on issues regarding health care costs, expenditures, reimbursement and cost containment;

(3) a benefits and services council consisting of public and private program consumers, health care advocates, employees, retirees, educators and high-risk and other plan members, including staff from the insurance division of the public regulation commission on issues regarding services; plans and benefits, including prevention and wellness; affordability guidelines; gender, racial and ethnic health care disparities, including women, children and families; and other issues affecting health care consumers;

(4) a federal issues review council consisting of representatives from entities impacted by federal policies to analyze, advise and make recommendations about federal statutes, rules and federal programs that have adverse impacts on or offer opportunities for health care and health coverage; and

(5) a Native American health care council consisting of tribal, pueblo and off-reservation Native American representatives to advise on issues regarding Native American health coverage and health care delivery, tribal and pueblo health care plans and programs, the Indian health service and the federal Indian Self Determination and Education

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Assistance Act; provided, however, that the authority may use an existing Native American advisory council created by a health-related state agency; and provided further that the existing council shall advise the authority, the human services department, the department of health, the aging and long-term services department, the children, youth and families department and the Indian affairs department as follows:

(a) advise the authority regarding parts of the comprehensive plan that define general strategies for increasing health coverage and improving health care for Native American residents of the state;

(b) identify priorities that need to be accomplished to further the purposes of the Health Solutions New Mexico Act for Native Americans;

(c) prepare and recommend on an annual basis sections of the authority comprehensive plan that will lead to: 1) achieving priorities identified by the Native American health care council; and 2) coordinating use of available funding to increase coverage of and improve health care delivery to Native Americans;

(d) disseminate information about successful programs providing Native American health coverage to encourage program replication;

(e) recommend to the New Mexico telehealth and health information technology commission and the

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authority methods to encourage the cooperative use of existing technology infrastructure and telehealth services to achieve health information use and exchange for submission and payment of claims for Native American providers and for electronic medical records for Native Americans;

(f) develop collaboration and information-sharing consistent with state and federal law regarding medical records and state-tribal agreements;

(g) advise the authority on existing or proposed joint powers agreements, memoranda of understanding or other agreements with tribes to further the purposes of the Health Solutions New Mexico Act;

(h) advise the authority on how to partner with tribal and public schools, schools administered by the federal bureau of Indian affairs, tribal and public colleges and universities and the Indian health service to create a stronger work force for Indian health; and

(i) work with the Native American subcommittee of the behavioral health planning council pursuant to Section 24-1-28 NMSA 1978 to advise the authority and other state agencies regarding methods for inclusion of prevention, treatment and recovery services for substance abuse and mental illness in any coverage programs or plans administered or recommended by the authority.

M. The board may make rules and conduct both

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rulemaking and adjudicatory hearings as a body or by use of a hearing officer.

N. Prior to any action by the board, the findings and recommendations of an advisory council presented to the board for action shall be open for public comment for a period of no less than thirty days. At the close of the public comment period, the board shall consider the findings and recommendations along with all public comments and may adopt, modify or reject the findings and recommendations of an advisory council. If the board modifies or denies any finding or recommendation of an advisory council established pursuant to this section, the board shall justify its decision based on substantial evidence in the public record. If an emergency requires action in a time frame that will not accommodate the time frames for public comment as indicated in this subsection, the action of the board shall be temporary until such time as the public comment period can occur and the board can consider the findings and recommendations of the advisory council.

O. The authority may request staff assistance from any state agency, particularly health-related agencies, to provide information or staffing of an advisory council, and the state agency shall provide such assistance to the extent resources are available.

Section 5. [NEW MATERIAL] EXECUTIVE DIRECTOR.--The governor, in consultation with the board, shall appoint an

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executive director of the authority, subject to confirmation by the senate. The appointed executive director shall serve as executive director-designee until the senate acts to confirm or not to confirm the appointee. The executive director shall have at least three years of management or administrative experience in the health care delivery, financing or coverage sector. The board, in consultation with the governor, shall develop a process for evaluation of the executive director's performance. The executive director shall carry on the day-to-day operations of the authority. The executive director shall not be terminated without consultation between the board and the governor.

Section 6. [NEW MATERIAL] HEALTH COVERAGE AUTHORITY--STAFF.--

A. The executive director shall employ those persons necessary to administer and implement the powers and duties of the authority. The employees of the authority are exempt from the Personnel Act. The executive director may contract with persons for professional services that require specialized knowledge or expertise or that are for short-term projects.

B. The executive director shall employ in a full-time position a Native American liaison to:

(1) provide a contact person to aid in communication between the authority and tribal communities or

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Native Americans residing in the state;

(2) provide training to the staff of the authority in protocol, culturally competent behaviors and cultural history to assist the authority in providing effective service to tribes;

(3) work with the tribes, tribal members, Native Americans living off-reservation and Native Americans representing off-reservation Native American populations to resolve issues that arise with actions or programs of the authority;

(4) work with providers that predominantly serve Native Americans on technical assistance requests, education, outreach and program and policy development;

(5) interact with other state agency tribal liaisons and attend meetings of legislative committees that are discussing issues that involve both the authority and the Native American communities in the state;

(6) suggest and implement, with the executive director's approval, efforts to improve the manner and outcome of interactions with tribes and Native American populations living in urban environments; and

(7) perform other duties as assigned by the executive director.

C. The executive director shall organize the staff into operational units to facilitate the authority's work,

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including:

(1) a health policy and research division to conduct studies, research and other data analyses to assist in the setting of standards and guidelines and in recommending policy and legislative changes;

(2) a plan management division to manage risk pools and health coverage programs administered by the authority;

(3) an outreach and education division to interact with the public, employers and employees, conduct outreach and education activities, including education about wellness, prevention and the benefits of health coverage, respond to inquiries and assist with policy advisory functions and groups; and

(4) an administrative services division to manage the budget, funds, premiums, contracts, accounting, information technology, human resources and other administrative activities.

D. As used in Subsection B of this section:

(1) "tribal" means of or belonging to a tribe; and

(2) "tribe" means a federally recognized Indian nation, tribe or pueblo located wholly or partly in New Mexico.

Section 7. [NEW MATERIAL] HEALTH COVERAGE AUTHORITY--

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DUTIES.--The authority shall:

A. by January 1, 2009:

(1) develop guidelines for benefits or services that will constitute coverage pursuant to Section 10 of the Health Solutions New Mexico Act; and

(2) develop guidelines for affordability of coverage and make recommendations regarding premium assistance or other subsidies that factor in the amount or percentage of household income spent on health care;

B. by July 1, 2009 and at least every three years thereafter, subsequent to obtaining and considering public input and in consultation with appropriate state agencies and the authority's advisory councils, develop a comprehensive plan that includes:

(1) recommendations to the governor, the legislature, the public regulation commission and other state agencies for policy, budgetary, regulatory or legislative actions necessary to increase health care coverage, access, health professional supply and quality of care;

(2) methods to address trends, factors and other elements to control health care costs, including preventing disease and improving care of persons with chronic health conditions, to help reduce demand for high-cost treatments and future costs;

(3) a comprehensive benefits or services plan

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that defines optimal coverage for persons living in New Mexico, taking into consideration individuals who turn to prayer, ceremonies, traditional healers or other spiritual or cultural practices for healing and wellness; and

(4) actions to be taken by the authority or other state entities, with expected completion dates and responsible parties, to accomplish the recommendations and actions identified in the comprehensive plan, subject to available appropriations and resources;

C. by September 1, 2010, submit a written report to the governor and legislature with findings and recommendations, after consideration of actuarial, solvency, fiscal and policy analyses, and after public and stakeholder input, about:

(1) whether or how to consolidate any actuarial pools, in whole or in part, that are administratively managed by the authority; and

(2) whether to allow employers with more than fifty qualifying employees to purchase coverage through any of these programs or pools;

D. annually, or as often as resources allow, conduct:

(1) studies and analyses of health care and health coverage functions and trends, including information on the cost and type of coverage available and obtained in the state;

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(2) household and employer surveys to ascertain the extent of coverage offered and participation rates; and

(3) studies and analyses of existing or proposed insurance benefit mandates imposed by law or rule;

E. by July 1, 2009 or as soon thereafter as possible, subject to available appropriations and other resources, provide one or more reports to the governor, the legislature and the public, including analyses and legal or policy implications of the following:

(1) the cost to employers, whether offering employer-sponsored insurance or not, of imposing a payroll tax to pay for or subsidize the cost of premiums;

(2) the cost of varying benefit or service plans, including different patient cost-sharing models;

(3) the cost to the general fund of full enrollment in Title 19 or Title 21 of the federal Social Security Act, including outreach and enrollment mechanisms designed to enroll all eligible individuals whether through public or private sources;

(4) nonmedical costs of coverage, including separation of health insurers' profit from administrative expenses;

(5) costs and implications of allowing nongovernmental employers to buy into risk pools administered

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by the authority for state or other public employees and retirees;

(6) costs and subsidies required to offer affordable coverage as defined by the authority to all persons living in the state;

(7) historical and ongoing costs and implications of reimbursement methodologies before and after the introduction of federal medicare advantage plans pursuant to Title 18 of the federal Social Security Act;

(8) impacts of the federal Employee Retirement Income Security Act of 1974, the federal tax code, the federal Social Security Act and other federal laws impacting health coverage and health care delivery, including the feasibility of additional waivers or state plan amendments pursuant to Title 19 or Title 21 of the federal Social Security Act;

(9) costs and implications of realigning the payment and training systems for licensed health professionals to create incentives for primary and preventive services rather than specialty and subspecialty care;

(10) costs and implications of moving from guaranteed issue in the individual market to a community rating system for all health insurance products;

(11) costs and implications of various methods of establishing rate ranges paid to providers of health care services, including adequacy of rates and rate ranges and the

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impact of current rates on health service delivery, access, health professional supply and outcomes;

(12) costs and implications of providers' choices about acceptance or refusal of payment from state, federal or joint state-federal programs and commercial insurance;

(13) cost implications to providers and health care access on public and private provider credentialing processes;

(14) disparities in disease rates and in access to health coverage and health care by gender, ethnicity, race, age, population health, language, cultural and other factors; and

(15) such other analyses as directed by the legislature or recommended by the authority's advisory councils and determined appropriate by the board; provided, however, that any item identified pursuant to this paragraph may be excluded from the second or subsequent plans if the item is not recognized as a pressing issue by a majority of the board based on public input and findings of the authority or any of the advisory councils;

F. in consultation or in conjunction with the insurance division of the public regulation commission, the department of health, the human services department, the higher education department or other appropriate state agency or

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governing body, develop or make recommendations regarding:

(1) performance standards for health insurers and providers;

(2) quality of care standards, including a payment incentive for performance or to improve health care outcomes;

(3) methods for increasing coverage of preventive services, disease management and wellness programs;

(4) health care practitioner training, recruitment and retention activities and incentives;

(5) consideration of having the authority assume or coordinate with the human services department on the management of health coverage programs pursuant to Title 19 or Title 21 of the federal Social Security Act, where appropriate and cost-effective for the beneficiaries of those programs and the public payers;

(6) the feasibility of allowing individuals to purchase a state medicaid-type product, with premiums based on income and affordability guidelines developed by the authority if the individual is not covered by commercial health coverage or otherwise eligible for publicly sponsored health coverage, employer-sponsored health coverage or premium assistance;

(7) legal, policy and fiscal feasibility or implications of allowing employers not otherwise eligible to purchase coverage pursuant to the Medical Insurance Pool Act or

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the Health Insurance Alliance Act to purchase coverage pursuant to the Group Benefits Act at rates based on the employer group's health status or claims experience but within the experience rating limitations pursuant to the Small Group Rate and Renewability Act;

(8) recommendations regarding portability of coverage, including the feasibility of developing a statewide insurance clearinghouse or exchange function within the authority for groups and individuals to purchase coverage and health insurers to offer coverage;

(9) the feasibility and options for implementation of risk equalization processes that can spread risk among health insurers that provide major medical policies to minimize adverse selection that can result from guaranteed issues of coverage products;

(10) data and information reporting requirements for health insurers across all health product lines to increase transparency and accountability; and

(11) education and training programs for health insurance brokers and agents that provide opportunities for them to offer state-sponsored or state-funded health coverage products;

G. administer and manage programs and funds for provision of coverage for small employers, public employees and retirees and persons with high risks, including making

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recommendations to the governor and the legislature regarding safeguards to protect the financial viability of funds dedicated to the health care needs of public employees, retirees and other beneficiaries of health coverage administered or overseen by the authority;

H. develop and administer transition or other health plans, benefits or services products to meet the needs of individuals covered by the plans administered by the authority or individuals who are awaiting coverage by public or private health plans for all or some health conditions;

I. provide materials, training, outreach activities, public service announcements and other media approaches to educate the general public about:

(1) the benefits of wellness, prevention and disease management activities;

(2) the benefits of health coverage for individuals, families and employers; and

(3) health coverage requirements and options for individuals, families, employers and other groups;

J. to the extent not otherwise required or available by law or rule, define, collect, monitor and report:

(1) quality data of providers, including adverse incident reporting and hospital infection rates, and common data reporting for health insurers, ensuring that individual patient information is protected and remains

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confidential; and

(2) data about health care costs, quality and access across all sectors of the health care field, ensuring that individual patient information and corporate proprietary information is protected and remains confidential;

K. promote consumer access to and information about innovative, efficacious and cost-effective pharmaceuticals;

L. to the extent not otherwise required or available by law or rule, provide an alternative dispute resolution process for provider complaint resolution without intrusion into the contractual relationship between a payer and a provider;

M. enter into joint powers or other agreements with Native American tribes or pueblos, which may include data-sharing agreements, to improve health care or encourage coverage of tribal or pueblo members; and

N. report quarterly to the governor, the legislature and the public on performance measures set by the authority.

Section 8. [NEW MATERIAL] IMMUNITY FROM LIABILITY FOR BROKERS AND AGENTS.--Health insurance brokers and agents that participate in training about state-sponsored or state-funded health coverage products that are certified by the authority as having participated in such training shall not be liable for any action associated with offering those products so long as

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they are acting in good faith and in accordance with the training received.

Section 9. [NEW MATERIAL] REPORTING AND USE OF DATA.--

A. Health insurers, providers and employers shall report to the authority such data about health coverage, services delivered, incidents and infection rates and outcomes achieved in a format required or approved by the authority after consultation with other state entities authorized to collect related data.

B. Data reported shall be in aggregate form except where patient-specific data is necessary to provide unduplicated information. Data shall be reported electronically to the extent possible. The authority shall use and report data received only in aggregate form and shall not use or release any individual-identifying information or corporate proprietary information for any purpose except as provided by state or federal law or by court order.

C. In developing such data reporting requirements, the authority shall seek and consider input from health insurers, providers, employers, advisory councils created pursuant to Section 4 of the Health Solutions New Mexico Act and the public regarding the format, timing and method of transmission of data to prevent duplicative reporting and to make reporting of data the least burdensome possible while achieving the purposes of that act.

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D. The authority may use data collected by provider associations or other entities and shall not request data already collected by and available from other state agencies.

Section 10. [NEW MATERIAL] REQUIREMENT TO SHOW PROOF OF HEALTH CARE COVERAGE.--

A. Beginning January 1, 2010, every person living in New Mexico shall provide:

(1) proof of health coverage in a public or private health care coverage plan or program;

(2) proof of financial responsibility for health care services; or

(3) a statement objecting to coverage for religious reasons.

B. Proof of health coverage shall meet guidelines for coverage set by the authority and shall be provided upon new or renewal application for a driver's license or a professional, recreational or other license issued by the state; upon filing of income tax returns; upon employment with an employer required to report pursuant to this subsection; or upon registration or enrollment in a public or private school, college or university in the state.

C. Information about individuals unable to provide the proof required pursuant to Subsection A of this section shall be reported to the authority in a format required by the authority. Notwithstanding the provisions of Subsections A and

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B of this section, this information shall be used only for purposes of outreach and connection to health coverage options for those individuals unable to show proof of coverage, unless or until legislative action is taken on recommendation of the authority pursuant to Subsection F of this section.

D. Beginning July 1, 2009, the authority shall identify individuals in the state that do not have health care coverage. The authority may identify these individuals through coordination with appropriate governing bodies and state agencies upon new or renewal application for a driver's license or a professional, recreational or other license issued by the state; upon filing of income tax returns; upon employment with an employer required to report pursuant to this subsection; or upon registration or enrollment in a public or private school, college or university in the state. The authority shall provide assistance, education and outreach to individuals that do not have health care coverage and shall report annually about the number of individuals unable to provide proof of health coverage.

E. By July 1, 2010, the authority shall develop procedures to verify that the following individuals have coverage:

(1) individuals living in households with incomes greater than four hundred percent of the federal poverty level; and

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(2) children in households with incomes less than three hundred percent of the federal poverty level who are eligible for public programs pursuant to Title 19 or Title 21 of the federal Social Security Act.

F. By July 1, 2010, the authority shall make recommendations to the governor and the legislature regarding enforcement mechanisms for noncompliance with the requirement in Subsection A of this section, taking into account guidelines established by the authority regarding coverage and affordability pursuant to Section 7 of the Health Solutions New Mexico Act.

G. Individuals in households with incomes less than three hundred percent of the federal poverty level shall not be required to purchase or enroll in health care coverage unless coverage is offered through the individual's employer, available through a public program or otherwise affordable based on guidelines developed by the authority.

H. Nothing in this section shall require adults who object to obtaining health coverage for religious reasons to obtain or provide proof of such coverage. Such adults may sign a declaration of religious objection with any entity requiring proof of coverage. A parent may not object to or refuse to provide proof of coverage for the parent's children, regardless of the parent's religious belief.

Section 11. [NEW MATERIAL] HEALTHY NEW MEXICO WORK FORCE

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FUND CREATED.--

A. The "healthy New Mexico work force fund" is created in the state treasury. The fund and any income produced by the fund shall be deposited in a segregated account and invested by the state investment council 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 any general or special obligation or debt of the state, other than as authorized by this section.

B. The fund shall consist of money appropriated to the fund, income from investment of the fund, employers' contributions, employees' contributions, insurance or reinsurance proceeds and other funds received by gift, grant, bequest or otherwise for deposit in the fund, including refunds from health insurers, all of which are appropriated to and for the purposes of the fund.

C. Disbursements from the fund shall be made by warrant signed by the secretary of finance and administration upon vouchers signed by the executive director of the authority.

D. Subject to appropriation by the legislature, money in the fund shall be used to fund outreach and pay for health care premiums or services through publicly authorized programs to expand coverage or as otherwise provided by law. Any unexpended or unencumbered balance remaining in the fund at

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the end of any fiscal year shall not revert.

Section 12. [NEW MATERIAL] EMPLOYER CONTRIBUTIONS TO THE FUND.--

A. Beginning January 1, 2010, each employer that has an average of six or more employees in a previous calendar year, and beginning January 1, 2011, each employer, regardless of the number of employees, shall make an annual contribution not to exceed five hundred dollars ($500) for each full-time employee and two hundred fifty dollars ($250) for each part-time employee, subject to a maximum annual adjustment based on the medical price index component of the federal department of labor's consumer price index, per employee. The amount of the contribution shall be set annually by the authority.

B. Employers shall calculate the contribution to the fund for the previous calendar year. Upon submission of a tax return or other form required by the taxation and revenue department, an employer shall multiply the number of full-time employees and the number of part-time employees that worked more than ninety days in the previous calendar year by the amount set for each employee by the authority. The employer shall subtract the total amount paid toward the cost of health coverage or health care of all of its employees during the calendar year for which it is filing a return from the contribution amount calculated for all the employees. If the

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total is zero or less, the employer shall pay nothing. If the total is more than zero, the employer shall pay the amount calculated.

C. The taxation and revenue department shall collect amounts calculated and contributed by employers as described in this section and shall deposit those funds into the fund.

D. An employer shall demonstrate that the employer has offered its employees for whom the employer does not offer a health insurance plan a pre-tax health coverage option pursuant to Section 125 of the federal Internal Revenue Code of 1986, whether or not the employer chooses to pay any portion of the health coverage premium or costs.

E. An employer shall collect and report to the authority information about the health coverage of its employees in a format and time frame developed by the authority.

F. Notwithstanding the provisions of this section, tribes and pueblos as employers are exempt from the fund contribution requirement and are precluded from receiving assistance from the fund, although individual tribal and pueblo members may receive assistance in obtaining coverage or services from the fund, if they are otherwise eligible.

G. Notwithstanding the provisions of Section 7-1-8 NMSA 1978, the taxation and revenue department may provide

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information to the authority pursuant to this section.

H. For purposes of this section:

(1) "full-time employee" means an employee who works or is expected to work an average of more than twenty hours per week;

(2) "health care" means the diagnosis or treatment of an illness or injury; and

(3) "part-time employee" means an employee who works or is expected to work an average of no more than twenty hours per week.

Section 13. 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~~] board of directors of the health coverage authority;

B. "director" means the executive director of the [~~risk management division of the general services department~~] health coverage authority;

C. "employee" means a salaried officer, employee or legislator of the state; a salaried officer or an employee of a local public body; or an elected or appointed supervisor of a soil and water conservation district;

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

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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 14. Section 10-7C-4 NMSA 1978 (being Laws 1990, 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~~] health coverage authority [~~created pursuant to the Retiree Health Care Act~~];

C. "basic plan of benefits" means only those

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coverages generally associated with a medical plan of benefits;

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

E. "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;

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 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

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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 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) a dependent child over nineteen 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; 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;

(5) 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~~]

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(6) a surviving dependent child who is the dependent child of a deceased eligible retiree whose other parent is also deceased; or

(7) an individual who would qualify as an employee's dependent pursuant to the provisions of a participating employer's health insurance benefit plan had the employee not retired;

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 authority, 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 member", which means a person who is not a retiree and who:

(a) has served without salary as a

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member of the governing authority 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;

(b) has maintained group health insurance coverage through that member's governing authority 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; 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 authority to participate in the program;

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

(a) has served with salary as a member of the governing authority 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, if such group health insurance was available and offered to the member

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during the member's service as a member of the governing authority; 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 authority to participate in the program;

(3) an "eligible participating retiree", which means a person who:

(a) falls within the definition of a retiree, has made contributions to the 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 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

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retiree by the educational retirement director, the executive secretary of the public employees retirement association or the governing authority 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 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~~] the retiree's 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 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

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the educational retirement director, the executive director of the public employees retirement board or the governing authority of an independent public employer;

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

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

I. "fund" means the retiree health care 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

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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 to be advisable;

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;

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;

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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:

(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 15. Section 22-29-3 NMSA 1978 (being Laws 1986,

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Chapter 94, Section 3, as amended by Laws 2007, Chapter 41, Section 1 and by Laws 2007, Chapter 236, Section 1) 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 for purposes of risk-related coverage and the health coverage authority for purposes of group health insurance;

B. "board" means the board of directors of the public school insurance authority for purposes of risk-related coverage and the board of directors of the health coverage authority for purposes of group health insurance;

C. "charter school" means a school organized as a charter school pursuant to the provisions of the Charter Schools Act;

D. "director" means the director of the public school insurance authority for purposes of risk-related coverage and the executive director of the health coverage authority for purposes of group health insurance;

E. "due process reimbursement" means the reimbursement of a school district's or charter school's expenses for attorney fees, hearing officer fees and other reasonable expenses incurred as a result of a due process hearing conducted pursuant to the federal Individuals with Disabilities Education Improvement Act;

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F. "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, regional education cooperatives and nonprofit organizations dedicated to the improvement of public education and whose membership is composed exclusively of public school employees, public schools or school districts;

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

H. "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;

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

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

Section 16. 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

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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 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 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 contract shall be disbursed to the individual school districts, charter schools and other participating entities on a pro rata basis.

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F. Disbursements from the fund for purposes other than procuring and paying for insurance or insurance-related services, including [~~but not limited to~~] third-party administration, premiums, claims and cost containment activities, shall be made only upon warrant drawn by the secretary of finance and administration pursuant to vouchers signed by the director or [~~his~~] the director's designee; provided that the [~~chairman~~] chair of the board may sign vouchers if the position of director is vacant.

G. On and after July 1, 2010, the fund shall consist of two accounts: the "risk account" and the "group health insurance account". All premiums related to risk insurance shall be deposited into the risk account and all expenditures related to risk insurance shall be made from the risk account. All premiums related to group health insurance shall be deposited into the group health insurance account and all expenditures related to group health insurance shall be made from the group health insurance account. On July 1, 2010, the secretary of finance and administration, with the advice of the public school insurance authority and the health coverage authority, shall determine the initial balance of each account."

Section 17. Section 59A-22-5 NMSA 1978 (being Laws 1984, Chapter 127, Section 426, as amended) is amended to read:

"59A-22-5. TIME LIMIT ON CERTAIN DEFENSES.--

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A. There shall be a provision for comprehensive major medical policies as follows: As of the date of issue of this policy, no misstatements, except willful or fraudulent misstatements, made by the applicant in the application for this policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy.

[~~A.~~] B. There shall be a provision for policies other than comprehensive major medical policies as follows: After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for [~~such~~] this policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such two-year period.

C. The foregoing policy [~~provision~~] provisions shall not be so construed as to affect any initial two-year period nor to limit the application of Sections 59A-22-17 through 59A-22-19, 59A-22-21 and 59A-22-22 NMSA 1978 in the event of misstatement with respect to age or occupation or other insurance.

D. A policy [~~which~~] that the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age fifty or (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing

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the following provision, from which the clause in parentheses may be omitted at the insurance company's option, under the caption "Incontestable":

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled) it shall become incontestable as to the statements contained in the application.

[~~B.~~] E. For individual policies that do not reimburse or pay as a result of hospitalization, medical or surgical expenses, no claim for loss incurred or disability, as defined in the policy, shall be reduced or denied on the ground that a disease or physical condition disclosed on the application and not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy. As an alternative, those policies may contain provisions under which coverage may be excluded for a period of six months following the effective date of coverage as to a given covered insured for a preexisting condition, provided that:

(1) the condition manifested itself within a period of six months prior to the effective date of coverage in [~~such~~] a manner [~~as~~] that would cause a reasonably prudent person to seek diagnosis, care or treatment; or

(2) medical advice or treatment relating to

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the condition was recommended or received within a period of six months prior to the effective date of coverage.

[~~C.~~] F. Individual policies that reimburse or pay as a result of hospitalization, medical or surgical expenses may contain provisions under which coverage is excluded during a period of six months following the effective date of coverage as to a given covered insured for a preexisting condition, provided that:

(1) the condition manifested itself within a period of six months prior to the effective date of coverage in [~~such~~] a manner [~~as~~] that would cause a reasonably prudent person to seek diagnosis, care or treatment; or

(2) medical advice or treatment relating to the condition was recommended or received within a period of six months prior to the effective date of coverage.

[~~D.~~] G. The preexisting condition exclusions authorized in Subsections [~~B and C~~] E and F of this section shall be waived to the extent that similar conditions have been satisfied under any prior health insurance coverage if the application for new coverage is made not later than thirty-one days following the termination of prior coverage. In that case, the new coverage shall be effective from the date on which the prior coverage terminated.

[~~E.~~] H. Nothing in this section shall be construed to require the use of preexisting conditions or prohibit the

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use of preexisting conditions that are more favorable to the insured than those specified in this section."

Section 18. Section 59A-23B-3 NMSA 1978 (being Laws 1991, Chapter 111, Section 3, as amended) is amended to read:

"59A-23B-3. POLICY OR PLAN--DEFINITION--CRITERIA.--

A. For purposes of the Minimum Healthcare Protection Act, "policy or plan" means a healthcare benefit policy or healthcare benefit plan that the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan chooses to offer to individuals, families or groups of fewer than twenty members formed for purposes other than obtaining insurance coverage and that meets the requirements of Subsection B of this section. For purposes of the Minimum Healthcare Protection Act, "policy or plan" shall not mean a healthcare policy or healthcare benefit plan that an insurer, health maintenance organization, fraternal benefit society or nonprofit healthcare plan chooses to offer outside the authority of the Minimum Healthcare Protection Act.

B. A policy or plan shall meet the following criteria:

(1) the individual, family or group obtaining coverage under the policy or plan has been without healthcare insurance, a health services plan or employer-sponsored healthcare coverage for the six-month period immediately preceding the effective date of its coverage under a policy or

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plan, provided that the six-month period shall not apply to:

(a) a group that has been in existence for less than six months and has been without healthcare coverage since the formation of the group;

(b) an employee whose healthcare coverage has been terminated by an employer;

(c) a dependent who no longer qualifies as a dependent under the terms of the contract; or

(d) an individual and an individual's dependents who no longer have healthcare coverage as a result of termination or change in employment of the individual or by reason of death of a spouse or dissolution of a marriage, notwithstanding rights the individual or individual's dependents may have to continue healthcare coverage on a self-pay basis pursuant to the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985;

(2) the policy or plan includes the following managed care provisions to control costs:

(a) an exclusion for services that are not medically necessary or are not covered by preventive health services; and

(b) a procedure for preauthorization of elective hospital admissions by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan; and

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(3) subject to a maximum limit on the cost of healthcare services covered in any calendar year of not less than fifty thousand dollars ($50,000) and, effective for policies written or renewed on or after January 1, 2009, of not less than one hundred thousand dollars ($100,000), adjusted for changes not to exceed the medical price index component of the federal department of labor's consumer price index at intervals and in a manner established by rule pursuant to the Minimum Healthcare Protection Act, the policy or plan provides the following minimum healthcare services to covered individuals:

(a) inpatient hospitalization coverage or home care coverage in lieu of hospitalization or a combination of both, not to exceed twenty-five days of coverage inclusive of any deductibles, co-payments or co-insurance; provided that a period of inpatient hospitalization coverage shall precede any home care coverage;

(b) prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy and one office visit per week during the ninth month and until term; provided that coverage for each office visit shall also include prenatal counseling and education and necessary and appropriate screening, including history, physical examination and the laboratory and diagnostic procedures deemed appropriate by the

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physician based upon recognized medical criteria for the risk group of which the patient is a member;

(c) obstetrical care, including physicians' and certified nurse-midwives' services, delivery room and other medically necessary services directly associated with delivery;

(d) well-baby and well-child care, including periodic evaluation of a child's physical and emotional status, a history, a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards; provided that such evaluation and care shall be covered when performed at approximately the age intervals of birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years and six years;

(e) coverage for low-dose screening mammograms for determining the presence of breast cancer; provided that the mammogram coverage shall include one baseline mammogram for persons age thirty-five through thirty-nine years, one biennial mammogram for persons age forty through forty-nine years and one annual mammogram for persons age fifty years and over; and further provided that the mammogram coverage shall only be subject to deductibles and co-insurance requirements consistent with those imposed on other benefits

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under the same policy or plan;

(f) coverage for cytologic screening, to include a Papanicolaou test and pelvic exam for asymptomatic as well as symptomatic women;

(g) a basic level of primary and preventive care, including no less than seven physician, nurse practitioner, nurse-midwife or physician assistant office visits per calendar year, including any ancillary diagnostic or laboratory tests related to the office visit;

(h) coverage for childhood immunizations, in accordance with the current schedule of immunizations recommended by the American academy of pediatrics, including coverage for all medically necessary booster doses of all immunizing agents used in childhood immunizations; provided that coverage for childhood immunizations and necessary booster doses may be subject to deductibles and co-insurance consistent with those imposed on other benefits under the same policy or plan; and

(i) coverage for smoking cessation treatment.

C. A policy or plan may include the following managed care and cost control features to control costs:

(1) a panel of providers who have entered into written agreements with the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan to

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provide covered healthcare services at specified levels of reimbursement; provided that such written agreement shall contain a provision relieving the individual, family or group covered by the policy or plan from an obligation to pay for a healthcare service performed by the provider that is determined by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan not to be medically necessary;

(2) a requirement for obtaining a second opinion before elective surgery is performed;

(3) a procedure for utilization review by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan; and

(4) a maximum limit on the cost of healthcare services covered in a calendar year of not less than fifty thousand dollars ($50,000) and, effective for policies written or renewed on or after January 1, 2009, of not less than one hundred thousand dollars ($100,000), adjusted for changes not to exceed the medical price index component of the federal department of labor's consumer price index at intervals and in a manner established by rule pursuant to the Minimum Healthcare Protection Act.

D. Nothing contained in Subsection C of this section shall prohibit an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan

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from including in the policy or plan additional managed care and cost control provisions that the superintendent determines to have the potential for controlling costs in a manner that does not cause discriminatory treatment of individuals, families or groups covered by the policy or plan.

E. Notwithstanding any other provisions of law, a policy or plan shall not exclude coverage for losses incurred for a preexisting condition more than six months from the effective date of coverage. The policy or plan shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment recommended by or received from a physician within six months before the effective date of coverage.

F. A medical group, independent practice association or health professional employed by or contracting with an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan shall not maintain an action against an insured person, family or group member for sums owed by an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan that are higher than those agreed to pursuant to a policy or plan."

Section 19. Section 59A-23C-5 NMSA 1978 (being Laws 1991, Chapter 153, Section 5, as amended) is amended to read:

"59A-23C-5. RESTRICTIONS RELATING TO PREMIUM RATES.--

A. Premium rates for health benefit plans subject

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to the Small Group Rate and Renewability Act shall be subject to the following provisions:

(1) the index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than [~~twenty percent~~] the following percentages for policies issued or delivered in the respective year:

(a) twenty percent through December 31, 2008;

(b) eighteen percent for calendar year 2009;

(c) sixteen percent for calendar year 2010;

(d) fourteen percent for calendar year 2011;

(e) twelve percent for calendar year 2012; and

(f) ten percent for every year thereafter;

(2) for a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business, shall not vary from the index rate by more than [~~twenty percent of the index rate~~] the

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following percentages of the index rate for policies issued or delivered in the respective year:

(a) twenty percent through December 31, 2008;

(b) eighteen percent for calendar year 2009;

(c) sixteen percent for calendar year 2010;

(d) fourteen percent for calendar year 2011;

(e) twelve percent for calendar year 2012; and

(f) ten percent for every year thereafter;

(3) the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

(b) an adjustment, not to exceed ten percent annually and adjusted pro rata for rating periods of

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less than one year due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

(c) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business; and

(4) in the case of health benefit plans issued prior to the effective date of the Small Group Rate and Renewability Act, a premium rate for a rating period may exceed the ranges described in Paragraph (1) or (2) of this subsection for a period of five years following the effective date of the Small Group Rate and Renewability Act. In that case, the percentage increase in the premium rate charged to a small employer in that class of business for a new rating period may not exceed the sum of the following:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(b) any adjustment due to change in coverage or change in the case characteristics of the small

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employer as determined from the carrier's rate manual for the class of business.

B. Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

C. A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue.

D. Prior to usage and June 14, 1991, each carrier shall file with the superintendent the rate manuals and any updates thereto for each class of business. A rate filing fee is payable under Subsection U of Section 59A-6-1 NMSA 1978 for the filing of each update. The superintendent shall disapprove within sixty days of receipt of a complete filing or the filing is deemed approved. If the superintendent disapproves the form during the sixty-day review period, [~~he~~] the superintendent shall give the carrier written notice of the disapproval

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stating the reasons for disapproval. At any time, the superintendent, after a hearing, may disapprove a form or withdraw a previous approval. The superintendent's order after the hearing shall state the grounds for disapproval or withdrawal of a previous approval and the date not less than twenty days later when disapproval or withdrawal becomes effective."

Section 20. Section 59A-23E-5 NMSA 1978 (being Laws 1997, Chapter 243, Section 5, as amended) is amended to read:

"59A-23E-5. GROUP HEALTH PLAN--RULES FOR CREDITING PREVIOUS COVERAGE.--

A. A period of creditable coverage shall not be counted with respect to enrollment of an individual under a group health plan if, after the period and before the enrollment date, there was a [~~sixty-three-day~~] ninety-five-day continuous period during which the individual was not covered under any creditable coverage.

B. In determining the continuous period for the purpose of Subsection A of this section, any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period shall not be counted."

Section 21. Section 59A-54-3 NMSA 1978 (being Laws 1987, Chapter 154, Section 3, as amended) is amended to read:

"59A-54-3. DEFINITIONS.--As used in the Medical Insurance

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Pool Act:

A. "board" means the board of directors of the pool and, effective July 1, 2010, the health coverage authority;

B. "creditable coverage" means, with respect to an individual, coverage of the individual pursuant to:

(1) a group health plan;

(2) health insurance coverage;

(3) Part A or Part B of Title 18 of the Social Security Act;

(4) Title 19 of the Social Security Act except coverage consisting solely of benefits pursuant to Section 1928 of that title;

(5) 10 USCA Chapter 55;

[~~(6) a medical care program of the Indian health service or of an Indian nation, tribe or pueblo;~~

~~(7)~~] (6) the Medical Insurance Pool Act;

[~~(8)~~] (7) a health plan offered pursuant to 5 USCA Chapter 89;

[~~(9)~~] (8) a public health plan as defined in federal regulations; or

[~~(10)~~] (9) a health benefit plan offered pursuant to Section 5(e) of the federal Peace Corps Act;

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

(1) for whom, as of the date on which the

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individual seeks coverage under the Medical Insurance Pool Act, the aggregate of the periods of creditable coverage is eighteen or more months;

(2) whose most recent prior creditable coverage was under a group health plan, [~~government~~] governmental plan, church plan or health insurance coverage, as such plan or coverage is defined in Section 59A-23E-2 NMSA 1978, offered in connection with such a plan;

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

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

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

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

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

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

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

G. "health maintenance organization" means any person who provides, at a minimum, either directly or through contractual or other arrangements with others, basic health

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care services to enrollees on a fixed prepayment basis and who is responsible for the availability, accessibility and quality of the health care services provided or arranged, or as defined by Subsection M of Section 59A-46-2 NMSA 1978;

H. "health plan" means any arrangement by which persons, including dependents or spouses, covered or making application to be covered under the pool have access to hospital and medical benefits or reimbursement, including group or individual insurance or subscriber contract; coverage through health maintenance organizations, preferred provider organizations or other alternate delivery systems; coverage under prepayment, group practice or individual practice plans; coverage under uninsured arrangements of group or group-type contracts, including employer self-insured, cost-plus or other benefits methodologies not involving insurance or not subject to New Mexico premium taxes; coverage under group-type contracts that are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by medicare or other governmental benefits. "Health plan" includes coverage through health insurance;

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

J. "insurer" means an insurance company

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

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

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

M. "preexisting condition" means a physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended for or received by an applicant within six months before the effective date of coverage, except that pregnancy is not considered a preexisting condition for a federally defined eligible individual; and

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

Section 22. Section 59A-54-4 NMSA 1978 (being Laws 1987, Chapter 154, Section 4, as amended) is amended to read:

"59A-54-4. POOL CREATED--BOARD.--

A. [~~There is created a nonprofit entity to be known as~~] The "New Mexico medical insurance pool" is created.

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All insurers shall organize and remain members of the pool as a condition of their authority to transact insurance business in this state. [~~The board is a governmental entity for purposes of the Tort Claims Act.~~

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

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

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~~D. The members of the board appointed by the members of the pool shall be appointed for initial terms of four years or less, staggered so that the term of one member shall expire on June 30 of each year. The members of the board appointed by the superintendent shall be appointed for initial terms of five years or less, staggered so that the term of one member expires on June 30 of each year. Following the initial terms, members of the board shall be appointed for terms of three years. If the members of the pool fail to make the initial appointments required by this subsection within sixty days following the first organizational meeting, the superintendent shall make those appointments. Whenever a vacancy on the board occurs, the superintendent shall fill the vacancy by appointing a person to serve the balance of the unexpired term. The person appointed shall meet the requirements for initial appointment to that position. Members of the board may be reimbursed from the pool subject to the limitations provided by the Per Diem and Mileage Act and shall receive no other compensation, perquisite or allowance.~~

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

[~~F.~~] D. The superintendent shall, after notice and hearing, approve the plan of operation, provided it is

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

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

Section 23. 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

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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~~] a health plan that provides coverage for comprehensive major medical or comprehensive physician and hospital services;

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

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

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

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

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

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

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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

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

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

(1) a person's eligibility for a policy issued under the Health Insurance Alliance Act 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

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

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

E. Except for a person eligible as provided in Paragraph (7) of Subsection A of this section, a pool policy may contain provisions under which coverage is excluded during a six-month period following the effective date of coverage as to a given individual for preexisting conditions. An individual who voluntarily terminated a previous policy, including termination for nonpayment of premium, shall have a six-month waiting period 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~~] sixty-three 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

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the pool if:

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

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

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

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

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

(6) the most recent coverages within the coverage period described in Paragraph (7) of Subsection A of this section were terminated as a result of nonpayment of premium or fraud; or

(7) the individual has been offered the option of continuation coverage under a federal COBRA

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continuation provision as defined in Subsection F of Section 59A-23E-2 NMSA 1978 or under a similar state program and [~~he~~] the individual has elected the coverage and did not exhaust the continuation coverage under the provision or program, provided, however, that an unemployed former employee who has not exhausted COBRA coverage shall be eligible.

H. Any person whose health insurance coverage from a qualified state high-risk pool 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~~] sixty-three 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. Except for a federally defined eligible individual, an individual terminated from an individual or group policy, other than a high-risk pool policy, due to nonresidency in another state, shall obtain a termination notice, documentation of a quote for coverage at a rate higher than one hundred twenty-five percent of the pool's standard rate or be otherwise determined eligible before receiving coverage under the pool policy.

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

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

Section 24. Section 59A-54-16 NMSA 1978 (being Laws 1987, Chapter 154, Section 16, as amended) is amended to read:

"59A-54-16. POOL POLICY.--

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

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

C. In the case of a small group policy, a pool policy offered under the Medical Insurance Pool Act shall provide covered family members the right to continue the policy as the named insured or through a conversion policy upon the death of the named insured or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the named insured by election to do so within

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a period of time specified in the contract subject to the requirements of this section [~~59A-54-16 NMSA 1978~~]."

Section 25. Section 59A-56-3 NMSA 1978 (being Laws 1994, Chapter 75, Section 3, as amended) is amended to read:

"59A-56-3. DEFINITIONS.--As used in the Health Insurance Alliance Act:

A. "alliance" means the New Mexico health insurance alliance;

B. "approved health plan" means any arrangement for the provisions of health insurance offered through and approved by the alliance;

C. "board" means the board of directors of the [~~alliance~~] health coverage authority;

D. "child" means a dependent unmarried individual who is less than twenty-five years of age;

E. "creditable coverage" means, with respect to an individual, coverage of the individual pursuant to:

(1) a group health plan;

(2) health insurance coverage;

(3) Part A or Part B of Title 18 of the federal Social Security Act;

(4) Title 19 of the federal Social Security Act except coverage consisting solely of benefits pursuant to Section 1928 of that title;

(5) 10 USCA Chapter 55;

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[~~(6) a medical care program of the Indian health service or of an Indian nation, tribe or pueblo;~~

~~(7)~~] (6) the Medical Insurance Pool Act;

[~~(8)~~] (7) a health plan offered pursuant to 5 USCA Chapter 89;

[~~(9)~~] (8) a public health plan as defined in federal regulations; or

[~~(10)~~] (9) a health benefit plan offered pursuant to Section 5(e) of the federal Peace Corps Act;

F. "department" means the insurance division of the commission;

G. "director" means an individual who serves on the board;

H. "earned premiums" means premiums paid or due during a calendar year for coverage under an approved health plan less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year;

I. "eligible expenses" means the allowable charges for a health care service covered under an approved health plan;

J. "eligible individual":

(1) means an individual who:

(a) as of the date of the individual's application for coverage under an approved health plan, has

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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 those plans are defined in Subsections P, N and D of Section 59A-23E-2 NMSA 1978, respectively, or health insurance offered in connection with any of those plans, but 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 an approved health plan 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

(b) is entitled to continuation coverage pursuant to Section 59A-56-20 or 59A-23E-19 NMSA 1978; and

(2) does not include an individual who:

(a) has or is eligible for coverage under a group health plan;

(b) is eligible for coverage under medicare or a state plan under Title 19 of the federal Social Security Act or any successor program;

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

(d) during the most recent coverage within the coverage period described in Subparagraph (a) of

Paragraph (1) of this subsection was terminated from coverage as a result of nonpayment of premium or fraud; or

(e) has been offered the option of coverage under a COBRA continuation provision as that term is defined in Subsection F of Section 59A-23E-2 NMSA 1978, or under a similar state program, except for continuation coverage under Section 59A-56-20 NMSA 1978, and did not exhaust the coverage available under the offered program;

K. "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for that enrollment;

L. "gross earned premiums" means premiums paid or due during a calendar year for all health insurance written in the state less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year;

M. "group health plan" means an employee welfare benefit plan to the extent the plan provides hospital, surgical or medical expenses benefits to employees or their dependents, as defined by the terms of the plan, directly through insurance, reimbursement or otherwise;

N. "health care service" means a service or product furnished an individual for the purpose of

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preventing, alleviating, curing or healing human illness or injury and includes services and products incidental to furnishing the described services or products;

O. "health insurance" means "health" insurance as defined in Section 59A-7-3 NMSA 1978; any hospital and medical expense-incurred policy; nonprofit health care plan service contract; health maintenance organization subscriber contract; short-term, accident, fixed indemnity, specified disease policy or disability income insurance contracts and limited health benefit or credit health insurance; coverage for health care services under uninsured arrangements of group or group-type contracts, including employer self-insured, cost-plus or other benefits methodologies not involving insurance or not subject to New Mexico premium taxes; coverage for health care services under group-type contracts that are not available to the general public and can be obtained only because of connection with a particular organization or group; coverage by medicare or other governmental programs providing health care services; but "health insurance" does not include insurance issued pursuant to provisions of the Workers' Compensation Act or similar law, automobile medical payment insurance or provisions by which benefits are payable with or without regard to fault and are required by law to be contained in any liability insurance policy;

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P. "health maintenance organization" means a health maintenance organization as defined by Subsection M of Section 59A-46-2 NMSA 1978;

Q. "incurred claims" means claims paid during a calendar year plus claims incurred in the calendar year and paid prior to April 1 of the succeeding year, less claims incurred previous to the current calendar year and paid prior to April 1 of the current year;

R. "insured" means a small employer or its employee and an individual covered by an approved health plan, a former employee of a small employer who is covered by an approved health plan through conversion or an individual covered by an approved health plan that allows individual enrollment;

S. "medicare" means coverage under both Parts A and B of Title 18 of the federal Social Security Act;

T. "member" means a member of the alliance;

U. "nonprofit health care plan" means a health care plan as defined in Subsection K of Section 59A-47-3 NMSA 1978;

V. "premiums" means the premiums received for coverage under an approved health plan during a calendar year;

W. "small employer" means a person that is a resident of this state, has employees at least fifty percent

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of whom are residents of this state, is actively engaged in business and that on at least fifty percent of its working days during either of the two preceding calendar years, employed no fewer than two and no more than fifty eligible employees; provided that:

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

(2) companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state income taxation shall be considered one employer; and

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

X. "superintendent" means the superintendent of insurance;

Y. "total premiums" means the total premiums for business written in the state received during a calendar year; and

Z. "unearned premiums" means the portion of a premium previously paid for which the coverage period is in

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the future."

Section 26. Section 59A-56-4 NMSA 1978 (being Laws 1994, Chapter 75, Section 4, as amended) is amended to read:

"59A-56-4. ALLIANCE CREATED [~~BOARD CREATED~~].--

A. The "New Mexico health insurance alliance" is created [~~as a nonprofit public corporation~~] for the purpose of providing increased access to health insurance in the state. All insurance companies authorized to transact health insurance business in this state, nonprofit health care plans, health maintenance organizations and self-insurers not subject to federal preemption shall organize and be members of the alliance as a condition of their authority to offer health insurance in this state, except for an insurance company that is licensed under the Prepaid Dental Plan Law or a company that is solely engaged in the sale of dental insurance and is licensed under a provision of the Insurance Code.

[~~B. The alliance shall be governed by a board of directors constituted pursuant to the provisions of this section. The board is a governmental entity for purposes of the Tort Claims Act, but neither the board nor the alliance shall be considered a governmental entity for any other purpose.~~

~~C. Each member shall be entitled to one vote in person or by proxy at each meeting.~~

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~~D.~~] B. The alliance shall operate subject to the supervision and approval of the board. [~~The board shall consist of:~~

~~(1) five directors, elected by the members, who shall be officers or employees of members and shall consist of two representatives of health maintenance organizations and three representatives of other types of members;~~

~~(2) five directors, appointed by the governor, who shall be officers, general partners or proprietors of small employers, one director of which shall represent nonprofit corporations;~~

~~(3) four directors, appointed by the governor, who shall be employees of small employers; and~~

~~(4) the superintendent or the superintendent's designee, who shall be a nonvoting member, except when the superintendent's vote is necessary to break a tie.~~

~~E. The superintendent shall serve as chairman of the board unless the superintendent declines, in which event the superintendent shall appoint the chairman.~~

~~F. The directors elected by the members shall be elected for initial terms of three years or less, staggered so that the term of at least one director expires on June 30 of each year. The directors appointed by the governor shall~~

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~~be appointed for initial terms of three years or less, staggered so that the term of at least one director expires on June 30 of each year. Following the initial terms, directors shall be elected or appointed for terms of three years. A director whose term has expired shall continue to serve until a successor is elected or appointed and qualified.~~

~~G. Whenever a vacancy on the board occurs, the electing or appointing authority of the position that is vacant shall fill the vacancy by electing or appointing an individual to serve the balance of the unexpired term; provided, when a vacancy occurs in one of the director's positions elected by the members, the superintendent is authorized to appoint a temporary replacement director until the next scheduled election of directors elected by the members is held. The individual elected or appointed to fill a vacancy shall meet the requirements for initial election or appointment to that position.~~

~~H. Directors may be reimbursed by the alliance as provided in the Per Diem and Mileage Act for nonsalaried public officers, but shall receive no other compensation, perquisite or allowance from the alliance.~~]"

Section 27. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] HEALTH INSURERS--DIRECT SERVICES--

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GUARANTEED ISSUE--PREEXISTING CONDITIONS.--

A. A health insurer shall make reimbursement for direct services at a rate not less than eighty-seven percent of premiums across all health product lines over the preceding three calendar years, but not earlier than calendar year 2008, as determined by reports filed with the insurance division of the commission; provided, however, that the calculation does not include premium taxes. Nothing in this subsection shall be construed to preclude a purchaser from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services for one or more products or for one or more years.

B. Effective January 1, 2009, a health insurer shall issue coverage to any individual who requests and offers to purchase the coverage without permanent exclusion of preexisting conditions.

C. A health insurer may impose a waiting period not to exceed six months before payment for any service related to a preexisting condition.

D. A health insurer shall offer or make a referral to a transition product to provide coverage during the waiting period due to a preexisting condition.

E. A health insurer may continue an individual policy in existence on July 1, 2008 that has a permanent

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exclusion of payment for preexisting conditions until renewal. Upon renewal of such a policy, an insured, at the sole discretion of the insured, may opt to continue the existing individual policy with the exclusion of payment for a preexisting condition.

F. A health insurer shall ensure that an insured's privacy and confidentiality are protected and made applicable to individual policies, similar to privacy requirements pursuant to the federal Health Insurance Portability and Accountability Act of 1996 for other policies.

G. For the purposes of this section:

(1) "coverage" does not include short-term, accident, fixed indemnity, specified disease policy or disability income, limited benefit insurance, credit insurance, workers' compensation, automobile, medical or insurance under which benefits are payable with or without regard to fault and that is required by law to be contained in any liability insurance policy;

(2) "direct services" means services rendered to an individual by a health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of an assessment that covers

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services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act; provided, however, that direct services does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

(3) "health insurer" means a person duly authorized to transact the business of health insurance in the state pursuant to the Insurance Code but does not include a person that only issues a limited benefit policy intended to supplement major medical coverage, including medicare supplement, long-term care, disability income, disease-specific, accident only or hospital indemnity only insurance policies;

(4) "preexisting condition" means a physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended for or received by an applicant for health insurance within six months before the effective date of coverage, except that pregnancy is not considered a preexisting condition for federally defined individuals; and

(5) "premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, recoveries from third parties or other insurers and

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interests."

Section 28. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] HEALTH INSURER--INDIAN HEALTH SERVICE.--A health insurer shall allow an Indian health service provider or other provider pursuant to the federal Indian Self-Determination and Education Assistance Act that meets quality and credentialing standards to participate in the insurer's provider network; provided, however, that participation in a provider network shall not require the provider to reduce, expand or alter the eligibility requirements for the provider."

Section 29. TEMPORARY PROVISION--INTERIM TRANSITIONAL ADVISORY GROUP.--

A. An "interim transitional advisory group" is created. The advisory group is comprised of the director of the medical assistance division of the human services department, the superintendent of the insurance division of the public regulation commission and the chairs of or a member selected from the:

(1) board of directors of the health coverage authority;

(2) board of directors of the New Mexico health insurance alliance;

(3) board of directors of the New Mexico

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medical insurance pool;

(4) former New Mexico health policy commission;

(5) group benefits committee pursuant to the Group Benefits Act;

(6) board of the retiree health care authority;

(7) board of directors of the public school insurance authority; and

(8) school board of any public school district with a student enrollment in excess of sixty thousand students.

B. The interim transitional advisory group shall:

(1) select a chair and vice chair of the advisory group;

(2) recommend to the health coverage authority a budget request for fiscal year 2010, taking into account existing administrative costs and resources of the governing bodies and agencies to be administered by the health coverage authority;

(3) begin analyses that will assist the health coverage authority in setting affordability guidelines and making recommendations for benefits and services that will count as coverage; and

(4) operate as the board of directors of the

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health coverage authority until a majority of the authority board is appointed and the board begins operation, after which, the interim transitional advisory group shall remain in existence as an advisory council to the board through June 30, 2009 or as long as the board deems necessary to effect a transition of programs and responsibilities to the authority pursuant to this act.

Section 30. TEMPORARY PROVISION--TRANSITION OF HEALTH COVERAGE PROGRAMS TO THE HEALTH COVERAGE AUTHORITY.--The health coverage authority shall:

A. by July 1, 2009, combine under the auspices of the health coverage authority the administrative management of the New Mexico health insurance alliance, the retiree health care authority, the health coverage programs pursuant to the Group Benefits Act, state-sponsored premium assistance programs pursuant to Subsection B of Section 27-2-12 NMSA 1978 and the New Mexico state coverage insurance program or its successor program administered by the human services department; provided, however, that the purposes and financing mechanisms of the respective programs are maintained, identifiable and accounted for separately;

B. by July 1, 2010, combine under the auspices of the health coverage authority the management of the medical insurance pool, the public school insurance authority as it relates to group health insurance but not including risk-

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related coverages as those are defined in the Public School Insurance Authority Act; and the publicly funded health care program of any public school district with a student enrollment in excess of sixty thousand students; provided, however, that each program's actuarial and benefit pool and funding streams are maintained, identifiable and accounted for separately to ensure that respective beneficiaries obtain the services to which they are entitled; and

C. by July 1, 2009, review the programs and policies of the Medical Insurance Pool Act and make recommendations to the legislature and the governor to:

(1) address the coverage of pregnancy during the six-month waiting period for payment of claims due to preexisting conditions;

(2) require individuals that are not eligible for continuation of coverage pursuant to the federal Health Insurance Portability and Accountability Act of 1996 or the federal Consolidated Omnibus Budget Reconciliation Act of 1985 after being covered through groups that voluntarily cancel coverage previously offered to employees to apply for individual or other coverage prior to applying for coverage through the medical insurance pool; and

(3) offer more health plan options for individuals covered by the medical insurance pool.

Section 31. TEMPORARY PROVISION--NEW MEXICO HEALTH

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POLICY COMMISSION--TRANSFER OF PERSONNEL, PROPERTY CONTRACT AND REFERENCES IN LAW.--On July 1, 2008:

A. all personnel, appropriations, money, records, equipment, supplies and other property of the New Mexico health policy commission shall be transferred to the health coverage authority;

B. all contracts of the New Mexico health policy commission shall be binding and effective on the health coverage authority; and

C. all references in law to the New Mexico health policy commission shall be deemed to be references to the health coverage authority.

Section 32. TEMPORARY PROVISION--GROUP BENEFITS COMMITTEE--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2009:

A. all personnel, appropriations, money, records, equipment, supplies and other property of the group benefits committee shall be transferred to the health coverage authority;

B. all contracts of the group benefits committee shall be binding and effective on the health coverage authority;

C. all references in law to the group benefits committee shall be deemed to be references to the health coverage authority;

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D. as determined by the secretary of finance and administration:

(1) all personnel of the general services department whose duties are primarily related to administering the provisions of the Group Benefits Act are transferred to the health coverage authority; and

(2) all appropriations, money, records, equipment, supplies and other property of the general services department that are directly related to administering the provisions of the Group Benefits Act are transferred to the health coverage authority; and

E. all contracts of the general services department that directly relate to functions performed pursuant to the Group Benefits Act shall be binding and effective on the health coverage authority.

Section 33. TEMPORARY PROVISION--RETIREE HEALTH CARE AUTHORITY--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2009:

A. all personnel, appropriations, money, records, equipment, supplies and other property of the retiree health care authority shall be transferred to the health coverage authority;

B. all contracts of the retiree health care authority shall be binding and effective on the health coverage authority; and

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C. all references in law to the retiree health care authority shall be deemed to be references to the health coverage authority.

Section 34. TEMPORARY PROVISION--NEW MEXICO HEALTH INSURANCE ALLIANCE--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2009:

A. all personnel, appropriations, money, records, equipment, supplies and other property of the board of directors of the New Mexico health insurance alliance shall be transferred to the health coverage authority;

B. all contracts of the board of directors of the New Mexico health insurance alliance shall be binding and effective on the health coverage authority; and

C. all references in law to the board of directors of the New Mexico health insurance alliance shall be deemed to be references to the health coverage authority.

Section 35. TEMPORARY PROVISION--INSURANCE PROGRAMS OF THE HUMAN SERVICES DEPARTMENT--TRANSFER OF PERSONNEL, PROPERTY AND CONTRACTS.--On July 1, 2009:

A. as determined by the secretary of finance and administration upon the advice of the secretary of human services, all personnel, appropriations, money, records, equipment, supplies and other property of the human services department that are directly related to the state-sponsored premium assistance programs and the New Mexico state coverage

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insurance program or its successor program shall be transferred to the health coverage authority; and

B. all contracts of the human services department that are directly related to the state-sponsored premium assistance programs or the New Mexico state coverage insurance program or its successor program shall be binding and effective on the health coverage authority.

Section 36. TEMPORARY PROVISION--PUBLIC SCHOOL INSURANCE AUTHORITY--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2010:

A. as determined by the secretary of finance and administration:

(1) all personnel of the public school insurance authority whose duties are primarily related to administering the group health insurance program are transferred to the health coverage authority; and

(2) all appropriations, money, records, equipment, supplies and other property of the public school insurance authority that are directly related to administering the group health insurance program are transferred to the health coverage authority;

B. all contracts of the public school insurance authority that relate to the group health insurance program shall be binding and effective on the health coverage authority; and

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C. all references in law to the public school insurance authority as they relate to the group health insurance program shall be deemed to be references to the health coverage authority.

Section 37. TEMPORARY PROVISION--CERTAIN SCHOOL DISTRICTS--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2010:

A. all personnel, appropriations, money, records, equipment, supplies and other property of a publicly funded health care system of any public school district with a student enrollment in excess of sixty thousand students shall be transferred to the health coverage authority;

B. all contracts of a publicly funded health care system of any public school district with a student enrollment in excess of sixty thousand students shall be binding and effective on the health coverage authority; and

C. all references in law to a publicly funded health care system of any public school district with a student enrollment in excess of sixty thousand students shall be deemed to be references to the health coverage authority.

Section 38. TEMPORARY PROVISION--NEW MEXICO MEDICAL INSURANCE POOL--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2010:

A. all personnel, appropriations, money, records, equipment, supplies and other property of the board of

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directors of the New Mexico medical insurance pool shall be transferred to the health coverage authority;

B. all contracts of the board of directors of the New Mexico medical insurance pool shall be binding and effective on the health coverage authority; and

C. all references in law to the board of directors of the New Mexico medical insurance pool shall be deemed to be references to the health coverage authority.

Section 39. TEMPORARY PROVISION--MORATORIUM ON INSURANCE BENEFIT MANDATES.--To allow health care, health coverage and other reform efforts to be phased in and take effect, the state shall not enact any subsequent health insurance benefit mandates or other coverage requirements before January 1, 2011 except as required by federal law or as certified by the department of health to protect broad-based public health and safety or to prevent epidemics or other major disease outbreaks.

Section 40. REPEAL.--

A. Sections 9-7-11.1 and 9-7-11.2 NMSA 1978 (being Laws 1991, Chapter 139, Sections 1 and 2, as amended) are repealed effective July 1, 2008.

B. Sections 10-7B-3 and 10-7C-6 NMSA 1978 (being Laws 1989, Chapter 231, Section 3 and Laws 1990, Chapter 6, Section 6, as amended) are repealed effective July 1, 2009.

Section 41. EFFECTIVE DATE.--

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A. The effective date of the provisions of Sections 1 through 12 of this act is May 15, 2008.

B. The effective date of the provisions of Sections 17 through 21, 23, 24 and 27 through 39 of this act is July 1, 2008.

C. The effective date of the provisions of Sections 13, 14, 25 and 26 of this act is July 1, 2009.

D. The effective date of the provisions of Sections 15, 16 and 22 of this act is July 1, 2010.

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