HOUSE JUDICIARY COMMITTEE SUBSTITUTE FOR
HOUSE HEALTH AND GOVERNMENT AFFAIRS COMMITTEE SUBSTITUTE FOR
HOUSE BILL 62

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

AN ACT

RELATING TO HEALTH CARE REFORM; ENACTING THE HEALTH SOLUTIONS NEW MEXICO ACT; CREATING THE HEALTH CARE AUTHORITY; CREATING THE HEALTHY NEW MEXICO WORK FORCE FUND; PROVIDING INSURANCE REFORM INITIATIVES; TRANSFERRING ADMINISTRATIVE AUTHORITY OF CERTAIN HEALTH COVERAGE PROGRAMS TO THE HEALTH CARE AUTHORITY; MAKING AN APPROPRIATION.

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

Section 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 8 of this act may be cited as the "Health Solutions New Mexico Act".

Section 2. [NEW MATERIAL] DEFINITIONS.--As used in the Health Solutions New Mexico Act:

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

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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 care 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, 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

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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;

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

L. "tribal" means of or belonging to a tribe; and

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

Section 3. [NEW MATERIAL] HEALTH CARE AUTHORITY--CREATION--BOARD OF DIRECTORS--POWERS--DUTIES.--

A. The "health care 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 and two nonvoting members as follows:

(1) five voting members appointed by the governor, one from each of the five public regulation commission districts;

(2) five voting members appointed by the New Mexico legislative council, one from each of the five public regulation commission districts;

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(3) the superintendent of insurance as a voting member;

(4) the secretary of health as a nonvoting member; provided, however, that the secretary shall not preside over the board at any time nor attend meetings in executive session; and

(5) the secretary of human services as a nonvoting member; provided, however, that the secretary shall not preside over the board at any time nor attend meetings in executive session.

C. The voting 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 four 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.

D. A vacancy shall be filled by appointment by the original appointing authority for the remainder of the unexpired term.

E. A majority of the eleven voting members shall constitute a quorum. Any binding decision by the board shall require seven out of eleven members voting in favor.

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F. The board may allow members' participation in meetings by any electronic medium.

G. 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.

H. An appointed board member shall recuse the board member's self in any proceeding in which the member:

(1) has a professional, personal, familial or other intimate relationship that renders the member unable to exercise the member's functions impartially;

(2) has a pecuniary interest in the outcome of the proceeding; or

(3) served as an attorney, advisor or consultant in the matter before the board in previous employment or contract.

I. 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) executive-level experience in management or finance in a business not related to health care;

(2) executive-level experience in a business not related to health care that employs ten or fewer individuals;

(3) executive-level experience in a business

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not related to health care that employs eleven or more individuals;

(4) experience in the field of health or human services consumer advocacy;

(5) experience in health care finance, economics or actuarial analysis;

(6) experience related to health policy;

(7) experience related to health care delivery;

(8) experience in labor organization and advocacy; and

(9) experience in public health.

J. At least one board member shall be a Native American; at least one board member shall be a licensed physician pursuant to the Medical Practice Act; and at least one board member shall be a nurse having a graduate-level education in nursing.

K. The board may remove a board member from the board only for lack of attendance, neglect of duty or malfeasance in office and in accordance with policies adopted by the board.

L. A board member may receive per diem and mileage in accordance with the Per Diem and Mileage Act.

M. The board shall meet at least once per calendar quarter. The board shall comply with all statutes and rules

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applicable to state agencies and public boards; provided, however, that the authority shall not promulgate any rule unless and to the extent specifically provided that power by the legislature.

N. The board shall create the following advisory councils, and may create other ad hoc councils, to provide the board with analyses and expert policy and program recommendations. At least once each year, each council shall present its findings and make recommendations on issues requested by the board. The councils shall include:

(1) a delivery system policy council;

(2) a cost containment and finance council;

(3) a benefits and services council;

(4) a federal issues review council;

(5) a health disparities council; and

(6) a Native American health care council;

provided, however, that the authority may use an existing Native American advisory council created by a health-related state agency.

O. Prior to any action by the board, the findings and recommendations of an advisory council shall be open for public comment for a period of no less than thirty days. If an emergency requires action in a time frame that will not accommodate the period for public comment, any action of the board shall be temporary until such time as the public comment

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period can occur.

P. The authority may request staff assistance from any state agency.

Section 4. [NEW MATERIAL] EXECUTIVE DIRECTOR.--The board shall appoint an executive director of the authority. The executive director shall carry on the day-to-day operations of the authority. The executive director shall have at least seven years of management or administrative experience in health care delivery, policy, management, financing or coverage. The executive director is exempt from the Personnel Act.

Section 5. [NEW MATERIAL] HEALTH CARE AUTHORITY--STAFF.--

A. The executive director shall employ or contract with those persons necessary to administer and implement the powers and duties of the authority.

B. The executive director shall employ in a full-time position a Native American liaison between the authority and tribal communities or Native Americans residing in the state.

C. The executive director shall organize the staff into operational units, including:

(1) a health policy and research division;

(2) a plan management division;

(3) an outreach and education division; and

(4) an administrative services division.

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Section 6. [NEW MATERIAL] HEALTH CARE AUTHORITY--DUTIES.--The authority shall:

A. by January 1, 2010, 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, 2010 and at least every three years thereafter, develop a comprehensive plan that includes recommendations to the governor, the legislature, the public regulation commission and other state agencies for:

(1) policy, budgetary, regulatory or legislative actions necessary to increase health care coverage, access, health professional supply and quality of care;

(2) methods to address health care costs; and

(3) actions to be taken by the authority or other state entities, with expected completion dates, to accomplish the recommendations identified in the comprehensive plan;

C. by September 1, 2011, submit a written report to the governor and legislature with findings and recommendations about:

(1) consolidation of any actuarial pools administratively managed by the authority; and

(2) allowing qualifying employees to purchase coverage through any programs or pools managed by the

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authority;

D. conduct studies of health care coverage and trends, including information on the cost and type of coverage available and existing or proposed insurance benefits;

E. gather information on health care coverage, including the offering or purchase of health care coverage by employers for their employees and the enrollment of individuals in group or individual health care coverage plans;

F. by July 1, 2010, provide reports and recommendations to the governor, the legislature and the public, including cost-benefit analyses of:

(1) requiring a contribution or assessment by employers related to health insurance premiums;

(2) varying benefit or service plans;

(3) means for full enrollment in and management of Title 19 or Title 21 of the federal Social Security Act;

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

(5) allowing nongovernmental employers to buy into risk pools administered by the authority;

(6) incentives or subsidies for affordable coverage;

(7) implications of reimbursement methodologies used by different payers;

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(8) 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;

(9) realigning the payment and training systems for licensed health professionals to create incentives for primary and preventive services;

(10) moving from guaranteed issue in the individual market to a community rating system;

(11) various methods of establishing rate ranges paid to providers of health care services;

(12) providers' payment from state, federal or joint state-federal programs and commercial insurance;

(13) standardized credentialing processes;

(14) disparities by gender, ethnicity, race, age, population health, language, cultural and other factors;

(15) performance standards for health insurers and providers;

(16) quality of care standards, including incentives to improve health care outcomes;

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

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

(19) allowing individuals to purchase a state

medicaid-type product;

(20) portability of coverage;

(21) implementation of risk equalization processes to minimize adverse selection;

(22) information reporting requirements for health insurers;

(23) education and training programs for health insurance brokers and agents;

(24) health coverage requirements for contractors doing business with the state or its political subdivisions;

(25) options for comprehensive statewide health coverage for all New Mexicans through a combination of public and private financing; and

(26) other analyses or initiatives as directed by the legislature or recommended by the authority's advisory councils and determined appropriate by the board;

G. develop and administer plans, benefits or services to meet the needs of individuals covered by the plans administered by the authority, awaiting coverage by public or private health plans;

H. for purposes of procurement:

(1) conduct procurement of health insurance coverage, health plan services or third party administrative services pursuant to the Procurement Code; and

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(2) require that bidders disclose the name of any lobbyist or consultant involved in the procurement process and any expenditure, campaign contribution or charitable donation made during the procurement process;

I. provide training, outreach activities and other media approaches to educate the general public about wellness and health insurance coverage;

J. to the extent allowed by law, collect and report:

(1) data of providers and health insurers, ensuring that individual patient information remains confidential; and

(2) data about health care costs, quality and access, ensuring that individual patient information and corporate proprietary information remains confidential;

K. to the extent not otherwise required or available by law or contract, provide an alternative dispute resolution process for provider and health insurer complaint resolution;

L. 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;

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

authority; and

N. by October 1, 2011, analyze and report to the appropriate interim legislative committee on:

(1) demographic analysis of individuals without health coverage;

(2) experience of other states with requirements for health coverage;

(3) availability and funding of public and private health coverage or insurance programs; and

(4) recommendations for enforcement of required health coverage.

Section 7. [NEW MATERIAL] HEALTHY NEW MEXICO WORK FORCE 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, employees' contributions, insurance or reinsurance proceeds and other funds received by gift, grant, bequest or otherwise for deposit

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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 the end of any fiscal year shall not revert.

Section 8. [NEW MATERIAL] EMPLOYEES OFFERED PRE-TAX HEALTH COVERAGE OPTION.--An employer that has five or more employees shall demonstrate to the authority, in a form and manner required by the authority, 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.

Section 9. 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:

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A. "committee" means the [~~group benefits committee~~] board of directors of the health care authority;

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

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 10. 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 authority [~~created pursuant to the Retiree Health Care Act~~];

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

D. "board" means the board of directors of the [~~retiree~~] health care 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

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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 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

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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~~]

(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

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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 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

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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 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

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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 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

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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 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

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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 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

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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;

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

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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 11. Section 22-29-3 NMSA 1978 (being Laws 1986, 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 care 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 care 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;

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

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

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

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

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

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

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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.

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, 2011, 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

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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, 2011, the secretary of finance and administration, with the advice of the public school insurance authority and the health care authority, shall determine the initial balance of each account."

Section 13. Section 59A-6-5 NMSA 1978 (being Laws 1984, Chapter 127, Section 105, as amended) is amended to read:

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

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

(1) the Law Enforcement Protection Fund Act;

(2) Section 59A-6-1.1 NMSA 1978; and

(3) the Voter Action Act.

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

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payment.

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

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

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

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

(3) to the healthy New Mexico work force fund, that part of the balance derived pursuant to Section 59A-6-2 NMSA 1978 that exceeds one-twelfth of the amount collected

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pursuant to Section 59A-6-2 NMSA 1978 for calendar year 2009 and subject to appropriation by the legislature; and

[~~(3)~~] (4) to the general fund, the balance remaining in the insurance department suspense fund derived from all other kinds of insurance business."

Section 14. 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.--

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

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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 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

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

Section 15. 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

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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 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

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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

(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

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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 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

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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 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

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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 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

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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 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 16. 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 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

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(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 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:

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(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 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:

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(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 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

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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 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 17. 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.

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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 18. 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 Pool Act:

A. "board" means the board of directors of the pool and, effective July 1, 2011, the health care 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

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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 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;

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

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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 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

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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 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

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condition for a federally defined eligible individual; and

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

Section 19. 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. 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~~

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~~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.~~

~~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~~

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~~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 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.

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[~~C.~~] 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 20. Section 59A-54-12 NMSA 1978 (being Laws 1987, Chapter 154, Section 12, as amended) is amended to read:

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

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

(1) is not eligible as an insured or covered dependent for [~~any~~] 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

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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 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~~] ninety-five-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

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dependent as the second employee may choose a pool policy in lieu of the health plan under that act; and

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

C. Coverage under a pool policy is in excess of and shall not duplicate coverage under any other form of health insurance.

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

E. Except for a person eligible as provided in Paragraph (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.

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~~] ninety-five days following the involuntary termination. In that case, coverage in the pool shall be

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effective from the date on which the prior coverage was terminated. This subsection does not prohibit preexisting conditions coverage in a pool policy that is more favorable to the insured than that specified in this subsection.

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

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

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

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

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

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

(6) the most recent coverages within the

coverage period described in Paragraph (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 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~~] ninety-five days after that termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

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

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

(2) except for the eligibility for medicare, would otherwise be eligible for coverage pursuant to the

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criteria of this section."

Section 21. Section 59A-54-13 NMSA 1978 (being Laws 1987, Chapter 154, Section 13, as amended) is amended to read:

"59A-54-13. BENEFITS.--

A. The health insurance policy issued by the pool shall pay for medically necessary eligible health care services rendered or furnished for the diagnoses or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under Section 59A-54-14 NMSA 1978 and are not otherwise limited or excluded. Eligible expenses are the charges for the health care services and items for which benefits are extended under the pool policy. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations shall be established by the board and shall, at a minimum, reflect the levels of health insurance coverage generally available in New Mexico for small group policies; provided that a health insurance policy issued by the pool shall not include a lifetime maximum benefit. The superintendent shall approve the benefit package developed by the board to ensure its compliance with the Medical Insurance Pool Act. The benefit package shall include therapy services and hearing aids.

B. The Medical Insurance Pool Act shall not be construed to prohibit the pool from issuing additional types

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of health insurance policies with different types of benefits [~~which~~] that, in the opinion of the board, may be of benefit to the citizens of New Mexico.

C. The board may design and employ cost-containment measures and requirements, including preadmission certification and concurrent inpatient review, for the purpose of making the pool more cost effective."

Section 22. 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

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

Section 23. 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 and, effective July 1, 2010, the health care 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

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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;

[~~(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

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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 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~~] ninety-five-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

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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 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

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"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;

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 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 the future."

Section 24. 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~~

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~~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.~~

~~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~~

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~~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 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~~

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~~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 25. Section 59A-56-14 NMSA 1978 (being Laws 1994, Chapter 75, Section 14, as amended) is amended to read:

"59A-56-14. ELIGIBILITY--GUARANTEED ISSUE--PLAN PROVISIONS.--

A. A small employer is eligible for an approved health plan if on the effective date of coverage or renewal:

(1) at least fifty percent of its employees not otherwise insured elect to be covered under the approved health plan;

(2) the small employer has not terminated coverage with an approved health plan within three years of the date of application for coverage except to change to another approved health plan; and

(3) the small employer does not offer other general group health insurance coverage to its employees. For the purposes of this paragraph, general group health insurance coverage excludes coverage that:

(a) is offered by a state or federal agency to a small employer's employee whose eligibility for alternative coverage is based on the employee's income; or

(b) provides only a specific limited form of health insurance such as accident or disability

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income insurance coverage or a specific health care service such as dental care.

B. An individual is eligible for an approved health plan if on the effective date of coverage or renewal the individual meets the definition of an eligible individual under Section 59A-56-3 NMSA 1978.

C. An approved health plan shall provide in substance that attainment of the limiting age by an unmarried dependent individual does not operate to terminate coverage when the individual continues to be incapable of self-sustaining employment by reason of developmental disability or physical handicap and the individual is primarily dependent for support and maintenance upon the employee. Proof of incapacity and dependency shall be furnished to the alliance and the member that offered the approved health plan within one hundred twenty days of attainment of the limiting age. The board may require subsequent proof annually after a two-year period following attainment of the limiting age.

D. An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable with respect to a newly born child of the family member or the individual in whose name the contract is issued from the moment of birth, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required

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to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium shall be furnished to the member within thirty-one days after the date of birth in order to have the coverage from birth. An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable for an adopted child in accordance with the provisions of Section 59A-22-34.1 NMSA 1978.

E. Except as provided in Subsections G, H and I of this section, an approved health plan offered to a small employer may contain a preexisting condition exclusion only if:

(1) the exclusion relates to a condition, physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date;

(2) the exclusion extends for a period of not more than six months after the enrollment date; and

(3) the period of the exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

F. As used in this section, "preexisting condition exclusion" means a limitation or exclusion of

benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage for the benefits whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date, but genetic information is not included as a preexisting condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the condition related to the genetic information.

G. An insurer shall not impose a preexisting condition exclusion:

(1) in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;

(2) that excludes a child who is adopted or placed for adoption before the child's eighteenth birthday and who, as of the last day of the thirty-day period beginning on and following the date of the adoption or placement for adoption, is covered under creditable coverage; or

(3) that relates to or includes pregnancy as a preexisting condition.

H. The provisions of Paragraphs (1) and (2) of Subsection G of this section do not apply to any individual after the end of the first continuous [~~sixty-three-day~~] ninety-five-day period during which the individual was not

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covered under any creditable coverage.

I. 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 if the effective date of coverage for health insurance through the alliance is made not later than [~~sixty-three~~] ninety-five days following the termination of the prior coverage. In that case, coverage through the alliance shall be effective from the date on which the prior coverage was terminated. This subsection does not prohibit preexisting conditions coverage in an approved health plan that is more favorable to the covered individual than that specified in this subsection.

J. An approved health plan issued to an eligible individual shall not contain any preexisting condition exclusion.

K. An individual is not eligible for coverage by the alliance under an approved health plan issued to a small employer if the individual:

(1) is eligible for medicare; provided, however, if an individual has health insurance coverage from an employer whose group includes twenty or more individuals, an individual eligible for medicare who continues to be employed may choose to be covered through an approved health plan;

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(2) has voluntarily terminated health insurance issued through the alliance within the past twelve months unless it was due to a change in employment; or

(3) is an inmate of a public institution.

L. The alliance shall provide for an open enrollment period of sixty days from the initial offering of an approved health plan. Individuals enrolled during the open enrollment period shall not be subject to the preexisting conditions limitation.

M. If an insured covered by an approved health plan switches to another approved health plan that provides increased or additional benefits such as lower deductible or co-payment requirements, the member offering the approved health plan with increased or additional benefits may require the six-month period for preexisting conditions provided in Subsection E of this section to be satisfied prior to receipt of the additional benefits."

Section 26. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] HEALTH INSURERS--DIRECT SERVICES--GUARANTEED ISSUE FOR INDIVIDUALS--PREEXISTING CONDITIONS.--

A. A health insurer shall make reimbursement for direct services at a rate not less than eighty-five percent of premiums for coverage across all health product lines, including fully insured, commercial, state and federal

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programs, over the preceding three calendar years, but not earlier than calendar year 2009, as determined by reports filed with the insurance division of the commission.

B. If a health insurer makes reimbursement for direct services at a rate less than eighty-five percent of premiums pursuant to Subsection A of this section, based on reports filed with or an audit conducted by the insurance division of the commission, the difference between the amount reimbursed for direct services and eighty-five percent of premiums received shall be paid into the healthy New Mexico work force fund. Notwithstanding the provisions of Section 59A-2-11 NMSA 1978, the amount paid into the fund shall satisfy any fee, administrative fine or other penalty that may be assessed for making reimbursement at a rate less than eighty-five percent of premiums.

C. Effective January 1, 2010, a health insurer shall issue coverage to any individual who requests and offers to purchase the coverage without permanent exclusion of preexisting conditions.

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

E. 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.

F. A health insurer may continue an individual policy in existence on July 1, 2009 that has a permanent 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.

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 or individuals and any portion of an assessment that covers 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

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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, including a nonprofit health care plan, a health maintenance organization and self-insured entitites not subject to federal preemption, 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, interest and administrative fees received and claim payments made by:

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(a) an administrator or third party administrator pursuant to Chapter 59A, Article 12A NMSA 1978;

(b) a health maintenance organization;

(c) a nonprofit health care plan; or

(d) an insurer."

Section 27. 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 28. TEMPORARY PROVISION--NEW MEXICO HEALTH POLICY COMMISSION--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 New Mexico health policy commission shall be transferred to the health care authority;

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

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authority; and

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

Section 29. TEMPORARY PROVISION--TRANSITION OF HEALTH COVERAGE PROGRAMS TO THE HEALTH CARE AUTHORITY.--The health care authority shall:

A. by July 1, 2010, combine under the auspices of the health care 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; and

B. by July 1, 2011, combine under the auspices of the health care authority the management of the medical insurance pool, the public school insurance authority as it relates to group health insurance but not including risk-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.

Section 30. TEMPORARY PROVISION--GROUP BENEFITS COMMITTEE--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 group benefits committee shall be transferred to the health care authority;

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

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

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 care authority; and

(2) all appropriations, money, records, equipment, supplies and other property of the general services department that are directly related to

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administering the provisions of the Group Benefits Act are transferred to the health care 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 care authority.

Section 31. TEMPORARY PROVISION--RETIREE HEALTH CARE AUTHORITY--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 retiree health care authority shall be transferred to the health care authority;

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

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

Section 32. TEMPORARY PROVISION--NEW MEXICO HEALTH INSURANCE ALLIANCE--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 directors of the New Mexico health insurance alliance shall

be transferred to the health care authority;

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

Section 33. TEMPORARY PROVISION--INSURANCE PROGRAMS OF THE HUMAN SERVICES DEPARTMENT--TRANSFER OF PERSONNEL, PROPERTY AND CONTRACTS.--On July 1, 2010:

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 insurance program or its successor program shall be transferred to the health care 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 care authority.

Section 34. TEMPORARY PROVISION--PUBLIC SCHOOL INSURANCE AUTHORITY--TRANSFER OF PERSONNEL, PROPERTY,

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CONTRACTS AND REFERENCES IN LAW.--On July 1, 2011:

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 care 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 care 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 care authority; and

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 care authority.

Section 35. TEMPORARY PROVISION--CERTAIN SCHOOL DISTRICTS--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2011:

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 care 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 care 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 care authority.

Section 36. TEMPORARY PROVISION--NEW MEXICO MEDICAL INSURANCE POOL--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2011:

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

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

Section 37. REPEAL.--

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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, 2009.

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, 2010.

Section 38. EFFECTIVE DATE.--

A. The effective date of the provisions of Sections 1 through 8, 14 through 18, 20 through 23 and 27 through 36 of this act is July 1, 2008.

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

C. The effective date of the provisions of Sections 9, 10 and 24 of this act is July 1, 2010.

D. The effective date of the provisions of Section 13 of this act is January 1, 2011.

E. The effective date of the provisions of Sections 11, 12 and 19 of this act is July 1, 2011.

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