HOUSE BILL 592

49TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2009

INTRODUCED BY

Thomas C. Taylor

AN ACT

RELATING TO HEALTH INSURANCE; RECOMPILING THE HEALTH INSURANCE ALLIANCE ACT INTO CHAPTER 27 NMSA 1978; PROVIDING FOR THE HUMAN SERVICES DEPARTMENT TO ACT AS THE ADMINISTRATOR FOR THE HEALTH INSURANCE ALLIANCE; CREATING AN ADVISORY BOARD OF THE HEALTH INSURANCE ALLIANCE; PROVIDING FOR THE TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW; AMENDING AND RECOMPILING SECTIONS OF THE NMSA 1978; MAKING AN APPROPRIATION.

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

Section 1. Section 59A-56-1 NMSA 1978 (being Laws 1994, Chapter 75, Section 1, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"SHORT TITLE.--[~~Chapter 59A, Article 56 NMSA 1978~~] This act may be cited as the "Health Insurance Alliance Act"."

Section 2. Section 59A-56-2 NMSA 1978 (being Laws 1994,

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Chapter 75, Section 2, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"PURPOSE.--The purpose of the Health Insurance Alliance Act is to provide increased access to voluntary health insurance coverage for small employer groups in [~~New Mexico~~] the state. An additional purpose of the Health Insurance Alliance Act is to provide for access to voluntary health insurance coverage for individuals in the individual market who have met eligibility criteria established by that act."

Section 3. Section 59A-56-3 NMSA 1978 (being Laws 1994, Chapter 75, Section 3, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"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;~~

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

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

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(1) a group health plan;

(2) health insurance coverage;

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

(4) Title 19 or Title 21 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) the Medical Insurance Pool Act;

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

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

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

[~~F.~~] E. "department" means the [~~insurance division of the commission~~] human services department;

[~~G.~~] F. "director" means an individual who serves on the advisory board;

[~~H.~~] G. "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

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immediately preceding calendar year;

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

[~~J.~~] I. "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 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~~] the renewability provisions of the Health Insurance Alliance Act or Section 59A-23E-19 NMSA 1978; and

(2) does not include an individual who:

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

(b) is eligible for coverage under medicare or a state plan under Title 19 or Title 21 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~~] pursuant to the renewability provisions of the Health Insurance Alliance Act, and did not exhaust the coverage available under the offered program;

[~~K.~~] J. "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.~~] K. "gross earned premiums" means premiums paid

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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.~~] L. "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.~~] M. "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.~~] N. "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

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care services under group-type contracts that are not available to the general public and can be obtained only because of connection with a particular organization or group; coverage by medicare or other governmental programs providing health care services; but "health insurance" does not include insurance issued pursuant to provisions of the Workers' Compensation Act or similar law, automobile medical payment insurance or provisions by which benefits are payable with or without regard to fault and are required by law to be contained in any liability insurance policy;

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

[~~Q.~~] P. "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.~~] Q. "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.~~] R. "medicare" means coverage under both Parts

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A and B of Title 18 of the federal Social Security Act;

[~~T.~~] S. "member" means a member of the alliance;

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

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

[~~W.~~] V. "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

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current calendar year;

[~~X.~~] W. "superintendent" means the superintendent of insurance;

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

[~~Z.~~] Y. "unearned premiums" means the portion of a premium previously paid for which the coverage period is in the future."

Section 4. Section 59A-56-4 NMSA 1978 (being Laws 1994, Chapter 75, Section 4, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"ALLIANCE CREATED--ADVISORY BOARD CREATED.--

A. The "[~~New Mexico~~] health insurance alliance" is created [~~as a nonprofit public corporation for the purpose of providing~~] to provide 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 New Mexico Insurance Code.

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

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

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

C. The advisory board of the alliance is created. The advisory 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~~

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~~superintendent's vote is necessary to break a tie~~.

[~~E.~~] D. The superintendent shall serve as [~~chairman~~] chair of the advisory board unless the superintendent declines, in which event the superintendent shall appoint the [~~chairman~~] chair. The advisory board shall meet at least once each calendar year quarter with the secretary of the department or the secretary's designee to review the operations of the alliance and make recommendations to the secretary that will increase access to health insurance in the state. The secretary shall review and consider the recommendations of the advisory board.

[~~F.~~] E. 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.~~] F. Whenever a vacancy on the advisory 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;

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provided that, 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.~~] G. Subject to available appropriations, directors may be reimbursed by the alliance as provided in the Per Diem and Mileage Act for nonsalaried public officers, but shall receive no other compensation, perquisite or allowance from the alliance."

Section 5. Section 59A-56-5 NMSA 1978 (being Laws 1994, Chapter 75, Section 5, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"PLAN OF OPERATION.--

A. The [~~board~~] department shall submit a plan of operation to the superintendent and any amendments to the plan necessary or suitable to assure the fair, reasonable and equitable administration of the alliance.

B. The superintendent shall, after notice and hearing, approve the plan of operation if it is determined to assure the fair, reasonable and equitable administration of the alliance. The plan of operation shall become effective upon written approval of the superintendent consistent with the date

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on which health insurance coverage through the alliance pursuant to the provisions of the Health Insurance Alliance Act is made available. A plan of operation adopted 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~~] department and approved by the superintendent.

C. The plan of operation shall:

(1) establish procedures for the handling and accounting of assets of the alliance;

(2) establish regular times and places for meetings of the advisory board;

(3) establish procedures for records to be kept of all financial transactions and for annual fiscal reporting to the department and the superintendent;

(4) establish the amount of and the method for collecting assessments pursuant to Section [~~59A-56-11 NMSA 1978~~] 11 of the Health Insurance Alliance Act;

(5) establish a program to publicize the existence of the alliance, the approved health plans, the eligibility requirements and procedures for enrollment in an approved health plan and to maintain public awareness of the alliance;

(6) establish penalties for nonpayment of assessments by members;

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(7) establish procedures for alternative dispute resolution of disputes between members and insureds; and

(8) contain additional provisions necessary and proper for the execution of the powers and duties of the alliance."

Section 6. Section 59A-56-6 NMSA 1978 (being Laws 1994, Chapter 75, Section 6, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"[~~BOARD~~] DEPARTMENT--POWERS AND DUTIES.--

A. The [~~board~~] department shall have the general powers and authority granted to insurance companies licensed to transact health insurance business under the laws of this state.

B. The [~~board~~] department:

(1) may enter into contracts to carry out the provisions of the Health Insurance Alliance Act, including, with the approval of the superintendent, contracting with similar alliances of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions;

[~~(2) may sue and be sued;~~

~~(3)~~] (2) may conduct periodic audits of the members to assure the general accuracy of the financial data submitted to the alliance;

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[~~(4)~~] (3) shall establish maximum rate schedules, allowable rate adjustments, administrative allowances, reinsurance premiums and agent referral, servicing fees or commissions subject to applicable provisions in the New Mexico Insurance Code. In determining the initial year's rate for health insurance, the only rating factors that may be used are age, gender, geographic area of the place of employment and smoking practices. In any year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit a member from offering rates that differ depending upon family composition;

[~~(5)~~] (4) may direct a member to issue policies or certificates of coverage of health insurance in accordance with the requirements of the Health Insurance Alliance Act;

[~~(6)~~] (5) shall establish procedures for alternative dispute resolution of disputes between members and insureds;

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[~~(7)~~] (6) shall cause the alliance to have an annual audit of its operations by an independent certified public accountant;

[~~(8)~~] (7) shall conduct all advisory board meetings as if it were subject to the provisions of the Open Meetings Act;

[~~(9)~~] (8) shall draft one or more sample health insurance policies that are the prototype documents for the members;

[~~(10)~~] (9) shall determine the design criteria to be met for an approved health plan;

[~~(11)~~] (10) shall review each proposed approved health plan to determine if it meets the alliance-designed criteria and, if it does meet the criteria, approve the plan; provided that the [~~board~~] department shall not permit more than one approved health plan per member for each set of plan design criteria;

[~~(12)~~] (11) shall review annually each approved health plan to determine if it still qualifies as an approved health plan based on the alliance-designed criteria and, if the plan is no longer approved, arrange for the transfer of the insureds covered under the formerly approved plan to an approved health plan;

[~~(13)~~] (12) may terminate an approved health plan not operating as required by the [~~board~~] department;

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[~~(14)~~] (13) shall terminate an approved health plan if timely claim payments are not made pursuant to the plan; and

[~~(15)~~] (14) shall engage in significant marketing activities, including a program of media advertising, to inform small employers and eligible individuals of the existence of the alliance, its purpose and the health insurance available or potentially available through the alliance.

C. The alliance is subject to and responsible for examination by the superintendent. No later than March 1 of each year, the [~~board~~] department shall submit to the superintendent an audited financial report for the preceding calendar year in a form approved by the superintendent."

Section 7. Section 59A-56-7 NMSA 1978 (being Laws 1994, Chapter 75, Section 7) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"POLICY FORMS.--All policy forms of approved health plans shall conform in substance to prototype forms developed by the alliance and shall be filed with and approved by the department and the superintendent before they are issued."

Section 8. Section 59A-56-8 NMSA 1978 (being Laws 1994, Chapter 75, Section 8, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"APPROVED HEALTH PLAN.--

A. An approved health plan shall conform to the

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alliance's approved health plan design criteria. The [~~board~~] department may allow more than one plan design for approved health plans. A member may provide one approved health plan for each plan design approved by the [~~board~~] department.

B. The [~~board~~] department shall designate plan designs for approved health plans. The [~~board~~] department may designate plan designs for an approved health plan that provides catastrophic coverage or other benefit plan designs.

C. Each approved health plan shall offer a premium that is no greater than the average of the standard rate index for plans with the same characteristics.

D. Any member that provides or offers to renew a group health insurance contract providing health insurance benefits to employees of the state, a county, a municipality or a school district for which public funds are contributed shall offer at least one approved health plan to small employers and eligible individuals; provided, however, if a member does not offer anywhere in the United States a plan that meets substantially the design criteria of an approved health plan, the member shall not be required to offer an approved health plan.

E. If a plan design approved by the [~~board~~] department is not offered by any member already offering an approved health plan, but a member offers a substantially similar plan design outside the alliance, the [~~board~~]

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department may require the member to offer that plan design as an approved health plan through the alliance.

F. A member required to offer, and offering, an approved health plan pursuant to the requirement of Subsection D of this section shall continue to offer that plan for five consecutive years after the date the member was last required to offer the plan. A member offering an approved health plan but not required to offer it pursuant to the cited subsection may withdraw the plan but shall continue to offer it for five consecutive years after the date notice of future withdrawal is given to the [~~board~~] department unless:

(1) the member substitutes another approved health plan for the plan withdrawn; or

(2) the [~~board~~] department allows the plan to be withdrawn because it imposes a serious hardship upon the member.

G. No member shall be required to offer an approved health plan if the member notifies the department and the superintendent in writing that it will no longer offer health insurance, life insurance or annuities in the state, except for renewal of existing contracts, provided that:

(1) the member does not offer or provide health insurance, life insurance or annuities for a period of five years from the date of notification to the superintendent to any person in the state who is not covered by the member

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through a health insurance policy in effect on the date of the notification; and

(2) with respect to health or life insurance policies or annuities in effect on the date of notification to the superintendent, the member continues to comply with all applicable laws and regulations governing the provision of insurance in this state, including the payment of applicable taxes, fees and assessments."

Section 9. Section 59A-56-9 NMSA 1978 (being Laws 1994, Chapter 75, Section 9, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"REINSURANCE.--

A. A member offering an approved health plan shall be reinsured for certain losses by the alliance. Within six months following the end of each calendar year in which the member offering the approved health plan paid more in incurred claims, plus the member's reinsurance premium pursuant to Subsection B of this section, than seventy-five percent of earned premiums received by the member on all approved health plans issued by the member, the member shall receive from the alliance the excess amount for the calendar year by which the incurred claims and reinsurance premium exceeded seventy-five percent of the earned premiums received by the alliance or its administrator.

B. The alliance shall withhold from all premiums

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that it receives a reinsurance premium as established by the [~~board~~] department:

(1) for insured small employer groups, the reinsurance premium shall not exceed five percent of premiums paid by insured groups in the first year of coverage and shall not exceed ten percent of premiums for renewal years; and

(2) for eligible individuals, the reinsurance premium shall not exceed ten percent of premiums paid by individuals in the first year of coverage or continuation coverage and shall not exceed fifteen percent of premiums paid by individuals for renewal years. In determining the reinsurance premium for a particular calendar year, the [~~board~~] department shall set the reinsurance premium at a rate that will recover the total reinsurance loss for the preceding year over a reasonable number of years in accordance with sound actuarial principles."

Section 10. Section 59A-56-10 NMSA 1978 (being Laws 1994, Chapter 75, Section 10, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"ADMINISTRATION.--The alliance shall deduct from premiums collected for approved health plans an administrative charge as set by the [~~board~~] department. The administrative charge shall be determined before the beginning of each calendar year:

A. for insured small employer groups, the maximum administrative charge the alliance may charge is ten percent of

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premiums in the first year and five percent of premiums in renewal years; and

B. for eligible individuals, the maximum administrative charge the alliance may charge in any year is ten percent of premiums."

Section 11. Section 59A-56-11 NMSA 1978 (being Laws 1994, Chapter 75, Section 11, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"ASSESSMENTS.--

A. After the completion of each calendar year, the alliance shall assess all its members for the net reinsurance loss in the previous calendar year and for the net administrative loss that occurred in the previous calendar year, taking into account investment income for the period and other appropriate gains and losses using the following definitions:

(1) net reinsurance losses shall be the amount determined for the previous calendar year in accordance with Subsection A of Section [~~59A-56-9 NMSA 1978~~] 9 of the Health Insurance Alliance Act for all members offering an approved health plan reduced by reinsurance premiums charged by the alliance in the previous calendar year. Net reinsurance losses shall be calculated separately for group and individual coverage. If the reinsurance premiums for either category of coverage exceed the amount calculated in accordance with

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Subsection A of Section [~~59A-56-9 NMSA 1978~~] 9 of the Health Insurance Alliance Act, the premiums shall be applied first to offset the net reinsurance losses incurred in the other category of coverage and second to offset administrative losses; and

(2) net administrative losses shall be the administrative expenses incurred by the alliance in the previous calendar year and projected for the current calendar year less the sum of administrative allowances received by the alliance, but in the event of an administrative gain, net administrative losses for the purpose of assessments shall be considered zero and the gain shall be carried forward to the administrative fund for the next calendar year as an additional allowance.

B. The assessment for each member shall be determined by multiplying the total losses of the alliance's operation, as defined in Subsection A of this section, by a fraction, the numerator of which is an amount equal to that member's total premiums, or the equivalent, exclusive of premiums received by the member for an approved health plan for health insurance written in the state during the preceding calendar year and the denominator of which equals the total premiums of all health insurance written in the state during the preceding calendar year exclusive of premiums for approved health plans; provided that total premiums shall not include

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payments by the [~~secretary of human services~~] department pursuant to a contract issued under Section 1876 of the federal Social Security Act, total premiums exempted by the federal Employee Retirement Income Security Act of 1974 or federal government programs.

C. If assessments exceed actual reinsurance losses and administrative losses of the alliance, the excess shall be held at interest by the [~~board~~] department to offset future losses.

D. To enable the [~~board~~] department to properly determine the net reinsurance amount and its responsibility for reinsurance to each member:

(1) by April 15 of each year, each member offering an approved health plan shall submit a listing of all incurred claims for the previous year; and

(2) by April 15 of each year, each member shall submit a report that includes the total earned premiums received during the prior year less the total earned premiums exempted by federal government programs.

E. The alliance shall notify each member of the amount of its assessment due by May 15 of each year. The assessment shall be paid by the member by June 15 of each year.

F. The proportion of participation of each member in the alliance shall be determined annually by the [~~board~~] department, based on annual statements filed by each member and

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other reports deemed necessary by the [~~board~~] department. Any deficit incurred by the alliance shall be recouped by assessments apportioned among the members pursuant to the formula provided in Subsection B of this section; provided that fifty percent of the assessment paid for any member shall be allowed as a credit on the following annual premium tax return for that member.

G. The [~~board~~] department may defer, in whole or in part, the payment of an assessment of a member if, in the opinion of the [~~board~~] department, after approval of the superintendent, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event payment of an assessment against a member is deferred, the amount deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in Subsection A of this section. The member receiving the deferment shall pay the assessment in full plus interest at the prevailing rate as determined by regulation of the superintendent within four years from the date payment is deferred. After four years but within five years of the date of the deferment, the [~~board~~] department may sue to recover the amount of the deferred payment plus interest and costs. [~~Board~~] Department actions to recover deferred payments brought after five years of the date of deferment are barred. Any amount received shall be deducted from future assessments or

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reimbursed pro rata to the members paying the deferred assessment."

Section 12. Section 59A-56-12 NMSA 1978 (being Laws 1994, Chapter 75, Section 12) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"INITIAL ADMINISTRATIVE ASSESSMENT.--Following the superintendent's approval or adoption of the plan of operations, the [~~board~~] department may impose an initial assessment of five hundred dollars ($500) on each member. New members shall also be subject to the initial assessment. These funds shall not be considered as income to offset any administrative expenses in future assessments. Additional expenses to establish and to operate the alliance shall first be assessed following the first calendar year of operation of the alliance."

Section 13. Section 59A-56-13 NMSA 1978 (being Laws 1994, Chapter 75, Section 13, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"ALLIANCE ADMINISTRATOR.--

A. The [~~board~~] department may select an alliance administrator through a competitive request for proposal process. The [~~board~~] department shall evaluate proposals based on criteria established by the [~~board~~] department that shall include:

(1) proven ability to administer health

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insurance programs;

(2) an estimate of total charges for administering the alliance for the proposed contract period; and

(3) ability to administer the alliance in a cost-efficient manner.

B. The alliance administrator contract shall be for a period up to four years, subject to annual renegotiation of the fees and services, and shall provide for cancellation of the contract for cause, termination of the alliance by the legislature or the combining of the alliance with a governmental body.

C. At least one year prior to the expiration of an alliance administrator contract, the [~~board~~] department may invite all interested parties, including the current administrator, to submit proposals to serve as alliance administrator for a succeeding contract period. Selection of the administrator for a succeeding contract period shall be made at least six months prior to the expiration of the current contract.

D. The alliance administrator shall:

(1) take applications for an approved health plan from small employers or a referring agent;

(2) establish a premium billing procedure for collection of premiums from insureds. Billings shall be made

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on a periodic basis, not less than monthly, as determined by the [~~board~~] department;

(3) pay the member that offers an approved health plan the net premium due after deduction of reinsurance and administrative allowances;

(4) provide the member with any changes in the status of insureds;

(5) perform all necessary functions to assure that each member is providing timely payment of benefits to individuals covered under an approved health plan, including:

(a) making information available to insureds relating to the proper manner of submitting a claim for benefits to the member offering the approved health plan and distributing forms on which submissions shall be made; and

(b) making information available on approved health plan benefits and rates to insureds;

(6) submit regular reports to the [~~board~~] department regarding the operation of the alliance, the frequency, content and form of which shall be determined by the [~~board~~] department;

(7) following the close of each fiscal year, determine premiums of members, the expense of administration and the paid and incurred health care service charges for the year and report this information to the [~~board~~] department and the superintendent on a form prescribed by the superintendent;

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and

(8) establish the premiums for reinsurance and the administrative charges, subject to approval of the [~~board~~] department.

E. The [~~board~~] department may require members issuing policies through the alliance to perform, subject to the oversight of the [~~board~~] department, any or all of the administrative functions of the alliance related to enrollment, billing or other activity that members regularly perform in the normal course of business. Members shall be required to submit regular reports to the [~~board~~] department of such activities, as specified by the [~~board~~] department. Members performing such functions shall not be entitled to receive any portion of the administrative assessment or any other payment from the alliance for performing such services."

Section 14. Section 59A-56-14 NMSA 1978 (being Laws 1994, Chapter 75, Section 14, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"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

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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 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~~] 3 of the Health Insurance Alliance Act.

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

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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~~] department 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 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,

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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

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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 period during which the individual was not 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 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.

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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, that 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;

(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

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of the additional benefits."

Section 15. Section 59A-56-15 NMSA 1978 (being Laws 1994, Chapter 75, Section 15) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"NOTICE OF ALLIANCE BY MEMBERS.--

A. [~~By January 1, 1995~~] Members shall provide notice and applications for coverage through the alliance to a small employer that receives:

(1) a rejection of coverage for health insurance;

(2) a notice that the rate for health insurance similar to coverage through the alliance will exceed the maximum rate of health insurance through the alliance; or

(3) a notice of reduction or limitation of coverage, including a restrictive rider, from a provider of health insurance, if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a small group considered a standard risk for the type of coverage provided by an approved health plan.

B. The notice shall state that the small employer is eligible but is not required to apply for health insurance provided through the alliance. Application for the health insurance shall be on forms prescribed by the [~~board~~] department and made available to all members."

Section 16. Section 59A-56-17 NMSA 1978 (being Laws 1994,

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Chapter 75, Section 17, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"BENEFITS.--

A. An approved health plan shall pay for medically necessary eligible expenses that exceed the deductible, co-payment and co-insurance amounts applicable under the provisions of Section [~~59A-56-18 NMSA 1978~~] 17 of the Health Insurance Alliance Act and are not otherwise limited or excluded. The Health Insurance Alliance Act does not prohibit the [~~board~~] department from approving additional types of health plan designs with similar cost-benefit structures or other types of health plan designs. An approved health plan for small employers shall, at a minimum, reflect the levels of health insurance coverage generally available in New Mexico for small employer group policies, but an approved health plan for small employers may also offer health plan designs that are not generally available in New Mexico for small employer group policies.

B. The [~~board~~] department may design and require an approved health plan to contain cost-containment measures and requirements, including managed care, pre-admission certification and concurrent inpatient review and the use of fee schedules for health care providers, including the diagnosis-related grouping system and the resource-based relative value system."

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Section 17. Section 59A-56-18 NMSA 1978 (being Laws 1994, Chapter 75, Section 18, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"DEDUCTIBLES--CO-INSURANCE--MAXIMUM OUT-OF-POCKET PAYMENTS.--

A. Subject to the limitations provided in Subsection C of this section, an approved health plan offered through the alliance may impose a deductible on a per-person calendar year basis. An approved health plan offered by a health maintenance organization shall provide equivalent cost-benefit structures. The [~~board~~] department may authorize deductibles in other amounts and equivalent cost-benefit structures.

B. Subject to the limitations provided in Subsection C of this section, a mandatory co-insurance requirement for an approved health plan may be imposed as a percentage of eligible expenses in excess of a deductible. Health maintenance organizations shall impose equivalent cost-benefit structures.

C. The maximum aggregate out-of-pocket payments for eligible expenses by the covered individual shall be determined by the [~~board~~] department."

Section 18. Section 59A-56-21 NMSA 1978 (being Laws 1994, Chapter 75, Section 21, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

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"[~~REGULATIONS~~] RULES.--The superintendent shall:

A. adopt [~~regulations~~] rules that provide for disclosure by members of the availability of health insurance from the alliance; and

B. adopt [~~regulations~~] rules to carry out the provisions of the Health Insurance Alliance Act."

Section 19. Section 59A-56-24 NMSA 1978 (being Laws 1994, Chapter 75, Section 24, as amended) is recompiled in Chapter 27 NMSA 1978 and is amended to read:

"BENEFIT PAYMENTS REDUCTION.--

A. An approved health plan shall be the last payer of benefits whenever any other benefit is available. Benefits otherwise payable under the approved health plan shall be reduced by all amounts paid or payable through any other health insurance and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal program, excluding medicaid.

B. The [~~administrator or the~~] alliance shall have a cause of action against any person covered by an approved health plan for the recovery of the amount of benefits paid that are not for eligible expenses. Benefits due from the approved health plan may be reduced or refused as a set-off

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against any amount recoverable under this section."

Section 20. Section 59A-56-25 NMSA 1978 (being Laws 1994, Chapter 75, Section 25, as amended) is recompiled in Chapter 27 and is amended to read:

"EXPANDED SERVICE DEVELOPMENT.--The [~~insurance division of the commission, in cooperation with the~~] alliance, in cooperation with the superintendent, shall develop a plan to provide health insurance coverage for uninsured children, individuals and other employers, including outreach and technical assistance activities conducted by the alliance to increase employer, employee and public awareness of available health insurance coverage options and to assist employers in securing or retaining health insurance coverage for employees and their dependents."

Section 21. TEMPORARY PROVISION--NEW MEXICO HEALTH INSURANCE ALLIANCE--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2009:

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

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

C. all references in law to the board of directors

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of the New Mexico health insurance alliance shall be deemed to be references to the human services department.

Section 22. TEMPORARY PROVISION--RECOMPILATION INSTRUCTIONS.--The compiler shall recompile Sections 59A-56-16, 59A-56-19, 59A-56-20, 59A-56-22 and 59A-56-23 NMSA 1978 (being Laws 1994, Chapter 75, Sections 16, 19, 20, 22 and 23, as amended) as part of Chapter 27 NMSA 1978.

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