HOUSE BILL 246

**50TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2011**

INTRODUCED BY

Roberto "Bobby" J. Gonzales

AN ACT

RELATING TO HEALTH INSURANCE; AMENDING THE HEALTH INSURANCE ALLIANCE ACT TO PROVIDE INCREASED ACCESS TO VOLUNTARY HEALTH INSURANCE COVERAGE FOR LARGE EMPLOYER GROUPS.

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

**SECTION 1.** Section 59A-56-2 NMSA 1978 (being Laws 1994, Chapter 75, Section 2, as amended) is amended to read:

"59A-56-2. PURPOSE.--The purpose of the Health Insurance Alliance Act is to provide increased access to voluntary health insurance coverage for small and large employer groups in New Mexico. 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 2.** Section 59A-56-3 NMSA 1978 (being Laws 1994,

underscored material = new
[bracketed material] = delete

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;

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

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

(1) a group health plan;

(2) health insurance coverage;

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

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

(5) 10 USCA Chapter 55;

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

(7) the Medical Insurance Pool Act;

underscored material = new
[bracketed material] = delete

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

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

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

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

J. "eligible individual":

(1) means an individual who:

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

underscored material = new
[~~bracketed material~~] = delete

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

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

(2) does not include an individual who:

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

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

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

(d) during the most recent coverage within the coverage period described in Subparagraph (a) of Paragraph (1) of this subsection was terminated from coverage as a result of nonpayment of premium or fraud; or

(e) has been offered the option of coverage under a COBRA continuation provision as that term is

underscored material = new
[bracketed material] = delete

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. "employer" means a large or small employer;

[~~K.~~] L. "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.~~] M. "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.~~] N. "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.~~] O. "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;

underscored material = new
[~~bracketed material~~] = delete

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

[~~Q.~~] R. "incurred claims" means claims paid during

underscored material = new
[~~bracketed material~~] = delete

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

T. "large employer" means a person that is a resident of this state, that has employees at least fifty percent of whom are residents of this state, that 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 fifty-one 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

underscored material = new
[~~bracketed material~~] = delete

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;

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

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

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

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

[~~W.~~] Y. "small employer" means a person that is a resident of this state, that has employees at least fifty percent of whom are residents of this state, that 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

underscored material = new
[~~bracketed material~~] = delete

(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.~~] Z. "superintendent" means the superintendent of insurance;

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

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

**SECTION 3.** 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

underscored material = new
[~~bracketed material~~] = delete

insurance in this state, except for an insurance company that is licensed under the Prepaid Dental Plan Law or a company that is solely engaged in the sale of dental insurance and is licensed under a provision of the Insurance Code.

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

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

D. 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~~

underscored material = new
[~~bracketed material~~] = delete

~~(4)~~] (2) two directors, appointed by the governor, who shall be officers, general partners or proprietors of large employers;

(3) two directors, appointed by the governor, who shall be officers, general partners or proprietors of small employers;

(4) one director, appointed by the governor, who shall be an officer, general partner or proprietor of a nonprofit corporation; and

(5) 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~~] chair of the board unless the superintendent declines, in which event the superintendent shall appoint the [~~chairman~~] chair.

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.

underscored material = new
[~~bracketed material~~] = delete

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 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. 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 4.** Section 59A-56-6 NMSA 1978 (being Laws 1994, Chapter 75, Section 6, as amended) is amended to read:

"59A-56-6. BOARD--POWERS AND DUTIES.--

A. The board 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:

(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

underscored material = new
[bracketed material] = delete

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) may conduct periodic audits of the members to assure the general accuracy of the financial data submitted to the alliance;

(4) 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 Insurance Code. In determining the initial year's rate for health insurance, the only rating factors that may be used are age, gender pursuant to this section, 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 the following percentage of the lower rate for policies issued or delivered in the respective year; provided, however, that gender shall not be used as a rating factor for policies issued or delivered on or after January 1, 2014:

(a) twenty percent for calendar year 2010;

(b) fifteen percent for calendar year

2011;

(c) ten percent for calendar year 2012; and

(d) five percent for calendar year 2013.

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

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

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

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

(10) shall determine the design criteria to be

underscored material = new
[bracketed material] = delete

met for an approved health plan;

(11) 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 shall not permit more than one approved health plan per member for each set of plan design criteria;

(12) 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) may terminate an approved health plan not operating as required by the board;

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

(15) 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 shall submit to the superintendent an audited financial report for the preceding calendar year in a

underscored material = new
[~~bracketed material~~] = delete

form approved by the superintendent."

**SECTION 5.** Section 59A-56-8 NMSA 1978 (being Laws 1994, Chapter 75, Section 8, as amended) is amended to read:

"59A-56-8. APPROVED HEALTH PLAN.--

A. An approved health plan shall conform to the alliance's approved health plan design criteria. The board 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.

B. The board shall designate plan designs for approved health plans. The board 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, that 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

underscored material = new
[~~bracketed material~~] = delete

plan.

E. If a plan design approved by the board 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 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 unless:

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

(2) the board 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 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

underscored material = new
[~~bracketed material~~] = delete

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 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 6.** Section 59A-56-9 NMSA 1978 (being Laws 1994, Chapter 75, Section 9, as amended) is amended to read:

"59A-56-9. 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

underscored material = new
[bracketed material] = delete

administrator.

B. The alliance shall withhold from all premiums that it receives a reinsurance premium as established by the board:

(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 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 7.** Section 59A-56-10 NMSA 1978 (being Laws 1994, Chapter 75, Section 10, as amended) is amended to read:

"59A-56-10. ADMINISTRATION.--The alliance shall deduct from premiums collected for approved health plans an administrative charge as set by the board. The administrative charge shall be determined before the beginning of each calendar year:

underscored material = new
[~~bracketed material~~] = delete

A. for insured [~~small~~] employer groups, the maximum administrative charge the alliance may charge is ten percent of 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 8.** Section 59A-56-13 NMSA 1978 (being Laws 1994, Chapter 75, Section 13, as amended) is amended to read:

"59A-56-13. ALLIANCE ADMINISTRATOR.--

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

(1) proven ability to administer health 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

underscored material = new
[~~bracketed material~~] = delete

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 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 on a periodic basis, not less than monthly, as determined by the board;

(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

underscored material = new
[~~bracketed material~~] = delete

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 regarding the operation of the alliance, the frequency, content and form of which shall be determined by the board;

(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 and the superintendent on a form prescribed by the superintendent; and

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

E. The board may require members issuing policies through the alliance to perform, subject to the oversight of the board, 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 of such activities, as specified by the board. 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."

underscored material = new
[bracketed material] = delete

**SECTION 9.** 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~~] An 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~~] an 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.

underscored material = new
[~~bracketed material~~] = delete

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 to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the

underscored material = new
[bracketed material] = delete

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~~] an 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

underscored material = new
[~~bracketed material~~] = delete

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 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

underscored material = new
[bracketed material] = delete

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.

K. An individual is not eligible for coverage by the alliance under an approved health plan issued to [~~a small~~] an 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

underscored material = new
[~~bracketed material~~] = delete

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 10.** Section 59A-56-15 NMSA 1978 (being Laws 1994, Chapter 75, Section 15) is amended to read:

"59A-56-15. NOTICE OF ALLIANCE BY MEMBERS.--

A. By January 1, [~~1995~~] 2012, members shall provide notice and applications for coverage through the alliance to a [~~small~~] large 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

underscored material = new
[~~bracketed material~~] = delete

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~~] large 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 and made available to all members."

**SECTION 11.** Section 59A-56-16 NMSA 1978 (being Laws 1994, Chapter 75, Section 16) is amended to read:

"59A-56-16. ENROLLMENT.--

A. New employees and their dependents may enroll in their [~~small~~] employer's approved health plan within thirty-one days of completion of their employer's eligibility period. If application for enrollment is not made during this period, the employee and dependents may be required to submit evidence of insurability.

B. Insureds shall notify the alliance at least thirty-one days prior to their anniversary date of the approved health plan of their intent to switch coverage to another approved health plan."

**SECTION 12.** Section 59A-56-17 NMSA 1978 (being Laws 1994, Chapter 75, Section 17, as amended) is amended to read:

"59A-56-17. BENEFITS.--

A. An approved health plan shall pay for medically

underscored material = new
[~~bracketed material~~] = delete

necessary eligible expenses that exceed the deductible, co-payment and co-insurance amounts applicable under the provisions of Section 59A-56-18 NMSA 1978 and are not otherwise limited or excluded. The Health Insurance Alliance Act does not prohibit the board 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 or large employer group policies.

B. The board 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."

**SECTION 13.** Section 59A-56-19 NMSA 1978 (being Laws 1994, Chapter 75, Section 19, as amended) is amended to read:

"59A-56-19. DEPENDENT FAMILY MEMBER REQUIRED COVERAGE--[~~SMALL~~] EMPLOYER RESPONSIBILITY.--

A. [~~A small~~] An employer shall collect or make a

payroll deduction from the compensation of an employee for the portion of the approved health plan cost the employee is responsible for paying. The [~~small~~] employer may contribute to the cost of that plan on behalf of the employee.

B. [~~A small~~] An employer shall make available to dependent family members of an employee covered by an approved health plan the same approved health plan. The [~~small~~] employer may contribute to the cost of group coverage.

C. All premiums collected, deducted from the compensation of employees or paid on their behalf by the [~~small~~] employer shall be promptly remitted to the alliance."

**SECTION 14.** Section 59A-56-20 NMSA 1978 (being Laws 1994, Chapter 75, Section 20, as amended) is amended to read:

"59A-56-20. RENEWABILITY.--

A. An approved health plan shall contain provisions under which the member offering the plan is obligated to renew the health insurance if premiums are paid until the day the plan is replaced by another plan or the [~~small~~] employer terminates coverage.

B. An approved health plan issued to an eligible individual shall contain provisions under which the member offering the plan is obligated to renew the health insurance except for:

(1) nonpayment of premium;

(2) fraud; or

underscored material = new
[~~bracketed material~~] = delete

(3) termination of the approved health plan, except that the individual has the right to transfer to another approved health plan.

C. If an approved health plan ceases to exist, the alliance shall provide an alternate approved health plan.

D. An approved health plan shall provide covered individuals the right to continue health insurance coverage through an approved health plan as individual health insurance provided by the same member upon the death of the employee or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the employee or by termination of employment by electing to do so within a period of time specified in the health insurance if the employee was covered under an approved health plan while employed for at least six consecutive months. The individual may be charged an additional administrative charge for the individual health insurance.

E. The right to continue health insurance coverage provided in this section terminates if the covered individual resides outside the United States for more than six consecutive months."



underscored material = new
[~~bracketed material~~] = delete