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SENATE BILL 90

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

INTRODUCED BY

George K. Munoz

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,

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1 Chapter 75, Section 3, as amended) is amended to read:

2 "59A-56-3. DEFINITIONS.--As used in the Health Insurance
3 Alliance Act:

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

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

9 C. "board" means the board of directors of the
10 alliance;

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

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

15 (1) a group health plan;

16 (2) health insurance coverage;

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

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

22 (5) 10 USCA Chapter 55;

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

25 (7) the Medical Insurance Pool Act;

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

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

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

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

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

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

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

19 J. "eligible individual":

20 (1) means an individual who:

21 (a) as of the date of the individual's
22 application for coverage under an approved health plan, has an
23 aggregate of eighteen or more months of creditable coverage,
24 the most recent of which was under a group health plan,
25 governmental plan or church plan as those plans are defined in

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

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

12 (2) does not include an individual who:

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

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

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

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

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

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1 defined in Subsection F of Section 59A-23E-2 NMSA 1978, or
2 under a similar state program, except for continuation coverage
3 under Section 59A-56-20 NMSA 1978, and did not exhaust the
4 coverage available under the offered program;

5 K. "employer" means a large or small employer;

6 [~~K.~~] L. "enrollment date" means, with respect to an
7 individual covered under a group health plan or health
8 insurance coverage, the date of enrollment of the individual in
9 the plan or coverage or, if earlier, the first day of the
10 waiting period for that enrollment;

11 [~~L.~~] M. "gross earned premiums" means premiums paid
12 or due during a calendar year for all health insurance written
13 in the state less any unearned premiums at the end of that
14 calendar year plus any unearned premiums from the end of the
15 immediately preceding calendar year;

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

21 [~~N.~~] O. "health care service" means a service or
22 product furnished an individual for the purpose of preventing,
23 alleviating, curing or healing human illness or injury and
24 includes services and products incidental to furnishing the
25 described services or products;

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

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

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

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1 a calendar year plus claims incurred in the calendar year and
2 paid prior to April 1 of the succeeding year, less claims
3 incurred previous to the current calendar year and paid prior
4 to April 1 of the current year;

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

11 T. "large employer" means a person that is a
12 resident of this state, that has employees at least fifty
13 percent of whom are residents of this state, that is actively
14 engaged in business and that on at least fifty percent of its
15 working days during either of the two preceding calendar years,
16 employed no fewer than fifty-one eligible employees; provided
17 that:

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

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

24 (3) in the case of an employer that was not in
25 existence throughout a preceding calendar year, the

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1 determination of whether the employer is a small or large
2 employer shall be based on the average number of employees that
3 it is reasonably expected to employ on working days in the
4 current calendar year;

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

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

8 ~~[U.]~~ W. "nonprofit health care plan" means a health
9 care plan as defined in Subsection K of Section 59A-47-3 NMSA
10 1978;

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

13 ~~[W.]~~ Y. "small employer" means a person that is a
14 resident of this state, that has employees at least fifty
15 percent of whom are residents of this state, that is actively
16 engaged in business and that, on at least fifty percent of its
17 working days during either of the two preceding calendar years,
18 employed no fewer than two and no more than fifty eligible
19 employees; provided that:

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

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

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

7 [~~X.~~] Z. "superintendent" means the superintendent
8 of insurance;

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

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

15 SECTION 3. Section 59A-56-4 NMSA 1978 (being Laws 1994,
16 Chapter 75, Section 4, as amended) is amended to read:

17 "59A-56-4. ALLIANCE CREATED--BOARD CREATED.--

18 A. The "New Mexico health insurance alliance" is
19 created as a nonprofit public corporation for the purpose of
20 providing increased access to health insurance in the state.
21 All insurance companies authorized to transact health insurance
22 business in this state, nonprofit health care plans, health
23 maintenance organizations and self-insurers not subject to
24 federal preemption shall organize and be members of the
25 alliance as a condition of their authority to offer health

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

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

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

13 D. The alliance shall operate subject to the
14 supervision and approval of the board. The board shall consist
15 of:

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

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

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

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1 ~~(4)~~] (2) two directors, appointed by the
2 governor, who shall be officers, general partners or
3 proprietors of large employers;

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

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

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

13 E. The superintendent shall serve as [~~chairman~~]
14 chair of the board unless the superintendent declines, in which
15 event the superintendent shall appoint the [~~chairman~~] chair.

16 F. The directors elected by the members shall be
17 elected for initial terms of three years or less, staggered so
18 that the term of at least one director expires on June 30 of
19 each year. The directors appointed by the governor shall be
20 appointed for initial terms of three years or less, staggered
21 so that the term of at least one director expires on June 30 of
22 each year. Following the initial terms, directors shall be
23 elected or appointed for terms of three years. A director
24 whose term has expired shall continue to serve until a
25 successor is elected or appointed and qualified.

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

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

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

18 "59A-56-6. BOARD--POWERS AND DUTIES.--

19 A. The board shall have the general powers and
20 authority granted to insurance companies licensed to transact
21 health insurance business under the laws of this state.

22 B. The board:

23 (1) may enter into contracts to carry out the
24 provisions of the Health Insurance Alliance Act, including,
25 with the approval of the superintendent, contracting with

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1 similar alliances of other states for the joint performance of
2 common administrative functions or with persons or other
3 organizations for the performance of administrative functions;

4 (2) may sue and be sued;

5 (3) may conduct periodic audits of the members
6 to assure the general accuracy of the financial data submitted
7 to the alliance;

8 (4) shall establish maximum rate schedules,
9 allowable rate adjustments, administrative allowances,
10 reinsurance premiums and agent referral, servicing fees or
11 commissions subject to applicable provisions in the Insurance
12 Code. In determining the initial year's rate for health
13 insurance, the only rating factors that may be used are age,
14 gender pursuant to this section, geographic area of the place
15 of employment and smoking practices. In any year's rate, the
16 difference in rates in any one age group that may be charged on
17 the basis of a person's gender shall not exceed another
18 person's rates in the age group by more than the following
19 percentage of the lower rate for policies issued or delivered
20 in the respective year; provided, however, that gender shall
21 not be used as a rating factor for policies issued or delivered
22 on or after January 1, 2014:

23 (a) twenty percent for calendar year
24 2010;

25 (b) fifteen percent for calendar year

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1 2011;

2 (c) ten percent for calendar year 2012;

3 and

4 (d) five percent for calendar year 2013.

5 No person's rate shall exceed the rate of any other person
6 with similar family composition by more than two hundred fifty
7 percent of the lower rate, except that the rates for children
8 under the age of nineteen may be lower than the bottom rates in
9 the two hundred fifty percent band. The rating factor
10 restrictions shall not prohibit a member from offering rates
11 that differ depending upon family composition;

12 (5) may direct a member to issue policies or
13 certificates of coverage of health insurance in accordance with
14 the requirements of the Health Insurance Alliance Act;

15 (6) shall establish procedures for alternative
16 dispute resolution of disputes between members and insureds;

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

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

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

25 (10) shall determine the design criteria to be

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1 met for an approved health plan;

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

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

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

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

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

22 C. The alliance is subject to and responsible for
23 examination by the superintendent. No later than March 1 of
24 each year, the board shall submit to the superintendent an
25 audited financial report for the preceding calendar year in a

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1 form approved by the superintendent."

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

4 "59A-56-8. APPROVED HEALTH PLAN.--

5 A. An approved health plan shall conform to the
6 alliance's approved health plan design criteria. The board may
7 allow more than one plan design for approved health plans. A
8 member may provide one approved health plan for each plan
9 design approved by the board.

10 B. The board shall designate plan designs for
11 approved health plans. The board may designate plan designs
12 for an approved health plan that provides catastrophic coverage
13 or other benefit plan designs.

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

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

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1 plan.

2 E. If a plan design approved by the board is not
3 offered by any member already offering an approved health plan,
4 but a member offers a substantially similar plan design outside
5 the alliance, the board may require the member to offer that
6 plan design as an approved health plan through the alliance.

7 F. A member required to offer, and offering, an
8 approved health plan pursuant to the requirement of Subsection
9 D of this section shall continue to offer that plan for five
10 consecutive years after the date the member was last required
11 to offer the plan. A member offering an approved health plan
12 but not required to offer it pursuant to the cited subsection
13 may withdraw the plan but shall continue to offer it for five
14 consecutive years after the date notice of future withdrawal is
15 given to the board unless:

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

18 (2) the board allows the plan to be withdrawn
19 because it imposes a serious hardship upon the member.

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

25 (1) the member does not offer or provide

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1 health insurance, life insurance or annuities for a period of
2 five years from the date of notification to the superintendent
3 to any person in the state who is not covered by the member
4 through a health insurance policy in effect on the date of the
5 notification; and

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

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

14 "59A-56-9. REINSURANCE.--

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

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1 administrator.

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

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

9 (2) for eligible individuals, the reinsurance
10 premium shall not exceed ten percent of premiums paid by
11 individuals in the first year of coverage or continuation
12 coverage and shall not exceed fifteen percent of premiums paid
13 by individuals for renewal years. In determining the
14 reinsurance premium for a particular calendar year, the board
15 shall set the reinsurance premium at a rate that will recover
16 the total reinsurance loss for the preceding year over a
17 reasonable number of years in accordance with sound actuarial
18 principles."

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

21 "59A-56-10. ADMINISTRATION.--The alliance shall deduct
22 from premiums collected for approved health plans an
23 administrative charge as set by the board. The administrative
24 charge shall be determined before the beginning of each
25 calendar year:

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1 A. for insured [~~small~~] employer groups, the maximum
2 administrative charge the alliance may charge is ten percent of
3 premiums in the first year and five percent of premiums in
4 renewal years; and

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

8 **SECTION 8.** Section 59A-56-13 NMSA 1978 (being Laws 1994,
9 Chapter 75, Section 13, as amended) is amended to read:

10 "59A-56-13. ALLIANCE ADMINISTRATOR.--

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

15 (1) proven ability to administer health
16 insurance programs;

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

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

22 B. The alliance administrator contract shall be for
23 a period up to four years, subject to annual renegotiation of
24 the fees and services, and shall provide for cancellation of
25 the contract for cause, termination of the alliance by the

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1 legislature or the combining of the alliance with a
2 governmental body.

3 C. At least one year prior to the expiration of an
4 alliance administrator contract, the board may invite all
5 interested parties, including the current administrator, to
6 submit proposals to serve as alliance administrator for a
7 succeeding contract period. Selection of the administrator for
8 a succeeding contract period shall be made at least six months
9 prior to the expiration of the current contract.

10 D. The alliance administrator shall:

11 (1) take applications for an approved health
12 plan from [~~small~~] employers or a referring agent;

13 (2) establish a premium billing procedure for
14 collection of premiums from insureds. Billings shall be made
15 on a periodic basis, not less than monthly, as determined by
16 the board;

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

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

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

25 (a) making information available to

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1 insureds relating to the proper manner of submitting a claim
2 for benefits to the member offering the approved health plan
3 and distributing forms on which submissions shall be made; and

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

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

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

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

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

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1 SECTION 9. Section 59A-56-14 NMSA 1978 (being Laws 1994,
2 Chapter 75, Section 14, as amended) is amended to read:

3 "59A-56-14. ELIGIBILITY--GUARANTEED ISSUE--PLAN
4 PROVISIONS.--

5 A. [~~A-small~~] An employer is eligible for an
6 approved health plan if on the effective date of coverage or
7 renewal:

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

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

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

19 (a) is offered by a state or federal
20 agency to [~~a-small~~] an employer's employee whose eligibility
21 for alternative coverage is based on the employee's income; or

22 (b) provides only a specific limited
23 form of health insurance such as accident or disability income
24 insurance coverage or a specific health care service such as
25 dental care.

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

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

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

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1 required premium shall be furnished to the member within
2 thirty-one days after the date of birth in order to have the
3 coverage from birth. An approved health plan shall provide
4 that the health insurance benefits applicable for eligible
5 dependents are payable for an adopted child in accordance with
6 the provisions of Section 59A-22-34.1 NMSA 1978.

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

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

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

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

20 F. As used in this section, "preexisting condition
21 exclusion" means a limitation or exclusion of benefits relating
22 to a condition based on the fact that the condition was present
23 before the date of enrollment for coverage for the benefits
24 whether or not any medical advice, diagnosis, care or treatment
25 was recommended or received before that date, but genetic

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1 information is not included as a preexisting condition for the
2 purposes of limiting or excluding benefits in the absence of a
3 diagnosis of the condition related to the genetic information.

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

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

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

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

16 H. The provisions of Paragraphs (1) and (2) of
17 Subsection G of this section do not apply to any individual
18 after the end of the first continuous sixty-three-day period
19 during which the individual was not covered under any
20 creditable coverage.

21 I. The preexisting condition exclusions described
22 in Subsection E of this section shall be waived to the extent
23 to which similar exclusions have been satisfied under any prior
24 health insurance coverage if the effective date of coverage for
25 health insurance through the alliance is made not later than

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1 sixty-three days following the termination of the prior
2 coverage. In that case, coverage through the alliance shall be
3 effective from the date on which the prior coverage was
4 terminated. This subsection does not prohibit preexisting
5 conditions coverage in an approved health plan that is more
6 favorable to the covered individual than that specified in this
7 subsection.

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

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

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

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

23 (3) is an inmate of a public institution.

24 L. The alliance shall provide for an open
25 enrollment period of sixty days from the initial offering of an

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1 approved health plan. Individuals enrolled during the open
2 enrollment period shall not be subject to the preexisting
3 conditions limitation.

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

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

14 "59A-56-15. NOTICE OF ALLIANCE BY MEMBERS.--

15 A. By January 1, [~~1995~~] 2012, members shall provide
16 notice and applications for coverage through the alliance to a
17 [~~small~~] large employer that receives:

18 (1) a rejection of coverage for health
19 insurance;

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

23 (3) a notice of reduction or limitation of
24 coverage, including a restrictive rider, from a provider of
25 health insurance, if the effect of the reduction or limitation

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1 is to substantially reduce coverage compared to the coverage
2 available to a small group considered a standard risk for the
3 type of coverage provided by an approved health plan.

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

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

11 "59A-56-16. ENROLLMENT.--

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

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

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

24 "59A-56-17. BENEFITS.--

25 A. An approved health plan shall pay for medically

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

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

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

23 "59A-56-19. DEPENDENT FAMILY MEMBER REQUIRED COVERAGE--
24 [~~SMALL~~] EMPLOYER RESPONSIBILITY.--

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

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

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

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

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

14 "59A-56-20. RENEWABILITY.--

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

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

24 (1) nonpayment of premium;

25 (2) fraud; or

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

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

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

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