SENATE BILL 19

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

INTRODUCED BY

Timothy Z. Jennings by request

AN ACT

RELATING TO HEALTH CARE REFORM; ENACTING THE HEALTH CARE BENEFITS ACT; CREATING THE HEALTH CARE BENEFITS ADMINISTRATION; CREATING THE HEALTHY NEW MEXICO FUND; TRANSFERRING ADMINISTRATIVE AUTHORITY OF CERTAIN HEALTH COVERAGE PROGRAMS TO THE HEALTH CARE BENEFITS ADMINISTRATION; PROVIDING FOR TRANSITION OF ADMINISTRATIVE AUTHORITY OF CERTAIN HEALTH COVERAGE PROGRAMS; MAKING AN APPROPRIATION.

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

Section 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 9 of this act may be cited as the "Health Care Benefits Act".

Section 2. [NEW MATERIAL] DEFINITIONS.--As used in the Health Care Benefits Act:

A. "administration" means the health care benefits

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administration;

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

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

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

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

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

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

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

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

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

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

Section 3. [NEW MATERIAL] HEALTH CARE BENEFITS ADMINISTRATION--CREATION--BOARD--POWERS--DUTIES.--

A. The "health care benefits administration" is created as an adjunct agency pursuant to Section 9-1-6 NMSA 1978. The administration shall be governed by a board of directors.

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

(1) three members appointed by the governor, one of whom shall be a licensed physician pursuant to the Medical Practice Act; one of whom shall be a nurse with a graduate-level education in nursing; and one of whom shall have at least three years' experience in health care finance, economics or actuarial analysis;

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

(a) one member shall be a Native American;

(b) one member shall have at least three years' experience in labor organization and advocacy;

(c) one member shall have at least three

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years' experience in health or human services advocacy;

(d) one member shall have at least three years' executive-level experience in a business not related to health care that employs ten or fewer individuals; and

(e) one member shall have at least three years' executive-level experience in management or finance in a business not related to health care;

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

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

(5) the superintendent of insurance or the superintendent's designee.

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

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

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E. A majority of the eleven voting members shall constitute a quorum. The board may allow members' participation in meetings by telephone or other electronic medium. Every odd-numbered year, the board shall elect its chair and vice chair in open session from any of the appointed members; provided, however, that the secretary of health, the secretary of human services and the superintendent of insurance or their designees shall not serve as chair or vice chair. A chair or vice chair shall serve no more than two consecutive two-year terms.

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

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

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

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

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

H. A board member is entitled to receive per diem and mileage in accordance with the Per Diem and Mileage Act.

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I. The board shall meet at least once per calendar quarter. Unless otherwise indicated in the Health Care Benefits Act, the board is subject to and shall comply with statutes and rules applicable to state agencies, including the Administrative Procedures Act; provided, however, that the administration shall not promulgate rules unless specifically provided that power by the legislature.

J. The board:

(1) shall create the following advisory councils, each of which shall include representatives of beneficiaries, providers, payers and insurers, to provide the board with analyses and expert recommendations:

(a) a delivery system council;

(b) a cost containment and finance council whose analyses shall include review of federal issues;

(c) a benefits and services council; and

(d) a Native American health care council; provided, however, that the administration may use an existing Native American advisory council created by a health-related state agency;

(2) may create other ad hoc advisory councils representing beneficiaries, payers, providers, advocates and other stakeholders; and

(3) shall, in creating any council, give due consideration to the ethnic, economic and geographic diversity

of the state.

K. At least once each year or as requested by the board, each of the advisory councils created pursuant to Paragraph (1) of Subsection J of this section shall present its findings and make recommendations to the board on issues requested by the board.

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

Section 4. [NEW MATERIAL] EXECUTIVE DIRECTOR APPOINTMENT.--From the effective date of the Health Care Benefits Act through June 30, 2013, the governor, in consultation with the board, shall appoint an executive director of the administration, subject to confirmation by the senate. The appointed executive director shall serve as executive director-designee until the senate acts to confirm or not to confirm the appointee.

Section 5. [NEW MATERIAL] HEALTH CARE BENEFITS ADMINISTRATION--EXECUTIVE DIRECTOR QUALIFICATIONS AND DUTIES--STAFF.--

A. The executive director shall have at least seven

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years of management or administrative experience in health care delivery, policy, management, financing or coverage. The executive director shall carry on the day-to-day operations of the administration. The executive director is exempt from the Personnel Act.

B. The executive director shall employ those persons necessary to administer and implement the powers and duties of the administration. The executive director may contract with persons for professional services that require specialized knowledge or expertise or that are for short-term projects.

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

D. The executive director shall organize the staff into operational units to facilitate the administration's work, including:

(1) a health analysis and research division;

(2) a plan management division;

(3) an outreach and education division; and

(4) an administrative services division.

Section 6. [NEW MATERIAL] HEALTH CARE BENEFITS ADMINISTRATION--DUTIES.--The administration shall:

A. administer and manage health plans, benefits,

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programs, services products and funds for the provision of coverage for small employers and public employees and retirees, within available resources, including:

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

(2) developing and administering transitional or other health plans, benefits or services products to meet the needs of individuals covered by the health plans administered by the administration or individuals who are awaiting coverage by public or private health plans for all or some health conditions, within available resources;

B. by July 1, 2009, develop and present to the governor and legislature proposed guidelines for:

(1) health plans, benefits or services that may constitute health coverage for any requirement to show proof of health coverage;

(2) affordability of health coverage that factors in the amount or percentage of household income that may reasonably be spent on health care, including guidelines regarding premium assistance or other subsidies required to make health coverage affordable at various household income levels; and

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(3) a comprehensive health benefits or services plan that defines optimal health coverage for persons living in New Mexico, including varying benefit or service plans and different patient cost-sharing models, taking into consideration individuals who turn to prayer, ceremonies, traditional healers or other spiritual or cultural practices for healing and wellness;

C. by January 1, 2011, submit a written report to the governor and legislature with findings and recommendations, after consideration of actuarial, solvency, fiscal and data analyses, and after public and stakeholder input, about whether and, if recommended, how to consolidate any actuarial pools, in whole or in part, that are administratively managed by the administration;

D. by July 1, 2011, or as soon thereafter as possible, subject to available appropriations and other resources, and in consultation or in conjunction with the insurance division of the public regulation commission, the department of health, the human services department, the higher education department or other appropriate state agency or governing body, provide one or more reports to the governor, the legislature and the public, including fiscal analyses or legal or policy implications and recommendations regarding:

(1) the feasibility of the following:

(a) having the administration assume, or

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

(b) having the administration assume the management of the medical insurance pool or coordinate with the medical insurance pool; or

(c) allowing profit-making or nonprofit employers not otherwise eligible to purchase health coverage pursuant to the Health Insurance Alliance Act or the Medical Insurance Pool Act to purchase health coverage pursuant to the Group Benefits Act or the at rates based on the employer group's health status or claims experience but within the experience rating limitations pursuant to the Small Group Rate and Renewability Act;

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

(3) methods to address trends, factors and other elements to control health care costs, including methods for increasing wellness, preventing disease, improving care of persons with chronic health conditions and obtaining access to innovative, efficacious and cost-effective pharmaceuticals to help reduce demand for high-cost treatments and future costs;

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(4) data and information reporting requirements for health insurers across all health product lines to increase transparency and accountability, including data regarding nonmedical costs of health coverage, separating health insurers' profits from administrative expenses;

(5) portability of health coverage, including the feasibility of developing a statewide insurance clearing house or exchange function within the administration for groups and individuals to purchase health coverage and for health insurers to offer health coverage;

(6) performance standards for health insurers and providers;

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

(8) health care practitioner training, recruitment and retention activities and incentives, including incentives for increasing the number of primary and preventive health care practitioners rather than specialty and subspecialty care practitioners;

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

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

(11) the implications of imposing a payroll tax on all employers, whether offering employer-sponsored insurance or not, to pay for or subsidize the costs of premiums for persons unable to afford health coverage;

(12) federal laws, policies and practices that affect access to health care, health coverage, health care delivery and health outcomes, including the federal Indian Health Care Improvement Act, the federal Employee Retirement Income Security Act of 1974, the federal tax code, the federal Social Security Act and the federal Health Insurance Portability and Accountability Act of 1996;

(13) the costs and implications of moving to a community rating system for all health insurance products;

(14) methods of establishing adequate rate ranges paid to providers and the impact of current rates on health service delivery, health care access, health professional supply and health outcomes;

(15) the impact on health care cost and health care access due to:

(a) providers' choices about acceptance or refusal of payment from state, federal or joint

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state-federal programs and commercial insurance; and

(b) public and private provider credentialing processes, including provisional credentialing;

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

(17) such other analyses as directed by the legislature or recommended by the administration's advisory councils and determined appropriate by the board;

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

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

(2) household and employer surveys to ascertain the extent of health coverage offered and take-up rates; and

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

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

(1) the benefits of wellness, prevention and

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disease management activities;

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

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

G. to the extent not otherwise required or available by law or rule, define, collect, monitor and report data about health care costs at the health insurer and provider levels, quality, including adverse incidents and hospital infection rates, and access across all sectors of the health care field, ensuring that individual patient information and corporate proprietary information are protected and remain confidential;

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

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

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

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Section 7. [NEW MATERIAL] IMPACT OF REFORM INITIATIVES--REPORT BY THE HEALTH CARE BENEFITS ADMINISTRATION.--

A. The administration shall arrange for an external evaluation of the initiatives required by the Health Care Benefits Act no sooner than January 1, 2012 nor later than January 1, 2014. The evaluation shall be conducted in collaboration with the human services department, the department of health and the insurance division of the public regulation commission. The findings and recommendations of the evaluation shall be reported to the legislative finance committee, the interim legislative health and human services committee and the governor. The evaluation shall include a review of:

(1) the functioning and capacity of the administration;

(2) the progress toward or the barriers against the achievement of identified goals designed to increase health coverage;

(3) medical and nonmedical costs of health care and health coverage offered by commercial carriers and public programs;

(4) the progress made toward electronic claims submission, electronic payment transactions and electronic medical records;

(5) available access to quality health care

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throughout the state with an emphasis on underserved areas and populations; and

(6) quantifiable progress toward enhancing the health outcomes of people living in the state.

B. The administration shall, in consultation with the insurance division of the public regulation commission, review reform provisions pursuant to the New Mexico Insurance Code to determine their costs and impact on employers, groups, employees and individuals and provide a report on recommendations regarding the reforms, including whether to retain, revise or repeal them.

Section 8. [NEW MATERIAL] REPORTING AND USE OF DATA.--

A. Health insurers and providers, except individual practitioners, shall report to the administration the appropriate data about health coverage, health care and health coverage costs, health services delivered, incidents and infection rates and health outcomes achieved in a format required or approved by the administration after consultation with other state entities authorized to collect related data.

B. Data reported shall be in aggregate form except where patient-specific information is necessary to provide unduplicated information. Data shall be reported electronically to the extent possible. The administration shall use and report data received only in aggregate form and shall not use or release any individual-identifying information

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or corporate proprietary information for any purpose except as provided by state or federal law or by court order.

C. In developing such data reporting requirements, the administration shall seek and consider input from health insurers, providers, advisory councils created pursuant to Section 3 of the Health Care Benefits Act and the public regarding the format, timing and method of transmission of data to prevent duplicative reporting and to make reporting of data the least burdensome possible while achieving the purposes of that act.

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

Section 9. [NEW MATERIAL] HEALTHY NEW MEXICO FUND--CREATED.--

A. The "healthy New Mexico fund" is created in the state treasury. The fund and any income produced by the fund shall be deposited in a segregated account and invested by the state investment council in consultation with the administration. Money in the fund shall be used solely for the purposes of the fund and shall not be used to pay any general or special obligation or debt of the state, other than as authorized by this section.

B. The fund shall consist of money appropriated to

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the fund, income from investment of the fund, employees' contributions, insurance or reinsurance proceeds and other funds received by gift, grant, bequest or otherwise for deposit in the fund, including refunds or payments from health insurers designated to be deposited in this fund, all of which are appropriated to and for the purposes of the fund.

C. Disbursements from the fund for purposes other than procuring and paying for insurance or insurance-related services, including third-party administration, premiums, claims and cost-containment activities, shall be made only upon warrant drawn by the secretary of finance and administration pursuant to vouchers signed by the executive director or the executive director's designee; provided that the chair of the board may sign vouchers if the position of director is vacant.

D. Subject to appropriation by the legislature, money in the fund shall be used to fund outreach and pay for health care premiums or services through publicly authorized programs to expand coverage or as otherwise provided by law. Any unexpended or unencumbered balance remaining in the fund at the end of any fiscal year shall not revert.

Section 10. Section 10-7B-2 NMSA 1978 (being Laws 1989, Chapter 231, Section 2, as amended) is amended to read:

"10-7B-2. DEFINITIONS.--As used in the Group Benefits Act:

A. "committee" means the [~~group benefits committee~~]

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board of directors of the health care benefits administration;

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

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

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

E. "professional claims administrator" means any person or legal entity that has at least five years of experience handling group benefits claims, as well as such other qualifications as the director may determine from time to time with the committee's advice;

F. "small employer" means a person having for-profit or nonprofit status that employs an average of fifty or fewer persons over a twelve-month period; and

G. "state" or "state agency" means the state of New Mexico or any of its branches, agencies, departments, boards, instrumentalities or institutions."

Section 11. Section 10-7C-4 NMSA 1978 (being Laws 1990, Chapter 6, Section 4, as amended) is amended to read:

"10-7C-4. DEFINITIONS.--As used in the Retiree Health Care Act:

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A. "active employee" means an employee of a public institution or any other public employer participating in either the Educational Retirement Act, the Public Employees Retirement Act, the Judicial Retirement Act, the Magistrate Retirement Act or the Public Employees Retirement Reciprocity Act or an employee of an independent public employer;

B. "authority" means the [~~retiree~~] health care [~~authority created pursuant to the Retiree Health Care Act~~] benefits administration;

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

D. "board" means the board of directors of the [~~retiree~~] health care [~~authority~~] benefits administration;

E. "current retiree" means an eligible retiree who is receiving a disability or normal retirement benefit under the Educational Retirement Act, the Public Employees Retirement Act, the Judicial Retirement Act, the Magistrate Retirement Act, the Public Employees Retirement Reciprocity Act or the retirement program of an independent public employer on or before July 1, 1990;

F. "eligible dependent" means a person obtaining retiree health care coverage based upon that person's relationship to an eligible retiree as follows:

(1) a spouse;

(2) an unmarried child under the age of

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nineteen who is:

(a) a natural child;

(b) a legally adopted child;

(c) a stepchild living in the same household who is primarily dependent on the eligible retiree for maintenance and support;

(d) a child for whom the eligible retiree is the legal guardian and who is primarily dependent on the eligible retiree for maintenance and support, as long as evidence of the guardianship is evidenced in a court order or decree; or

(e) a foster child living in the same household;

(3) a child described in Subparagraphs (a) through (e) of Paragraph (2) of this subsection who is between the ages of nineteen and twenty-five and is a full-time student at an accredited educational institution; provided that "full-time student" shall be a student enrolled in and taking twelve or more semester hours or its equivalent contact hours in primary, secondary, undergraduate or vocational school or a student enrolled in and taking nine or more semester hours or its equivalent contact hours in graduate school;

(4) a dependent child over nineteen who is wholly dependent on the eligible retiree for maintenance and support and who is incapable of self-sustaining employment by

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reason of mental retardation or physical handicap; provided that proof of incapacity and dependency shall be provided within thirty-one days after the child reaches the limiting age and at such times thereafter as may be required by the board;

(5) a surviving spouse defined as follows:

(a) "surviving spouse" means the spouse to whom a retiree was married at the time of death; or

(b) "surviving spouse" means the spouse to whom a deceased vested active employee was married at the time of death; or

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

G. "eligible employer" means either:

(1) a "retirement system employer", which means an institution of higher education, a school district or other entity participating in the public school insurance authority, a state agency, state court, magistrate court, municipality, county or public entity, each of which is affiliated under or covered by the Educational Retirement Act, the Public Employees Retirement Act, the Judicial Retirement Act, the Magistrate Retirement Act or the Public Employees Retirement Reciprocity Act; or

(2) an "independent public employer", which means a municipality, county or public entity that is not a

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retirement system employer;

H. "eligible retiree" means:

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

(a) has served without salary as a member of the governing authority of an employer eligible to participate in the benefits of the Retiree Health Care Act and is certified to be such by the executive director of the public school insurance authority;

(b) has maintained group health insurance coverage through that member's governing authority if such group health insurance coverage was available and offered to the member during the member's service as a member of the governing authority; and

(c) was participating in the group health insurance program under the Retiree Health Care Act prior to July 1, 1993; or

(d) notwithstanding the provisions of Subparagraphs (b) and (c) of this paragraph, is eligible under Subparagraph (a) of this paragraph and has applied before August 1, 1993 to the authority to participate in the program;

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

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(a) has served with salary as a member of the governing authority of an employer eligible to participate in the benefits of the Retiree Health Care Act;

(b) has maintained group health insurance through that member's governing authority, if such group health insurance was available and offered to the member during the member's service as a member of the governing authority; and

(c) was participating in the group health insurance program under the Retiree Health Care Act prior to July 1, 1993; or

(d) notwithstanding the provisions of Subparagraphs (b) and (c) of this paragraph, is eligible under Subparagraph (a) of this paragraph and has applied before August 1, 1993 to the authority to participate in the program;

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

(a) falls within the definition of a retiree, has made contributions to the fund for at least five years prior to retirement and whose eligible employer during that period of time made contributions as a participant in the Retiree Health Care Act on the person's behalf, unless that person retires on or before July 1, 1995, in which event the time period required for employee and employer contributions shall become the period of time between July 1, 1990 and the

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date of retirement, and who is certified to be a retiree by the educational retirement director, the executive secretary of the public employees retirement board or the governing authority of an independent public employer;

(b) falls within the definition of a retiree, retired prior to July 1, 1990 and is certified to be a retiree by the educational retirement director, the executive secretary of the public employees retirement association or the governing authority of an independent public employer; but this paragraph does not include a retiree who was an employee of an eligible employer who exercised the option not to be a participating employer pursuant to the Retiree Health Care Act and did not after January 1, 1993 elect to become a participating employer; unless the retiree: 1) retired on or before June 30, 1990; and 2) at the time of retirement did not have a retirement health plan or retirement health insurance coverage available from [~~his~~] the retiree's employer; or

(c) is a retiree who: 1) was at the time of retirement an employee of an eligible employer who exercised the option not to be a participating employer pursuant to the Retiree Health Care Act, but which eligible employer subsequently elected after January 1, 1993 to become a participating employer; 2) has made contributions to the fund for at least five years prior to retirement and whose eligible employer during that period of time made contributions as a

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participant in the Retiree Health Care Act on the person's behalf, unless that person retires less than five years after the date participation begins, in which event the time period required for employee and employer contributions shall become the period of time between the date participation begins and the date of retirement; and 3) is certified to be a retiree by the educational retirement director, the executive director of the public employees retirement board or the governing authority of an independent public employer;

(4) a "legislative member", which means a person who is not a retiree and who served as a member of the New Mexico legislature for at least two years, but is no longer a member of the legislature and is certified to be such by the legislative council service; or

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

I. "fund" means the retiree health care fund;

J. "group health insurance" means coverage that

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includes but is not limited to life insurance, accidental death and dismemberment, hospital care and benefits, surgical care and treatment, medical care and treatment, dental care, eye care, obstetrical benefits, prescribed drugs, medicines and prosthetic devices, medicare supplement, medicare carveout, medicare coordination and other benefits, supplies and services through the vehicles of indemnity coverages, health maintenance organizations, preferred provider organizations and other health care delivery systems as provided by the Retiree Health Care Act and other coverages considered by the board to be advisable;

K. "ineligible dependents" include:

(1) those dependents created by common law relationships;

(2) dependents while in active military service;

(3) parents, aunts, uncles, brothers, sisters, grandchildren and other family members left in the care of an eligible retiree without evidence of legal guardianship; and

(4) anyone not specifically referred to as an eligible dependent pursuant to the rules and regulations adopted by the board;

L. "participating employee" means an employee of a participating employer, which employee has not been expelled from participation in the Retiree Health Care Act pursuant to

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Section 10-7C-10 NMSA 1978;

M. "participating employer" means an eligible employer who has satisfied the conditions for participating in the benefits of the Retiree Health Care Act, including the requirements of Subsection M of Section 10-7C-7 NMSA 1978 and Subsection D or E of Section 10-7C-9 NMSA 1978, as applicable;

N. "public entity" means a flood control authority, economic development district, council of governments, regional housing authority, conservancy district or other special district or special purpose government; and

O. "retiree" means a person who:

(1) is receiving:

(a) a disability or normal retirement benefit or survivor's benefit pursuant to the Educational Retirement Act;

(b) a disability or normal retirement benefit or survivor's benefit pursuant to the Public Employees Retirement Act, the Judicial Retirement Act, the Magistrate Retirement Act or the Public Employees Retirement Reciprocity Act; or

(c) a disability or normal retirement benefit or survivor's benefit pursuant to the retirement program of an independent public employer to which that employer has made periodic contributions; or

(2) is not receiving a survivor's benefit but

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is the eligible dependent of a person who received a disability or normal retirement benefit pursuant to the Educational Retirement Act, the Public Employees Retirement Act, the Judicial Retirement Act, the Magistrate Retirement Act or the Public Employees Retirement Reciprocity Act."

Section 12. Section 22-29-3 NMSA 1978 (being Laws 1986, Chapter 94, Section 3, as amended by Laws 2007, Chapter 41, Section 1 and by Laws 2007, Chapter 236, Section 1) is amended to read:

"22-29-3. DEFINITIONS.--As used in the Public School Insurance Authority Act:

A. "authority" means the public school insurance authority for purposes of risk-related coverage and the health care benefits administration for purposes of group health insurance;

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

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

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

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administration for purposes of group health insurance;

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

F. "educational entities" means state educational institutions as enumerated in Article 12, Section 11 of the constitution of New Mexico and other state diploma, degree-granting and certificate-granting post-secondary educational institutions, regional education cooperatives and nonprofit organizations dedicated to the improvement of public education and whose membership is composed exclusively of public school employees, public schools or school districts;

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

H. "group health insurance" means coverage that includes life insurance, accidental death and dismemberment, medical care and treatment, dental care, eye care and other coverages as determined by the authority;

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

J. "school district" means a school district as defined in Subsection [~~R~~] S of Section 22-1-2 NMSA 1978,

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excluding any school district with a student enrollment in excess of sixty thousand students."

Section 13. Section 22-29-6 NMSA 1978 (being Laws 1986, Chapter 94, Section 6, as amended) is amended to read:

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

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

B. The board shall determine which money in the fund constitutes the long-term reserves of the authority. The state investment officer shall invest the long-term reserves of the authority in accordance with the provisions of Sections 6-8-1 through 6-8-16 NMSA 1978. The state treasurer shall invest the money in the fund that does not constitute the long-term reserves of the fund in accordance with the applicable provisions of Chapter 6, Article 10 NMSA 1978.

C. All appropriations shall be subject to budget review through the department [~~of education~~], the state budget division of the department of finance and administration and the legislative finance committee.

D. The authority shall provide that premiums are collected from school districts and charter schools

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participating in the authority sufficient to provide the required insurance coverage and to pay the expenses of the authority. All premiums shall be credited to the fund.

E. Any reserves remaining at the termination of an insurance contract shall be disbursed to the individual school districts, charter schools and other participating entities on a pro rata basis.

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

G. On and after July 1, 2009, the fund shall consist of two accounts: the "risk account" and the "group health insurance account". All premiums related to risk insurance shall be deposited into the risk account, and all expenditures related to risk insurance shall be made from the risk account. All premiums related to group health insurance shall be deposited into the group health insurance account, and all expenditures related to group health insurance shall be made from the group health insurance account. On July 1, 2009,

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

Section 14. Section 59A-6-5 NMSA 1978 (being Laws 1984, Chapter 127, Section 105, as amended) is amended to read:

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

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

(1) the Law Enforcement Protection Fund Act;

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

(3) the Voter Action Act.

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

C. The "insurance operations fund" is created in the state treasury. The fund shall consist of the

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

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

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

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

(3) to the healthy New Mexico fund, that part of the balance derived pursuant to Section 59A-6-2 NMSA 1978 that exceeds one-fourth of the amount collected pursuant to Section 59A-6-2 NMSA 1978 for calendar year 2009; and

[~~(3)~~] (4) to the general fund, the balance remaining in the insurance department suspense fund derived

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from all other kinds of insurance business."

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

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

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

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

C. "board" means the board of directors of the [~~alliance~~] health care benefits administration;

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~~

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~~health service or of an Indian nation, tribe or pueblo;~~

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

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

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

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

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

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

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

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

J. "eligible individual":

(1) means an individual who:

(a) as of the date of the individual's application for coverage under an approved health plan, has an aggregate of eighteen or more months of creditable coverage,

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

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

(2) does not include an individual who:

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

(b) is eligible for coverage under 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

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

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

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

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

N. "health care service" means a service or product furnished an individual for the purpose of preventing, alleviating, curing or healing human illness or injury and includes services and products incidental to furnishing the

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described services or products;

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

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

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

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

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

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

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

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

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

(1) in determining the number of eligible

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employees, the spouse or dependent of an employee may, at the employer's discretion, be counted as a separate employee;

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

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

X. "superintendent" means the superintendent of insurance;

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

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

Section 16. 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.

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All insurance companies authorized to transact health insurance business in this state, nonprofit health care plans, health maintenance organizations and self-insurers not subject to federal preemption shall organize and be members of the alliance as a condition of their authority to offer health insurance in this state, except for an insurance company that is licensed under the Prepaid Dental Plan Law or a company that is solely engaged in the sale of dental insurance and is licensed under a provision of the Insurance Code.

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

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

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

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

~~(2) five directors, appointed by the governor,~~

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~~who shall be officers, general partners or proprietors of small employers, one director of which shall represent nonprofit corporations;~~

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

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

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

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

~~G. Whenever a vacancy on the board occurs, the electing or appointing authority of the position that is vacant shall fill the vacancy by electing or appointing an individual to serve the balance of the unexpired term; provided, when a~~

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~~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 17. Section 59A-56-14 NMSA 1978 (being Laws 1994, Chapter 75, Section 14, as amended) is amended to read:

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

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

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

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

(3) the small employer does not offer other

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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.

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

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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, 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

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more than six months after the enrollment date; and

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

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

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

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

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

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

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

I. The preexisting condition exclusions described in Subsection E of this section shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the effective date of coverage for health insurance through the alliance is made not later than [~~sixty-three~~] ninety-five days following the termination of the prior coverage. In that case, coverage through the alliance shall be effective from the date on which the prior coverage was terminated. This subsection does not prohibit preexisting conditions coverage in an approved health plan that is more favorable to the covered individual than that specified in this subsection.

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

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

(1) is eligible for medicare; provided, however, that if an individual has health insurance coverage

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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 of the additional benefits."

Section 18. TEMPORARY PROVISION--NEW MEXICO HEALTH POLICY COMMISSION--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On January 1, 2009, as determined by the secretary of finance and administration upon advice of the

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executive director of the New Mexico health policy commission:

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

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

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

Section 19. TEMPORARY PROVISION--TRANSITION OF HEALTH COVERAGE PROGRAMS TO THE HEALTH CARE BENEFITS ADMINISTRATION.--The health care benefits administration shall:

A. by July 1, 2009, combine under the auspices of the health care benefits administration the administrative management of the public school insurance authority as it relates to group health insurance but not including risk-related coverages as those are defined in the Public School Insurance Authority Act, the health coverage programs pursuant to the Group Benefits Act and the publicly funded health care program of any public school district with a student enrollment in excess of sixty thousand students; provided, however, that the purposes and financing mechanisms of the respective programs are maintained, identifiable and accounted for

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separately to ensure that respective beneficiaries obtain the services to which they are entitled; and

B. by July 1, 2010, combine under the auspices of the health care benefits administration the management of the New Mexico health insurance alliance, the retiree health care authority and state-sponsored premium assistance programs pursuant to Subsection B of Section 27-2-12 NMSA 1978 and the New Mexico state coverage insurance program or its successor program administered by the human services department; provided, however, that each program's actuarial and benefit pool and funding streams are maintained, identifiable and accounted for separately to ensure that respective beneficiaries obtain the services to which they are entitled.

Section 20. TEMPORARY PROVISION--PUBLIC SCHOOL INSURANCE AUTHORITY--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2009:

A. as determined by the secretary of finance and administration upon the advice of the executive director of the public school insurance authority:

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

(2) all appropriations, money, records, equipment, supplies and other property of the public school

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insurance authority that are directly related to administering the group health insurance program are transferred to the health care benefits administration;

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

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

Section 21. TEMPORARY PROVISION--GROUP BENEFITS COMMITTEE--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2009:

A. as determined by the secretary of finance and administration upon the advice of the director of the risk management division of the general services department, all personnel, appropriations, money, records, equipment, supplies and other property of the group benefits committee shall be transferred to the health care benefits administration;

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

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

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benefits administration;

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

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

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

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

Section 22. TEMPORARY PROVISION--CERTAIN SCHOOL DISTRICTS--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2009:

A. as determined by the secretary of finance and administration upon the advice of the superintendent of the respective school district, all personnel, appropriations, money, records, equipment, supplies and other property of a publicly funded health care system of any public school district with a student enrollment in excess of sixty thousand

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students shall be transferred to the health care benefits administration;

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

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

Section 23. TEMPORARY PROVISION--NEW MEXICO HEALTH INSURANCE ALLIANCE--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2010:

A. as determined by the secretary of finance and administration upon the advice of the executive director of the New Mexico health insurance alliance, all personnel, appropriations, money, records, equipment, supplies and other property of the board of directors of the New Mexico health insurance alliance shall be transferred to the health care benefits administration;

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

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

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be references to the health care benefits administration.

Section 24. TEMPORARY PROVISION--RETIREE HEALTH CARE AUTHORITY--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2010:

A. as determined by the secretary of finance and administration upon the advice of the executive director of the retiree health care authority, all personnel, appropriations, money, records, equipment, supplies and other property of the retiree health care authority shall be transferred to the health care benefits administration;

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

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

Section 25. TEMPORARY PROVISION--INSURANCE PROGRAMS OF THE HUMAN SERVICES DEPARTMENT--TRANSFER OF PERSONNEL, PROPERTY AND CONTRACTS.--On July 1, 2010:

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

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shall be transferred to the health care benefits administration; and

B. all contracts of the human services department that are directly related to the state-sponsored premium assistance programs shall be binding and effective on the health care benefits administration.

Section 26. REPEAL.--

A. Sections 9-7-11.1 and 9-7-11.2 NMSA 1978 (being Laws 1991, Chapter 139, Sections 1 and 2, as amended) are repealed effective January 1, 2009.

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

Section 27. DELAYED REPEAL.--Section 4 of this act is repealed effective July 1, 2013.

Section 28. SEVERABILITY.--If any part or application of this act is held invalid, the remainder or its application to other situations or persons shall not be affected.

Section 29. EFFECTIVE DATE.--

A. The effective date of the provisions of Section 17 of this act is January 1, 2009.

B. The effective date of the provisions of Sections 10, 12 and 13 of this act is July 1, 2009.

C. The effective date of the provisions of Section 14 of this act is January 1, 2010.

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D. The effective date of the provisions of Sections 11, 15 and 16 of this act is July 1, 2010.