SENATE BILL 334

45TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2001

INTRODUCED BY

Carroll H. Leavell

AN ACT

RELATING TO INSURANCE; MAKING CHANGES IN PROVISIONS OF THE HEALTH INSURANCE ALLIANCE ACT.

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

Section 1. 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;

D. "child" means a dependent unmarried individual who is less than nineteen years of age or an unmarried individual who is enrolled full time in an accredited educational institution until the individual becomes 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 Social Security Act;

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

(5) 10 USCA Chapter 55;

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

(7) the Comprehensive Health Insurance Pool Act;

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

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

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

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F. "department" means the [~~department of~~] insurance division of the public regulation commission;

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

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

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

J. "eligible individual":

(1) means an individual who:

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

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and before the enrollment date, there was a sixty-three-day or longer period during all of which the individual was not covered under any creditable coverage; or

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

(2) does not include an individual who:

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

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

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

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

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

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individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for that enrollment;

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

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

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

O. "health insurance" means "health" insurance as defined in Section 59A-7-3 NMSA 1978; any hospital and medical expense-incurred policy; nonprofit health care plan service contract; health maintenance organization subscriber contract; short-term, accident, fixed indemnity, specified disease policy or disability income insurance contracts and limited

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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;

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,

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a former employee of a small employer who is covered by an approved health plan through conversion or an individual covered by an approved health plan that allows individual enrollment;

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

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

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

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

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

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

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

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

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

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

B. The board:

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

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

(2) may sue and be sued;

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

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

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

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

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

(8) shall [~~conduct all board meetings as if it were subject to the provisions of the Open Meetings Act~~] open its meetings to the public unless the topic under discussion involves personnel issues, litigation or potential litigation or other matters determined by the board to be confidential;

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

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

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

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criteria;

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

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

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

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

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

Section 3. Section 59A-56-9 NMSA 1978 (being Laws 1994, Chapter 75, Section 9, as amended) is amended to read:

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

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

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

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

(2) for eligible individuals, the reinsurance premium shall not exceed ten percent of premiums paid by individuals in the first year of coverage or continuation coverage and shall not exceed fifteen percent of premiums paid by individuals for renewal years. In determining the

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reinsurance premium for a particular calendar year, the board shall set the reinsurance premium at a rate that will recover the total reinsurance loss for the preceding year over a reasonable number of years in accordance with sound actuarial principles."

Section 4. Section 59A-56-11 NMSA 1978 (being Laws 1994, Chapter 75, Section 11, as amended) is amended to read:

"59A-56-11. ASSESSMENTS.--

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

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

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first to offset the net reinsurance losses incurred in the other category of coverage and second to offset administrative losses; and

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

B. The assessment for each member shall be determined by multiplying the total losses of the alliance's operation, as defined in Subsection A of this section, by a fraction, the numerator of which is an amount equal to that member's total premiums, or the equivalent, exclusive of premiums received by the member for an approved health plan for health insurance written in the state during the preceding calendar year and the denominator of which equals the total premiums of all health insurance written in the state during the preceding calendar year exclusive of premiums for approved health plans; provided that total premiums shall not include payments by the secretary of human services pursuant to a contract issued under Section 1876 of the federal Social

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Security Act, total premiums exempted by the federal Employee Retirement Income Security Act of 1974 or federal government programs.

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

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

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

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

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

F. The proportion of participation of each member in the alliance shall be determined annually by the board, based on annual statements filed by each member and other reports deemed necessary by the board. Any deficit incurred by the alliance shall be recouped by assessments apportioned

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among the members pursuant to the formula provided in Subsection B of this section; provided that [~~thirty~~] fifty percent of the assessment paid for any member shall be allowed as a credit on the following annual premium tax return for that member.

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

Section 5. Section 59A-56-13 NMSA 1978 (being Laws 1994,

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Chapter 75, Section 13, as amended) is amended to read:

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

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

(1) proven ability to administer health insurance programs;

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

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

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

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

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months prior to the expiration of the current contract.

D. The alliance administrator shall:

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

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

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

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

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

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

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

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

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

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

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

Section 6. REPEAL.--Laws 1994, Chapter 75, Section 35, as amended by Laws 1997, Chapter 27, Section 1, is repealed.

Section 7. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2001.

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