HOUSE HEALTH, GOVERNMENT AND INDIAN AFFAIRS
COMMITTEE SUBSTITUTE FOR
HOUSE BILL 168

51ST LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2013

AN ACT

RELATING TO HEALTH COVERAGE; AMENDING, REPEALING AND ENACTING SECTIONS OF THE HEALTH INSURANCE ALLIANCE ACT TO PROVIDE FOR THE ESTABLISHMENT OF A HEALTH INSURANCE EXCHANGE TO OFFER QUALIFIED HEALTH PLANS IN THE INDIVIDUAL AND EMPLOYER HEALTH INSURANCE MARKETS; DECLARING AN EMERGENCY.

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

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

"59A-56-2. PURPOSE.--The purpose of the Health Insurance Alliance Act is to provide:

A. increased access to voluntary approved health [~~insurance~~] plan coverage for small employer groups and eligible individuals in New Mexico [~~An additional purpose of the Health Insurance Alliance Act is to provide for access to~~

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~~voluntary health insurance coverage for individuals in the individual market who have met eligibility criteria established by that act~~]; and

B. through a health insurance exchange:

(1) access to and assistance in comparing and applying to enroll in qualified health plans for individuals and employers; and

(2) access to cost-sharing subsidies, tax credits for qualified health plan purchase, exemptions to federal requirements to obtain health coverage and eligibility determinations for medicaid."

SECTION 2. 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. "agent" means a person appointed by a carrier authorized to transact business in this state to act as its representative in any given locality;

[~~A.~~] B. "alliance" means the New Mexico health insurance alliance;

[~~B.~~] C. "approved health plan" means any arrangement for the provisions of health insurance, other than a qualified health plan, offered through and approved by the alliance;

[~~C.~~] D. "board" means the board of directors of the

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alliance;

E. "broker" means a person licensed as a broker pursuant to the Insurance Code;

F. "carrier" means a person that is subject to licensure by the superintendent or subject to the provisions of the Insurance Code and that provides one or more health benefits or insurance plans in the state;

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

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

(1) a group health plan;

(2) health insurance coverage;

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

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

(5) 10 USCA Chapter 55;

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

(7) the Medical Insurance Pool Act;

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

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

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

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

J. "dependent" means "dependent" as defined in Section 152 of the federal Internal Revenue Code of 1986;

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

[~~H.~~] L. "earned premiums" means premiums paid or due during a calendar year for coverage under an approved health plan or a qualified 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.~~] M. "eligible expenses" means the allowable charges for a health care service covered under an approved health plan or a qualified health plan;

[~~J.~~] N. "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~~] three or more months of creditable coverage, the most recent of which was under a group health

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

(b) is entitled to continuation coverage pursuant to Section 59A-56-20 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

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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.~~] O. "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.~~] P. "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.~~] Q. "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.~~] R. "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;

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S. "health care services, finance or coverage sector" means a business sector that includes carriers and other health insurance issuers, health maintenance or managed care organizations, nonprofit health plans, self-insured group health plans, trade associations of carriers, producers, persons licensed or otherwise authorized to provide health care in the regular course of business and health care facilities;

[~~O.~~] T. "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

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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;

U. "health insurance exchange" means an entity established pursuant to federal law to provide qualified health plans to qualified individuals and qualified employers on the individual, small group or large group health insurance market, that uses an internet web site through which applicants may obtain standardized comparative information about qualified health plans and that offers enrollment assistance through navigators and a toll-free telephone hotline;

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

[~~Q.~~] W. "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.~~] X. "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;

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

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

AA. "Native American" means an individual who:

(1) is a member of any federally recognized Indian nation, tribe or pueblo or is an Alaska Native; or

(2) has been deemed eligible for services and programs provided to Native Americans by the United States public health service or the bureau of Indian affairs;

BB. "navigator" means a person that, in a manner culturally and linguistically appropriate to the state's diverse populations, conducts public education, distributes tax credit and qualified health plan enrollment information, facilitates enrollment in qualified health plans or provides referrals to consumer assistance or ombudsman services. "Navigator" does not mean a carrier or a person that receives any consideration, directly or indirectly, from any carrier in connection with the enrollment of a qualified individual in a qualified health plan; provided that a broker may be a navigator if the broker receives no consideration, directly or indirectly, from any carrier in connection with the enrollment of a qualified individual or qualified employer in a qualified health plan, an approved health plan or any other health coverage;

[~~U.~~] CC. "nonprofit health care plan" means a

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health care plan as defined in Subsection K of Section 59A-47-3 NMSA 1978;

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

EE. "producer" means an agent or broker licensed pursuant to the applicable provisions of the Insurance Code;

FF. "qualified employer" means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees eligible for one or more qualified health plans offered in the small group market through the health insurance exchange; provided that the employer elects to provide coverage through the health insurance exchange to all of its eligible employees who are principally employed in the state;

GG. "qualified health plan" means health insurance coverage or a group health plan that the board has determined meets the requirements in federal law for coverage to be offered through the health insurance exchange;

HH. "qualified individual" means an individual who:

(1) seeks to enroll or who participates in a qualified health plan offered through the health insurance exchange and who meets one of the following residency requirements:

(a) is a resident of the state and is,

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and continues to be, legally domiciled and physically residing on a full-time basis in a place of habitation in the state that remains the individual's principal residence and from which the individual is absent only for a temporary or transitory purpose;

(b) is a full-time student attending an educational institution outside of the state but, prior to attending the educational institution, met the requirements of Subparagraph (a) of this paragraph;

(c) is a full-time student attending an institution of higher education located in the state;

(d) whether a resident or not, is a dependent; or

(e) whether a resident or not, is an employee of a qualified employer;

(2) is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges; and

(3) is a citizen or national of the United States or is an alien lawfully present in the United States during the entire period for which enrollment in the health insurance exchange is sought;

[~~W.~~] II. "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~~

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~~business and that, on at least fifty percent of its working days during either of the two preceding calendar years, employed no fewer than two and no more than fifty eligible employees; provided that:~~

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

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

~~(3) in the case of an employer that was not in existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year~~] actively engaged in a business that employed an average of at least one, but not more than fifty, full-time-equivalent employees on business days during the preceding calendar year and that employs at least one employee on the first day of the plan year; provided that:

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

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

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determination of whether the employer is a small employer shall be based on the average number of employees that the employer is reasonably expected to employ on working days in the current calendar year; and

(3) the person is not a self-insured entity;

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

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

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

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

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

A. The "New Mexico health insurance alliance" is created as a nonprofit public corporation for the purpose of providing increased access to health coverage through approved health [~~insurance in the state~~] plans and, by operation of a health insurance exchange, to qualified health plans. 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

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alliance for the purpose of offering approved health plans 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~~], including the exchange and the board, is a governmental entity for purposes of the Tort Claims Act and shall operate consistently with the provisions of the Governmental Conduct Act, the Inspection of Public Records Act, the Financial Disclosure Act and the Open Meetings Act and shall not be subject to the Procurement Code or the Personnel Act.

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

D. The alliance, including the exchange, 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~~

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~~of two representatives of health maintenance organizations and three representatives of other types of members~~] one director, appointed by the governor, who shall be an officer or an employee of a carrier;

(2) five directors [~~appointed by the governor~~], who shall be officers, general partners or proprietors of small employers, one director of which shall represent a nonprofit [~~corporations~~] corporation. These directors shall be appointed as follows:

(a) two shall be appointed by the governor, including the member representing a nonprofit corporation;

(b) one shall be appointed by the president pro tempore of the senate;

(c) one shall be appointed by the speaker of the house of representatives; and

(d) one shall be appointed by the New Mexico legislative council;

(3) four directors [~~appointed by the governor~~], who shall be employees of small employers. [~~and~~] These directors shall be appointed as follows:

(a) two shall be appointed by the governor;

(b) one shall be appointed by the minority floor leader of the senate; and

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(c) one shall be appointed by the minority floor leader of the house of representatives;

(4) one director, appointed by the governor, who shall be a consumer advocate;

(5) the secretary of human services or the secretary's designee, who shall be a voting member; and

[~~(4)~~] (6) 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 governor shall appoint no more than four directors who belong to the same political party.

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

[~~F.~~] G. The directors [~~elected by the members~~] appointed by legislators shall be [~~elected~~] 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. 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

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expired shall continue to serve until a successor is [~~elected or~~] appointed and qualified.

[~~G.~~] H. 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 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.~~] I. 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.

J. While serving on the board, appointed directors shall not have any affiliation with or any income derived from current or active employment in, a contract with or consultation for the health care services, finance or coverage sectors; providing that the following exceptions shall apply:

(1) the directors' administration and offering of approved health plans in accordance with the directors' duties pursuant to the Health Insurance Alliance Act shall not

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be considered to violate the provisions of this section;

(2) the director appointed pursuant to Paragraph (1) of Subsection D of this section shall not be considered to have a conflict of interest with respect to that director's association with a carrier; and

(3) one director may be a health care provider and shall not be considered to have a conflict of interest arising from that director's receipt of payment for services as a health care provider.

K. A director may be removed from the board by a majority vote of two-thirds of the directors. The board shall set standards for attendance and may remove a director for lack of attendance, neglect of duty or malfeasance in office. A director shall not be removed without proceedings consisting of at least one ten-day notice of hearing and an opportunity to be heard. Removal proceedings shall be before the board and in accordance with procedures adopted by the board.

L. The board shall be composed, as a whole, to assure representation of the state's Native American population, ethnic diversity, cultural diversity and geographic diversity. Except as provided in Subsection M of this section, directors shall have demonstrated knowledge or experience in at least one of the following areas:

(1) purchasing coverage in the individual market;

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(2) purchasing coverage in the small employer market;

(3) health care finance;

(4) health care economics;

(5) health care policy;

(6) the enrollment of underserved residents in health care coverage; or

(7) administering private or public health care insurance.

M. A maximum of one director whom the governor appoints and one director whom the New Mexico legislative council appoints may be exempt from the qualifications provided in Paragraphs (1) through (7) of Subsection L of this section."

SECTION 4. Section 59A-56-5 NMSA 1978 (being Laws 1994, Chapter 75, Section 5, as amended) is amended to read:

"59A-56-5. PLAN OF OPERATION.--

A. Within thirty days of the effective date of this 2013 act, the board shall submit a plan of operation to the superintendent and any amendments to the plan necessary or suitable to assure the fair, reasonable and equitable administration of the alliance, including the health insurance exchange.

B. The superintendent shall, after notice and hearing, approve the plan of operation if it is determined to assure the fair, reasonable and equitable administration of the

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alliance. The plan of operation shall become effective upon written approval of the superintendent consistent with the date on which health insurance coverage through the alliance pursuant to the provisions of the Health Insurance Alliance Act is made available. A plan of operation adopted by the superintendent shall continue in force until modified by [~~him~~] the superintendent or superseded by a subsequent plan of operation submitted by the board and approved by the superintendent.

C. The plan of operation shall:

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

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

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

(4) establish the amount of and the method for collecting assessments pursuant to [~~Section 59A-56-11 NMSA 1978~~] this 2013 act;

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

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

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

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

(9) relating to the health insurance exchange, provide for the following events:

(a) by October 1, 2013, or in accordance with a schedule approved or provided by the federal center for consumer information and insurance oversight, the acceptance of applications from qualified individuals and qualified employers to purchase qualified health plans on the health insurance exchange;

(b) by October 1, 2013, or in accordance with a schedule approved or provided by the federal center for consumer information and insurance oversight, the availability of navigator services for persons applying for medicaid or to purchase qualified health plans through the health insurance exchange; and

(c) by January 1, 2014, or in accordance with a schedule approved or provided by the federal center for consumer information and insurance oversight, the sale of

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qualified health plans to qualified individuals and qualified employers;

(10) establish procedures to implement the provisions of the Health Insurance Alliance Act consistent with state law and federal law, including:

(a) determination of which qualified health plans will be offered through the health insurance exchange;

(b) eligibility determination for purchasing qualified health plans on the health insurance exchange, for cost-sharing subsidies, tax credits, enrollment in medicaid, exemption from the federal requirement for certain individuals to have health coverage and eligibility for related public programs as provided by rules adopted by the superintendent; and

(c) enrollment of qualified individuals and qualified employers;

(11) establish a program to publicize the existence of the health insurance exchange and qualified health plans offered by the health insurance exchange and the eligibility requirements and procedures for enrollment in a qualified health plan, premium assistance subsidies, tax credits or other public health coverage programs and to maintain public awareness of the health insurance exchange;

(12) establish conflict-of-interest policies

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and procedures; and

(13) provide for the timely and efficient integration of the functions of the alliance and the operation of a health insurance exchange pursuant to this 2013 act."

SECTION 5. Section 59A-56-6 NMSA 1978 (being Laws 1994, Chapter 75, Section 6, as amended) is amended to read:

"59A-56-6. APPROVED HEALTH PLANS--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 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

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commissions subject to applicable provisions in the Insurance Code. In determining the initial year's rate for health insurance, the only rating factors that may be used are age, [~~gender pursuant to this section~~] geographic area of the place of employment and smoking practices. In any year's rate, the difference in rates in any one age group that may be charged [~~on the basis of a person's gender shall not exceed another person's rates in the age group by more than the following percentage of the lower rate for policies issued or delivered in the respective year; provided, however, that gender shall not be used as a rating factor for policies issued or delivered on or after January 1, 2014:~~

~~(a) twenty percent for calendar year 2010;~~

~~(b) fifteen percent for calendar year 2011;~~

~~(c) ten percent for calendar year 2012;~~ ~~and~~

~~(d) five percent for calendar year 2013.~~

~~No person's rate~~] shall not 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

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that differ depending upon family composition;

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

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

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

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

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

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

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

[~~(12)~~] (11) shall review annually each approved health plan to determine if it still qualifies as an approved health plan based on the alliance-designed criteria

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and, if the plan is no longer approved, arrange for the transfer of the insureds covered under the formerly approved plan to an approved health plan;

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

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

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

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

SECTION 6. Section 59A-56-11 NMSA 1978 (being Laws 1994, Chapter 75, Section 11, as amended) is amended to read:

"59A-56-11. APPROVED HEALTH PLANS--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

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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 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

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

G. The board 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

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

"59A-56-13. [~~ALLIANCE ADMINISTRATOR~~] EXECUTIVE DIRECTOR.--

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

(1) proven ability to administer health insurance programs; and

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

~~(3)~~] (2) ability to administer the alliance in a cost-efficient manner.

[~~B. The alliance administrator contract shall be~~

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~~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 months prior to the expiration of the current contract.~~

~~D.~~] B. The [~~alliance administrator~~] executive director shall:

(1) take applications for [~~an~~] approved health plans from small employers or referring agents;

(2) take applications for qualified health [~~plan~~] plans from [~~small~~] qualified employers, [~~or a~~] navigators, qualified individuals and referring [~~agent~~] agents;

[~~(2)~~] (3) for approved health plans, 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)~~] (4) pay the [~~member~~] carrier that offers an approved health plan or a qualified health plan the net

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premium due after deduction of reinsurance and administrative allowances;

[~~(4)~~] (5) provide the [~~member~~] carrier with any changes in the status of insureds;

[~~(5)~~] (6) perform all necessary functions to assure that each [~~member~~] carrier is providing timely payment of benefits to individuals covered under an approved health plan or a qualified health plan, including:

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

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

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

[~~(7)~~] (8) following the close of each fiscal year, determine premiums of [~~members~~] carriers, 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

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[~~(8)~~] (9) establish the premiums for reinsurance and the administrative charges, subject to approval of the board.

[~~E.~~] C. The board may require [~~members~~] carriers issuing [~~policies~~] approved health plans and qualified health plans 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~~] carriers regularly perform in the normal course of business. [~~Members~~] Carriers shall be required to submit regular reports to the board of such activities, as specified by the board. [~~Members~~] Carriers 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 8. 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

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coverage with an approved health plan within three years of the date of application for coverage except to change to another approved health plan; [~~and~~]

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

(a) is offered by a state or federal agency to a small employer's employee whose eligibility for alternative coverage is based on the employee's income; or

(b) provides only a specific limited form of health insurance such as accident or disability income insurance coverage or a specific health care service such as dental care; and

(4) the small employer is a resident of the state; has employees of whom at least fifty percent are residents of the state; and is actively engaged in business.

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 individual is eligible for a qualified health plan if on the effective date of coverage or renewal the individual meets the definition of a qualified individual under Subsection HH of Section 59A-56-3 NMSA 1978. An employer is

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eligible for a qualified health plan if on the effective date of coverage or renewal the employer meets the definition of a qualified employer under Subsection FF of Section 59A-56-3 NMSA 1978.

[~~C.~~] D. An approved health plan or qualified health plan shall provide in substance that attainment of the limiting age by [~~an unmarried~~] a child or 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 or qualified health plan within one hundred twenty days of attainment of the limiting age. The board may require subsequent proof annually after a two-year period following attainment of the limiting age.

[~~D.~~] E. An approved health plan or a qualified health plan shall provide that the health insurance benefits applicable for eligible [~~dependents~~] children 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

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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 or a qualified health plan shall provide that the health insurance benefits applicable for eligible [~~dependents~~] children 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~~]

F. As of January 1, 2014, an approved health plan shall not contain a preexisting condition exclusion for any individual, regardless of age. Before January 1, 2014, an approved health plan offered to a small employer or an eligible individual shall not contain a preexisting condition exclusion that relates to an individual under nineteen years of age. As pertaining to individuals over nineteen years of age, an approved health plan offered to an eligible employer before January 1, 2014 may contain a preexisting condition exclusion, except as provided in Subsection I of this section, 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~~] three-month

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period ending on the enrollment date;

(2) the exclusion extends for a period of not more than [~~six~~] three 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.~~] G. 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~~

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~~adoption, is covered under creditable coverage; or~~

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

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

H. A qualified health plan issued to a qualified individual shall not contain any preexisting condition exclusion.

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

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

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~~exclusion.~~

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

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

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

(3) is an inmate of a public institution.

[~~L.~~] K. 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~~] L. Before January 1, 2014, an insured who is over nineteen years of age 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

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Subsection [E] F of this section to be satisfied prior to receipt of the additional benefits."

SECTION 9. Section 59A-56-15 NMSA 1978 (being Laws 1994, Chapter 75, Section 15) is amended to read:

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

A. By January 1, 1995, members shall provide notice and applications for approved health plan coverage through the alliance to a small employer that receives:

(1) a rejection of approved health plan coverage [~~for health insurance~~];

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

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

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

SECTION 10. Section 59A-56-16 NMSA 1978 (being Laws 1994,

Chapter 75, Section 16) is amended to read:

"59A-56-16. ENROLLMENT IN APPROVED HEALTH PLANS.--

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

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

SECTION 11. Section 59A-56-17 NMSA 1978 (being Laws 1994, Chapter 75, Section 17, as amended) is amended to read:

"59A-56-17. APPROVED HEALTH PLAN BENEFITS.--

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

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small employer group policies, but an approved health plan for small employers may also offer health plan designs that are not generally available in New Mexico for small employer group policies.

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

SECTION 12. Section 59A-56-18 NMSA 1978 (being Laws 1994, Chapter 75, Section 18, as amended) is amended to read:

"59A-56-18. APPROVED HEALTH PLANS--DEDUCTIBLES--CO-INSURANCE--MAXIMUM OUT-OF-POCKET PAYMENTS.--

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

B. Subject to the limitations provided in Subsection C of this section, a mandatory co-insurance requirement for an approved health plan may be imposed as a

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percentage of eligible expenses in excess of a deductible. Health maintenance organizations shall impose equivalent cost-benefit structures.

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

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

"59A-56-19. DEPENDENT FAMILY MEMBER REQUIRED APPROVED HEALTH PLAN COVERAGE--SMALL EMPLOYER RESPONSIBILITY.--

A. A small employer shall collect or make a payroll deduction from the compensation of an employee for the portion of the approved health plan cost that the employee is responsible for paying. The small employer may contribute to the cost of that plan on behalf of the employee.

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

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

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

"59A-56-20. APPROVED HEALTH PLANS--QUALIFIED HEALTH

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PLANS--RENEWABILITY.--

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

B. An approved health plan issued to an eligible individual or a qualified health plan issued to a qualified individual shall contain provisions under which the [~~member~~] carrier offering the plan is obligated to renew the health insurance except for:

(1) nonpayment of premium;

(2) conduct that constitutes fraud; [~~or~~]

(3) the eligible individual's or qualified individual's intentional misrepresentation of a material fact as prohibited by the terms of the approved health plan or the qualified health plan; or

[~~(3)~~] (4) termination of the approved health plan or qualified health plan, except that the eligible individual or qualified individual has the right to transfer to another approved health plan or qualified health plan.

C. If an approved health plan or a qualified health plan ceases to exist, the alliance shall provide an alternate approved health plan or, through the health insurance exchange,

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an alternate qualified health plan.

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

E. The right to continue [~~health insurance~~] approved health plan or qualified health plan coverage provided in this section terminates if the covered individual resides outside the United States for more than six consecutive months or, for a qualified individual, otherwise fails to meet the definition of a qualified individual under Subsection HH of Section 59A-56-3 NMSA 1978."

SECTION 15. Section 59A-56-21 NMSA 1978 (being Laws 1994, Chapter 75, Section 21, as amended) is amended to read:

"59A-56-21. [~~REGULATIONS~~] RULES.--The superintendent shall:

A. adopt [~~regulations~~] rules that provide for

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disclosure by members of the availability of approved health plans and qualified health [~~insurance from the alliance~~] plans; and

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

SECTION 16. Section 59A-56-23 NMSA 1978 (being Laws 1994, Chapter 75, Section 23, as amended) is amended to read:

"59A-56-23. APPROVED HEALTH PLANS--RATES--STANDARD RISK RATE--EXPERIENCE RATING PROHIBITED.--

A. The alliance shall determine a standard risk rate index by actuarially calculating the average index rates that the insurer has filed under the requirements of the Small Group Rate and Renewability Act with the benefits similar to the alliance's standard approved health plan. A standard risk rate based on age and other appropriate demographic characteristics may be used. In determining the standard risk rate, the alliance shall consider the benefits provided by the approved health plan.

B. Experience rating is not allowed other than for reinsurance purposes.

C. All rates and rate schedules shall be submitted to the superintendent for approval prior to use."

SECTION 17. Section 59A-56-24 NMSA 1978 (being Laws 1994, Chapter 75, Section 24, as amended) is amended to read:

"59A-56-24. APPROVED HEALTH PLANS--BENEFIT PAYMENTS

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REDUCTION.--

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

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

SECTION 18. A new section of the Health Insurance Alliance Act is enacted to read:

"[NEW MATERIAL] HEALTH INSURANCE EXCHANGE--BOARD POWERS.--

A. The board shall:

(1) ensure that the health insurance exchange:

(a) beginning October 1, 2013, or in accordance with a schedule approved or provided by the federal

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center for consumer information and insurance oversight, accepts applications from qualified individuals and qualified employers to purchase qualified health plans on the health insurance exchange;

(b) beginning October 1, 2013, or in accordance with a schedule approved or provided by the federal center for consumer information and insurance oversight, makes available navigator services for persons applying for medicaid or to purchase qualified health plans through the health insurance exchange; and

(c) beginning January 1, 2014, or in accordance with a schedule approved or provided by the federal center for consumer information and insurance oversight, offers qualified health plans for purchase by qualified individuals and qualified employers;

(2) by October 1, 2013, or in accordance with a schedule approved or provided by the federal center for consumer information and insurance oversight, in accordance with rules that the superintendent has promulgated, shall establish a dispute resolution process for applicants that have been denied:

(a) qualified health plan status;

(b) qualified individual status;

(c) qualified employer status;

(d) a premium tax credit subsidy;

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(e) a cost-sharing subsidy for a qualified health plan; or

(f) exemption from the federal requirement to purchase health insurance;

(3) establish one walk-in customer service center where persons may apply for any status, credit or exemption listed in Paragraph (2) of this subsection and, if eligible, enroll in qualified health plans or public coverage programs;

(4) establish a navigator program;

(5) cooperate with the medical assistance division of the human services department to share information and facilitate transitions in enrollment between the exchange and medicaid, the state children's health insurance program or any other state public health coverage program;

(6) between October 1, 2013 and January 1, 2015, provide quarterly reports to the legislature, the governor and the superintendent on the implementation of the exchange and report annually and upon request thereafter;

(7) create, make appointments to and duly consider recommendations of an advisory committee or committees made up of stakeholders, including carriers, health care consumers, health care providers, health care practitioners, brokers, qualified employer representatives and advocates for low-income or underserved residents;

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(8) create an advisory committee made up of Native Americans, some of whom live on a reservation and some of whom do not live on a reservation, to advise the alliance on the implementation of the provisions of the Health Insurance Alliance Act and to guide the implementation of the Native American-specific provisions of the federal Patient Protection and Affordable Care Act and the federal Indian Health Care Improvement Act; and

(9) designate a Native American liaison, who shall assist the alliance in developing and ensuring implementation of communication and collaboration between the exchange and Native Americans in the state. The tribal liaison shall serve as a contact person between the exchange and New Mexico Indian nations, tribes and pueblos and shall ensure that training is provided to the staff of the exchange.

B. The board may:

(1) seek and receive grant funding from federal, state or local governments or private philanthropic organizations to defray the costs of operating the exchange;

(2) create ad hoc advisory councils;

(3) request assistance from other boards, commissions, departments, agencies and organizations as necessary to provide appropriate expertise to accomplish the board's duties with respect to the health insurance exchange;

(4) enter into contracts with persons or other

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organizations as necessary or proper to carry out the provisions and purposes of the Health Insurance Alliance Act, including the authority to contract or employ staff for the performance of administrative, legal, actuarial, accounting and other functions, provided that any contractor shall be subject to the conflict-of-interest provisions set forth in Subsection J of Section 59A-56-4 NMSA 1978;

(5) enter into contracts with similar exchanges of other states for the joint performance of common administrative functions;

(6) enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities; provided that these agreements include adequate protections of the confidentiality of the information to be shared and comply with all state and federal laws and regulations;

(7) sue or be sued or otherwise take any necessary or proper legal action in the execution of its duties and powers;

(8) appoint board committees, which may include non-board members, to provide technical assistance in the operation of the exchange and any other function within the authority of the exchange;

(9) conduct periodic audits to assure the general accuracy of the financial data submitted to the

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exchange; and

(10) charge assessments or user fees to carriers, qualified employers or producers or otherwise generate funding necessary to support exchange operations; provided that assessments shall be limited solely to the reasonable administration costs of the health insurance exchange."

SECTION 19. A new section of the Health Insurance Alliance Act is enacted to read:

"[NEW MATERIAL] QUALIFIED HEALTH PLANS.--

A. A qualified health plan shall conform to federal and state law governing qualified health plans and the alliance's qualified health plan design criteria. A carrier offering a qualified health plan shall:

(1) be licensed and in good standing to offer health insurance in the state;

(2) offer through the health insurance exchange at least one qualified health plan in the silver level of coverage and at least one plan in the gold level of coverage, pursuant to the levels of coverage as described in rules the superintendent has promulgated pursuant to federal law;

(3) charge the same premium for each qualified health plan within each level of coverage without regard to whether the plan is offered through the alliance directly from

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the carrier or through an agent or broker; and

(4) comply with the regulations that the federal secretary of health and human services has promulgated and any other requirements that the board or the superintendent has established.

B. If a qualified health plan design approved by the board is not offered by any carrier already offering a qualified health plan, but a carrier offers a substantially similar plan design outside the alliance, the board may require the carrier to offer that plan design as a qualified health plan through the alliance.

C. A carrier offering a qualified health plan may withdraw the plan but shall continue to offer it for five consecutive years after the date notice of future withdrawal is given to the board, unless:

(1) the carrier substitutes another qualified health plan for the plan withdrawn; or

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

D. The following items and services, as defined by federal and state law and rules the superintendent has promulgated, are essential benefits that shall be included in any health insurance certified as a qualified health plan:

(1) ambulatory patient services;

(2) emergency services;

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(3) hospitalization;

(4) maternity and newborn care;

(5) mental health and substance abuse disorder services, including behavioral health treatment;

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

(9) preventive and wellness services and chronic disease management; and

(10) pediatric services, including oral and vision care."

SECTION 20. A new section of the Health Insurance Alliance Act is enacted to read:

"[NEW MATERIAL] ENROLLMENT--QUALIFIED HEALTH PLANS.--

A. An individual is eligible for a qualified health plan if, on the effective date of coverage or renewal, the individual meets the definition of a qualified individual under Subsection HH of Section 59A-56-3 NMSA 1978. An employer is eligible for a qualified health plan if on the effective date of coverage or renewal the employer meets the definition of a qualified employer under Subsection FF of Section 59A-56-3 NMSA 1978.

B. If a child's coverage ended or did not begin for the reasons set forth in this section, a qualified health plan

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shall provide the child an opportunity to enroll in a qualified health plan for which coverage continues for at least sixty days and shall provide written notice of the opportunity to enroll no later than the first day of the plan year. A written notice of the opportunity for special enrollment provided pursuant to this section shall include a statement that a child whose coverage ended, who was denied coverage or who was not eligible for coverage because dependent coverage of children was unavailable before the child reached twenty-six years of age is eligible to enroll in a qualified health plan or other health insurance. This notice may be provided to a principal insured on behalf of the principal insured's child. For an individual who enrolls in a qualified health plan, the coverage shall take effect not later than the first day of the first plan or policy year.

C. For qualified health plans offered on the health insurance exchange, the alliance shall provide for an initial open enrollment period from October 1, 2013 through February 28, 2014, or in accordance with a schedule approved or provided by the federal center for consumer information and insurance oversight. Thereafter, the alliance shall provide for annual open enrollment periods for qualified health plans, as provided in federal law and by rules that the superintendent has promulgated. Except as provided pursuant to Subsections B and E of this section, new employees and their dependents may

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enroll in their qualified employer's qualified health plan within thirty-one days of completion of their employer's eligibility period. If application for enrollment is not made during this period, the new employee and the new employee's dependents may be required to submit evidence of eligibility for a special enrollment period pursuant to Section 9801 of the federal Internal Revenue Code of 1986.

D. An insured shall notify the alliance at least thirty-one days before the insured's yearly anniversary date of the qualified health plan of the insured's intent to switch coverage to another qualified health plan.

E. The health insurance exchange shall provide a monthly opportunity to enroll or switch enrollment between qualified health plans to any individual who is a Native American."

SECTION 21. A new section of the Health Insurance Alliance Act is enacted to read:

"[NEW MATERIAL] ELIGIBILITY--GUARANTEED ISSUE--PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS.--

A. An individual is eligible for a qualified health plan if on the effective date of coverage or renewal the individual meets the definition of a qualified individual under Subsection HH of Section 59A-56-3 NMSA 1978. An employer is eligible for a qualified health plan if on the effective date of coverage or renewal the employer meets the definition of a

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qualified employer under Subsection FF of Section 59A-56-3 NMSA 1978.

B. A qualified health plan shall provide in substance that attainment of the limiting age by a child or 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 qualified health plan within one hundred twenty days of attainment of the limiting age. The board may require subsequent proof annually after a two-year period following attainment of the limiting age.

C. A qualified health plan shall provide that the health insurance benefits applicable for eligible children 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

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coverage from birth. A qualified health plan shall provide that the health insurance benefits applicable for eligible children are payable for an adopted child in accordance with the provisions of Section 59A-22-34.1 NMSA 1978.

D. A qualified health plan issued to a qualified individual shall not contain any preexisting condition exclusion.

E. 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."

SECTION 22. DELAYED REPEAL.--Sections 59A-56-2, 59A-56-6 through 59A-56-12, 59A-56-14 through 59A-56-19 and 59A-56-22 through 59A-56-25 NMSA 1978 (being Laws 1994, Chapter 75, Sections 2, 6 through 12, 14 through 19 and 22 through 25, as amended) are repealed effective January 1, 2015.

SECTION 23. EFFECTIVE DATE.--The effective date of the provisions of Section 21 of this act is January 1, 2015.

SECTION 24. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

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