SENATE BILL 199

42ND LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 1996

INTRODUCED BY

JANICE D. PASTER

FOR THE HEALTH CARE TASK FORCE

AN ACT

RELATING TO INSURANCE; AMENDING AND ENACTING CERTAIN PROVISIONS OF THE HEALTH INSURANCE ALLIANCE ACT; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978; REPEALING A SECTION OF LAWS 1994; DECLARING AN EMERGENCY.

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

Section 1. Section 59A-54-12 NMSA 1978 (being Laws 1987, Chapter 154, Section 12, as amended) is amended to read:

"59A-54-12. ELIGIBILITY--POLICY PROVISIONS.--

A. A person is eligible for a pool policy only if on the effective date of coverage or renewal of coverage the person is a New Mexico resident and:

(1) is not eligible as an insured or covered dependent for any health plan that provides coverage for comprehensive major medical or comprehensive physician and hospital services;

(2) is only eligible for a health plan that is offered at a rate higher than that available from the pool;

(3) has been rejected for coverage for comprehensive major medical

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or comprehensive physician and hospital services; or

(4) is only eligible for a health plan with a rider, waiver or restrictive provision for that particular individual based on a specific condition.

B. Coverage under a pool policy is in excess of and shall not duplicate coverage under any other form of health insurance.

C. A pool policy shall provide that coverage of a dependent unmarried person terminates when the person becomes nineteen years of age or, if the person is enrolled full time in an accredited educational institution, when he becomes twenty-five years of age. The policy shall also provide in substance that attainment of the limiting age does not operate to terminate coverage when the person is and continues to be:

(1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

(2) primarily dependent for support and maintenance upon the person in whose name the contract is issued.

Proof of incapacity and dependency shall be furnished to the insurer within one hundred twenty days of attainment of the limiting age and subsequently as required by the insurer but not more frequently than annually after the two-year period following attainment of the limiting age.

D. A pool policy that provides coverage for a family member of the person in whose name the contract is issued shall, as to the coverage of the family member or the individual in whose name the contract was issued, provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the family member or the person in whose name the contract is issued from the moment of coverage of injury or illness, 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 carrier within thirty-one days after the date of birth in order to have the coverage continued beyond the thirty-one day period.

E. A pool policy may contain provisions under which coverage is excluded during a six-month period following the effective date of coverage as to a given individual for pre-existing conditions, as long as either of the following exists:

(1) the condition has manifested itself within a period of six months before the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnoses or treatment; or

(2) medical advice or treatment was recommended or received within a period of six months before the effective date of coverage.

F. The pre-existing condition exclusions described in Subsection E of this section shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage [~~which~~] that was involuntarily terminated, if the application for pool coverage is made not later than thirty-one days following the involuntary termination. In that case, coverage in the pool shall be effective from the date on which the prior coverage was terminated. This subsection does not prohibit pre-existing conditions coverage in a pool policy that is more favorable to the insured than that specified in this subsection.

G. An individual is not eligible for coverage by the pool if:

(1) he is, at the time of application, eligible for medicare or medicaid, which would provide coverage for amounts in excess of limited policies such as dread disease, cancer policies or hospital indemnity policies;

(2) he has terminated coverage by the pool within the past twelve months; or

(3) he is an inmate of a public institution or is eligible for public

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programs for which medical care is provided.

H. Any person whose health insurance coverage from a qualified state health policy with similar coverage is terminated because of nonresidency in another state may apply for coverage under the pool. If the coverage is applied for within thirty-one days after that termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

I. A person otherwise eligible and having coverage pursuant to the provisions of the Comprehensive Health Insurance Pool Act shall not become ineligible because that person becomes eligible for coverage pursuant to the provisions of the Health Insurance Alliance Act."

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

"59A-56-2. PURPOSE.--The purpose of the Health Insurance Alliance Act is to provide increased access to voluntary health insurance coverage in New Mexico [~~The initial purpose is to improve access to health insurance coverage for small employers on a voluntary basis~~]. An additional purpose of the Health Insurance Alliance Act is to provide for the development of [~~a plan~~] plans for [~~expanded~~] health insurance coverage [~~to include uninsured children, other employer groups~~] for children, small employers and individuals."

Section 3. Section 59A-56-3 NMSA 1978 (being Laws 1994, Chapter 75, Section 3) 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 provision of health insurance offered through and approved by the alliance [~~by which insureds have access to health insurance~~];

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. "department" means the department of insurance;

[~~D.~~] F. "director" means an individual who serves on the board;

[~~E.~~] G. "earned premiums" means premiums paid or due during [~~the~~] 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 [~~previous~~] immediately preceding calendar year;

[~~F.~~] H. "eligible expenses" [~~are~~] means the allowable charges for a health care service [~~and items for which benefits are extended~~] covered under an approved health plan;

I. "gross earned premiums" means premiums paid or due during a calender 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;

[~~G.~~] J. "health care service" means a service or product furnished an individual [~~or incidental to the furnishing of the service or product~~] 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;

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

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credit health insurance; coverage for health care services under uninsured arrangements of group or group-type contracts, including employer self-insured, cost-plus or other benefits methodologies not involving insurance or not subject to New Mexico premium taxes; coverage for health care services under group-type contracts that are not available to the general public and can be obtained only because of connection with a particular organization or group; or coverage by medicare or other governmental [~~benefits; or "health insurance" as defined by Section 59A-7-3 NMSA 1978~~] programs providing health care services; but "health insurance" does not include insurance [~~arising out of~~] issued pursuant to provisions of the Workers' Compensation Act or similar law, automobile medical payment insurance or [~~insurance under~~] provisions by which benefits are payable with or without regard to fault [~~and~~] that [~~is~~] are required by law to be contained in any liability insurance policy;

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

[~~J.~~] M. "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;

[~~K.~~] N. "insured" means a small employer or its employee and an individual covered by an approved health plan, [~~or an individual~~] 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;

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

[~~M.~~] P. "member" means [~~an insurance company authorized to transact health insurance business in this state, a nonprofit health care plan, a health maintenance organization or self-insurers not subject to federal preemption, but does not include an insurance company~~

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~~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~~] a member of the alliance;

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

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

[~~N.~~] S. "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 the preceding calendar year employed no [~~less~~] 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; and

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

~~O.~~] T. "superintendent" means the superintendent of insurance;

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

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

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

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

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A. The "New Mexico health insurance alliance" is created as a nonprofit [~~independent~~] public corporation for the purpose of providing increased access to health insurance in the state. All insurance companies authorized to transact health insurance business in this state, nonprofit health care plans, health maintenance organizations and self-insurers not subject to federal preemption shall organize and be members of the alliance as a condition of their authority to offer health 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. The alliance [~~shall~~] is not [~~be considered~~] a governmental agency for any purpose.

B. The [~~board of directors of the New Mexico health insurance~~] alliance [~~is created~~] 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 the board shall not be considered a governmental entity for any other purpose.

C. The superintendent shall, within sixty days after [~~the effective date of the Health Insurance Alliance Act~~] March 4, 1994, give notice to all members of the time and place for the initial organizational meeting of the alliance. Each member shall be entitled to one vote in person or by proxy at the organizational meeting.

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

(1) five directors, [~~appointed~~] elected by the members, who shall be officers or employees of members and shall consist of one representative of a nonprofit health care plan, two representatives of health maintenance organizations and two representatives of other types of members;

(2) five directors, appointed by the governor, who shall be officers, general partners or proprietors of small employers [~~and~~] who, after the term of the initial

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appointments, are covered by approved health plans;

(3) four directors appointed by the governor, who shall be employees of small employers, and who, after the term of the initial appointments, are employees of small employers covered by approved health plans; and

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

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

F. The directors [~~appointed~~] elected by the members shall be [~~appointed~~] elected for initial terms of three years or less, staggered so that the term of at least one director [~~shall expire~~] 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 [~~shall expire~~] expires on June 30 of each year. Following the initial terms, directors shall be elected or appointed for terms of three years. [~~If the members fail to make the initial appointments within sixty days following the first organizational meeting, the superintendent shall make those appointments.~~] A director whose term has expired shall continue to serve until his successor is elected or appointed.

G. Whenever a vacancy on the board occurs, the electing or appointing authority of [~~that director~~] the director's 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. Directors may be reimbursed by the alliance as provided in the Per Diem

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and Mileage Act in the same manner and amounts as nonsalaried public officers, but shall receive no other compensation, perquisite or allowance from the alliance."

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

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

A. 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.

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 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. [~~If the board fails to submit a plan of operation within one hundred eighty days after the appointment of the board, the superintendent shall, after notice and hearing, adopt and promulgate a plan of operation.~~] A plan of operation adopted by the superintendent shall continue in force until modified by him 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

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pursuant to Section [~~11 of the Health Insurance Alliance Act~~] 59A-56-11 NMSA 1978;

(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;

(6) establish penalties for [~~noncollection~~] nonpayment of assessments [~~from~~] 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."

Section 6. Section 59A-56-6 NMSA 1978 (being Laws 1994, Chapter 75, Section 6) 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 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, [~~and~~]

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servicing fees [~~and any other actuarial functions appropriate to the operation of the alliance, but within the limits established~~] 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;

(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 [~~an agency~~] subject to the provisions of the Open Meetings Act;

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

(10) shall determine the design criteria to be 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

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[~~provided that~~], but the board shall not permit more than one approved health plan per member for each set of plan design criteria;

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

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

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

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

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

Section 7. Section 59A-56-8 NMSA 1978 (being Laws 1994, Chapter 75, Section 8) is amended to read:

"59A-56-8. APPROVED HEALTH PLAN [~~OR SERVICE~~].--

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

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

[~~B. The~~] C. Each approved health plan shall offer a premium that is no greater than [~~fifteen~~] ten percent over and no less than [~~fifteen~~] ten percent under the average of the standard rate index for plans with the same characteristics.

[~~C.~~] D. Any member that [~~submits a bid for~~] provides or offers to [~~provide or renews~~] renew a group health insurance contract providing health insurance benefits to employees of the state, a county, a municipality or a school district for which public funds are contributed shall offer at least one approved health plan to small employers; provided, however, if a member does not offer anywhere in the United States a plan that meets substantially the design criteria of an approved health plan, the member shall not be required to offer an approved health plan.

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

F. An approved health plan shall be offered for at least five consecutive years following the date last required in accordance with Subsection D of this section or after notifying the board of its future withdrawal if not required in accordance with Subsection D of this section unless:

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

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

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

(1) the member does not offer or provide health insurance, life insurance or annuities for a period of five years from the date of notification to the superintendent to any person in the state who is not covered by the member through a health insurance policy in effect on the date of the notification; and

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

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

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

A. [~~Any~~] A member offering an approved health plan [~~to small employers~~] 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 [~~than~~], plus the member's reinsurance premium pursuant to Subsection B of this section, than eighty-five percent of earned premiums received by the member [~~received in gross earned premiums~~] on all approved health plans issued by the member, [~~combined~~] 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 percent of the [~~gross~~] 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. The reinsurance premium shall not exceed five percent

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of premiums paid [~~by insured groups~~] in [~~their~~] the first year of coverage and shall not exceed ten percent of [~~such~~] premiums for renewal years. In determining the reinsurance premium for a particular calendar year, the board shall set the reinsurance premium at a rate that will recover the total reinsurance loss for the preceding year over a reasonable number of years in accordance with sound actuarial principles."

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

"59A-56-10. ADMINISTRATION.--The alliance shall deduct from premiums collected for approved health plans an administrative charge as set by the board. The administrative charge shall be determined before the beginning of each calendar year. The maximum administrative charge the alliance may charge is ten percent of [~~gross~~] premiums [~~from a small employer~~] in the first year and five percent of [~~gross~~] premiums in renewal years."

Section 10. Section 59A-56-11 NMSA 1978 (being Laws 1994, Chapter 75, Section 11) 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 [~~total~~] 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 [~~reinsurance incurred claims against the alliance for the previous calendar year reduced by the reinsurance earned~~] 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; and

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(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 [~~earned~~] received by the alliance and any legislative appropriation for the period, 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 [~~equals~~] is an amount equal to that member's total [~~premium~~] premiums, or [~~its~~] 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 [~~premiums~~] written in the state during the preceding calendar year exclusive of premiums for approved health plans; provided that [~~premium income~~] 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, [~~and shall not include premium income~~] total premiums exempted by the federal Employee Retirement Income Security Act of 1974 or [~~other~~] 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 [~~or health charges of each approved~~

~~health plan for the previous year, including all claims or health charges incurred in the previous year and paid prior to April 1 of the current year. From this amount shall be subtracted and identified by list all incurred claims or health charges of each approved health plan paid in the previous year's months of January, February and March incurred prior to~~] for the previous year; and

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

E. The alliance shall notify [~~members~~] each member of the amount of [~~the~~] 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 the assessment paid for any member shall be allowed as a credit on the future premium tax return for that member, with the credit limited to fifty percent of the premium tax due the first year the assessment is imposed; forty percent the second year; and thirty percent the third and all subsequent years.

G. The board may [~~abate or~~] 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 [~~abated or~~] deferred, the amount [~~by which such assessment is abated or~~] 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 abatement or deferment shall remain liable to the alliance for the deficiency for four years including interest at the prevailing rate as determined by regulation of the superintendent. The board may sue to recover the abatement or deferment plus interest and costs.~~] 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.

H. In addition to the assessments provided in this section for reinsurance and administrative losses, the board may impose on all members annually an assessment not to exceed two hundred dollars ($200) for the board to hire consultants and plan and develop alliance programs. This additional assessment shall be allowed as a credit on the next premium tax due for the member."

Section 11. Section 59A-56-13 NMSA 1978 (being Laws 1994, Chapter 75, Section 13) 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 [~~handle accident and~~] administer health insurance programs;

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

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(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 [~~each four-year period of service by the~~] an alliance administrator contract, the board [~~shall~~] may invite all interested parties, including the current administrator, to submit [~~bids~~] proposals to serve as alliance administrator for [~~up to~~] a succeeding [~~four-year~~] contract period. Selection of the administrator for a succeeding contract period shall be made at least six months prior to the expiration of the current contract.

D. The alliance administrator shall:

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

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

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

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

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

(a) making information available to insureds relating to the proper manner of submitting a claim for benefits to the member offering the approved health

plan and distributing forms on which submissions shall be made; and

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

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

(7) following the close of each fiscal year, determine [~~net written~~] premiums of members, the expense of administration and the paid and incurred [~~losses~~] 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."

Section 12. Section 59A-56-14 NMSA 1978 (being Laws 1994, Chapter 75, Section 14) 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 eligible employees not otherwise insured elect to be covered under the approved health plan; [~~and~~]

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

(3) the small employer does not offer other general group health insurance coverage to its employees. For the purposes of this paragraph, general group health insurance coverage excludes coverage providing only a specific limited form of health insurance such as accident or disability income insurance coverage or a specific health care

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service such as dental care.

B. An approved health plan shall provide [~~that coverage of a dependent unmarried individual terminates when the individual becomes nineteen years of age or, if the individual is enrolled full time in an accredited educational institution, when the individual becomes twenty-five years of age~~] coverage for a child. The policy shall also provide in substance that attainment of the limiting age by an unmarried dependent individual does not operate to terminate coverage when the individual continues to be incapable of self-sustaining employment by reason of [~~mental retardation~~] developmental disability or physical handicap and the individual is primarily dependent for support and maintenance upon the employee. Proof of incapacity and dependency shall be furnished to the alliance and the member that offered the approved health plan within one hundred twenty days of attainment of the limiting age. The board may require subsequent proof annually after a two-year period following attainment of the limiting age.

C. An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable with respect to a newly born child of the family member or the individual in whose name the contract is issued from the moment of birth, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium shall be furnished to the member within thirty-one days after the date of birth in order to have the coverage from birth. An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable for an adopted child in accordance with the provisions of Section 59A-22-34.1 NMSA 1978.

D. Except as provided in Subsections E, [~~and~~] G and H of this section, an approved health plan may contain provisions under which coverage is excluded during a six-

month period following the effective date of coverage of an individual for preexisting conditions, as long as either of the following exists:

(1) the condition has manifested itself within a period of six months before the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis or treatment; or

(2) medical advice or treatment was recommended or received within a period of six months before the effective date of coverage.

E. The preexisting condition exclusions described in Subsection D of this section shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the application for health insurance through the alliance is made not later than thirty-one 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 [~~insured~~] covered individual than that specified in this subsection.

F. An individual is not eligible for coverage by the alliance if he:

(1) [~~he~~] is [~~at the time of application~~] 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) [~~he~~] 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) [~~he~~] is an inmate of a public institution [~~or is eligible for public programs, other than state-funded programs, for which medical care is provided~~].

G. The alliance shall provide for an open enrollment period of sixty days from

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the initial offering of an approved health plan. Individuals enrolled during the open enrollment period shall not be subject to the preexisting conditions limitation.

H. If an insured covered by an approved health plan switches to another approved health plan that provides increased or additional benefits such as lower deductible or co-payment requirements, the member offering the approved health plan with increased or additional benefits may require the six-month period for preexisting conditions provided in Subsection D of this section to be satisfied prior to receipt of the additional benefits.

I. An approved health plan shall provide for a thirty-day reinstatement period from the end of a grace period provided by the approved health plan, requiring payments of all back premiums plus a penalty of five percent of the annualized premium. Any claims incurred between the date through which premiums have been paid and the date of reinstatement are not covered unless covered by the conditions of the approved health plan."

Section 13. Section 59A-56-17 NMSA 1978 (being Laws 1994, Chapter 75, Section 17) is amended to read:

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

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

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

"59A-56-18. 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. [~~A deductible plan of five hundred dollars ($500) shall initially be offered.~~] Approved health plans offered by health maintenance [~~organization plans~~] organizations shall provide equivalent cost-benefit structures. The board may authorize deductibles in other amounts and equivalent cost-benefit structures. [~~The deductible shall be applied to the first five hundred dollars ($500) or any other amount determined as deductible by the board of eligible expenses incurred by the covered individual.~~]

B. Subject to the limitations provided in Subsection C of this section, a mandatory co-insurance requirement [~~shall~~] for an approved health plan may be imposed [~~at an average not to exceed thirty percent~~] as a percentage of eligible expenses in excess of [~~the mandatory~~] a deductible. Health maintenance organizations shall impose equivalent cost-benefit structures.

C. The maximum aggregate out-of-pocket payments for eligible expenses [~~or health care services~~] by the covered individual shall be determined by the board."

Section 15. Section 59A-56-19 NMSA 1978 (being Laws 1994, Chapter 75, Section 19) is amended to read:

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

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

B. A small employer shall make available to dependent family members of an employee covered by an approved health plan the same approved health plan. The small employer may contribute to the cost of [~~group~~] family 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 16. Section 59A-56-20 NMSA 1978 (being Laws 1994, Chapter 75, Section 20) is amended to read:

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

A. An approved health plan shall contain provisions under which the member offering the plan is obligated to renew the health insurance if premiums are paid until the day the plan is replaced by another plan or the small employer terminates coverage. An individual covered by health insurance under an approved health plan may retain coverage until he [~~first~~] becomes eligible for medicare as the primary coverage, except that in a family policy [~~the age of the younger family member shall be used to continue the coverage and as the basis for eligibility~~] coverage under an approved health plan shall continue for any person in the family who is not eligible for medicare.

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

C. An approved health plan shall provide covered individuals the right to

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continue health insurance coverage through an approved health plan as individual health insurance provided by the same member upon the death of the employee or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the employee or by termination of employment by electing to do so within a period of time specified in the health insurance, provided that 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.

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

Section 17. Section 59A-56-21 NMSA 1978 (being Laws 1994, Chapter 75, Section 21) is amended to read:

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

A. adopt [~~rules~~] regulations that provide for disclosure by members of the availability of health insurance from the alliance; and

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

Section 18. Section 59A-56-23 NMSA 1978 (being Laws 1994, Chapter 75, Section 23) is amended to read:

"59A-56-23. 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

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characteristics may be used. No standard risk rate shall be more than [~~fifteen~~] ten percent higher or [~~fifteen~~] ten percent lower than the average index rate. 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 19. Section 59A-56-24 NMSA 1978 (being Laws 1994, Chapter 75, Section 24) is amended to read:

"59A-56-24. BENEFIT PAYMENTS 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 [~~law~~] program, excluding medicaid.

B. The administrator 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 [~~covered~~] 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 20. A new section of the Health Insurance Alliance Act is enacted to read:

"[NEW MATERIAL] HEALTH INSURANCE COVERAGE FOR CHILDREN.--

A. The board may adopt a children's health insurance program that conforms to one or more prototypes established by the board.

B. Members providing approved health plans in the alliance are eligible to bid

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to provide a children's health insurance plan. A children's health insurance plan is not considered a separate approved health plan within the meaning of the Health Insurance Alliance Act.

C. If an employer offers a group health insurance plan for employees that includes coverage for children and if the employee chooses to provide coverage for eligible children through the children's health insurance program of the alliance instead of the employer's group health insurance plan, the employer shall pay as part of the premium for the children's health insurance plan the contribution that the employer would have paid to provide coverage to the child through the employer's group health insurance plan.

D. The board shall provide an addendum to the plan of operation for the superintendent's approval to assure the fair, reasonable and equitable administration of the children's health insurance program.

E. All policy forms written to conform to the prototype of the children's health insurance plans shall be filed and approved by the superintendent before they are issued."

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

"[NEW MATERIAL] EXEMPTION.--The alliance is exempt from payment of all fees and taxes levied by this state or any of its political subdivisions."

Section 22. TEMPORARY PROVISION--REPORT.--The department of insurance and the New Mexico health insurance alliance shall prepare and publish a report to the legislature by October 1, 1996 on the alliance programs and recommendations to facilitate participation in the alliance programs.

Section 23. REPEAL.--Laws 1994, Chapter 75, Section 35 is repealed.

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

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FORTY-SECOND LEGISLATURE

SECOND SESSION, 1996

JANUARY 24, 1996

Mr. President:

Your **COMMITTEES' COMMITTEE**, to whom has been referred

SENATE BILL 199

has had it under consideration and finds same to be **GERMANE**, PURSUANT TO CONSTITUTIONAL PROVISIONS, and thence referred to the **CORPORATIONS AND TRANSPORTATION COMMITTEE**.

Respectfully submitted,

_____

SENATOR MANNY M. ARAGON, Chairman

Adopted_____ Not Adopted_____

.108460.2

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(Chief Clerk) (Chief Clerk)

Date _____

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FORTY-SECOND LEGISLATURE **SB 199/a**

SECOND SESSION, 1996

January 30, 1996

Mr. President:

Your **CORPORATIONS & TRANSPORTATION COMMITTEE**, to whom has been referred

SENATE BILL 199

has had it under consideration and reports same with recommendation that it **DO PASS**, amended as follows:

1. On page 39, strike lines 10 through 25 in their entirety and on page 40, strike lines 1 through 17 in their entirety.

2. Renumber the succeeding sections accordingly.

3. On page 40, line 20, after "legislature" insert "and the governor".

4. On page 40, lines 20 and 21, strike the comma and "1996" and insert in lieu thereof "of each year, beginning on October 1, 1996".

5. On page 40, line 22, after the period insert the following new sentence to read:

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"The report shall include a director's report from members and insured representatives that reflects comments made by members and insureds regarding the alliance for each year the directors are required to report to the legislature and the governor.".

6. On page 40, between lines 24 and 25, insert the following new section to read:

"Section 24. DELAYED REPEAL.--The Health Insurance Alliance Act is repealed June 30, 2003.".

7. Renumber the succeeding section accordingly,

and thence referred to the **FINANCE COMMITTEE.**

Respectfully submitted,

Underscored material = new
[bracketed material] = delete

_____

Roman M. Maes, III, Chairman

Adopted_____ Not Adopted_____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 7 For 0 Against

Yes: 7

No: 0

Excused: McKibben, Reagan

Absent: 0

Underscored material = new
[bracketed material] = delete

FORTY-SECOND LEGISLATURE **SB 199/a**

SECOND SESSION, 1996

February 3, 1996

Mr. President:

Your **FINANCE COMMITTEE**, to whom has been referred

SENATE BILL 199, as amended

has had it under consideration and reports same with recommendation that it **DO PASS**, amended as follows:

1. Strike Senate Corporations and Transportation Committee Amendment 6.

2. On page 1, line 20, after the subsection designation "A." strike "A" and insert in lieu thereof 'Except as provided in Subsection I of this section, a".

3. On page 5, strike lines 11 through 15 and insert in lieu thereof:

"I. A person's eligibility for a policy issued under the Health Insurance Alliance Act shall not preclude a person from remaining on or choosing a pool policy; provided, a self-employed person who qualifies for an approved health plan under the Health Insurance Alliance Act by using a dependent as the second employee may choose a pool policy in lieu of the health plan under that act."".

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[bracketed material] = delete

4. On page 10, line 1, strike "and" and between lines 1 and 2, insert the following new paragraph:

"(2) a self-employed person who qualifies as a small employer by using a spouse or dependent as a second employee, and one of the two is covered under a policy pursuant to the Comprehensive Health Insurance Pool Act, is a small employer for purposes of the Health Insurance Alliance Act; and".

5. Renumber the succeeding paragraph accordingly.

6. On page 40, strike lines 23 and 24 in their entirety.

7. On page 40, between lines 24 and 25, insert the following new section to read:

"Section 23. Laws 1994, Chapter 75, Section 35 is amended to read:

"Section 35. DELAYED REPEAL.--The Health Insurance Alliance Act is repealed June 30, [~~1998~~] 2003."".

Respectfully submitted,

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

_____

Ben D. Altamirano, Chairman

Adopted_____ Not Adopted_____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 8 For 0 Against

Yes: 8

No: 0

Excused: Donisthorpe, Duran, Ingle, Kidd, Kysar

Absent: None

FORTY-SECOND LEGISLATURE

SECOND SESSION

February 5, 1996

SENATE FLOOR AMENDMENT number _____ to SENATE BILL 199, as amended

Amendment sponsored by Senator Janice D. Paster

1. Strike Senate Finance Committee Amendments 3, 4 and 5.

2. On page 5, strike lines 11 through 15 and insert in lieu thereof:

"I. A person's eligibility for a policy issued under the Health Insurance Alliance Act shall not preclude a person from remaining on a pool policy, and a self-employed person who qualifies for an approved health plan under the Health Insurance Alliance Act by using a dependent as the second employee may choose a pool policy in lieu of the health plan under that act."".

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[~~bracketed material~~] = delete

_____

Janice D. Paster

Adopted _____ Not Adopted _____

(Chief Clerk) (Chief Clerk)

Date _____

Underscored material = new
[bracketed material] = delete

State of New Mexico
House of Representatives

FORTY-SECOND LEGISLATURE

SECOND SESSION, 1996

February 11, 1996

Mr. Speaker:

Your **BUSINESS AND INDUSTRY COMMITTEE,** to whom has been referred

SENATE BILL 199, as amended

has had it under consideration and reports same with recommendation that it **DO PASS.**

Respectfully submitted,

_____

Fred Luna, Chairman

Adopted _____ Not Adopted _____

(Chief Clerk) (Chief Clerk)

Date _____

Underscored material = new
[bracketed material] = delete

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The roll call vote was 9 For 0 Against

Yes: 9

Excused: None

Absent: Gubbels, J.G.Taylor, Varela

S0199BI1