HOUSE BILL 406

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

INTRODUCED BY

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AN ACT

RELATING TO HEALTH CARE; ENACTING THE SELF-INSURED HEALTH CARE ACT; CREATING A FUND; PRESCRIBING PENALTIES; MAKING AN APPROPRIATION.

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

Section 1. SHORT TITLE.--This act may be cited as the "Self-Insured Health Care Act".

Section 2. DEFINITIONS.--As used in the Self-Insured Health Care Act:

A. "fund" means the "self-insured health care fund";

B. "group insurance association" means a not-for-profit unincorporated association consisting of two or more employers who are engaged in the same or similar type of business or are members of the same trade or professional

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association that has been in existence for not less than five years and who enter into agreements to pool their liabilities for health insurance benefits under a self-insured health care plan;

C. "self-insured health care plan" means a health care plan established by two or more employers to provide health insurance to employees or their employees' beneficiaries; and

D. "superintendent" means the superintendent of insurance.

Section 3. PURPOSE.--The purpose of the Self-Insured Health Care Act is to provide small employers the ability to provide affordable quality health insurance to employees by pooling small employer purchasing power and improving the state's economy by making affordable health insurance available to small business employees.

Section 4. SELF-INSURED HEALTH CARE PLAN--QUALIFICATIONS FOR CERTIFICATION BY SUPERINTENDENT.--

A. A self-insured health care plan may be established by a group insurance association that is formed by a nonprofit trade association, industry association, political subdivision of the state, religious organization or professional association of employers or professionals that has a constitution or bylaws and that has been organized and maintained in good faith for a continuous period of five years

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for purposes other than that of obtaining or providing insurance. The plan may not be offered or advertised to the public generally.

B. A board of trustees shall operate the self-insured health care plan pursuant to a trust agreement. The trustees shall have complete fiscal control over the plan and be responsible for all operations of it. The trustees shall be owners, partners, officers, directors or employees of one or more employers in the group insurance association. A trustee may not be an owner, officer or employee of the administrator or service company of the plan. The trustees shall have the authority to approve applications of association members for participation in the plan and to contract with an authorized administrator or service company to administer the day-to-day affairs of the plan. The trustees shall operate the plan in accordance with sound actuarial principles.

Section 5. SUPERINTENDENT--POWERS AND DUTIES.--

A. The superintendent shall:

(1) approve an application for a self-insured health care plan that includes:

(a) a copy of the constitution or bylaws of the association;

(b) the names and addresses of the trustees of the plan;

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(c) a copy of the bylaws or trust agreement that governs the operation of the arrangement;

(d) a copy of the policy, contract, certificate, summary plan description or other evidence of the benefits and coverages provided to covered employees;

(e) a copy of the fidelity bond in an amount not less than ten percent of the funds handled annually and issued in the name of the plan covering its trustees, employees, administrator or other individuals managing or handling the funds or assets of the arrangement and no less than one thousand dollars ($1,000) or more than five hundred thousand dollars ($500,000), except as provided pursuant to the Self-Insured Health Care Act;

(f) a copy of the arrangement's excess insurance agreement; and

(g) evidence showing that the arrangement will be operated in accordance with sound actuarial principles;

(2) suspend or revoke approval of a self-insured health care plan that has failed to comply with eligibility or filing requirements pursuant to this section, unless the trustees of the plan take action to correct the deficiency within a reasonable time after notification by the superintendent;

(3) deny, suspend or revoke a plan's approval

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if he finds that the plan has:

(a) failed to meet the financial requirements of the Self-Insured Health Care Act or has violated any lawful order or rules;

(b) refused to be examined or to produce its accounts, records and files for examination, or any of its officers has refused to give information with respect to its affairs or to perform any other legal obligation as to such examination when required by the superintendent; or

(c) failed to pay any final judgment rendered against it in this state within sixty days after the judgment became final; and

(4) notify the trustees of a plan if he finds that sufficient improvements to an inadequate condition of a plan have been made.

B. The superintendent may:

(1) after due notice to all interested parties and opportunity for hearing and consideration of the record, prescribe a fidelity bond required by this section in an amount over five hundred thousand dollars ($500,000);

(2) upon reasonable notice, conduct an examination of the loss reserves, financial condition, specific excess insurance and working capital of a multiple-employer self-funded health care arrangement, and if he

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preliminarily finds inadequacies or that the self-insured health care plan does not have combined working capital in an amount to assure financial strength and liquidity of the plan to pay claims promptly and meet its obligations to covered employees, the superintendent shall notify the trustees of the plan, who shall file a response within thirty days with the superintendent;

(3) suspend or revoke the approval of a plan if he finds that the arrangement has failed to correct or reasonably improve an inadequate condition within sixty days of notification of the inadequacy; and

(4) request information from a self-insured health care plan that summarizes paid and incurred expenses, contributions or premiums received and evidence that the plan is actuarially sound.

C. The superintendent shall not:

(1) approve a plan that does not have sufficient revenues to pay liabilities, as determined in accordance with sound actuarial principles; or

(2) approve a policy or contract form, application form, certificate, rider, endorsement, summary plan description or other evidence of coverage that:

(a) fails to comply with the Self-Insured Health Care Act;

(b) contains or incorporates by

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reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous or misleading clauses, or exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the contract;

(c) has any title, heading or other indication of its provisions that is misleading;

(d) is printed or otherwise reproduced in such manner as to render any material provision of the form substantially illegible; or

(e) contains provisions that are unfair or inequitable, or contrary to the public policy of this state or that encourage misrepresentation.

Section 6. APPROVED SELF-INSURED HEALTH CARE PLAN--TRUSTEES' DUTIES.--A self-insured health care plan shall meet the following conditions for approval of the plan:

A. issue to each covered employee a policy contract, certificate, summary plan description or other evidence of the benefits and coverages provided under the plan, including in boldfaced print in a conspicuous location the statement: "The benefits and coverages described herein are provided through a trust fund established and funded by a group of employers.";

B. retain the services of a qualified independent third party administrator for the purpose of claims

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administration;

C. comply with the Patient Protection Act;

D. maintain specific excess insurance with a retention level determined in accordance with sound actuarial principles;

E. establish and maintain appropriate loss reserves determined in accordance with sound actuarial principles;

F. remove a trustee found by the superintendent to:

(1) be incompetent;

(2) be guilty of, or to have pled guilty or no contest to a felony or a crime involving moral turpitude;

(3) have had any type of insurance license revoked in this or any other state; or

(4) have improperly manipulated assets, accounts or specific excess insurance or to have otherwise acted in bad faith;

G. make all contracts with administrators or service companies available for inspection by the superintendent;

H. if notified by the superintendent that an inadequate condition exists, implement steps within sixty days to correct the inadequacy, file proof of reasonable improvement or adequate condition with the superintendent

within six months of the implementation of the improvements and report quarterly thereafter to the superintendent;

I. file for approval by the superintendent the policy or contract form, application form, certificate, rider, endorsement, summary plan description or other evidence of coverage;

J. provide to the superintendent complete records of the plan's assets, transactions and affairs in accordance with the superintendent's rules; and

K. have and maintain its principal place of business in this state.

Section 7. SELF-INSURED HEALTH CARE GUARANTEE FUND CREATED--INSOLVENCY PROTECTION.--

A. The "self-insured health care guarantee fund" is created. The trustees of a self-insured health care plan shall deposit into the fund, within thirty days after the close of the plan's fiscal year, cash, securities or any combination of these or other measures approved by the superintendent. The deposit shall be equal in value to twenty-five percent of the preceding twelve months' health care claims expenditures, not reinsured, but not to exceed one hundred thousand dollars ($100,000) in value. All income from the deposit shall belong to the depositing plan and shall be paid to it as it becomes available.

B. A plan that has made a securities deposit to

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the superintendent for the fund may withdraw that deposit or any part of the deposit after making a substitute deposit of cash, securities or any combination of these or other measures of equal value if the superintendent approves.

C. No judgment creditor or other claimant of a group insurance association shall have the right to levy upon any of the assets of the self-insured health care guarantee fund.

D. A surety bond in value equivalent to the deposit required pursuant to this section may be filed with the superintendent in lieu of the deposit. The bond shall be one issued by an authorized surety insurer. No bond shall be canceled or subject to cancellation unless at least sixty days' advance notice of cancellation in writing is filed with the superintendent. No bond shall be approved unless it covers liabilities arising from all policies and contracts issued and entered into during the time the bond is in effect and unless the bond provides the same degree of security as would be provided by a deposit of securities.

E. In the event of an insolvency termination, the deposit held in the self-insured health care guarantee fund, or the bond held by the superintendent, shall be applied to the extent of the insolvency or termination of the plan. Funds remaining that exceed the amount needed to make the insolvent plan solvent or meet the terminal liability shall be

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returned to the trustees for distribution for the exclusive benefit of plan participants.

Section 8. EMPLOYER LIABILITY.--The liability of each employer for the obligations of the self-insured health care plan shall be individual, several and proportionate but not joint. Each employer participant shall have a contingent assessment liability for payment of actual losses and expenses incurred while the policy was in force. Each policy issued by the plan shall contain a statement of the contingent liability. Both the applications for insurance and policy shall contain the following statement: "This is a fully assessable policy. In the event the arrangement is unable to pay its obligations, participating employers shall be required to contribute on a pro rata earned premium basis the money necessary to meet any unfulfilled obligations."

Section 9. TERMINATION OF PLAN.--If a self-insured health care plan is terminated for any reason, it shall pay all outstanding claims, debts and obligations. The plan may retain sufficient funds to provide coverage for an additional period the trustees consider prudent. The trustees may purchase additional insurance for protection against potential future claims. Money remaining in the plan after satisfaction of all obligations upon termination shall be paid to participating employers or covered employees as of the termination date in a manner approved by the superintendent.

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Any rehabilitation, liquidation, conservation or dissolution of a multiple-employer self-funded health care arrangement shall be conducted under the supervision of the superintendent, who shall have all power with respect thereto granted to him under the laws governing the rehabilitation, liquidation, conservation or dissolution of insurers.

Section 10. ANNUAL REPORTS AND TRIENNIAL ACTUARIAL REPORTS.--

A. A self-insured health care plan shall file an annual report with the superintendent within four months of the end of the fiscal year, unless extended by the superintendent for good cause. The report shall:

(1) be verified by the oath of a member of the board of trustees or by an administrative executive appointed by the board, showing its condition on the last day of the preceding fiscal year;

(2) contain a financial statement of the arrangement, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant; and

(3) include an analysis of the adequacy of reserves and contributions or premiums charged, based on a review of past and projected claims and expenses.

B. A self-insured health care plan shall have a report prepared at least once every three years by an actuary

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who is a member of the American academy of actuaries on the actuarial soundness of the arrangement. The report shall include:

(1) evidence of the adequacy of the contribution rate in meeting the level of benefits provided and changes, if any, needed in the contribution rates to achieve or preserve a level of funding adequate to enable payment of the benefit amounts provided under the plan;

(2) a valuation of present assets based on statement value and prospective assets and liabilities of the plan and the extent of any unfunded accrued liabilities;

(3) a plan to amortize any unfunded liabilities and a description of actions taken to reduce unfunded liabilities;

(4) a description and explanation of actuarial assumptions;

(5) a schedule illustrating the amortization of any unfunded liabilities;

(6) a comparative review illustrating the level of funds available to the arrangement from rates, investment income and other sources realized over the period covered by the report, indicating the assumptions used;

(7) a statement by the actuary that the report is complete and accurate and that in his opinion the techniques and assumptions used are reasonable and meet the

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requirements and intent of the Self-Insured Health Care Act; and

(8) other factors or statements as may be reasonably required by the superintendent in order to determine the actuarial soundness of the plan.

Section 11. PENALTIES.--

A. It is a violation of the Self-Insured Health Care Act for a person to operate a multiple-employer self-funded health care plan without approval from the superintendent. A violation of the Self-Insured Health Care Act is punishable by a fine of not less than five thousand dollars ($5,000) or more than twenty-five thousand dollars ($25,000) for each violation.

B. The superintendent may issue a cease and desist order if he finds a person is operating a multiple-employer self-funded health care plan without approval.

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