SENATE BILL 7

42ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SPECIAL SESSION, 1996

INTRODUCED BY

EMMIT M. JENNINGS

AN ACT

RELATING TO MEDICAL INSURANCE COVERAGE; ALLEVIATING ADDITIONAL BURDENS PLACED ON THE MEDICAID PROGRAM AND THE STATE'S RESPONSIBILITY UNDER THAT PROGRAM; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978; REPEALING A SECTION OF LAWS 1994.

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) is amended to read:

"59A-56-2. PURPOSE OF ACT.--The purpose of the Health Insurance Alliance Act is to provide increased access to voluntary health insurance coverage in New Mexico. An additional purpose of the Health Insurance Alliance Act is to provide for the development of plans for health insurance coverage for children, small employers and individuals. To the

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1 extent that the Health Insurance Alliance Act continues to
2 provide increased access to voluntary health insurance coverage,
3 another purpose of the Health Insurance Alliance Act is to
4 alleviate increased burdens placed on the medicaid program and
5 to alleviate the responsibility of the human services department
6 to make additional medicaid expenditures for those persons who
7 may be forced to become medicaid eligible instead of being able
8 to enroll in the health insurance alliance."
9 Section 2. Section 59A-54-12 NMSA 1978 (being Laws 1987,
10 Chapter 154, Section 12, as amended) is amended to read:
11 "59A-54-12. ELIGIBILITY--POLICY PROVISIONS.--
12 A. Except as provided in Subsection I of this
13 section, a person is eligible for a pool policy only if on the
14 effective date of coverage or renewal of coverage the person is
15 a New Mexico resident and:
16 (1) is not eligible as an insured or covered
17 dependent for any health plan that provides coverage for
18 comprehensive major medical or comprehensive physician and
19 hospital services;
20 (2) is only eligible for a health plan that is
21 offered at a rate higher than that available from the pool;
22 (3) has been rejected for coverage for
23 comprehensive major medical or comprehensive physician and
24 hospital services; or
25 (4) is only eligible for a health plan with a

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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

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1 whose name the contract was issued, provide that the health
2 insurance benefits applicable for children are payable with
3 respect to a newly born child of the family member or the person
4 in whose name the contract is issued from the moment of coverage
5 of injury or illness, including the necessary care and treatment
6 of medically diagnosed congenital defects and birth
7 abnormalities. If payment of a specific premium is required to
8 provide coverage for the child, the contract may require that
9 notification of the birth of a child and payment of the required
10 premium shall be furnished to the carrier within thirty-one days
11 after the date of birth in order to have the coverage continued
12 beyond the thirty-one day period.
13 E. A pool policy may contain provisions under which
14 coverage is excluded during a six-month period following the
15 effective date of coverage as to a given individual for pre-
16 existing conditions, as long as either of the following exists:
17 (1) the condition has manifested itself within
18 a period of six months before the effective date of coverage in
19 such a manner as would cause an ordinarily prudent person to
20 seek diagnoses or treatment; or
21 (2) medical advice or treatment was recommended
22 or received within a period of six months before the effective
23 date of coverage.
24 F. The pre-existing condition exclusions described
25 in Subsection E of this section shall be waived to the extent to

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which similar exclusions have been satisfied under any prior health insurance coverage 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 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

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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'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."

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;

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;

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E. "department" means the department of insurance;

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

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

H. "eligible expenses" means the allowable charges for a health care service 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;

J. "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;

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 plan service contract; health maintenance organization subscriber contract; short-term,

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accident, fixed indemnity, specified disease policy, long-term care 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; or coverage by medicare or other governmental programs providing health care services; but "health insurance" does not include insurance issued pursuant to provisions of the Workers' Compensation Act or similar law, automobile medical payment insurance or provisions by which benefits are payable with or without regard to fault that are required by law to be contained in any liability insurance policy;

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

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;

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N. "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;

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

P. "member" means 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;

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 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 eligible to file a combined tax return or a consolidated tax return for purposes of state income taxation shall be considered one employer;

T. "superintendent" means the superintendent of

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1 insurance;

2 U. "total premiums" means the total premiums for

3 business written in the state received during a calendar year;

4 and

5 V. "unearned premiums" means the portion of a

6 premium previously paid for which the coverage period is in the

7 future."

8 Section 4. Section 59A-56-4 NMSA 1978 (being Laws 1994,

9 Chapter 75, Section 4) is amended to read:

10 "59A-56-4. ALLIANCE CREATED--BOARD CREATED.--

11 A. The "New Mexico health insurance alliance" is

12 created as a nonprofit public corporation for the purpose of

13 providing increased access to health insurance in the state.

14 All insurance companies authorized to transact health insurance

15 business in this state, nonprofit health care plans, health

16 maintenance organizations and self-insurers not subject to

17 federal preemption shall organize and be members of the alliance

18 as a condition of their authority to offer health insurance in

19 this state, except for an insurance company that is licensed

20 under the Prepaid Dental Plan Law or a company that is solely

21 engaged in the sale of dental insurance and is licensed under a

22 provision of the Insurance Code. The alliance is not a

23 governmental agency for any purpose.

24 B. The alliance shall be governed by a board of

25 directors constituted pursuant to the provisions of this

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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 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, 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 who, after the term of the initial 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, who

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

G. Whenever a vacancy on the board occurs, the electing or appointing authority of 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

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position.

H. Directors may be reimbursed by the alliance as provided in the Per Diem 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. 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

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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;

(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 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."

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

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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 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

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

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1 (12) shall review annually each approved health
2 plan to determine if it still qualifies as an approved health
3 plan based on the alliance designed criteria and, if the plan is
4 no longer approved, arrange for the transfer of the insureds
5 covered under the formerly approved plan to an approved health
6 plan;
7 (13) may terminate an approved health plan not
8 operating as required by the board;
9 (14) shall terminate an approved health plan if
10 timely claim payments are not made pursuant to the plan; and
11 (15) shall engage in significant marketing
12 activities, including a program of media advertising, to inform
13 small employers and eligible individuals of the existence of the
14 alliance, its purpose and the health insurance available or
15 potentially available through the alliance.
16 C. The alliance is subject to and responsible for
17 examination by the superintendent. No later than March 1 of
18 each year, the board shall submit to the superintendent an
19 audited financial report for the preceding calendar year in a
20 form approved by the superintendent."
21 Section 7. Section 59A-56-8 NMSA 1978 (being Laws 1994,
22 Chapter 75, Section 8) is amended to read:
23 "59A-56-8. APPROVED HEALTH PLAN.--
24 A. An approved health plan shall conform to the
25 alliance's approved health plan design criteria. The board may

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1 allow more than one plan design for approved health plans. A
2 member may provide one approved health plan for each plan design
3 approved by the board.
4 B. The board shall designate plan designs for
5 standard approved health plans. The board may designate plan
6 designs for an approved health plan that provides catastrophic
7 coverage or other benefit plan designs.
8 C. Each approved health plan shall offer a premium
9 that is no greater than ten percent over and no less than ten
10 percent under the average of the standard rate index for plans
11 with the same characteristics.
12 D. Any member that provides or offers to renew a
13 group health insurance contract providing health insurance
14 benefits to employees of the state, a county, a municipality or
15 a school district for which public funds are contributed shall
16 offer at least one approved health plan to small employers;
17 provided, however, if a member does not offer anywhere in the
18 United States a plan that meets substantially the design
19 criteria of an approved health plan, the member shall not be
20 required to offer an approved health plan.
21 E. If a plan design approved by the board is not
22 offered by any member already offering an approved health plan,
23 but a member offers a substantially similar plan design outside
24 the alliance, the board may require the member to offer that
25 plan design as an approved health plan through the alliance.

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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

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1 taxes, fees and assessments."

2 Section 8. Section 59A-56-9 NMSA 1978 (being Laws 1994,

3 Chapter 75, Section 9) is amended to read:

4 "59A-56-9. REINSURANCE.--

5 A. A member offering an approved health plan shall

6 be reinsured for certain losses by the alliance. Within six

7 months following the end of each calendar year in which the

8 member offering the approved health plan paid more in incurred

9 claims, plus the member's reinsurance premium pursuant to

10 Subsection B of this section, than eighty-five percent of earned

11 premiums received by the member on all approved health plans

12 issued by the member, the member shall receive from the alliance

13 the excess amount for the calendar year by which the incurred

14 claims and reinsurance premium exceeded eighty-five percent of

15 the earned premiums received by the alliance or its

16 administrator.

17 B. The alliance shall withhold from all premiums

18 that it receives a reinsurance premium as established by the

19 board. The reinsurance premium shall not exceed five percent of

20 premiums paid in the first year of coverage and shall not exceed

21 ten percent of premiums for renewal years. In determining the

22 reinsurance premium for a particular calendar year, the board

23 shall set the reinsurance premium at a rate that will recover

24 the total reinsurance loss for the preceding year over a

25 reasonable number of years in accordance with sound actuarial

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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 premiums in the first year and five percent of 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 net reinsurance loss in the previous calendar year and for the net administrative loss that occurred in the previous calendar year, taking into account investment income for the period and other appropriate gains and losses using the following definitions:

(1) net reinsurance losses shall be the amount determined for the previous calendar year in accordance with Subsection A of Section 59A-56-9 NMSA 1978 for all members offering an approved health plan reduced by reinsurance premiums charged by the alliance in the previous calendar year; and

(2) net administrative losses shall be the

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1 administrative expenses incurred by the alliance in the previous
2 calendar year and projected for the current calendar year less
3 the sum of administrative allowances received by the alliance
4 and any legislative appropriation for the period, but, in the
5 event of an administrative gain, net administrative losses for
6 the purpose of assessments shall be considered zero, and the
7 gain shall be carried forward to the administrative fund for the
8 next calendar year as an additional allowance.
9 B. The assessment for each member shall be
10 determined by multiplying the total losses of the alliance's
11 operation, as defined in Subsection A of this section, by a
12 fraction, the numerator of which is an amount equal to that
13 member's total premiums, or the equivalent, exclusive of
14 premiums received by the member for an approved health plan for
15 health insurance written in the state during the preceding
16 calendar year and the denominator of which equals the total
17 premiums of all health insurance written in the state during the
18 preceding calendar year exclusive of premiums for approved
19 health plans; provided that total premiums shall not include
20 payments by the secretary of human services pursuant to a
21 contract issued under Section 1876 of the federal Social
22 Security Act, total premiums exempted by the federal Employee
23 Retirement Income Security Act of 1974 or federal government
24 programs.
25 C. If assessments exceed actual reinsurance losses

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1 and administrative losses of the alliance, the excess shall be
2 held at interest by the board to offset future losses.
3 D. To enable the board to properly determine the net
4 reinsurance amount and its responsibility for reinsurance to
5 each member:
6 (1) by April 15 of each year, each member
7 offering an approved health plan shall submit a listing of all
8 incurred claims for the previous year; and
9 (2) by April 15 of each year, each member shall
10 submit a report that includes the total earned premiums received
11 during the prior year less the total earned premiums exempted by
12 federal government programs.
13 E. The alliance shall notify each member of the
14 amount of its assessment due by May 15 of each year. The
15 assessment shall be paid by the member by June 15 of each year.
16 F. The proportion of participation of each member in
17 the alliance shall be determined annually by the board, based on
18 annual statements filed by each member and other reports deemed
19 necessary by the board. Any deficit incurred by the alliance
20 shall be recouped by assessments apportioned among the members
21 pursuant to the formula provided in Subsection B of this
22 section; provided that the assessment paid for any member shall
23 be allowed as a credit on the future premium tax return for that
24 member, with the credit limited to fifty percent of the premium
25 tax due the first year the assessment is imposed; forty percent

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1 the second year; and thirty percent the third and all subsequent
2 years.
3 G. The board may defer, in whole or in part, the
4 payment of an assessment of a member if, in the opinion of the
5 board, after approval of the superintendent, payment of the
6 assessment would endanger the ability of the member to fulfill
7 its contractual obligations. In the event payment of an
8 assessment against a member is deferred, the amount deferred may
9 be assessed against the other members in a manner consistent
10 with the basis for assessments set forth in Subsection A of this
11 section. The member receiving the deferment shall pay the
12 assessment in full plus interest at the prevailing rate as
13 determined by regulation of the superintendent within four years
14 from the date payment is deferred. After four years but within
15 five years of the date of the deferment, the board may sue to
16 recover the amount of the deferred payment plus interest and
17 costs. Board actions to recover deferred payments brought after
18 five years of the date of deferment are barred. Any amount
19 received shall be deducted from future assessments or reimbursed
20 pro rata to the members paying the deferred assessment.
21 H. In addition to the assessments provided in this
22 section for reinsurance and administrative losses, the board may
23 impose on all members annually an assessment not to exceed two
24 hundred dollars ($200) for the board to hire consultants and
25 plan and develop alliance programs. This additional

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1 assessment shall be allowed as a credit on the next premium tax
2 due for the member."
3 Section 11. Section 59A-56-13 NMSA 1978 (being Laws 1994,
4 Chapter 75, Section 13) is amended to read:
5 "59A-56-13. ALLIANCE ADMINISTRATOR.--
6 A. The board may select an alliance administrator
7 through a competitive request for proposal process. The board
8 shall evaluate proposals based on criteria established by the
9 board that shall include:
10 (1) proven ability to administer health
11 insurance programs;
12 (2) an estimate of total charges for
13 administering the alliance for the proposed contract period; and
14 (3) ability to administer the alliance in a
15 cost-efficient manner.
16 B. The alliance administrator contract shall be for
17 a period up to four years, subject to annual renegotiation of
18 the fees and services, and shall provide for cancellation of the
19 contract for cause, termination of the alliance by the
20 legislature or the combining of the alliance with a governmental
21 body.
22 C. At least one year prior to the expiration of an
23 alliance administrator contract, the board may invite all
24 interested parties, including the current administrator, to
25 submit proposals to serve as alliance administrator for a

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1 succeeding contract period. Selection of the administrator for
2 a succeeding contract period shall be made at least six months
3 prior to the expiration of the current contract.
4 D. The alliance administrator shall:
5 (1) take applications for an approved health
6 plan from small employers or a referring agent;
7 (2) establish a premium billing procedure for
8 collection of premiums from insureds. Billings shall be made on
9 a periodic basis, not less than monthly, as determined by the
10 board;
11 (3) pay the member that offers an approved
12 health plan the net premium due after deduction of reinsurance
13 and administrative allowances;
14 (4) provide the member with any changes in the
15 status of insureds;
16 (5) perform all necessary functions to assure
17 that each member is providing timely payment of benefits to
18 individuals covered under an approved health plan, including:
19 (a) making information available to
20 insureds relating to the proper manner of submitting a claim for
21 benefits to the member offering the approved health plan and
22 distributing forms on which submissions shall be made; and
23 (b) making information available on
24 approved health plan benefits and rates to insureds;
25 (6) submit regular reports to the board

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1 regarding the operation of the alliance, the frequency, content
2 and form of which shall be determined by the board;
3 (7) following the close of each fiscal year,
4 determine premiums of members, the expense of administration and
5 the paid and incurred health care service charges for the year
6 and report this information to the board and the superintendent
7 on a form prescribed by the superintendent; and
8 (8) establish the premiums for reinsurance and
9 the administrative charges, subject to approval of the board."
10 Section 12. Section 59A-56-14 NMSA 1978 (being Laws 1994,
11 Chapter 75, Section 14) is amended to read:
12 "59A-56-14. ELIGIBILITY--GUARANTEED ISSUE--PLAN
13 PROVISIONS.--
14 A. A small employer is eligible for an approved
15 health plan if on the effective date of coverage or renewal:
16 (1) at least fifty percent of its eligible
17 employees not otherwise insured elect to be covered under the
18 approved health plan;
19 (2) the small employer has not terminated
20 coverage with an approved health plan within three years of the
21 date of application for coverage except to change to another
22 approved health plan; and
23 (3) the small employer does not offer other
24 general group health insurance coverage to its employees. For
25 the purposes of this paragraph, general group health insurance

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1 coverage excludes coverage providing only a specific limited
2 form of health insurance such as accident or disability income
3 insurance coverage or a specific health care service such as
4 dental care.
5 B. An approved health plan shall provide coverage
6 for a child. The policy shall also provide in substance that
7 attainment of the limiting age by an unmarried dependent
8 individual does not operate to terminate coverage when the
9 individual continues to be incapable of self-sustaining
10 employment by reason of developmental disability or physical
11 handicap and the individual is primarily dependent for support
12 and maintenance upon the employee. Proof of incapacity and
13 dependency shall be furnished to the alliance and the member
14 that offered the approved health plan within one hundred twenty
15 days of attainment of the limiting age. The board may require
16 subsequent proof annually after a two-year period following
17 attainment of the limiting age.
18 C. An approved health plan shall provide that the
19 health insurance benefits applicable for eligible dependents are
20 payable with respect to a newly born child of the family member
21 or the individual in whose name the contract is issued from the
22 moment of birth, including the necessary care and treatment of
23 medically diagnosed congenital defects and birth abnormalities.
24 If payment of a specific premium is required to provide coverage
25 for the child, the contract may require that notification of the

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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, 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

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1 days following the termination of the prior coverage. In that
2 case, coverage through the alliance shall be effective from the
3 date on which the prior coverage was terminated. This
4 subsection does not prohibit preexisting conditions coverage in
5 an approved health plan that is more favorable to the covered
6 individual than that specified in this subsection.

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

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

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

17 (3) is an inmate of a public institution.

18 G. The alliance shall provide for an open enrollment
19 period of sixty days from the initial offering of an approved
20 health plan. Individuals enrolled during the open enrollment
21 period shall not be subject to the preexisting conditions
22 limitation.

23 H. If an insured covered by an approved health plan
24 switches to another approved health plan that provides increased
25 or additional benefits such as lower deductible or co-payment

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1 requirements, the member offering the approved health plan with
2 increased or additional benefits may require the six-month
3 period for preexisting conditions provided in Subsection D of
4 this section to be satisfied prior to receipt of the additional
5 benefits.

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

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

16 "59A-56-17. BENEFITS.--

17 A. An approved health plan shall pay for medically
18 necessary eligible expenses that exceed the deductible, co-
19 payment and co-insurance amounts applicable under the provisions
20 of Section 59A-56-18 NMSA 1978 and are not otherwise limited or
21 excluded. The Health Insurance Alliance Act does not prohibit
22 the board from approving additional types of health plan designs
23 with similar cost-benefit structures or other types of health
24 plan designs. An approved health plan for small employers
25 shall, at a minimum, reflect the levels of health insurance

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1 coverage generally available in New Mexico for small employer
2 group policies, but an approved health plan for small employers
3 may also offer health plan designs that are not generally
4 available in New Mexico for small employer group policies.
5 B. The board may design and require an approved
6 health plan to contain cost-containment measures and
7 requirements, including managed care, pre-admission
8 certification, concurrent inpatient review and the use of fee
9 schedules for health care providers, including the diagnosis-
10 related grouping system and the resource-based relative value
11 system."
12 Section 14. Section 59A-56-18 NMSA 1978 (being Laws 1994,
13 Chapter 75, Section 18) is amended to read:
14 "59A-56-18. DEDUCTIBLES--CO-INSURANCE--MAXIMUM OUT-OF-
15 POCKET PAYMENTS.--
16 A. Subject to the limitations provided in Subsection
17 C of this section, an approved health plan offered through the
18 alliance may impose a deductible on a per-person calendar year
19 basis. Approved health plans offered by health maintenance
20 organizations shall provide equivalent cost-benefit structures.
21 The board may authorize deductibles in other amounts and
22 equivalent cost-benefit structures.
23 B. Subject to the limitations provided in Subsection
24 C of this section, a mandatory co-insurance requirement for an
25 approved health plan may be imposed as a percentage of eligible

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1 expenses in excess of a deductible. Health maintenance
2 organizations shall impose equivalent cost-benefit structures.
3 C. The maximum aggregate out-of-pocket payments for
4 eligible expenses by the covered individual shall be determined
5 by the board."
6 Section 15. Section 59A-56-19 NMSA 1978 (being Laws 1994,
7 Chapter 75, Section 19) is amended to read:
8 "59A-56-19. DEPENDENT FAMILY MEMBER REQUIRED COVERAGE--
9 SMALL EMPLOYER RESPONSIBILITY.--
10 A. A small employer shall collect or make a payroll
11 deduction from the compensation of an employee for the portion
12 of the approved health plan cost the employee is responsible for
13 paying. The small employer may contribute to the cost of that
14 plan on behalf of the employee.
15 B. A small employer shall make available to
16 dependent family members of an employee covered by an approved
17 health plan the same approved health plan. The small employer
18 may contribute to the cost of family coverage.
19 C. All premiums collected, deducted from the
20 compensation of employees or paid on their behalf by the small
21 employer shall be promptly remitted to the alliance."
22 Section 16. Section 59A-56-20 NMSA 1978 (being Laws 1994,
23 Chapter 75, Section 20) is amended to read:
24 "59A-56-20. RENEWABILITY.--
25 A. An approved health plan shall contain provisions

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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 becomes eligible for medicare as the primary coverage, except that in a family policy 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 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

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1 resides outside the United States for more than six consecutive
2 months."
3 Section 17. Section 59A-56-21 NMSA 1978 (being Laws 1994,
4 Chapter 75, Section 21) is amended to read:
5 "59A-56-21. REGULATIONS.--The superintendent shall:
6 A. adopt regulations that provide for disclosure by
7 members of the availability of health insurance from the
8 alliance; and
9 B. adopt regulations to carry out the provisions of
10 the Health Insurance Alliance Act."
11 Section 18. Section 59A-56-23 NMSA 1978 (being Laws 1994,
12 Chapter 75, Section 23) is amended to read:
13 "59A-56-23. RATES--STANDARD RISK RATE--EXPERIENCE RATING
14 PROHIBITED.--
15 A. The alliance shall determine a standard risk rate
16 index by actuarially calculating the average index rates that
17 the insurer has filed under the requirements of the Small Group
18 Rate and Renewability Act with the benefits similar to the
19 alliance's standard approved health plan. A standard risk rate
20 based on age and other appropriate demographic characteristics
21 may be used. No standard risk rate shall be more than ten
22 percent higher or ten percent lower than the average index rate.
23 In determining the standard risk rate, the alliance shall
24 consider the benefits provided by the approved health plan.
25 B. Experience rating is not allowed other than for

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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 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 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. TEMPORARY PROVISION--REPORT.--The department of insurance and the New Mexico health insurance alliance shall prepare and publish a report to the legislature and the governor

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1 by October 1 of each year, beginning on October 1, 1996 on the
2 alliance programs and recommendations to facilitate
3 participation in the alliance programs. The report shall
4 include a director's report from members and insured
5 representatives that reflects comments made by members and
6 insureds regarding the alliance for each year the directors are
7 required to report to the legislature and the governor.
8 Section 21. Laws 1994, Chapter 75, Section 35 is amended
9 to read:
10 "Section 35. DELAYED REPEAL.--The Health Insurance
11 Alliance Act is repealed June 30, 2003."
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FORTY-SECOND LEGISLATURE
FIRST SPECIAL SESSION, 1996

March 20, 1996

Mr. President:

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

SENATE BILL 7

has had it under consideration and reports same with recommendation that it **DO NOT PASS**, but that

SENATE FINANCE COMMITTEE SUBSTITUTE FOR SENATE BILL 7

DO PASS.

Respectfully submitted,

____

Ben D. Altamirano, Chairman

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Adopted___________________________ Not Adopted___________________________

(Chief Clerk) (Chief Clerk)

1
2
3 Date ___________________________
4
5
6 The roll call vote was 11 For 0 Against
7 Yes: 11
8 No: 0
9 Excused: Aragon, Ingle
10 Absent: None
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SENATE FINANCE COMMITTEE SUBSTITUTE FOR
SENATE BILL 7

42ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SPECIAL SESSION, 1996

AN ACT

RELATING TO MEDICAL INSURANCE COVERAGE; ALLEVIATING ADDITIONAL BURDENS PLACED ON THE MEDICAID PROGRAM AND THE STATE'S RESPONSIBILITY UNDER THAT PROGRAM; 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-56-2 NMSA 1978 (being Laws 1994, Chapter 75, Section 2) is amended to read:

"59A-56-2. PURPOSE OF ACT.--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. To the extent that the Health Insurance Alliance Act continues to

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provide increased access to voluntary health insurance coverage, another purpose of the Health Insurance Alliance Act is to alleviate increased burdens placed on the medicaid program and to alleviate the responsibility of the human services department to make additional medicaid expenditures for those persons who may be forced to become medicaid eligible instead of being able to enroll in the health insurance alliance."

Section 2. 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~~] Except as provided in Subsection I of this section, 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 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

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1 insurance.
2 C. A pool policy shall provide that coverage of a
3 dependent unmarried person terminates when the person becomes
4 nineteen years of age or, if the person is enrolled full time in an
5 accredited educational institution, when he becomes twenty-five
6 years of age. The policy shall also provide in substance that
7 attainment of the limiting age does not operate to terminate
8 coverage when the person is and continues to be:
9 (1) incapable of self-sustaining employment by
10 reason of mental retardation or physical handicap; and
11 (2) primarily dependent for support and maintenance
12 upon the person in whose name the contract is issued.
13 Proof of incapacity and dependency shall be furnished to the
14 insurer within one hundred twenty days of attainment of the
15 limiting age and subsequently as required by the insurer but not
16 more frequently than annually after the two-year period following
17 attainment of the limiting age.
18 D. A pool policy that provides coverage for a family
19 member of the person in whose name the contract is issued shall, as
20 to the coverage of the family member or the individual in whose
21 name the contract was issued, provide that the health insurance
22 benefits applicable for children are payable with respect to a
23 newly born child of the family member or the person in whose name
24 the contract is issued from the moment of coverage of injury or
25 illness, including the necessary care and treatment of medically

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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-

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1 existing conditions coverage in a pool policy that is more
2 favorable to the insured than that specified in this subsection.
3 G. An individual is not eligible for coverage by the pool
4 if:
5 (1) he is, at the time of application, eligible for
6 medicare or medicaid, which would provide coverage for amounts in
7 excess of limited policies such as dread disease, cancer policies
8 or hospital indemnity policies;
9 (2) he has terminated coverage by the pool within
10 the past twelve months; or
11 (3) he is an inmate of a public institution or is
12 eligible for public programs for which medical care is provided.
13 H. Any person whose health insurance coverage from a
14 qualified state health policy with similar coverage is terminated
15 because of nonresidency in another state may apply for coverage
16 under the pool. If the coverage is applied for within thirty-one
17 days after that termination and if premiums are paid for the entire
18 coverage period, the effective date of the coverage shall be the
19 date of termination of the previous coverage.
20 I. A person's eligibility for a policy issued under the
21 Health Insurance Alliance Act shall not preclude a person from
22 remaining on a pool policy, and a self-employed person who
23 qualifies for an approved health plan under the Health Insurance
24 Alliance Act by using a dependent as the second employee may choose
25 a pool policy in lieu of the health plan under that act."

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1 Section 3. Section 59A-56-3 NMSA 1978 (being Laws 1994,
2 Chapter 75, Section 3) is amended to read:
3 "59A-56-3. DEFINITIONS.--As used in the Health Insurance
4 Alliance Act:
5 A. "alliance" means the New Mexico health insurance
6 alliance;
7 B. "approved health plan" means any arrangement for the
8 provision of health insurance offered through and approved by the
9 alliance [~~by which insureds have access to health insurance~~];
10 C. "board" means the board of directors of the alliance;
11 D. "child" means a dependent unmarried individual who is
12 less than nineteen years of age or an unmarried individual who is
13 enrolled full time in an accredited educational institution until
14 the individual becomes twenty-five years of age;
15 E. "department" means the department of insurance;
16 [~~D.~~] F. "director" means an individual who serves on the
17 board;
18 [~~E.~~] G. "earned premiums" means premiums paid or due
19 during [~~the~~] a calendar year for coverage under an approved health
20 plan less any unearned premiums at the end of that calendar year
21 plus any unearned premiums from the end of the [~~previous~~]
22 immediately preceding calendar year;
23 [~~F.~~] H. "eligible expenses" [~~are~~] means the allowable
24 charges for a health care service [~~and items for which benefits are~~
25 ~~extended~~] covered under an approved health plan;

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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 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

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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~~

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~~health care plan, a health maintenance organization or self-insurers not subject to federal preemption, but does not include 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~~] 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;

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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.--

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

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1 for any other purpose.

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

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

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

15 (2) five directors, appointed by the governor, who
16 shall be <u>officers, general partners or proprietors of</u> small
17 employers [~~and~~] who, after the term of the initial appointments,
18 are covered by approved health plans;

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

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

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1 E. The superintendent shall serve as chair of the board
2 unless he declines, in which event he shall appoint the chair.
3 F. The directors [~~appointed~~] elected by the members shall
4 be [~~appointed~~] elected for initial terms of three years or less,
5 staggered so that the term of at least one director [~~shall expire~~]
6 expires on June 30 of each year. The directors appointed by the
7 governor shall be appointed for initial terms of three years or
8 less, staggered so that the term of at least one director [~~shall~~
9 ~~expire~~] expires on June 30 of each year. Following the initial
10 terms, directors shall be elected or appointed for terms of three
11 years. [~~If the members fail to make the initial appointments~~
12 ~~within sixty days following the first organizational meeting, the~~
13 ~~superintendent shall make those appointments.~~] A director whose
14 term has expired shall continue to serve until his successor is
15 elected or appointed.
16 G. Whenever a vacancy on the board occurs, the electing
17 or appointing authority of [~~that director~~] the director's position
18 that is vacant shall fill the vacancy by electing or appointing an
19 individual to serve the balance of the unexpired term; provided,
20 when a vacancy occurs in one of the director's positions elected by
21 the members, the superintendent is authorized to appoint a
22 temporary replacement director until the next scheduled election of
23 directors elected by the members is held. The individual elected
24 or appointed to fill a vacancy shall meet the requirements for
25 initial election or appointment to that position.

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H. Directors may be reimbursed by the alliance as provided in the Per Diem 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.

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1 C. The plan of operation shall:
2 (1) establish procedures for the handling and
3 accounting of assets of the alliance;
4 (2) establish regular times and places for meetings
5 of the board;
6 (3) establish procedures for records to be kept of
7 all financial transactions and for annual fiscal reporting to the
8 superintendent;
9 (4) establish the amount of and the method for
10 collecting assessments pursuant to Section [11 of the Health
11 Insurance Alliance Act] 59A-56-11 NMSA 1978;
12 (5) establish a program to publicize the existence
13 of the alliance, the approved health plans, the eligibility
14 requirements and procedures for enrollment in an approved health
15 plan and to maintain public awareness of the alliance;
16 (6) establish penalties for [noncollection]
17 nonpayment of assessments [from] by members;
18 (7) establish procedures for alternative dispute
19 resolution of disputes between members and insureds; and
20 (8) contain additional provisions necessary and
21 proper for the execution of the powers and duties of the alliance."
22 Section 6. Section 59A-56-6 NMSA 1978 (being Laws 1994,
23 Chapter 75, Section 6) is amended to read:
24 "59A-56-6. BOARD--POWERS AND DUTIES.--
25 A. The board shall have the general powers and authority

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1 granted to insurance companies licensed to transact health
2 insurance business under the laws of this state.
3 B. The board:
4 (1) may enter into contracts to carry out the
5 provisions of the Health Insurance Alliance Act, including, with
6 the approval of the superintendent, contracting with similar
7 alliances of other states for the joint performance of common
8 administrative functions or with persons or other organizations for
9 the performance of administrative functions;
10 (2) may sue and be sued;
11 (3) may conduct periodic audits of the members to
12 assure the general accuracy of the financial data submitted to the
13 alliance;
14 (4) shall establish maximum rate schedules,
15 allowable rate adjustments, administrative allowances, reinsurance
16 premiums and agent referral, [~~and~~] servicing fees [~~and any other~~
17 ~~actuarial functions appropriate to the operation of the alliance,~~
18 ~~but within the limits established~~] or commissions subject to
19 applicable provisions in the Insurance Code. In determining the
20 initial year's rate for health insurance, the only rating factors
21 that may be used are age, gender, geographic area of the place of
22 employment and smoking practices. In any year's rate, the
23 difference in rates in any one age group that may be charged on the
24 basis of a person's gender shall not exceed another person's rates
25 in the age group by more than twenty percent of the lower rate, and

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1 no person's rate shall exceed the rate of any other person with
2 similar family composition by more than two hundred fifty percent
3 of the lower rate, except that the rates for children under the age
4 of nineteen may be lower than the bottom rates in the two hundred
5 fifty percent band. The rating factor restrictions shall not
6 prohibit a member from offering rates that differ depending upon
7 family composition;
8 (5) may direct a member to issue policies or
9 certificates of coverage of health insurance in accordance with the
10 requirements of the Health Insurance Alliance Act;
11 (6) shall establish procedures for alternative
12 dispute resolution of disputes between members and insureds;
13 (7) shall cause the alliance to have an annual audit
14 of its operations by an independent certified public accountant;
15 (8) shall conduct all board meetings as if it were
16 [~~an agency~~] subject to the provisions of the Open Meetings Act;
17 (9) shall draft one or more sample <u>health insurance</u>
18 policies that are the prototype documents for the members;
19 (10) shall determine the design criteria to be met
20 for an approved health plan;
21 (11) shall review each proposed approved health plan
22 to determine if it meets the alliance designed criteria and, if it
23 does meet the criteria, approve the plan [~~provided that~~], <u>but</u> the
24 board shall not permit more than one approved health plan per
25 member for each set of plan design criteria;

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(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

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1 member may provide one approved health plan for each plan design
2 approved by the board.
3 B. The board shall designate plan designs for standard
4 approved health plans. The board may designate plan designs for an
5 approved health plan that provides catastrophic coverage or other
6 benefit plan designs.
7 [~~B. The~~] C. Each approved health plan shall offer a
8 premium that is no greater than [~~fifteen~~] ten percent over and no
9 less than [~~fifteen~~] ten percent under the average of the standard
10 rate index for plans with the same characteristics.
11 [~~C.~~] D. Any member that [~~submits a bid for~~] provides or
12 offers to [~~provide or renews~~] renew a group health insurance
13 contract providing health insurance benefits to employees of the
14 state, a county, a municipality or a school district for which
15 public funds are contributed shall offer at least one approved
16 health plan to small employers; provided, however, if a member does
17 not offer anywhere in the United States a plan that meets
18 substantially the design criteria of an approved health plan, the
19 member shall not be required to offer an approved health plan.
20 E. If a plan design approved by the board is not offered
21 by any member already offering an approved health plan, but a
22 member offers a substantially similar plan design outside the
23 alliance, the board may require the member to offer that plan
24 design as an approved health plan through the alliance.
25 F. An approved health plan shall be offered for at least

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1 five consecutive years following the date last required in
2 accordance with Subsection D of this section or after notifying the
3 board of its future withdrawal if not required in accordance with
4 Subsection D of this section unless:
5 (1) the member substitutes another approved health
6 plan for the plan withdrawn; or
7 (2) the board allows the plan to be withdrawn
8 because it imposes a serious hardship upon the member.
9 G. No member shall be required to offer an approved
10 health plan if the member notifies the superintendent in writing
11 that it will no longer offer health insurance, life insurance or
12 annuities in the state, except for renewal of existing contracts,
13 provided that:
14 (1) the member does not offer or provide health
15 insurance, life insurance or annuities for a period of five years
16 from the date of notification to the superintendent to any person
17 in the state who is not covered by the member through a health
18 insurance policy in effect on the date of the notification; and
19 (2) with respect to health or life insurance
20 policies or annuities in effect on the date of notification to the
21 superintendent, the member continues to comply with all applicable
22 laws and regulations governing the provision of insurance in this
23 state, including the payment of applicable taxes, fees and
24 assessments."
25 Section 8. Section 59A-56-9 NMSA 1978 (being Laws 1994,

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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 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,

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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

(2) net administrative losses shall be the

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1 administrative expenses incurred by the alliance in the previous
2 calendar year and projected for the current calendar year less the
3 sum of administrative allowances [earned] received by the alliance
4 and any legislative appropriation for the period, but, in the event
5 of an administrative gain, net administrative losses for the
6 purpose of assessments shall be considered zero, and the gain shall
7 be carried forward to the administrative fund for the next calendar
8 year as an additional allowance.
9 B. The assessment for each member shall be determined by
10 multiplying the total losses of the alliance's operation, as
11 defined in Subsection A of this section, by a fraction, the
12 numerator of which [equals] is an amount equal to that member's
13 total [premium] premiums, or [its] the equivalent, exclusive of
14 premiums received by the member for an approved health plan for
15 health insurance written in the state during the preceding calendar
16 year and the denominator of which equals the total premiums of all
17 health insurance [premiums] written in the state during the
18 preceding calendar year exclusive of premiums for approved health
19 plans; provided that [premium income] total premiums shall not
20 include payments by the secretary of human services pursuant to a
21 contract issued under Section 1876 of the federal Social Security
22 Act, [and shall not include premium income] total premiums exempted
23 by the federal Employee Retirement Income Security Act of 1974 or
24 [other] federal government programs.
25 C. If assessments exceed actual reinsurance losses and

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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

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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

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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

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

B. The alliance administrator contract shall be for a

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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

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1 covered under an approved health plan, including:
2 (a) making information available to insureds
3 relating to the proper manner of submitting a claim for benefits to
4 the member offering the approved health plan and distributing forms
5 on which submissions shall be made; and
6 (b) making information available on approved
7 health plan benefits and rates to insureds;
8 (6) submit regular reports to the board regarding
9 the operation of the alliance, the frequency, content and form of
10 which shall be determined by the board;
11 (7) following the close of each fiscal year,
12 determine [~~net written~~] premiums <u>of members</u>, the expense of
13 administration and the paid and incurred [~~losses~~] <u>health care</u>
14 <u>service charges</u> for the year and report this information to the
15 board and the superintendent on a form prescribed by the
16 superintendent; and
17 (8) establish the premiums for reinsurance and the
18 administrative charges, subject to approval of the board."
19 Section 12. Section 59A-56-14 NMSA 1978 (being Laws 1994,
20 Chapter 75, Section 14) is amended to read:
21 "59A-56-14. ELIGIBILITY--GUARANTEED ISSUE--PLAN
22 PROVISIONS.--
23 A. A small employer is eligible for an approved health
24 plan if on the effective date of coverage or renewal:
25 (1) at least fifty percent of its <u>eligible</u> employees

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1 not otherwise insured elect to be covered under the approved health
2 plan; [and]
3 (2) the small employer has not terminated coverage
4 with an approved health plan within three years of the date of
5 application for coverage except to change to another approved
6 health plan; and
7 (3) the small employer does not offer other general
8 group health insurance coverage to its employees. For the purposes
9 of this paragraph, general group health insurance coverage excludes
10 coverage providing only a specific limited form of health insurance
11 such as accident or disability income insurance coverage or a
12 specific health care service such as dental care.
13 B. An approved health plan shall provide [that coverage
14 of a dependent unmarried individual terminates when the individual
15 becomes nineteen years of age or, if the individual is enrolled
16 full time in an accredited educational institution, when the
17 individual becomes twenty-five years of age] coverage for a child.
18 The policy shall also provide in substance that attainment of the
19 limiting age by an unmarried dependent individual does not operate
20 to terminate coverage when the individual continues to be incapable
21 of self-sustaining employment by reason of [mental retardation]
22 developmental disability or physical handicap and the individual is
23 primarily dependent for support and maintenance upon the employee.
24 Proof of incapacity and dependency shall be furnished to the
25 alliance and the member that offered the approved health plan

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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

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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

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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 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:

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1 "59A-56-17. BENEFITS.--
2 A. An approved health plan [~~issued through the alliance~~]
3 shall pay for [~~or provide~~] medically necessary eligible expenses
4 that exceed the deductible, co-payment and co-insurance amounts
5 applicable under the provisions of Section [~~18 of the Health~~
6 ~~Insurance Alliance Act~~] 59A-56-18 NMSA 1978 and are not otherwise
7 limited or excluded. The Health Insurance Alliance Act does not
8 prohibit the board from approving additional types of health plan
9 designs with similar cost-benefit structures or other types of
10 health plan designs. An approved health plan for small employers
11 shall, at a minimum, reflect the levels of health insurance
12 coverage generally available in New Mexico for small employer group
13 policies, but an approved health plan for small employers may also
14 offer health plan designs that are not generally available in New
15 Mexico for small employer group policies.
16 B. The board may design and require an approved health
17 plan to contain cost-containment measures and requirements,
18 including managed care, pre-admission certification, [~~and~~]
19 concurrent inpatient review and the use of fee schedules for health
20 care providers, including the diagnosis-related grouping system and
21 the resource-based relative value system."
22 Section 14. Section 59A-56-18 NMSA 1978 (being Laws 1994,
23 Chapter 75, Section 18) is amended to read:
24 "59A-56-18. DEDUCTIBLES--CO-INSURANCE--MAXIMUM OUT-OF-POCKET
25 PAYMENTS.--

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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:

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

A. A small employer [~~may~~] shall collect or make a payroll

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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.

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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 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."

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1 Section 18. Section 59A-56-23 NMSA 1978 (being Laws 1994,
2 Chapter 75, Section 23) is amended to read:
3 "59A-56-23. RATES--STANDARD RISK RATE--EXPERIENCE RATING
4 PROHIBITED.--
5 A. The alliance shall determine a standard risk rate
6 index by actuarially calculating the average index rates that the
7 insurer has filed under the requirements of the Small Group Rate
8 and Renewability Act with the benefits similar to the alliance's
9 standard approved health plan. A standard risk rate based on age
10 and other appropriate demographic characteristics may be used. No
11 standard risk rate shall be more than [~~fifteen~~] ten percent higher
12 or [~~fifteen~~] ten percent lower than the average index rate. In
13 determining the standard risk rate, the alliance shall consider the
14 benefits provided by the approved health plan.
15 B. Experience rating is not allowed other than for
16 reinsurance purposes.
17 C. All rates and rate schedules shall be submitted to the
18 superintendent for approval prior to use."
19 Section 19. Section 59A-56-24 NMSA 1978 (being Laws 1994,
20 Chapter 75, Section 24) is amended to read:
21 "59A-56-24. BENEFIT PAYMENTS REDUCTION.--
22 A. An approved health plan shall be the last payer of
23 benefits whenever any other benefit is available. Benefits
24 otherwise payable under the approved health plan shall be reduced
25 by all amounts paid or payable through any other health insurance

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1 and by all hospital and medical expense benefits paid or payable
2 under any workers' compensation coverage, automobile medical
3 payment or liability insurance, whether provided on the basis of
4 fault or no-fault, and by any hospital or medical benefits paid or
5 payable under or provided pursuant to any state or federal [~~law~~]
6 program, excluding medicaid.
7 B. The administrator or the alliance shall have a cause
8 of action against any person covered by an approved health plan for
9 the recovery of the amount of benefits paid that are not for
10 [~~covered~~] eligible expenses. Benefits due from the approved health
11 plan may be reduced or refused as a set-off against any amount
12 recoverable under this section."
13 Section 20. TEMPORARY PROVISION--REPORT.--The department of
14 insurance and the New Mexico health insurance alliance shall
15 prepare and publish a report to the legislature and the governor by
16 October 1 of each year beginning on October 1, 1996 on the alliance
17 programs and recommendations to facilitate participation in the
18 alliance programs. The report shall include a director's report
19 from members and insured representatives that reflects comments
20 made by members and insureds regarding the alliance for each year
21 the directors are required to report to the legislature and the
22 governor.
23 Section 21. REPEAL.--Laws 1994, Chapter 75, Section 35 is
24 repealed.
25 Section 22. EMERGENCY.--It is necessary for the public peace,

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1 health and safety that this act take effect immediately.

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State of New Mexico
House of Representatives

FORTY-SECOND LEGISLATURE
FIRST SPECIAL SESSION, 1996

March 21, 1996

Mr. Speaker:

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

SENATE FINANCE COMMITTEE SUBSTITUTE FOR SENATE BILL 7

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

Respectfully submitted,

Max Coll, Chairman

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2 Adopted ______________________ Not Adopted ______________________
(Chief Clerk) (Chief Clerk)
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Date ____________
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6 The roll call vote was 12 For 6 Against
7 Yes: 12
8 No: Bird, Buffett, Knowles, Reyes, Townsend, Wallace
9 Excused: None
10 Absent: None
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