HOUSE BILL 832

43RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 1997

INTRODUCED BY

M. MICHAEL OLGUIN

FOR THE HEALTH CARE REFORM COMMITTEE

AN ACT

RELATING TO INSURANCE; ENACTING THE HEALTH INSURANCE PORTABILITY ACT TO COMPLY WITH FEDERAL REQUIREMENTS; AMENDING PROVISIONS OF THE NEW MEXICO INSURANCE CODE TO BE CONSISTENT WITH FEDERAL REQUIREMENTS AND THAT ACT; PROVIDING FOR INCREASED PORTABILITY, ACCESS AND RENEWABILITY OF HEALTH INSURANCE; DECLARING AN EMERGENCY.

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

Section 1. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] SHORT TITLE.--Sections 1 through 17 of this act may be cited as the "Health Insurance Portability Act"."

Section 2. A new section of the New Mexico Insurance Code is enacted to read:

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"[NEW MATERIAL] DEFINITIONS.--As used in the Health Insurance Portability Act:

A. "affiliation period" means a period that must expire before health insurance coverage offered by a health maintenance organization becomes effective;

B. "beneficiary" means that term as defined in Section 3(8) of the Employee Retirement Income Security Act of 1974;

C. "bona fide association" means an association that:

(1) has been actively in existence for five or more years;

(2) has been formed and maintained in good faith for purpose other than obtaining insurance;

(3) does not condition membership in the association on any health status related factor relating to an individual, including an employee or a dependent of an employee;

(4) makes health insurance coverage offered through the association available to all members regardless of any health status related factor relating to the members or individuals eligible for coverage through a member; and

(5) does not offer health insurance coverage to an individual through the association except in connection with a member of the association;

D. "church plan" means that term as defined pursuant

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to Section 3(33) of the Employee Retirement Income Security Act of 1974;

E. "COBRA" means the federal Consolidated Omnibus Budget Reconciliation Act of 1985;

F. "COBRA continuation provision" means:

(1) Section 4980 of the Internal Revenue Code of 1986, except for Subsection (f)(1) of that section as it relates to pediatric vaccines;

(2) Part 6 of Subtitle B of Title 1 of the Employee Retirement Income Security Act of 1974 except for Section 609 of that part; or

(3) Title 22 of the federal Health Insurance Portability and Accountability Act of 1996;

G. "creditable coverage" means, with respect to an individual, coverage of the individual pursuant to:

(1) a group health plan;

(2) health insurance coverage;

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

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

(5) 10 USCA Chapter 55;

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

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(7) the Comprehensive Health Insurance Pool Act;

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

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

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

H. "eligible individual" means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan in the small group market, an individual whose eligibility shall be determined:

(1) in accordance with the terms of the plan;

(2) as provided by the issuer under the rules of the issuer that are uniformly applicable in the state to small employers in the small group market; and

(3) in accordance with state laws governing the issuer and the small group market;

I. "employee" means that term as defined in Section 3(6) of the Employee Retirement Income Security Act of 1974;

J. "employer" means that term as defined in Section 3(5) of the Employee Retirement Income Security Act of 1974 but to be an "employer", a person must employ two or more employees;

K. "employer contribution rule" means a requirement

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relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries;

L. "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for enrollment;

M. "excepted benefits" means benefits furnished pursuant to the following:

(1) coverage only accident or disability income insurance;

(2) coverage issued as a supplement to liability insurance;

(3) liability insurance;

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other similar insurance coverage specified in regulations under which benefits for medical care are secondary or incidental to other benefits;

(9) the following benefits if offered separately:

(a) limited scope dental or vision

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benefits;

(b) benefits for long-term care, nursing home care, home health care, community-based care or any combination of those benefits; and

(c) other similar limited benefits specified in regulations;

(10) the following benefits, offered as independent noncoordinated benefits:

(a) coverage only for a specified disease or illness; or

(b) hospital indemnity or other fixed indemnity insurance; and

(11) the following benefits if offered as a separate insurance policy:

(a) medicare supplemental health insurance as defined pursuant to Section 1882(g)(1) of the Social Security Act; and

(b) coverage supplemental to the coverage provided pursuant to Chapter 55 of Title 10 USCA and similar supplemental coverage provided to coverage pursuant to a group health plan;

N. "federal governmental plan" means a governmental plan established or maintained for its employees by the United States government or an instrumentality of that government;

O. "governmental plan" means that term as defined in

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Section 3(32) of the Employee Retirement Income Security Act of 1974 and includes a federal governmental plan;

P. "group health insurance coverage" means health insurance coverage offered in connection with a group health plan;

Q. "group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise;

R. "group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer;

S. "health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise, and items, including items and services paid for as medical care, pursuant to any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

T. "health insurance issuer" means an insurance company, insurance service or insurance organization, including

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a health maintenance organization, that is licensed to engage in the business of insurance in the state and that is subject to state law that regulates insurance within the meaning of Section 514(b)(2) of the Employee Retirement Income Security Act of 1974, but "health insurance issuer" does not include a group health plan;

U. "health maintenance organization" means:

(1) a federally qualified health maintenance organization;

(2) an organization recognized pursuant to state law as a health maintenance organization; or

(3) a similar organization regulated pursuant to state law for solvency in the same manner and to the same extent as a health maintenance organization defined in Paragraph (1) or (2) of this subsection;

V. "health status related factor" means any of the factors described in Section 2702(a)(1) of the federal Health Insurance Portability and Accountability Act of 1996;

W. "individual health insurance coverage" means health insurance coverage offered to an individual in the individual market, but "individual health insurance coverage" does not include short-term limited duration insurance;

X. "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan;

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Y. "large employer" means, in connection with a group health plan and with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year;

Z. "large group market" means the health insurance market under which individuals obtain health insurance coverage on behalf of themselves and their dependents through a group health plan maintained by a large employer;

AA. "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(1) the first period in which the individual is eligible to enroll under the plan; or

(2) a special enrollment period pursuant to Sections 8 and 9 of the Health Insurance Portability Act;

BB. "medical care" means amounts paid for:

(1) the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body;

(2) transportation primarily for and essential to medical care; and

(3) insurance covering medical care;

CC. "network plan" means health insurance coverage

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of a health insurance issuer under which the financing and delivery of medical care are provided through a defined set of providers under contract with the issuer;

DD. "nonfederal governmental plan" means a governmental plan that is not a federal governmental plan;

EE. "participant" means that term as defined in Section 3(7) of the Employee Retirement Income Security Act of 1974;

FF. "placed for adoption" means a child has been placed with a person who assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption of the child;

GG. "plan sponsor" means that term as defined in Section 3(16)(B) of the Employee Retirement Income Security Act of 1974;

HH. "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of the coverage for the benefits whether or not any medical advice, diagnosis, care or treatment was recommended before that date, but genetic information is not included as a preexisting condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the condition related to the genetic information;

II. "small employer" means, in connection with a

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group health plan and with respect to a calendar year and a plan year, an employer who employed an average of least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year;

JJ. "small group market" means the health insurance market under which individuals obtain health insurance coverage through a group health plan maintained by a small employer;

KK. "state law" means laws, decisions, rules, regulations or state action having the effect of law; and

LL. "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan."

Section 3. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD--CREDITING FOR PERIODS OF PREVIOUS COVERAGE.--Except as provided in Section 4 of the Health Insurance Portability Act, a group health plan and a health insurance issuer offering group health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

A. the exclusion relates to a condition, physical or

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mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date;

B. the exclusion extends for a period of not more than twelve months, or eighteen months in the case of a late enrollee, after the enrollment date; and

C. the period of the exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date."

Section 4. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] PROHIBITION OF EXCLUSIONS IN CERTAIN CASES.--

A. A group health plan or a health insurer offering group health insurance shall not impose a preexisting condition exclusion:

(1) in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;

(2) that excludes a child who is adopted or placed for adoption before his eighteenth birthday and who, as of the last day of the thirty-day period beginning on and following the date of the adoption or placement for adoption, is covered under creditable coverage; or

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

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

Section 5. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] RULES FOR CREDITING PREVIOUS COVERAGE.--

A. A period of creditable coverage shall not be counted with respect to enrollment of an individual under a group health plan if, after the period and before the enrollment date, there was a sixty-three-day continuous period during which the individual was not covered under any creditable coverage.

B. In determining the continuous period for the purpose of Subsection A of this section, any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage, or is in an affiliation period, shall not be counted."

Section 6. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] METHOD OF CREDITING COVERAGE--ELECTION--NOTICE OF ELECTION.--

A. Except as provided in Subsection B of this

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section, for purposes of applying Subsection C of Section 3 of the Health Insurance Portability Act a group health plan and a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period.

B. A group health plan or a health insurance issuer offering group health insurance coverage may elect to apply Subsection C of Section 3 of the Health Insurance Portability Act based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided in Subsection A of this section. The election shall be made uniformly for all participants and beneficiaries. If the election is made, a group health plan or an issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

C. A group health plan making an election pursuant to Subsection B of this section, whether or not health insurance coverage is provided in connection with the plan, shall:

(1) prominently state in disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made the election; and

(2) include in the statements made a description of the effect of this election.

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D. A health insurance issuer offering group health insurance coverage in the small or large group market making an election pursuant to Subsection B of this section shall:

(1) prominently state in disclosure statements concerning the coverage, and state to each employer at the time of the offer or sale of the coverage, that the issuer has made the election; and

(2) include in the statements made a description of the effect of this election."

Section 7. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] CERTIFICATION AND DISCLOSURE OF COVERAGE.--

A. Periods of creditable coverage with respect to an individual shall be established through the certification required by this section. A group health plan and a health insurance issuer offering group health insurance coverage shall provide the certification described in Subsection B of this section:

(1) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, to the extent practicable, at a time consistent with notices required pursuant to any COBRA continuation provision;

(2) in the case of an individual becoming

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covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(3) on the request on behalf of an individual made not later than twenty-four months after the date of cessation of the coverage described in Paragraph (1) or (2) of this subsection, whichever is later.

B. The required certification is a written certification of:

(1) the period of creditable coverage of the individual under the plan and the coverage, if any, under the COBRA continuation provision; and

(2) the waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

C. To the extent that medical care pursuant to a group health plan consists of group health insurance coverage, the plan satisfies the certification requirement of this section if the health insurance issuer offering the coverage provides for the certification pursuant to this section.

D. If a group health plan or health insurance issuer that has made an election pursuant to Subsection B of Section 6 of the Health Insurance Portability Act enrolls an individual for coverage under the plan or insurance and the individual provides a certification pursuant to this section, the entity providing the individual that certification:

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(1) shall upon request of the plan or issuer promptly disclose to the requester information on coverage of classes and categories of health benefits available under the entity's plan or coverage; and

(2) may charge the requesting plan or issuer the reasonable cost of disclosing the required information."

Section 8. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] SPECIAL ENROLLMENT PERIODS FOR INDIVIDUALS LOSING OTHER COVERAGE.--A group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan, or a dependent of the employee if the dependent is eligible but not enrolled for coverage, to enroll for coverage under the terms of the plan if:

A. the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

B. the employee stated in writing at the time coverage was offered that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer required such a statement at the time and provided the employee with notice of that requirement and the consequences of the requirement at the

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time;

C. the employee's or dependent's coverage described in Subsection A of this section:

(1) was under a COBRA continuation provision and the coverage under that provision was exhausted; or

(2) was not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment, or employer contributions toward the coverage were terminated; and

D. under the terms of the plan the employee requested enrollment not later than thirty days after the date of exhaustion of coverage described in Paragraph (1) of Subsection C of this section or termination of coverage or employer contribution described in Paragraph (2) of Subsection C of this section."

Section 9. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] SPECIAL ENROLLMENT PERIODS FOR DEPENDENT BENEFICIARIES.--

A. A group health plan shall provide for a dependent special enrollment period described in Subsection B of this section during which a person or, if not otherwise enrolled, the individual, may be enrolled under the plan as a dependent of the

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individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage, if:

(1) the plan makes coverage available to a dependent of an individual;

(2) the individual is a participant under the plan or has met any waiting period applicable to becoming a participant and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

(3) a person has become the dependent of the individual through marriage, birth, adoption or placement for adoption.

B. A dependent special enrollment period pursuant to this subsection shall be for a period of not less than thirty days and shall begin on the later of:

(1) the date dependent coverage is made available; or

(2) the date of the marriage, birth, adoption or placement for adoption described in Subsection A of this section.

C. If an individual seeks to enroll a dependent during the first thirty days of a dependent special enrollment period, the coverage of the dependent becomes effective:

(1) in the case of marriage, not later than the

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first day of the first month beginning after the date the completed request for enrollment is received;

(2) in the case of a dependent's birth, as of the date of the birth; or

(3) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement."

Section 10. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] USE OF AFFILIATION PERIOD BY HEALTH MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO PREEXISTING CONDITION EXCLUSION.--

A. A health maintenance organization that offers health insurance coverage in connection with a group health plan and does not impose any preexisting condition exclusion allowed pursuant to Section 3 of the Health Insurance Portability Act with respect to any particular coverage option may impose an affiliation period for the coverage option if that period:

(1) is applied uniformly without regard to any health status related factors; and

(2) does not exceed two months, or three months in the case of a late enrollee.

B. During an affiliation period, a health maintenance organization is not required to provide health care services or benefits to a participant or beneficiary, and it shall not charge a premium to a participant or beneficiary for

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any coverage.

C. An affiliation period begins to run on the enrollment date and shall run concurrently with any waiting period under the plan.

D. A health maintenance organization described in Subsection A of this section may use alternative methods different from those described in that subsection to address adverse selection as approved by the superintendent."

Section 11. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES IN ELIGIBILITY TO ENROLL.--

A. Except as provided in Subsection B of this section, a group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall not establish rules for eligibility or continued eligibility of any individual to enroll or continue to participate in a health plan based on any of the following health status related factors in relation to the individual or a dependent of the individual:

(1) health status;

(2) medical condition, including both physical and mental illnesses;

(3) claims experience;

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(4) receipt of health care;

(5) medical history;

(6) genetic information;

(7) evidence of insurability, including conditions arising out of acts of domestic violence; or

(8) disability.

B. To the extent consistent with the provisions of Section 3 of the Health Insurance Portability Act, the provisions of Subsection A of this section do not require a group health plan or group health insurance coverage to provide particular benefits other than those provided under the terms of the plan or coverage or to prevent the plan or coverage from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage."

Section 12. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES IN PREMIUM CONTRIBUTIONS.--

A. Except as provided in Subsection B of this section, a group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall not require an individual as a condition to enroll or continue to participate in a health plan to pay a

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premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of the health status related factors specified in Subsection A of Section 11 of the Health Insurance Portability Act in relation to the individual or an individual enrolled under the plan as a dependent of the individual.

B. The provisions of Subsection A of this section do not restrict the amount that an employer may be charged for coverage under a group health plan and do not prevent a group health plan or a health insurance issuer offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention."

Section 13. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] HEALTH INSURANCE ISSUERS--COVERAGE IN SMALL GROUP MARKET--EXCEPTIONS FOR NETWORK PLANS, INSUFFICIENT FINANCIAL CAPACITY AND BONA FIDE ASSOCIATIONS--EMPLOYER CONTRIBUTION RULES.--

A. Except as provided in Subsections B through G of this section, a health insurance issuer that offers health insurance coverage in the small group market shall:

(1) accept a small employer that applies for coverage;

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(2) accept for enrollment under the offered coverage an eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan; and

(3) not place a restriction on an eligible individual being a participant or a beneficiary that is inconsistent with Sections 11 and 12 of the of the Health Insurance Portability Act.

B. A health insurance issuer that offers health insurance coverage in the small group market through a network plan may:

(1) limit the employers that may apply for the coverage to those with eligible individuals who live, work or reside in the service area for the network plan; and

(2) deny coverage to employers within the service area for the network plan if the issuer has demonstrated to the superintendent that it:

(a) will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

(b) is applying this exception uniformly to all employers without regard to the claims experience of those employers, their employees and their dependents or any health status related factor relating to those employees and

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dependents.

C. A health insurance issuer, upon denying insurance coverage in any service area pursuant to the provisions of Subsection B of this section, shall not offer coverage in the small group market within the service area for a period of one hundred eighty days after the date coverage is denied.

D. A health insurance issuer may deny health insurance coverage in the small group market if the issuer has demonstrated to the superintendent that it:

(1) does not have the financial reserves necessary to underwrite additional coverage; and

(2) is applying this exception uniformly to all employers in the small group market in the state consistent with state law and without regard to the claims experience of those employers, their employees and their dependents or any health status related factor relating to those employees and dependents.

E. A health insurance issuer upon denying health insurance coverage in connection with group health plans pursuant to Subsection D of this section shall not offer coverage in connection with group health plans in the small group market in the state for a period of one hundred eighty days after the date coverage is denied or until the issuer has demonstrated to the superintendent that the issuer has sufficient financial reserves to underwrite the additional

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coverage, whichever is later. The superintendent may provide for the application of this subsection on a service-area-specific basis.

F. The requirement of Subsection A of this section does not apply to health insurance coverage offered by a health insurance issuer if the coverage is made available in the small group market only through one or more bona fide associations.

G. Subsection A of this section does not preclude a health insurance issuer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health plan in the small group market."

Section 14. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] GUARANTEED RENEWABILITY OF COVERAGE FOR EMPLOYERS IN THE GROUP MARKET--REQUIREMENT AND EXCEPTIONS TO REQUIREMENT.--

A. Except as provided in Subsections B through G of this section, a health insurance issuer that offers health insurance coverage in the small or large group market in connection with a group health plan shall renew or continue that coverage in force at the option of the plan sponsor of the plan.

B. A health insurance issuer may nonrenew or discontinue health insurance coverage offered pursuant to Subsection A of this section if:

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(1) the plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

(2) the plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of the coverage;

(3) the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules permitted pursuant to Subsection G of Section 13 of the Health Insurance Portability Act;

(4) the issuer is ceasing to offer coverage in the market in accordance with Subsection C of this section;

(5) in the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with that plan who lives, resides or works in the service area of the issuer or the area for which the issuer is authorized to do business and, in the case of the small group market, the issuer would deny enrollment with respect to the network plan pursuant to Paragraph (1) of Subsection B of Section 13 of the Health Insurance Portability Act; or

(6) in the case of health insurance coverage that is made available only through one or more bona fide

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associations, the membership of any employer in the association ceases, but only if the coverage is terminated pursuant to this paragraph uniformly without regard to any health status related factor relating to a covered individual.

C. A health insurance issuer may discontinue offering a particular type of group health insurance coverage offered in the small or large group market only if:

(1) the issuer provides notice to each plan sponsor provided coverage of this type in the market and to the participants and beneficiaries covered under the coverage of the discontinuation at least ninety days prior to the date of the discontinuation;

(2) the issuer offers to a plan sponsor provided coverage of this type in the market the option to purchase all, or in the case of the large group market, any, other health insurance coverage currently being offered by the issuer to a group health plan in that market; and

(3) in exercising the option to discontinue coverage of this type and in offering the option of coverage pursuant to Paragraph (2) of this subsection, the issuer acts uniformly without regard to the claims experience of those sponsors or any health status related factors relating to any participants or beneficiaries who may become eligible for that coverage.

D. If a health insurance issuer elects to

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discontinue offering all health insurance coverage in the small group market or the large group market, coverage may be discontinued only if:

(1) the issuer provides notice to the superintendent and to each plan sponsor and to participants and beneficiaries covered under the plan of the discontinuation at least one hundred eighty days prior to the date of discontinuation; and

(2) all health insurance issued or delivered for issuance in the state in the market is discontinued and coverage is not renewed.

E. After discontinuation pursuant to Subsection D of this section, the health insurance issuer shall not provide for the issuance of any health insurance coverage in the market involved during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not renewed.

F. At the time of coverage renewal pursuant to Subsection A of this section, a health insurance issuer may modify the coverage for a product offered to a group health plan:

(1) in the large group market; or

(2) in the small group market if, for coverage available in that market other than through a bona fide association, the modification is effective on a uniform basis

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among group health plans with that product.

G. If health insurance coverage is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to that employer."

Section 15. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] DISCLOSURE OF INFORMATION BY HEALTH INSURANCE ISSUERS.--

A. A health insurance issuer when offering health insurance coverage to a small employer shall:

(1) make a reasonable disclosure to the small employer, as part of its solicitation and sales materials, of the availability of information described in Subsection B of this section; and

(2) upon request of the small employer provide the information described.

B. Except as provided in Subsection D of this section, a health insurance issuer shall provide information pursuant to Subsection A of this section concerning:

(1) the provisions of coverage concerning the issuer's right to change premium rates and the factors that may affect changes in premium rates;

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(2) the provisions of coverage relating to renewability of coverage;

(3) the provisions of the coverage relating to preexisting condition exclusions; and

(4) the benefits and premiums available under all health insurance coverage for which the small employer is qualified.

C. Information furnished pursuant to this section shall be provided to small employers in a manner determined to be understandable by the average small employer and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

D. A health insurance issuer is not required by this section to disclose information that is proprietary and trade secret information."

Section 16. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] EXCLUSIONS, LIMITATIONS AND EXCEPTIONS FOR CERTAIN PLANS.--

A. The requirements of Sections 3 through 15 of the Health Insurance Portability Act do not apply to any group health plan and health insurance coverage offered in connection with a group health plan if, on the first day of the plan year, the plan has less than two employees who are current employees.

B. The requirements of Sections 3 through 15 of the

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Health Insurance Portability Act shall not apply with respect to a group health plan that is a nonfederal governmental plan if the plan sponsor makes an election under the provisions of this subsection in conformity with regulations of the federal secretary of health and human services. The period of an election for exclusion made pursuant to this subsection is for a single specified plan year or, in the case of a plan provided pursuant to a collective bargaining agreement, for the term of the agreement. The plan for which an election is made shall provide under the terms of the election for:

(1) notice to enrollees on an annual basis and at the time of enrollment of the facts and consequences of the election; and

(2) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with Section 7 of the Health Insurance Portability Act.

C. The requirements of Sections 3 through 15 of the Health Insurance Portability Act do not apply to a group health plan and group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in Paragraph (9) of Subsection M of Section 2 of the Health Insurance Portability Act if the benefits are:

(1) provided under a separate policy, certificate or contract of insurance; or

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(2) otherwise not an integral part of the plan.

D. The requirements of Sections 3 through 15 of the Health Insurance Portability Act do not apply to any group health plan and group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in Paragraph (10) of Subsection M of Section 2 of the Health Insurance Portability Act if:

(1) the benefits are provided under a separate policy, certificate or contract of insurance;

(2) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same sponsor; and

(3) the benefits are paid with respect to an event without regard to whether benefits are provided with respect to that event under any group health plan maintained by the same sponsor.

E. The requirements of Sections 3 through 15 of the Health Insurance Portability Act do not apply to any group health plan and group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in Paragraph (11) of Subsection M of Section 2 of the Health Insurance Portability Act if the benefits are provided under a separate policy, certificate or contract of insurance."

Section 17. A new section of the New Mexico Insurance Code

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is enacted to read:

"[NEW MATERIAL] TREATMENT OF PARTNERSHIPS AND SELF-EMPLOYED INDIVIDUALS.--

A. Any plan, fund or program that would not be an employee welfare benefit plan, except for the provisions of this section, that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care to current or former partners in the partnership or to their dependents directly or through insurance, reimbursement or otherwise, shall be treated as an employee welfare benefit plan that is a group health plan.

B. As used in this section:

(1) "employer" includes a partnership in relation to a partner; and

(2) "participant" includes:

(a) in connection with a group health plan maintained by a partnership, an individual who is a partner in relationship to the partnership; and

(b) in connection with a group health plan maintained by a self-employed individual under which one or more employees are participants, the self-employed individual, if he or his beneficiaries are or may become eligible to receive a benefit under the plan."

Section 18. Section 59A-18-13.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 26) is amended to read:

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"59A-18-13.1. ADJUSTED COMMUNITY RATING.--

A. [~~Until July 1, 1998~~] Every insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan that provides primary health insurance or health care coverage insuring or covering major medical expenses shall, in determining the initial year's premium charged for an individual, use only the rating factors of age, gender, geographic area of the place of employment and smoking practices, except that for individual policies the rating factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, society, organization or plan from offering rates that differ depending upon family composition.

[~~B. Effective July 1, 1998, every insurer, fraternal~~

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~~benefit society, health maintenance organization or nonprofit health care plan that provides primary health insurance or health care coverage insuring or covering major medical expenses shall charge the same premium for the same coverage to each New Mexico resident, regardless of a person's individual circumstances for medical risk, job risk or gender. The only rating factor that may be used is whether a person is under or over the age of nineteen.~~

~~C.~~] B. The superintendent shall adopt regulations to implement the provisions of this section."

Section 19. Section 59A-18-16 NMSA 1978 (being Laws 1984, Chapter 127, Section 345.1, as amended) is amended to read:

"59A-18-16. CONTINUATION OF COVERAGE AND CONVERSION RIGHTS--ACCIDENT AND HEALTH INSURANCE POLICIES--NOTICE.--Subject to the provisions of the Health Insurance Portability Act:

A. every accident and health insurance policy that provides hospital, surgical and medical expense benefits and that is delivered, issued for delivery or renewed in this state on or after January 1, 1985 shall provide:

(1) if an individual policy, covered family members the right to continue such policy as the named insured or through a conversion policy upon the death of the named insured or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the named insured; or

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(2) if a group policy:

(a) each member or employee of the group insured the right to continue such coverage for a period of six months and thereafter through a conversion policy upon termination of membership or employment with the group insured; and

(b) covered family members of an employee or member of the group insured the right to continue such coverage through a converted or separate policy upon the death of the member or employee of the group insured or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the member or employee of the group insured.

Where a continuation of coverage or conversion is made in the name of the spouse of the named insured or the spouse of the employee or member of the group insured, such coverage may, at the option of the spouse, include coverage for dependent children for whom the spouse has responsibility for care and support;

B. the right to a continuation of coverage or conversion pursuant to this section shall not exist with respect to any member or employee of the group insured or any covered family member in the event the coverage terminates for nonpayment of premium, nonrenewal of the policy or the expiration of the term for which the policy is issued. With

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respect to any member or employee of the group insured or any covered family member who is eligible for medicare or any other similar federal or state health insurance program, the right to a continuation of coverage or conversion shall be limited to coverage under a medicare supplement insurance policy as defined by the rules and regulations adopted by the superintendent;

C. coverage continued through the issuance of a converted or separate policy shall be provided at a reasonable, nondiscriminatory rate to the insured and shall consist of a form of coverage then being offered by the insurer as a conversion policy in the jurisdiction where the person exercising the conversion right resides that most nearly approximates the coverage of the policy from which conversion is exercised. Continued and converted coverages shall contain renewal provisions that are not less favorable to the insured than those contained in the policy from which the conversion is made, except that the person who exercises the right of conversion is entitled only to have included a right to coverage under a medicare supplement insurance policy, as defined by the rules and regulations adopted by the superintendent, after the attainment of the age of eligibility for medicare or any other similar federal or state health insurance program;

D. at the time of inception of coverage, the insurer shall furnish to each covered family member who is eighteen years of age or over and to each employee or member of the group

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insured a statement setting forth in summary form the continuation of coverage and conversion provisions of the policy;

E. the insurer shall notify in writing each employee or member, upon that employee's or member's termination of employment or membership with the group insured, of the continuation and conversion provisions of the policy. The employer may give the written notice specified herein. The employer should notify the insurer of the employee's or member's change of status and last known address. Under no circumstances shall the employer have any civil liability under the conversion provisions of the Insurance Code;

F. the eligible employee or member of the group insured or covered family member exercising the continuation or conversion right [~~must~~] shall notify the employer or insurer and make payment of the applicable premium within thirty days following the date of the notification given by the insurer pursuant to Subsection E of this section. There shall be no lapse of coverage during the period in which conversion is available;

G. coverage shall be provided through continuation or conversion without additional evidence of insurability and shall not impose any preexisting condition, limitations or other contractual time limitations other than those remaining unexpired under the policy or contract from which continuation

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or conversion is exercised;

H. benefits otherwise payable under a converted or separate policy may be reduced so they are not, during the first policy year of the converted or separate policy, in excess of those that would have been payable under the policy from which conversion is exercised. Benefits, if any, otherwise payable under a converted or separate policy are not payable for a loss claimed under the policy from which conversion is exercised; and

I. any probationary or waiting period set forth in the converted or separate policy is deemed to commence on the effective date of the applicant's coverage under the original policy."

Section 20. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] OUT-OF-STATE ASSOCIATIONS AND TRUSTS.--Unless the rate applicable to the certificate of coverage of an out-of-state association or trust complies with the requirements of Section 59A-18-13.1 or 59A-23C-5.1 NMSA 1978, the out-of-state association or trust shall not:

A. advertise in the state as a benefit of membership for any group health insurance policy available to its members or beneficiaries;

B. issue a certificate for delivery in New Mexico to any resident of the state; or

C. solicit membership in the state on the basis of the

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existence or availability of such health insurance coverage."

Section 21. Section 59A-23B-6 NMSA 1978 (being Laws 1991, Chapter 111, Section 6, as amended) is amended to read:

"59A-23B-6. FORMS AND RATES--APPROVAL OF THE SUPERINTENDENT [~~OF INSURANCE~~]--ADJUSTED COMMUNITY RATING.--

A. All policy or plan forms, including applications, enrollment forms, policies, plans, certificates, evidences of coverage, riders, amendments, endorsements and disclosure forms, shall be submitted to the department of insurance for approval prior to use.

B. No policy or plan may be issued in the state unless the rates have first been filed with and approved by the superintendent [~~of insurance~~]. This subsection shall not apply to policies or plans subject to the Small Group Rate and Renewability Act.

C. Until July 1, 1998, in determining the initial year's premium or rate charged for coverage under a policy or plan, the only rating factors that may be used are age, gender, geographic area of the place of employment and smoking practices. Until July 1, 1998, in determining the initial and any subsequent 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~~] rate 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

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family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, society, organization or plan from offering rates that differ depending upon family composition.

D. Effective July 1, 1998, each policy or plan covered by the Minimum Healthcare Protection Act shall charge the same premium for the same coverage to each New Mexico resident, regardless of a person's individual circumstances for medical risk, job risk or gender. The only rating factor that may be used is whether a person is under or over the age of nineteen.

E. The superintendent [~~of insurance~~] shall adopt regulations to implement the provisions of this section."

Section 22. Section 59A-23C-3 NMSA 1978 (being Laws 1991, Chapter 153, Section 3, as amended) is amended to read:

"59A-23C-3. DEFINITIONS.--As used in the Small Group Rate and Renewability Act:

A. "actuarial certification" means a written statement by a member of the American academy of actuaries or another individual acceptable to the superintendent that a small employer carrier is in compliance with the provisions of Section 59A-23C-5 NMSA 1978, based upon the person's examination,

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including a review of the appropriate records and of the actuarial assumptions and methods [~~utilized~~] used by the carrier in establishing premium rates for applicable health benefit plans;

B. "base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

C. "carrier" means any person who provides health insurance in this state. For the purposes of the Small Group Rate and Renewability Act, "carrier" or "insurer" includes a licensed insurance company, a licensed fraternal benefit society, a prepaid hospital or medical service plan, a health maintenance organization, a nonprofit health care organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation;

D. "case characteristics" means demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, that are considered by the carrier in the determination of premium rates for the small employer, but "case characteristics" does not include claim experience, health status and duration of coverage since issue;

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E. "class of business" means all small employers as shown on the records of the small employer carrier. A separate class of business may be established by the small employer carrier on the basis that the applicable health benefit plans have been acquired from another small employer carrier as a distinct grouping of plans;

F. "creditable coverage" means, with respect to an individual, coverage of the individual pursuant to:

(1) a group health plan;

(2) health insurance coverage;

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

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

(5) 10 USCA Chapter 55;

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

(7) the Comprehensive Health Insurance Pool Act;

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

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

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

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[~~F.~~] G. "department" means the department of insurance;

H. "group health plan" means an employee welfare benefit plan as defined Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise;

[~~G.~~] I. "health benefit plan" or "plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract or health maintenance organization subscriber contract. "Health benefit plan" does not include accident-only, credit, dental or disability income insurance, medicare supplement coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance or automobile medical-payment insurance;

[~~H.~~] J. "index rate" means, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

K. "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(1) the first period in which the individual is

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eligible to enroll under the plan; or

(2) a special enrollment period pursuant to Sections 8 and 9 of the Health Insurance Portability Act;

[~~I.~~] L. "new business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

[~~J.~~] M. "rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier;

[~~K.~~] N. "small employer" means any person, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent of its working days during either of the two preceding [~~year~~] years, employed no less 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 for purposes of state income taxation shall be considered one employer; and

(3) in the case of an employer that was not in

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existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year;

[~~L.~~] O. "small employer carrier" means any insurer that offers health benefit plans covering the employees of a small employer; and

[~~M.~~] P. "superintendent" means the superintendent of insurance."

Section 23. Section 59A-23C-5 NMSA 1978 (being Laws 1991, Chapter 153, Section 5, as amended) is amended to read:

"59A-23C-5. RESTRICTIONS RELATING TO PREMIUM RATES.--

A. Premium rates for health benefit plans subject to the Small Group Rate and Renewability Act shall be subject to the following provisions:

(1) the index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent;

(2) for a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business, shall not vary from the index rate by more than [~~twenty~~] fifteen percent of the index rate;

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(3) the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

(b) an adjustment, not to exceed ten percent annually and adjusted pro rata for rating periods of less than one year due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

(c) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business; and

(4) in the case of health benefit plans issued prior to the effective date of the Small Group Rate and Renewability Act, a premium rate for a rating period may exceed the ranges described in Paragraph (1) or (2) of this subsection for a period of five years following the effective date of the Small Group Rate and Renewability Act. In that case, the

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percentage increase in the premium rate charged to a small employer in that class of business for a new rating period may not exceed the sum of the following:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(b) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

B. Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

C. A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business

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without regard to case characteristics, claim experience, health status or duration since issue.

D. Prior to usage and [~~the effective date of the Small Group Rate and Renewability Act~~] June 14, 1991, each carrier shall file with the superintendent the rate manuals and any updates thereto for each class of business. A rate filing fee is payable under Subsection U of Section 59A-6-1 NMSA 1978 for the filing of each update. The superintendent shall disapprove within sixty days of receipt of a complete filing or the filing is deemed approved. If the superintendent disapproves [~~any such~~] the form during the sixty-day review period, he shall give the carrier written notice of the disapproval stating the [~~ground thereof~~] reasons for disapproval. At any time, the superintendent, after a hearing [~~thereof~~], may disapprove a form or withdraw a previous approval. The superintendent's order [~~on such~~] after the hearing shall state the grounds for disapproval or withdrawal of a previous approval and the date not less than twenty days later when disapproval or withdrawal becomes effective."

Section 24. Section 59A-23C-5.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 33) is amended to read:

"59A-23C-5.1. ADJUSTED COMMUNITY RATING.--

A. Until July 1, 1998, a health benefit plan that is offered by a carrier to a small employer shall be offered without regard to the health status of any individual in the

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group, except as provided in the Small Group Rate and Renewability Act. The only rating factors that may be used to determine the initial year's premium charged a group, subject to the maximum rate variation provided in this section for all rating factors, are the group members':

(1) [~~age~~] ages;

(2) [~~gender~~] genders;

(3) geographic [~~area~~] areas of the place of employment; or

(4) smoking practices.

B. Until July 1, 1998, in determining the initial and any subsequent 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~~] rate in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit a carrier from offering rates that differ depending upon family composition.

C. Effective July 1, 1998, a health benefit plan that is offered by a carrier to a small employer shall charge the

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same premium for the same coverage to each New Mexico resident, regardless of a person's individual circumstances for medical risk, job risk or gender. The only rating factor that may be used is whether a person is under or over the age of nineteen.

D. The superintendent shall adopt regulations to implement the provisions of this section."

Section 25. Section 59A-23C-7.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 32) is amended to read:

"59A-23C-7.1. PREEXISTING CONDITIONS--LIMITATIONS.--

A. A health benefit plan that is offered by a carrier to a small employer may include a preexisting condition [~~restriction that excludes coverage for a condition for up to six months after the effective date of the plan, provided that within six months before the effective date of coverage:~~

~~(1) medical advice or treatment for the condition was recommended by or received from a licensed health care provider; or~~

~~(2) the condition manifested itself in a manner that would cause a reasonable person to seek diagnosis or treatment~~] exclusion only if:

(1) the exclusion extends for a period of not more than twelve months, or eighteen months in the case of a late enrollee, after the enrollment date; and

(2) the period of the exclusion is reduced by the aggregate of the periods of creditable coverage applicable to

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the participant or beneficiary as of the enrollment date.

B. As used in this section, "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage for the benefits whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date, but genetic information is not included as a preexisting condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the condition related to the genetic information.

C. A carrier shall not impose a preexisting condition exclusion:

(1) in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;

(2) that excludes a child who is adopted or placed for adoption before his eighteenth birthday and who, as of the last day of the thirty-day period beginning on and following the date of the adoption or placement for adoption, is covered under creditable coverage; or

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

D. The provisions of Paragraphs (1) and (2) of Subsection C of this section do not apply to any individual after the end of the first continuous sixty-three-day period

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during which the individual was not covered under any creditable coverage.

[~~B.~~] E. The preexisting condition [~~restriction~~] exclusion authorized in this section shall be waived to the extent that similar conditions have been satisfied under a prior health benefit plan that was subject to the Small Group Rate and Renewability Act, provided the [~~application for~~] effective date of coverage under the new health benefit plan is made not later than [~~thirty-one~~] sixty-three days after the individual ceases to be a member of the group insured or the group ceases to be insured under the prior health benefit plan, whichever occurs first. If the conditions authorized in this section have been previously satisfied, coverage under the new health benefit plan shall be effective from the date on which the prior coverage terminated.

[~~C.~~] F. Nothing in this section requires the use in a health benefit plan offered by a carrier of a preexisting condition [~~restriction~~] exclusion. Nothing in this section prohibits the use of a preexisting condition [~~restrictions~~] exclusion that [~~are~~] is less restrictive on small employers and insured persons than the [~~conditions~~] exclusion authorized in this section.

[~~D.~~] G. The superintendent shall adopt regulations to implement the provisions of this section."

Section 26. Section 59A-23D-1 NMSA 1978 (being Laws 1995,

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Chapter 93, Section 1) is amended to read:

"59A-23D-1. SHORT TITLE.--[~~Sections 1 through 7 of this act~~] Chapter 59A, Article 23D NMSA 1978 may be cited as the "Medical Care Savings Account Act"."

Section 27. Section 59A-23D-2 NMSA 1978 (being Laws 1995, Chapter 93, Section 2) is amended to read:

"59A-23D-2. DEFINITIONS.--As used in the Medical Care Savings Account Act:

A. "account administrator" means any of the following that administers medical care savings accounts:

(1) a national or state chartered bank, savings and loan association, savings bank or credit union;

(2) a trust company authorized to act as a fiduciary in this state;

(3) an insurance company or health maintenance organization authorized to do business in this state pursuant to the [~~New Mexico~~] Insurance Code; or

[~~(4) an employer that has a self-insured health plan under the federal Employee Retirement Income Security Act of 1974;~~

~~(5) a broker, agent or investment advisor;~~

~~(6) a person who holds a certificate or registration as an insurance administrator or for whom the registration has been waived; or~~

~~(7) an employer who participates in the medical~~

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~~care savings account program;~~]

(4) a person approved by the federal health and human services secretary;

B. "deductible" means the total covered medical expense [~~the~~] an employee or his dependents must pay prior to any payment by [~~the~~] a qualified higher deductible health plan for a calendar year;

C. "department" means the department of insurance;

D. "dependent" means:

(1) a spouse;

(2) an unmarried or unemancipated child of the employee who is a minor and who is:

(a) a natural child;

(b) a legally adopted child;

(c) a stepchild living in the same household who is primarily dependent on the employee for maintenance and support;

(d) a child for whom the employee is the legal guardian and who is primarily dependent on the employee for maintenance and support, as long as evidence of the guardianship is evidenced in a court order or decree; or

(e) a foster child living in the same household, if the child is not otherwise provided with health care or health insurance coverage;

(3) an unmarried child described in Subparagraphs

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(a) through (e) of Paragraph (2) of this subsection who is between the ages of eighteen and twenty-five and is a full-time student at an accredited educational institution; provided, "full-time student" means a student is enrolled in and taking twelve or more semester hours or equivalent contact hours in secondary, undergraduate or vocational school or nine or more semester hours or equivalent contact hours in graduate school; or

(4) a child over the age of eighteen who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who is chiefly dependent on the employee for support and maintenance;

E. "eligible individual" means an individual who with respect to any month:

(1) is covered under a qualified higher deductible health plan as of the first day of that month;

(2) is not, while covered under a qualified higher deductible health plan, covered under any health plan that:

(a) is not a qualified higher deductible health plan; and

(b) provides coverage for any benefit that is covered under the qualified higher deductible health plan; and

(3) is covered by a qualified higher deductible health plan that is established and maintained by the employer

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of the individual or of the spouse of the individual when the employer is a small employer;

[~~E.~~] F. "eligible medical expense" means an expense paid by the employee for medical care described in Section 213(d) of the Internal Revenue Code of 1986 that is deductible for federal income tax purposes to the extent that those amounts are not compensated for by insurance or otherwise;

[~~F.~~] G. "employee" includes a self-employed individual;

[~~G.~~] H. "employer" includes a self-employed individual;

[~~H.~~] I. "medical care savings account" or "savings account" means an account established by an employer [~~to pay the eligible medical expenses of an employee and his dependents~~] in the United States exclusively for the purpose of paying the eligible medical expenses of the employee, but only if the written governing instrument creating the trust meets the following requirements:

(1) except in the case of a rollover contribution, no contribution will be accepted:

(a) unless it is in cash; or

(b) to the extent the contribution, when added to previous contributions to the trust for the calendar year, exceeds seventy-five percent of the highest annual limit deductible permitted pursuant to the Medical Care Savings

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Account Act;

(2) no part of the trust assets will be invested in life insurance contracts;

(3) the assets of the trust will not be commingled with other property except in a common trust fund or common investment fund; and

(4) the interest of an individual in the balance in his account is nonforfeitable;

[~~I.~~] J. "program" means the medical care savings account program established by an employer for his employees; [~~and~~

~~J.~~] K. "qualified higher deductible health plan" means a health coverage policy, certificate or contract that provides for payments for covered health care benefits that exceed the policy, certificate or contract deductible [~~and~~], that is purchased by an employer for the benefit of an employee and that has the following deductible provisions:

(1) self-only coverage with an annual deductible of not less than one thousand five hundred dollars ($1,500) or more than two thousand two hundred fifty dollars ($2,250) and a maximum annual out-of-pocket expense requirement of three thousand dollars ($3,000), not including premiums;

(2) family coverage with an annual deductible of not less than three thousand dollars ($3,000) or more than four thousand five hundred dollars ($4,500) and a maximum annual out-

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of-pocket expense requirement of five thousand five hundred dollars ($5,500), not including premiums; and

(3) preventive care coverage may be provided within the policies without the preventive care being subjected to the qualified higher deductibles; and

L. "small employer" means:

(1) with respect to any calendar year, an employer that employed an average of fifty or fewer employees on business days during either of the two preceding calendar years, but a preceding calendar year may be taken into account only if the employer was in existence throughout that year and if not in existence throughout a preceding calendar year, the determination shall be based on the average number of employees reasonably expected to be employed on business days in the current calendar year; or

(2) a growing employer that satisfies the conditions of Section 220C(4)(c) of the Internal Revenue Code of 1986."

Section 28. Section 59A-23D-3 NMSA 1978 (being Laws 1995, Chapter 93, Section 3) is amended to read:

"59A-23D-3. ACCOUNT ADMINISTRATOR--REGISTRATION WITH DEPARTMENT--DEPARTMENT POWERS AND DUTIES.--

A. An account administrator shall register annually with the department and pay [~~a~~] an annual registration fee of twenty-five dollars ($25.00). The registration fee shall be

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deposited in the general fund. Registration as an account administrator does not affect the regulation of a bank, savings and loan association, credit union, trust company or insurance company as otherwise provided by law.

B. An account administrator shall provide to the department annually a list of the employers for whom it provides account administration and the number of employees and dependents for whom it administers accounts. The information shall be provided in the form requested by the department. The department may request other information it deems appropriate from the account administrator; provided, however, that the department shall not request any information about an individual employee or dependent unless a complaint has been filed with the department by that employee or dependent and the information is required to investigate the complaint.

C. The department may receive, investigate and settle complaints about medical care savings accounts and account administrators or it may refer complaints to other appropriate agencies.

D. The department, beginning January 1, 1998, shall adjust annually the [~~maximum~~] deductible for qualified higher deductible health plans to reflect the [~~last known increase in the medical care component of the consumer price index published by the United States department of labor. For 1995, the maximum deductible shall not be less than one thousand dollars ($1,000)~~

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~~and not more than three thousand dollars ($3,000)~~

~~E. The department may adjust annually the maximum employer contribution to reflect the last known increase in the medical care component of the consumer price index. For 1995, the employer's contribution shall not exceed three thousand dollars ($3,000)~~] adjustment allowed by the Internal Revenue Code of 1986 for medical savings accounts."

Section 29. Section 59A-23D-5 NMSA 1978 (being Laws 1995, Chapter 93, Section 5) is amended to read:

"59A-23D-5. ACCOUNT ADMINISTRATOR--EMPLOYER AND EMPLOYEE RESPONSIBILITIES.--

A. [~~The~~] An employer, in conjunction with [~~the~~] an account administrator, shall provide a current written statement to employees that details how money in their medical care savings accounts is or will be invested and the rate of return employees may reasonably anticipate on the investment of the savings accounts. The account administrator shall file the statement with the department.

B. Except as provided in Section [~~6 of this act~~] 59A-23D-6 NMSA 1978, money in [~~the~~] a savings account shall be used solely for the purpose of paying the eligible medical expenses of [~~the~~] an employee and his dependents.

C. The account administrator shall reimburse the employee from the employee's medical care savings account for eligible medical expenses. When seeking reimbursement, the

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employee shall submit documentation of eligible medical expenses paid by the employee.

D. If an employer makes contributions to a program on a periodic installment basis, the employer may advance to an employee, interest free, an amount necessary to cover eligible medical expenses incurred that exceed the amount in the employee's savings account if the employee agrees to repay the advance from future installments or when he ceases to be an employee of the employer or a participant in the program. Such advances shall be exempt from taxation under the Income Tax Act."

Section 30. Section 59A-23D-6 NMSA 1978 (being Laws 1995, Chapter 93, Section 6) is amended to read:

"59A-23D-6. WITHDRAWALS.--

A. An employee may withdraw money without penalty from his medical care savings account for a purpose other than reimbursement of eligible medical expenses [~~when he reaches the age of fifty-nine and one-half~~] when the employee attains the age specified in Section 1811 of the Social Security Act. An employee may also withdraw money without penalty for payment of coverage for:

(1) a health plan during any period of continuation coverage required under any federal law;

(2) a qualified long-term care insurance contract as defined by Section 7702B(6) of the Internal Revenue Code of

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1986; or

(3) a health plan during a period in which the individual is receiving unemployment compensation under any federal or state law.

B. Except as provided in Subsection A of this section, if an employee withdraws money from the employee's medical care savings account [~~on the last business day of the account administrator's business year for a purpose not set forth in Section 4 of the Medical Care Savings Account Act the money withdrawn shall be considered income to the individual, subject to taxation. The withdrawal does not subject the employee to a penalty or make interest earned on the account during the tax year taxable as income to the employee~~] that is not used exclusively to pay eligible medical expenses of the employee or a dependent, it shall be included in the gross income of the employee for taxation purposes.

C. Except as provided in Subsection A of this section, if an employee withdraws money from the employee's medical care savings account for a purpose [~~not set forth in Section 4 of the Medical Care Savings Account Act at any time other than the last business day of the account administrator's business year~~] other than a rollover to a new account administrator:

(1) the amount of the withdrawal shall be considered gross income to the [~~individual~~] employee and subject to taxation; and

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(2) the administrator shall [~~withdraw and~~] also consider as a withdrawal on behalf of the employee [~~pay~~] a penalty equal to [~~ten~~] fifteen percent of the amount of the withdrawal and

[~~(3) all interest earned on the balance in the savings account during the tax year in which the withdrawal is made shall be considered income to the individual and subject to taxation~~] shall consider this as gross income to the employee for taxation purposes.

D. If an individual is no longer employed by an employer that participates in a program or if an employee chooses to cease participating in the program, the individual or employee shall, within sixty days of his final day of employment or participation:

(1) request, in writing, the [~~transfer~~] rollover of his savings account to a new account administrator;

(2) request, in writing, that the former employer's account administrator continue to administer the savings account, including in the request an agreement to pay the cost, if any, of account administration on that savings account; or

(3) withdraw the money from the savings account subject to the provisions of Subsection C of this section, if the withdrawal is not for the purpose of a rollover when within sixty days of the receipt of the funds they are placed with a

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new account administrator.

E. No more than [~~thirty days after the expiration of the sixty-day period~~] sixty days after the date of notification by the employee pursuant to Subsection D of this section, the account administrator shall:

(1) transfer the savings account to a new account administrator as requested;

(2) agree, in writing, to continue to act as the account administrator for the savings account; or

(3) mail a check to the individual or employee at his last known address for the amount in the account as of the day the check was issued [~~excluding the applicable withdrawal penalty. The penalty shall be paid to the human services department at the same time as the individual's or employee's check is issued~~].

F. Upon the death of an employee, the account administrator shall distribute the principal and accumulated interest of the savings account to the estate of the employee."

Section 31. Section 59A-23D-7 NMSA 1978 (being Laws 1995, Chapter 93, Section 7) is amended to read:

"59A-23D-7. REPORT.--

A. The superintendent [~~of insurance~~] shall report to the legislature on or before December 1, 1999 on the availability of health care coverage pursuant to the Medical Care Savings Account Act and the market share of programs in

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comparison with traditional employer-provided health insurance programs; the results of a survey of employer and employee satisfaction with programs; and the results of a loss ratio study relative to programs.

B. The superintendent shall adopt and promulgate regulations for enforcing and administering the provisions of the Medical Care Savings Account Act."

Section 32. Section 59A-54-3 NMSA 1978 (being Laws 1987, Chapter 154, Section 3, as amended) is amended to read:

"59A-54-3. DEFINITIONS.--As used in the Comprehensive Health Insurance Pool Act:

A. "board" means the board of directors of the pool;

B. "health care facility" means any entity providing health care services that is licensed by the department of health;

C. "health care services" means any services or products included in the furnishing to any individual of medical care or hospitalization or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing or healing human illness or injury;

D. "health insurance" means any hospital and medical expense-incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, short-term, accident, fixed indemnity, specified disease policy

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or disability income contracts and limited benefit or credit insurance, or as defined by Section 59A-7-3 NMSA 1978. [~~The term~~] "Health insurance" does not include insurance arising out of the Workers' Compensation Act or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy;

E. "health maintenance organization" means any person who provides, at a minimum, either directly or through contractual or other arrangements with others, basic health care services to enrollees on a fixed prepayment basis and who is responsible for the availability, accessibility and quality of the health care services provided or arranged, or as defined by Subsection [~~F~~] M of Section 59A-46-2 NMSA 1978;

F. "health plan" means any arrangement by which persons, including dependents or spouses, covered or making application to be covered under the pool have access to hospital and medical benefits or reimbursement, including group or individual insurance or subscriber contract; coverage through health maintenance organizations, preferred provider organizations or other alternate delivery systems; coverage under prepayment, group practice or individual practice plans; coverage 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

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New Mexico premium taxes; coverage under group-type contracts [~~which~~] that are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by medicare or other governmental benefits. [~~The term~~] "Health plan" includes coverage through health insurance;

G. "insured" means an individual resident of this state who is eligible to receive benefits from any insurer or other health plan;

H. "insurer" means an insurance company authorized to transact health insurance business in this state, a nonprofit health care plan, a health maintenance organization and self-insurers not subject to federal preemption. "Insurer" 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 not under that act, but under another provision of the Insurance Code;

I. "medicare" means coverage under both Part A and B of Title XVIII of the Social Security Act, [~~42 USC 1395 et seq.~~] as amended;

J. "pool" means the New Mexico comprehensive health insurance pool;

K. "superintendent" means the superintendent of insurance; and

L. "therapist" means a licensed physical,

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occupational, speech or respiratory therapist."

Section 33. 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. Except as provided in Subsection B 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; or

(5) has as of the date the individual seeks coverage from the pool an aggregate of eighteen or more months of creditable coverage, the most recent of which was under a group health plan, governmental plan or church plan as defined in Subsections Q, O and D, respectively, of Section 2 of the

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Health Insurance Portability Act, except for the purposes of aggregating creditable coverage a period of creditable coverage shall not be counted with respect to enrollment of an individual for coverage under the pool, if, after that period and before the enrollment date there was a sixty-three-day or longer period during all of which the individual was not covered under any creditable coverage.

B. 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; provided, a self-employed person who qualifies for an approved health plan under the Health Insurance Alliance Act by using a dependent as the second employee may choose a pool policy in lieu of the health plan under that act.

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

[~~C.~~] D. 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

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reason of [~~mental retardation~~] developmental disability 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.~~] E. A pool policy that provides coverage for a family member of the person in whose name the contract is issued shall, as to the coverage of the family member or the individual in whose name the contract was issued, provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the family member or the person in whose name the contract is issued from the moment of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium shall be furnished to the carrier within thirty-one days after the date of birth in order to have the coverage continued beyond the thirty-one day period.

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[~~E.~~] F. Except for a person eligible as provided in Paragraphs (5) of Subsection A of this section, 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.~~] G. The preexisting condition exclusions described in Subsection [~~E~~] F of this section shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage [~~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 preexisting conditions coverage in a pool policy that is more favorable to the insured than that specified in this subsection.

[~~G.~~] H. An individual is not eligible for coverage by

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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;

(4) he is eligible for coverage under a group health plan;

(5) he has other health insurance coverage;

(6) the most recent coverages within the coverage period described in Paragraph (5) of Subsection A of this section was terminated as a result of nonpayment of premium or fraud; or

(7) he has been offered the option of continuation coverage under a federal COBRA continuation provision as defined in Subsection F of Section 2 of the Health Insurance Portability Act or under a similar state program, and he has elected the coverage and did not exhaust the continuation coverage under the provision or program.

[~~H.~~] I. 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

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for coverage under the pool. If the coverage is applied for within thirty-one days after that termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage."

Section 34. Section 59A-56-1 NMSA 1978 (being Laws 1994, Chapter 75, Section 1) is amended to read:

"59A-56-1. SHORT TITLE.--[~~Sections 1 through 25 of this act~~] Chapter 59A, Article 56 NMSA 1978 may be cited as the "Health Insurance Alliance Act"."

Section 35. Section 59A-56-2 NMSA 1978 (being Laws 1994, Chapter 75, Section 2) is amended to read:

"59A-56-2. PURPOSE.--The purpose of the Health Insurance Alliance Act is to provide increased access to voluntary health insurance coverage for small employer groups 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 for expanded health insurance coverage to include uninsured children, other employer groups and individuals~~] access to voluntary health insurance coverage for individuals in the individual market who have met eligibility criteria established by that act."

Section 36. Section 59A-56-3 NMSA 1978 (being Laws 1994, Chapter 75, Section 3) is amended to read:

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"59A-56-3. DEFINITIONS.--As used in the Health Insurance Alliance Act:

A. "alliance" means the New Mexico health insurance alliance;

B. "approved health plan" means any arrangement for the provisions of health insurance offered through and approved by the alliance [~~by which insureds have access to health insurance~~];

C. "board" means the board of directors of the alliance;

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

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

(1) a group health plan;

(2) health insurance coverage;

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

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

(5) 10 USCA Chapter 55;

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

(7) the Comprehensive Health Insurance Pool Act;

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

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

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

F. "department" means the department of insurance;

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

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

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

J. "eligible individual":

(1) means an individual:

(a) who, as of the date of the individual's application for coverage under an approved health plan, has an aggregate of eighteen or more months of creditable coverage, the

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most recent of which was under a group health plan, governmental plan or church plan as those plans are defined in Subsections Q, O and D of Section 2 of the Health Insurance Portability Act, respectively, or health insurance offered in connection with any of those plans, but for the purposes of aggregating creditable coverage, a period of creditable coverage shall not be counted with respect to enrollment of an individual for coverage under an approved health plan, if, after that period and before the enrollment date there was a sixty-three-day or longer period during all of which the individual was not covered under any creditable coverage; or

(b) entitled to continuation coverage pursuant to Section 59A-56-20 NMSA 1978; and

(2) does not include an individual who:

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

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

(c) has other health insurance coverage;

(d) during the most recent coverage within the coverage period described in Subsection E of Section 59A-36-3 NMSA 1978 was terminated from coverage as a result of nonpayment of premium or fraud; or

(e) has been offered the option of coverage

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under a COBRA continuation provision as that term is defined in Subsection F of Section 2 of the Health Insurance Portability Act, or under a similar state program, except for continuation coverage under Section 59A-56-20 NMSA 1978, and did not exhaust the coverage available under the offered program;

K. "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for that enrollment;

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

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

[~~G.~~] N. "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

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described services or products;

[~~H.~~] O. "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; 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;

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

[~~J.~~] Q. "incurred claims" means claims paid during a calendar year plus claims incurred in the calendar year and paid prior to April 1 of the succeeding year, less claims incurred previous to the current calendar year and paid prior to April 1 of the current year;

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

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

U. "nonprofit health care plan" means a "health care

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

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

[~~N.~~] W. "small employer" means a person that is a resident of this state, has employees at least fifty percent of whom are residents of this state, is actively engaged in business and that on at least fifty percent of its working days during either of the two preceding calendar [~~year~~] years, employed no less 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 for purposes of state income taxation shall be considered one employer; and

(3) in the case of an employer that was not in existence throughout a preceding calender year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calender year;

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

Y. "total premiums" means the total premiums for

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

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

Section 37. 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 [~~The alliance shall not be considered a governmental agency for any purpose~~], except for an insurance company that is licensed under the Prepaid Dental Plan Law or a company that is solely engaged in the sale of dental insurance and is licensed under a provision of the Insurance Code.

B. The [~~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 neither the board nor the alliance shall

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[~~not~~] be considered a governmental entity for any other purpose.

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

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

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

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

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

(4) the superintendent or his designee, [~~The superintendent~~] who shall be a nonvoting member, except when his

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vote is necessary to break a tie.

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

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

G. Whenever a vacancy on the board occurs, the electing or appointing authority of [~~that director~~] the position that is vacant shall fill the vacancy by electing or appointing an individual to serve the balance of the unexpired term; provided, when a vacancy occurs in one of the director's positions elected by the members, the superintendent is authorized to appoint a temporary replacement director until the

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next scheduled election of directors elected by the members is held. The individual elected or appointed to fill a vacancy shall meet the requirements for initial election or appointment to that position.

H. Directors may be reimbursed by the alliance as provided in the Per Diem and Mileage Act for nonsalaried public officers, but shall receive no other compensation, perquisite or allowance from the alliance."

Section 38. 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~~

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~~and promulgate a plan of operation.~~] A plan of operation adopted by the superintendent shall continue in force until modified by him or superseded by a subsequent plan of operation submitted by the board and approved by the superintendent.

C. The plan of operation shall:

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

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

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

(4) establish the amount of and the method for collecting assessments pursuant to Section [~~11 of the Health Insurance Alliance Act~~] 59A-56-11 NMSA 1978;

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

(6) establish penalties for [~~noncollection~~] nonpayment of assessments [~~from~~] by members;

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

(8) contain additional provisions necessary and

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proper for the execution of the powers and duties of the alliance."

Section 39. Section 59A-56-6 NMSA 1978 (being Laws 1994, Chapter 75, Section 6) is amended to read:

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

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

B. The board:

(1) may enter into contracts to carry out the provisions of the Health Insurance Alliance Act, including, with the approval of the superintendent, contracting with similar alliances of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions;

(2) may sue and be sued;

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

(4) shall establish maximum rate schedules, allowable rate adjustments, administrative allowances, reinsurance premiums and agent referral, [~~and~~] servicing fees [~~and any other actuarial functions appropriate to the operation of the alliance, but within the limits established~~] or commissions subject to applicable provisions in the Insurance

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Code. In determining the initial year's rate for health insurance, the only rating factors that may be used are age, gender, geographic area of the place of employment and smoking practices. In any year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit a member from offering rates that differ depending upon family composition;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Each approved health plan offered to an eligible individual shall offer a premium that is no more than twenty-five percent over and no less than twenty-five percent under the average of the standard risk rate index determined pursuant to

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Section 59A-56-23 NMSA 1978.

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

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

G. A member required to offer, and offering, an approved health plan pursuant to the requirement of Subsection E of this section shall continue to offer that plan for five consecutive years after the date the member was last required to offer the plan. A member offering an approved health plan but not required to offer it pursuant to the cited subsection may withdraw the plan but shall continue to offer it for five consecutive years after the date notice of future withdrawal is given to the board unless:

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(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.

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

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

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

Section 41. Section 59A-56-9 NMSA 1978 (being Laws 1994, Chapter 75, Section 9) is amended to read:

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

A. [~~Any~~] A member offering an approved health plan [~~to~~

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~~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:

(1) for insured small employer groups, 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; and

(2) for eligible individuals, the reinsurance premium shall not exceed ten percent of premiums paid by individuals in the first year of coverage or continuation coverage and shall not exceed fifteen percent of premiums paid by individuals for renewal years; in determining the reinsurance premium for a particular calendar year, the board shall set the

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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 42. 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:

A. for insured small employer groups, 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; and

B. for eligible individuals, the maximum administrative charge the alliance may charge in any year is ten percent of premiums."

Section 43. 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:

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(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. Net reinsurance losses shall be calculated separately for group and individual coverage. If the reinsurance premiums for either category of coverage exceed the amount calculated in accordance with Subsection A of Section 59A-56-9 NMSA 1978, the premiums shall be applied first to offset the net reinsurance losses incurred in the other category of coverage and second to offset administrative losses; and

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

B. The assessment for each member shall be determined by multiplying the total losses of the alliance's operation, as

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defined in Subsection A of this section, by a fraction, the numerator of which [~~equals~~] is an amount equal to that member's total [~~premium~~] premiums, or [~~its~~] the equivalent, exclusive of premiums received by the member for an approved health plan for health insurance written in the state during the preceding calendar year and the denominator of which equals the total premiums of all health insurance [~~premiums~~] written in the state during the preceding calendar year exclusive of premiums for approved health plans; provided that [~~premium income~~] total premiums shall not include payments by the secretary of human services pursuant to a contract issued under Section 1876 of the federal Social Security Act, [~~and shall not include premium income~~] total premiums exempted by the federal Employee Retirement Income Security Act of 1974 or [~~other~~] federal government programs.

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

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

(1) by April 15 of each year, each member offering an approved health plan shall submit a listing of all incurred claims [~~or health charges of each approved health plan for the previous year, including all claims or health charges~~

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

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

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

F. The proportion of participation of each member in the alliance shall be determined annually by the board, based on annual statements filed by each member and other reports deemed necessary by the board. Any deficit incurred by the alliance shall be recouped by assessments apportioned among the members pursuant to the formula provided in Subsection B of this section; provided that the assessment paid for any member shall be allowed as a credit on the future premium tax return for that member, with the credit limited to fifty percent of the premium tax due the first year the assessment is imposed; forty percent

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the second year; and thirty percent the third and all subsequent years.

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

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from future assessments or reimbursed pro rata to the members paying the deferred assessment."

Section 44. 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 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

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to serve as alliance administrator for [~~up to~~] a succeeding [~~four-year~~] contract period. Selection of the administrator for a succeeding contract period shall be made at least six months prior to the expiration of the current contract.

D. The alliance administrator shall:

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

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

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

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

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

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

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

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

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

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

Section 45. Section 59A-56-14 NMSA 1978 (being Laws 1994, Chapter 75, Section 14) is amended to read:

"59A-56-14. ELIGIBILITY--GUARANTEED ISSUE--PLAN PROVISIONS.--

A. A small employer is eligible for an approved health plan if on the effective date of coverage or renewal:

(1) at least fifty percent of its employees not otherwise insured elect to be covered under the approved health plan; [~~and~~]

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

(3) the small employer does not offer other

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general group health insurance coverage to its employees. For the purposes of this paragraph, general group health insurance coverage excludes coverage providing only a specific limited form of health insurance such as accident or disability income insurance coverage or a specific health care service such as dental care.

B. An individual is eligible for an approved health plan if on the effective date of coverage or renewal he meets the definition of an eligible individual under Section 59A-56-3 NMSA 1978.

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

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board may require subsequent proof annually after a two-year period following attainment of the limiting age.

[~~C.~~] D. 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.~~] E. Except as provided in Subsections [~~E and G~~] G, H and I of this section, an approved health plan offered to a small employer 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~~

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~~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~~] a preexisting condition exclusion only if:

(1) the exclusion extends for a period of not more than six months, after the enrollment date; and

(2) the period of the exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

F. As used in this section, "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage for the benefits whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date, but genetic information is not included as a preexisting condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the condition related to the genetic information.

G. An insurer shall not impose a preexisting condition exclusion:

(1) in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;

(2) that excludes a child who is adopted or

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placed for adoption before his eighteenth birthday and who, as of the last day of the thirty-day period beginning on and following the date of the adoption or placement for adoption, is covered under creditable coverage; or

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

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

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

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

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exclusion.

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

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

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

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

[~~G.~~] L. The alliance shall provide for an open enrollment period of sixty days from the initial offering of an approved health plan. Individuals enrolled during the open enrollment period shall not be subject to the preexisting conditions limitation.

M. If 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

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increased or additional benefits may require the six-month period for preexisting conditions provided in Subsection E of this section to be satisfied prior to receipt of the additional benefits."

Section 46. Section 59A-56-17 NMSA 1978 (being Laws 1994, Chapter 75, Section 17) is amended to read:

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

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

B. The board may design and require an approved health plan to contain cost-containment measures and requirements, including managed care, pre-admission certification and

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concurrent inpatient review and the use of fee schedules for health care providers, including the diagnosis-related grouping system and the resource-based relative value system."

Section 47. Section 59A-56-18 NMSA 1978 (being Laws 1994, Chapter 75, Section 18) is amended to read:

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

A. Subject to the limitations provided in Subsection C of this section, an approved health plan offered through the alliance may impose a deductible on a per-person calendar year basis. [~~A deductible plan of five hundred dollars ($500) shall initially be offered.~~] An approved health plan offered by a health maintenance organization [~~plans~~] 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

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eligible expenses [~~or health care services~~] by the covered individual shall be determined by the board."

Section 48. 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 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 49. 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

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coverage. An individual covered by health insurance under an approved health plan may retain coverage until he [~~first~~] becomes eligible for medicare as the primary coverage, except that in a family policy [~~the age of the younger family member shall be used to continue the coverage and as the basis for eligibility~~] coverage under an approved health plan shall continue for any person in the family who is not eligible for medicare.

B. An approved health plan issued to an eligible individual shall contain provisions under which the member offering the plan is obligated to renew the health insurance except for:

(1) nonpayment of premium;

(2) fraud; or

(3) termination of the approved health plan, except that the individual has the right to transfer to another approved health plan.

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

[~~C.~~] D. 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

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employment by electing to do so within a period of time specified in the health insurance, if the employee was covered under an approved health plan while employed for at least six consecutive months. The individual may be charged an additional administrative charge for the individual health insurance.

E. 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 50. Section 59A-56-21 NMSA 1978 (being Laws 1994, Chapter 75, Section 21) is amended to read:

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

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

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

Section 51. Section 59A-56-23 NMSA 1978 (being Laws 1994, Chapter 75, Section 23) is amended to read:

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

A. The alliance shall determine a standard risk rate index by actuarially calculating the average index rates that the insurer has filed under the requirements of the Small Group Rate and Renewability Act with the benefits similar to the

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alliance's standard approved health plan. A standard risk rate based on age and other appropriate demographic characteristics may be used. No standard risk rate shall be more than [~~fifteen~~] ten percent higher or [~~fifteen~~] ten percent lower than the average index rate. In determining the standard risk rate, the alliance shall consider the benefits provided by the approved health plan.

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

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

Section 52. Section 59A-56-24 NMSA 1978 (being Laws 1994, Chapter 75, Section 24) is amended to read:

"59A-56-24. BENEFIT PAYMENTS REDUCTION.--

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

B. The administrator or the alliance shall have a

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

Section 53. A new section of the Health Insurance Alliance Act is enacted to read:

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

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

B. Members providing approved health plans in the alliance are eligible to bid to provide a children's health insurance program. A children's health insurance program is not considered a separate approved health plan within the meaning of the Health Insurance Alliance Act.

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

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

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

Section 54. A new section of the Health Insurance Alliance Act is enacted to read:

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

Section 55. TEMPORARY PROVISION--REPORT.--The department of insurance and the New Mexico health insurance alliance shall prepare and publish a report to the legislature by October 1, 1997 on the alliance program and recommendations to facilitate participation in the alliance programs.

Section 56. REPEAL.--Laws 1994, Chapter 75, Section 35 is repealed.

Section 57. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

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State of New Mexico
House of Representatives

FORTY-THIRD LEGISLATURE

FIRST SESSION, 1997

February 27, 1997

Mr. Speaker:

Your BUSINESS AND INDUSTRY COMMITTEE, to whom has been referred

HOUSE BILL 832

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

1. On page 12, line 6, strike "twelve" and insert "six".

2. On page 41, line 16, strike "Until July 1, 1998, in" and insert "In".

3. On page 41, line 20, after "practices" insert "except that for individual policies the rating factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment" and strike "Until July 1, 1998, in" and insert "In".

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4. On page 42, strike all of lines 9 through 14.

5. Reletter the following subsection accordingly.

6. On page 47, line 25, remove the brackets and line-through and strike "fifteen".

7. On page 51, line 11, strike "Until July 1, 1998, in" and insert "In".

8. On page 51, strike all of lines 24 and 25 and on page 52, strike all of lines 1 through 4.

9. Reletter the following subsection accordingly.

10. On page 52, between lines 20 and 21, insert the following paragraph:

"(1) the exclusion relates to a condition, physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date;".

11. Renumber the succeeding paragraphs accordingly.

12. On page 52, line 22, strike "twelve" and insert "six".

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13. On page 58, lines 1 and 2, strike "when the employer is a small employer".

14. On page 58, line 16, after "employee" insert "or a dependent".

15. On page 59, line 11, remove bracket and line through "and" and on line 12 insert an opening bracket before "J.".

16. On page 60, line 5, strike "; and" and insert a period and closing quotation marks.

17. On page 60, strike all of lines 6 through 18.

18. On page 80, lines 4 and 5, strike ", including medicare supplement insurance".

19. On page 80, lines 7 and 8, strike ", long-term care".

20. On page 84, strike all of line 18 following "employers" and strike line 19 through "plans".

21. On page 84, strike all of line 21 following "employers", strike all of line 22 and strike line 23 through "plans".

22. On page 91, lines 19 and 20, remove the brackets and line-through and strike "ten".

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23. On page 103, on lines 15 and 16, strike "coverage for a child. The policy shall also provide".

24. On page 105, between lines 5 and 6, insert the following paragraph:

"(1) the exclusion relates to a condition, physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date;".

25. Renumber the succeeding paragraphs accordingly.

26. On page 113, lines 3 and 4, remove the brackets and line-through and strike "ten".

27. On page 114, strike all of lines 6 through 25.

28. On page 115, strike all of lines 1 through 13.

29. Renumber the succeeding sections accordingly.

30. On page 115, strike lines 19 and 20.

31. Renumber the succeeding section accordingly.,

and thence referred to the JUDICIARY COMMITTEE.

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Respectfully submitted,

_____

Fred Luna, Chairman

Adopted _____ Not Adopted _____

(Chief Clerk)

(Chief Clerk)

Date _____

The roll call vote was 7 For 0 Against

Yes: 7

Excused: Alwin, Chavez, Lutz, J.G. Taylor, Varela

Absent: Getty

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FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

March 12, 1997

Mr. President:

Your CORPORATIONS & TRANSPORTATION COMMITTEE, to whom has been referred

HOUSE BILL 832, as amended

has had it under consideration and reports same with recommendation that it DO PASS, and thence referred to the PUBLIC AFFAIRS COMMITTEE.

Respectfully submitted,

_____

Roman M. Maes, III, Chairman

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Adopted_____ Not Adopted_____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 7 For 0 Against

Yes: 7

No: 0

Excused: Fidel, Griego, Howes

Absent: None

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FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

March 16, 1997

Mr. President:

Your PUBLIC AFFAIRS COMMITTEE, to whom has been referred

HOUSE BILL 832, as amended

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

Respectfully submitted,

_____
Shannon Robinson, Chairman

Adopted_____ Not Adopted_____

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[~~bracketed material~~] = delete

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 5 For 0 Against

Yes: 5

No: 0

Excused: Boitano, Garcia, Ingle, Rodarte

Absent: None

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