TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 11 HEALTH INSURANCE ALLIANCE PLAN OF OPERATION AND ELIGIBILITY CRITERIA

13.10.11.1 ISSUING AGENCY: New Mexico Public Regulation Commission, Insurance Division.
[13.10.11.1 NMAC - N, 6-1-01]

13.10.11.2 SCOPE: This rule applies to all persons who transact the business of health insurance in New Mexico or have dealings with the **alliance**.
[13.10.11.2 NMAC - N, 6-1-01]

13.10.11.3 STATUTORY AUTHORITY: Sections 59A-56-5 and 59A-56-21 NMSA 1978.
[13.10.11.3 NMAC - N, 6-1-01]

13.10.11.4 DURATION: Permanent.
[13.10.11.4 NMAC - N, 6-1-01]

13.10.11.5 EFFECTIVE DATE: June 1, 2001, unless a later date is cited at the end of a section.
[13.10.11.5 NMAC - N, 6-1-01]

13.10.11.6 OBJECTIVE: The purpose of this rule is to implement the Health Insurance Alliance Act, Chapter 59A, Article 56 NMSA 1978.
[13.10.11.6 NMAC - N, 6-1-01]

13.10.11.7 DEFINITIONS: In addition to the definitions in Section 59A-56-3 NMSA 1978, as used in this rule:

A. **act** means the Health Insurance Alliance Act, Chapter 59A, Article 56 NMSA 1978;

B. **alliance** means the New Mexico health insurance alliance;

C. **plan or plan of operation** means this rule.

[13.10.11.7 NMAC - N, 6-1-01]

13.10.11.8 MEMBERSHIP:

A. All persons listed in Section 59A-56-4 NMSA 1978 of the act shall organize and remain members of the **alliance** as a condition of their authority to transact insurance business in New Mexico.

B. Such persons who were authorized to transact insurance business in New Mexico as of March 4, 1994, shall be members of this **alliance**. Each insurer admitted thereafter shall automatically become a member of the **alliance** effective on the date of its admission. A member which ceases to be admitted after said date shall automatically cease to be a member effective on the day following the termination or expiration of its certificate of authority to transact the business of health insurance as defined in the act; provided, however, that such member shall remain liable for any assessment or assessments based on net losses sustained by the **alliance** through the end of the year of cessation. This liability shall constitute a claim against the member's deposit with the insurance division.

C. Issues of determination of eligibility of any person or entity as an **alliance** member shall be resolved by the board of directors. If a member is aggrieved by the final action or decision of the board, or if the board does not act on such complaint within 60 days, the member may appeal to the superintendent. Such appeal must be filed within 60 days after the action or decision of the board or the board's failure to act on such complaint.
[13.10.11.8 NMAC - N, 6-1-01]

13.10.11.9 BOARD OF DIRECTORS:

A. There shall be a board of directors, who shall be appointed or elected in accordance with the provisions of the act.

(1) The elected directors shall be elected by the members of the **alliance** as hereinafter provided.

(a) There shall be an annual membership meeting of all the **alliance** members no later than June 30 of each year for transaction of any appropriate business, including the election of member representatives to the board of directors.

(b) Prior to the annual membership meeting, the board of directors or its nominating committee shall select a nominee to succeed each board director who was elected by the general membership of the **alliance** and not appointed by the governor, and whose term is scheduled to expire on June 30 of that year. Such nominee will ensure that the required representation of members as set forth in the act is maintained. Nominees shall be made known to the members of the **alliance** at least 30 days prior to the annual membership meeting.

(c) The board of directors shall compile a list of all members of the **alliance**. At least 30 days prior to the annual membership meeting, a notice and proxy shall be sent to all members of the **alliance** soliciting votes for membership of the board of directors. Each **alliance** member shall be entitled to cast one vote in electing a member to the

board and shall be permitted to cast such vote in person, by mail or facsimile, or by proxy.

(d) The results of the election shall be tabulated and announced at the annual meeting.

(2) In the event a director elected by the general membership, or his or her alternate, is or becomes for any reason unable or unwilling to serve on the board, the superintendent of insurance shall appoint a person (representing the designated interest) to serve as a director until the next general meeting of the membership of the **alliance**, at which time the membership shall elect a director in accordance with paragraph 1 of subsection A to complete the remainder of the original term.

(3) In the event a director appointed by the governor, or his or her alternate, is or becomes for any reason unable or unwilling to serve on the board, the governor shall appoint a person (representing the designated interest) to serve as a director through the remainder of the original term.

(4) Any elected or appointed director shall serve until his or her successor has been duly elected or appointed and qualified to serve.

B. An annual meeting of the board shall be held no later than June 30 of each year, at such time and place as the board of directors may determine. At each annual meeting, the board shall:

(1) review the plan and submit to the superintendent any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the **alliance**;

(2) review underwriting policies and practices, policy forms and rates for coverage issued by the **alliance**;

(3) review, consider and act on any other matters deemed by it to be necessary and proper for the administration of the **alliance**; and

(4) review and evaluate the performance of the administration of the **alliance** and contracted consultants and vendors;

C. Special meetings of the board may be called by a majority of the directors or the chair of the board, and will be held at the time and place fixed by the person or persons calling the special meeting.

D. Written notice stating the time, place and, if a special meeting, the purpose of any meeting of the board will be delivered either personally, by mail, or by facsimile at the direction of the person or persons calling the meeting, to each director at least 72 hours before the scheduled date of the meeting. If mailed or sent by facsimile, a notice is deemed delivered when deposited, postage or charges prepaid, with the transmitting agency, addressed to the director. The board may establish dates and times for regularly scheduled meetings.

E. A majority of the directors appointed or elected present either in person or by telephone will constitute a quorum at the board meetings. The act of a majority of directors voting in person, by telephone, or by written proxy at a meeting at which a quorum is present shall be the act of the board, except a two-thirds majority of the directors appointed or elected shall be required for actions dealing with the levy of the assessments, approval and discharge of any contracted third-party administrator, removal of officers, or for the **alliance** to borrow money or to encumber assets of the **alliance**. The directors may act only as a board with each director having one vote.

F. Except as provided in this section, a written proxy may be given only to other board members and shall be delivered to the chair before the vote for which the proxy is effective. The written proxy shall specify the vote or meeting for which it shall be effective.

(1) A director may designate an alternate to serve in his or her place but only if the alternate represents the same interest as the director. One alternate for each director may be designated in writing and approved by the chair. An alternate shall have the same rights and privileges as a director when serving in his or her stead and no proxy or other additional designation shall be required.

(2) Whenever any notice is required to be given to any director, a waiver thereof in writing signed by the person entitled to the notice is equivalent to the giving of timely notice. The attendance of a director at a meeting constitutes a waiver of notice of the meeting except when attendance is for the sole purpose of objecting because the meeting is not lawfully called or convened.

G. The board may contract with an administrator. If it chooses to do so, the administrator shall be selected through a competitive bid process.

(1) The board shall evaluate bids submitted based on criteria established by the board which shall include:

(a) the bidder's proven ability to administer health insurance programs;

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

(c) the bidder's ability to administer the **alliance** in a cost efficient manner.

(2) The administrator shall serve for a period of up to four years subject to annual renegotiation of fees and services and removal for cause or earlier expiration of the contract term. At least one year prior to the expiration of the administrator's period of service, the board may invite all interested parties, including the current administrator, to submit proposals to serve as the administrator for the succeeding four-year period or such shorter contract term as the board deems appropriate. Selection of the administrator for a succeeding period shall be made at least six months prior to the expiration of the administrator's contract. If the board chooses to renew its contract with the then current administrator, it need not engage in a competitive bid process.

H. The board may hire such persons or organizations as attorneys at law, actuaries, accountants, claims personnel and such other specialists or persons or organizations with expertise in such areas and whose advice or assistance is deemed by the board to be necessary to the discharge of its duties imposed by law. The board may agree to compensate such

person or organizations so as to best serve the interest of the **alliance** and the public. Except in connection with the hiring of a new administrator, the **alliance** may, but need not, utilize a competitive bid process in connection with the selection of any contractor or consultant.

I. A written record of the proceedings of each board meeting shall be made. The original of the record shall be retained in the office of the **alliance** and a copy shall be forwarded to the superintendent's office. Copies of such minutes shall be available upon request.

J. The directors may be paid their expenses, if any, of attendance at each meeting of the board of directors according to the limitations provided by the New Mexico Per Diem and Mileage Act for non-salaried public officers, and shall receive no other compensation, perquisite or allowance from the **alliance** except de minimus benefits provided in connection with the scheduling or conduct of meetings, including meals, snacks or other benefits of minimal value. Members of special or standing committees may be allowed expenses for attending committee meetings as determined by the board of directors but subject to the Per Diem and Mileage Act and the provisions of the preceding sentence.

K. Members of the board of directors, or any committee designated by the board of directors, may participate in a meeting of the board of directors, or any committee, by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and such participation in a meeting shall constitute presence in person at the meeting for all purposes.

[13.10.11.9 NMAC - N, 6-1-01]

13.10.11.10 OFFICERS:

A. The officers of the board will be the chair of the board, a vice chair, and a secretary, and such other officers as the board may decide, who, except for the chair, will be elected annually by the board at its annual meeting to serve until their successors are elected and qualified. The superintendent shall serve as chair, unless he declines, in which event he shall appoint the chair. An officer, except the chair, may be removed with or without cause by the board, or may resign. Vacancies and newly created offices will be filled by the board. One person may hold more than one office, but no person may be both chair of the board and secretary. Officers will perform the duties, and will have the power and authority, assigned by the board, incident to the office, and provided in this plan.

B. The chair shall preside at meetings of the board of directors and shall assume such duties as shall be designated from time to time by the board of directors and as are consistent with the provisions of the act. The chair, when authorized by the board, will execute and deliver documents in the name of the **alliance**.

C. The vice chair of the board of directors shall function in the absence of the chair.

D. The secretary shall be responsible for the records of the **alliance** and the minutes of the proceedings of the directors; will give all notices required; and when authorized will execute, attest, seal, and deliver documents of the board.

[13.10.11.10 NMAC - N, 6-1-01]

13.10.11.11 COMMITTEES:

A. The board shall have the standing committees set forth below. Members of the committees shall be named by and serve at the pleasure of the chair. In addition to the authority specified, the committees shall have such duties and responsibilities as may be delegated to them from time to time by the board.

(1) Executive committee. The executive committee shall be comprised of the chair, the vice-chair, and the secretary, as well as the chairs of the finance and marketing committees and such other members of the board as the chair may designate. The executive committee shall have the authority to act for the board between meetings, subject to ratification by the board, and shall act as the board's audit committee.

(2) Finance committee. The finance committee shall be comprised of the chair and such other persons as the chair may designate. The finance committee shall be responsible for oversight of the financial affairs of the **alliance**, and for developing policies and procedures to manage such affairs, subject to approval by the board.

(3) Marketing committee. The marketing committee shall be comprised of at least one member of the board and such other persons as the chair may designate. The marketing committee shall have the authority to approve marketing expenditures within a budget and limits approved by the board.

(4) Grievance committee. The grievance committee shall be comprised of members of the board. The committee shall include at least three members, and shall be responsible for hearing and determining grievances in accordance with 13.10.11.17 NMAC and for resolving such other matters as may be delegated to it by the board. The chair may designate alternates to serve in the event a conflict of interest prevents a board member from participating in any grievance procedure.

B. The board may establish such other committees as it may from time to time deem necessary.

[13.10.11.11 NMAC - N, 6-1-01; A, 3-31-08]

13.10.11.12 OPERATIONS:

A. The board, in addition to the powers prescribed in the act, shall have the specific authority to enter into contracts and undertake such other activities as are necessary or proper to carry out the provisions and purposes of the act, including the authority, with the approval of the superintendent, to enter into contracts with similar alliances of other states for the joint performance of common administrative functions. The board may employ such persons, firms or corporations to

perform such administrative or other functions as are necessary for the operations of the **alliance**. Such persons, firms or corporations shall keep such records of their activities as may be required by the board.

B. The board may open one or more bank accounts for use in **alliance** business. Reasonable delegation of deposit and withdrawal authority for such accounts for **alliance** business may be made, consistent with prudent fiscal policy. The board may borrow money from any person, or organization as the board may deem advantageous for the **alliance** and the public. The **alliance** administration is responsible, within such authority as may be granted to it by the board, for the handling, safe-guarding, and disbursement of funds of the **alliance**, subject to and responsible to the board. The **alliance** administration may maintain the financial records of the **alliance** as directed by the board.

C. The board may review the act and other appropriate insurance laws and regulations in order to make recommendations to the superintendent for the improved operation of the **alliance**.

D. The board shall provide and accept applications for health insurance in accordance with the eligibility criteria set forth in this rule, and for any other insurance plans developed by the board of directors, which contain standard policy provisions as specified by the act.

E. The board shall adopt a plan for the periodic advertising of the general availability of health insurance coverage from the **alliance** and the eligibility requirements and procedures for enrollment in an approved health plan and to maintain public awareness of the **alliance**.

F. The board shall establish procedures to determine the amount of and method for collecting on assessments pursuant to the act. The board shall impose the initial administrative assessment. The board shall promptly inform the superintendent of the failure of any member to pay an assessment after 30 days' written notice to the member that payment is due. A minimum penalty of $1000, plus interest at the rate used by the IRS on the assessment, will be assessed against any member who fails to pay the assessment within the time prescribed by the board unless such other minimum penalty is established by the board and approved by the superintendent.

G. The board annually shall review operating expenses and outstanding contractual obligations and determine if an assessment is necessary for the proper administration of the **alliance** and, if so, the amount. If such assessment is deemed to be necessary, the board shall levy such assessment based upon the criteria set forth in Section 59A-56-11 NMSA 1978. The board may adopt other or additional methods of adjusting the formula to achieve equity of assessments among **alliance** members, within the provisions of the act. The board may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The assessment shall be imposed annually.

H. The **alliance** may adopt any additional policies or procedures necessary or proper for the execution of the powers and duties of the **alliance**.

[13.10.11.12 NMAC - N, 6-1-01]

13.10.11.13 INTERESTED PARTIES: No contract or transaction between the **alliance** and one or more of its directors, or between the **alliance** and any other corporation, partnership, association or other organization in which one or more if its directors are directors or officers, or have a financial interest, shall be void or voidable based only on one or more of the following:

A. the financial interest;

B. the presence at or participation in the meeting authorizing the contract or transaction; or

C. the counting of the director's vote for such purpose, if:

(1) the material facts as to his relationship or interest and as to the contract or transaction are disclosed or are known to the board of directors or the committee, and the board or committee in good faith authorized the contract or transaction by the affirmative votes of a majority of the disinterested directors or the committee, and the board or committee in good faith authorized the contract or transaction by the affirmative votes of a majority of the disinterested directors, even though the disinterested directors be less than a quorum; or

(2) the material facts as to his relationship or interest and as to the contract or transaction are disclosed or are known to the directors entitled to vote thereon, and the contract or transaction is specifically approved in good faith by vote of the directors; or

(3) the contract or transaction is fair as to the **alliance** as of the time it is authorized, approved or ratified, by the board of directors, or a committee thereof. Common or interested directors may be counted in determining the presence of a quorum at a meeting of the board of directors or of a committee which authorized the contract or transaction.

[13.10.11.13 NMAC - N, 6-1-01]

13.10.11.14 RECORDS AND REPORTS:

A. The fiscal year of the **alliance** shall be determined by the board.

B. The board of directors shall conduct periodic audits to assure the general accuracy of the financial data submitted to the **alliance** pursuant to Section 59A-56-11 NMSA 1978. The board shall cause the **alliance** to have an annual audit of its financial statements by an independent certified public accountant.

C. The **alliance** shall be subject to and responsible for examination by the superintendent. Not later than March 1 of each year, the board of directors shall submit to the superintendent an audited financial report for the preceding calendar year in a form approved by the superintendent. The report shall also review the activities of the **alliance** during the

preceding calendar year.

D. All policy forms issued through the **alliance** shall conform to the requirements of the act and must be filed with and approved by the superintendent before their use.

[13.10.11.14 NMAC - N, 6-1-01]

13.10.11.15 AGENTS: The **alliance** may pay referral or servicing fees or commissions subject to applicable provisions in the Insurance Code, or may require carriers to pay a commission to the insurance agent who refers an applicant to the **alliance** if that applicant is accepted. No agent shall be eligible to receive a commission or referral fee on or in connection with a plan issued through the **alliance** unless the agent has completed a continuing education course sanctioned by the **alliance** and has been certified by the **alliance**. Agents that have not enrolled any individual or group in the **alliance** for a period of two (2) years shall recertify. The **alliance** may decertify an agent for good cause, subject only to review pursuant to the grievance procedures set forth in 13.10.11.17 NMAC.

[13.10.11.15 NMAC - N, 6-1-01; A, 3-31-08]

13.10.11.16 INDEMNIFICATION:

A. All persons, except the superintendent and his staff, described in the act shall be indemnified by the **alliance** for all expenses incurred in the defense of any action, suit or proceeding brought against such person on account of any action taken by him in the performance of his powers and duties under the act, unless such person shall be finally adjudged to have committed a breach of duty involving gross negligence, bad faith, dishonesty, willful misfeasance or reckless disregard of the responsibilities of his office. This right of indemnification shall not extend to acts or omissions arising solely from a member's administration of an approved health plan. In the event of settlement before final adjudication, such indemnity shall be provided only if the **alliance** is advised by independent counsel that such person did not, in such counsel's opinion, commit such a breach of duty. The expense of such indemnification shall be assessed against member insurers in accordance with Section 59A-56-11 NMSA 1978. Any reference to persons in this article shall include the board or a committee thereof.

B. The indemnification provided by this section will not be deemed exclusive of any other rights to which those indemnified may be entitled under any other laws, agreements, voted of disinterested directors, or otherwise, both as to action in such person's official capacity and as to the action in another capacity while holding such office, and will continue as to a person who had ceased to be a director, employee or agent and will inure to the benefit of the heirs and personal representative of that person.

C. The **alliance**, upon resolution adopted by the board, may purchase and maintain insurance on behalf of any person who is or was a director, employee or agent of the **alliance** who, while a director, employee or agent of the **alliance** or is or were serving at the request of the **alliance** as a director, employee or agent of another foreign or domestic corporation, partnership, joint venture, trust, other enterprise or employee benefit plan, against any liability asserted against and incurred by the person in any such capacity or arising out of the person's status as such, whether or not the **alliance** would have the power to indemnify the person against such liability under the provisions of this section.

[13.10.11.16 NMAC - N, 6-1-01]

13.10.11.17 COMPLAINT AND GRIEVANCE PROCEDURES: In the event an insured, an agent, a group or a member believes the performance of the **alliance** or a member does not meet its expectations or conform to a policy or plan issued by a member through the **alliance**, that person may bring the matter to the attention of the **alliance** by a complaint or grievance. The **alliance** shall act promptly and impartially when considering all complaints and grievances.

A. Definitions. As used in this section:

(1) complaint means a relatively minor verbal or written expression of concern which may lend itself to resolution on an informal basis and which relates to the operation or decision of the **alliance** or a member of the **alliance**;

(2) grievance means a more serious written expression of concern or a complaint which had not been resolved to the person's satisfaction; both situations require a thorough investigation and a formal response to the parties;

(3) group means a small employer group eligible for coverage or covered by an insurance policy, nonprofit health care plan contract or HMO plan issued through the **alliance** by a member; and

(4) insured means a person covered under an insurance policy or a nonprofit health care plan contract, or enrolled in an HMO plan issued through the **alliance** by a member;

B. Handling a complaint. Complaints should be made to the executive director of the **alliance**. The executive director has the discretionary power to handle complaints on an informal basis. The grievance procedure outlined in Subsection C of 13.10.11.17 NMAC will be followed if the complainant or the responding party wishes to appeal the decision of the executive director, if a determination has already been made by the executive director, or if the executive director decides that the issue at hand needs to be reviewed by the grievance committee of the **alliance**.

C. Grievance procedure.

(1) Between an insured or group and a member.

(a) If the grievance is between an insured or a group and a member, the insured or group shall complete all internal complaint and grievance procedures offered by a member prior to filing a grievance with the **alliance**.

(b) An insured or group must submit the grievance in writing to the **alliance** within 30 days following

completion of the member's internal complaint or grievance process. If the member has no internal complaint or grievance process, or if the member has failed to respond to the complaint or grievance within 30 days after the insured or the group had made the complaint or grievance, the grievance must be submitted in writing to the **alliance** within 90 days after the incident occurred.

(c) The grievance should accurately describe the incident and must be signed by the insured or group filing the grievance.

(d) Upon receipt of the written grievance, the executive director of the **alliance** shall conduct a thorough review of the grievance and mail a response to the insured or group and to the member. If the parties are satisfied with the solution, the grievance matter shall be considered resolved.

(e) If the insured or group or the member is not satisfied with the solution proposed by the executive director, the grievance may be appealed in writing to the grievance committee of the **alliance**. Such appeal must be submitted within 30 days of the first grievance response and must include the reason for the appeal.

(2) Against the Alliance.

(a) Any person (including the insured, an agent, a group or a member) filing a grievance against the **alliance** must submit the grievance in writing to the **alliance** within 90 days after the incident occurred or within 90 days after the executive director makes an adverse decision on the complaint.

(b) The grievance should accurately describe the incident and must be signed by the person filing the grievance.

(c) Upon receipt of the written grievance, the executive director shall conduct a thorough review of the grievance and mail a response to the person. If the person is satisfied with the solution, the grievance matter shall be considered resolved.

(d) If the person is not satisfied with the solution proposed by the executive director, the grievance may be appealed in writing to the grievance committee of the **alliance**. Such appeal must be submitted within 30 days of the first grievance response and must include the reasons for the appeal.

D. Grievance committee.

(1) The grievance committee shall be composed of at least three members of the **alliance's** board of directors. Any director who represents a member or insured who is involved in a grievance shall not serve on the committee hearing the grievance.

(2) The committee shall convene 30 days after receipt of the appeal. The person filing the grievance will be invited to appear before the committee, along with any other parties involved in the grievance, to explain the appeal. After reviewing all previous findings of the plan and the executive director, and such other information as the committee may reasonably request, the committee will render a decision and deliver such in writing to all parties within 60 days after receipt of the appeal, unless good cause exists to extend the time. All decisions of the grievance committee are considered final.

(3) If any party involved is dissatisfied with the decision of the grievance committee, they may contact the New Mexico insurance division or they may pursue other remedies available to them. Prior to the filing of any legal proceedings or suit against the **alliance** or a member of the **alliance**, the complaint and grievance procedure prescribed in 13.10.11.17 NMAC must be utilized by any party alleging a claim.

(4) In adopting and utilizing this procedure to resolve disputes between a group or an insured and a member, the **alliance** and its grievance committee are providing a forum for alternative dispute resolution. Neither the **alliance** nor its grievance committee shall be a proper party to any dispute or suit between an insured or a group and a member.

[13.10.11.17 NMAC - N, 6-1-01; A, 3-31-08]

13.10.11.18 AMENDMENTS: The plan of operation may be altered, amended, or repealed by a two-thirds vote of directors elected or appointed, and approval of such action by the superintendent.

[13.10.11.18 NMAC - N, 6-1-01]

13.10.11.19 ELIGIBILITY CRITERIA:

A. The eligibility criteria in 13.10.11.20 NMAC through 13.10.11.33 NMAC apply to approved health plans for small employers; the eligibility criteria in 13.10.11.34 NMAC apply to approved health plans for individual coverage.

B. Members may utilize their normal business practices in implementing an approved health plan to the extent such practices are not inconsistent with the act, this rule, other applicable laws and regulations, or the approved health plan's benefit design.

C. Any misrepresentation relating to an employer's eligibility as a small employer or to an individual's eligibility for coverage may be grounds for rescission or cancellation of coverage and such other action as may be appropriate under law.

[13.10.11.19 NMAC - N, 6-1-01]

13.10.11.20 ELIGIBILITY AS A SMALL EMPLOYER:

A. An employer is eligible as a small employer if:

(1) the employer, if a corporation, is incorporated in New Mexico or is authorized to do business in New Mexico; if a person or other organization, is a resident of this state or has its principal place of business in this state; and

(2) at least 50 percent of all of its employees, eligible or not, live in New Mexico; and

(3) on at least 50 percent of its working days during either of the two preceding calendar years, the employer had at least two and no more than 50 eligible employees.

(a) If the employer has been in business for less than one calendar year, the determination of whether an employer is a small 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.

(b) A spouse or dependent of an employee, whether or not working in the business, may, at the employer's discretion, be counted as a separate employee for the sole purpose of determining the number of eligible employees. A spouse or dependent enrolling who is not employed in the business must still enroll for dependent coverage and need not complete an employee application; a spouse or dependent employed in the business has the option of enrolling as a dependent or an employee.

(c) Any self-employed person and all employees who comprise the "two to 50 group" of eligible employees must work for the qualifying business a minimum of 20 hours per week on a regular basis.

(d) Casual laborers and volunteers are not eligible.

(e) An employee eligible or enrolled in medicare shall be considered an eligible employee for the sole purpose of determining whether an employer is a small employer, provided that that employee otherwise qualifies as an eligible employee.

B. Affiliated companies, or companies eligible to file a combined New Mexico tax return, must be considered one employer. Companies eligible to file a combined New Mexico tax return include two or more integrated corporations that are more than 50 percent owned and controlled by the same person or entity and for which at least one of the following conditions exists:

(1) there is a unity of operations evidenced by central purchasing, advertising, accounting or other centralized services;

(2) there is a centralized management or executive force and centralized system of operation; or

(3) the operations of the corporation are dependent upon or contribute property or services to one another individually or as a group. Subsection R of Section 7-2A-2 and Section 7-2A-8.3 NMSA 1978.

C. The eligibility status of a small employer shall be determined as of the date of enrollment or renewal.

D. A small employer is not eligible for an **alliance** plan for three years after any termination of coverage issued to the employer through the **alliance**, if the termination was due to a failure to pay premiums timely, or to fraud, misuse of coverage, or violation of **alliance** policies. Any small employer applying for coverage under this paragraph within three years of the date of termination of its prior coverage through the **alliance** must complete a new application for coverage and be subject to all requirements, including preexisting condition requirements, that apply to a new employer group. All applications for coverage submitted by a small employer within three years of the date its prior coverage through the **alliance** has terminated must be approved by the executive director.

E. A small employer is not eligible for an **alliance** plan if it offers any other comprehensive group health insurance coverage to its employees, other than coverage sponsored by a recognized labor union. For purposes of this paragraph, comprehensive group health insurance coverage includes individual health insurance coverage if paid for or reimbursed by the employer, but excludes either individual or group 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.

F. A small employer shall remit all premiums due for its employees and their dependents to the **alliance**.

[13.10.11.20 NMAC - N, 6-1-01]

13.10.11.21 ELIGIBILITY OF EMPLOYEES OF SMALL EMPLOYERS:

A. Eligible employees.

(1) An employee of a small employer (or a self-employed person who is eligible under Subparagraph (b) of Paragraph (3) of Subsection A of 13.10.11.20 NMAC) is eligible to enroll in an approved health plan if:

(a) the employee (or the self-employed person) has completed the employer's waiting period;

(b) the employee (and any self-employed person) is working at least 20 hours per week on a regular basis (other than as a volunteer); and

(c) the employee (or the self-employed person) does not come within one of the categories of ineligible employees described in Subsection B of 13.10.11.21 NMAC.

(2) An individual already covered under an approved health plan may retain coverage after he or she first becomes eligible for medicare as primary coverage. If an individual who has a family coverage policy elects to terminate his or her coverage through the **alliance** when he or she becomes eligible for medicare, the family coverage under the approved health plan shall continue for any person in the family who is not eligible for medicare. The family rate shall be based on the age of the employee, unless the employee has terminated coverage, in which case the rate shall be based on the age of the eldest enrolled member of the family. The rate shall be adjusted to reflect the number of persons actually enrolled in the approved health plan.

B. Ineligible employees. An employee of a small employer, or a self-employed person, is not eligible to enroll in an approved health plan if:

(1) at the time of application, he is eligible for medicare and the group has fewer than 20 employees;

(2) if he is an inmate of a public institution; or

(3) if he or she previously was terminated by the carrier for cause under any plan.

C. Participation requirement. As of the date of the group's enrollment or renewal, at least 50 percent of the employer's eligible employees who are not otherwise covered under another comprehensive health plan or program must elect to be covered under the **alliance** plan. For purposes of this subsection, comprehensive health insurance coverage includes coverage sponsored by any recognized labor union and any group health insurance or individual health insurance coverage that is not paid for or reimbursed by the employer. If the employer is deemed to be a small group by virtue of having one employee and a dependent, then at least two persons must be covered under the **alliance** plan. Management or class subsets or carve-outs cannot be used to satisfy or circumvent participation requirements for the employer group.
[13.10.11.21 NMAC - N, 6-1-01]

13.10.11.22 DOCUMENTATION REQUIRED: The **alliance** shall require documentation that the employer qualifies as a small employer and satisfies eligibility and participation requirements. The **alliance** is particularly concerned that self-employed individuals are actively working for their business at least 20 hours per week. Required documentation must be received in the **alliance** office by the 15th of the month in order to be eligible for an effective date of the first of the following month. If the 15th of the month falls on a weekend or holiday, the documentation must be received by the **alliance** before 5:00 p.m. on the next business day.
[13.10.11.22 NMAC - N, 6-1-01]

13.10.11.23 DOCUMENTATION FOR NEW GROUPS AND EXISTING GROUPS ENROLLING WITH A NEW CARRIER: The **alliance** requires:

A. a completed application;

B. the employer's federal EID and New Mexico gross receipts tax ID numbers; or, for a new business that has not yet obtained tax ID numbers, a current valid business license;

C. a waiver of coverage, in the form specified by the **alliance**, signed by each eligible employee who does not desire coverage. If the employee has other coverage, the name of the carrier, as well as the subscriber and group names must be specified; and

D. for groups that file New Mexico department of labor employer's quarterly wage and contribution report (schedule A - SUTA), the employer's most recent SUTA.

(1) The employer must identify on the SUTA form each employee who is not eligible for coverage and must specify the reason that the employee is ineligible, e.g., on medicare, working less 20 hours per week, etc. For each employee who is not eligible, the employer must specify the employee's date of hire and hours per week worked.

(2) If an employer submits a SUTA but desires to enroll employees who are not identified on that report, the employer must submit the following applicable documentation for each such employee:

(a) for any new employees not yet identified on the most recent SUTA, W-4 forms;

(b) for each working owner, dependent or partner not identified on the SUTA, an affidavit, signed under oath, that the individual is working in the business at least 20 hours per week on a regular basis.

E. If the employer group is required to file a SUTA but has not yet done so because it is a new business (i.e., established within three months prior to the date of application), the employer shall submit an affidavit, signed under oath, that the employer is actively engaged in an ongoing business and reasonably expects to average between two and 50 employees for the next two years, together with a list of current employees. Each individual enrolling as an employee must submit a witnessed affidavit that the individual is working in the business at least 20 hours per week on a regular basis.

F. If the employer group is not required to file a SUTA, the employer must submit a witnessed affidavit that the employer is actively engaged in an ongoing business, and is working in the business at least 20 hours per week on a regular basis, together with the relevant portion of its latest complete federal income tax filing, as specified below, in order to allow the **alliance** to verify the existence of the business and validate actively working requirements through documented earned income/loss. The following forms, as applicable to the employer's business, are required. NOTE: If wages are reported on any of these forms, the employer must submit either a SUTA or a W-2 form.

(1) 1120 corporate return.

(2) 1120S corporate return.

(3) 1065 and Schedule K-1 for each eligible partner who elects coverage.

(4) Schedule C for business income profit or loss report for sole-proprietors.

(5) Schedule E for real estate or rental income.

(6) Schedule F for farm income.

[13.10.11.23 NMAC - N, 6-1-01; A, 3-31-08]

13.10.11.24 DOCUMENTATION FOR GROUPS RENEWING WITH THE SAME CARRIER:

A. For groups that file New Mexico department of labor employer's quarterly wage and contribution report (schedule A - SUTA), the employer's most recent SUTA.

(1) The employer must identify on the SUTA form each employee who is not eligible for coverage and must specify the reason that the employee is ineligible, (e.g., on medicare, working part time (i.e., less 20 hours per week),

terminated, etc). For each employee who is not eligible, the employer must specify the employee's date of hire and hours per week worked.

(2) The employer must submit an enrollment application for each employee desiring coverage who has not previously submitted an application and a waiver of coverage, in the form specified by the **alliance**, for each eligible employee who does not desire coverage and who has not previously submitted a waiver to the **alliance**. If the employee has other coverage, the name of the carrier, as well as the subscriber and group names must be specified;

(3) If an employer submits a SUTA but desires to enroll employees who are not identified on that report, the employer must submit the following applicable documentation for each such employee:

(a) for any new employees not yet identified on the most recent SUTA, W-4 forms;

(b) for each owner, working spouse or partner not identified on the SUTA, a witnessed affidavit that the individual is working in the business at least 20 hours per week on a regular basis.

B. If the employer group is not required to file a SUTA, the employer must submit its current business license, if it is required to have a business license, and a witnessed affidavit by each individual requesting coverage as a subscriber, that the individual is working in the business at least 20 hours per week on a regular basis.

[13.10.11.24 NMAC - N, 6-1-01; A, 3-31-08]

13.10.11.25 HMO SERVICE AREA REQUIREMENTS: In order to be eligible to enroll in an **alliance** plan offered by an HMO, an employee or spouse must live or work within the HMO's service area. The HMO may approve exceptions on an individual basis in accordance with the HMO's usual business practice.

[13.10.11.25 NMAC - N, 6-1-01]

13.10.11.26 WAITING PERIOD: The employer must establish a waiting period for new employees. The minimum waiting period is 30 days. The maximum waiting period is 180 days. The waiting period must be the same for all employees of a small employer. At the time a small employer first obtains coverage through the **alliance**, the small employer, at its discretion, may elect to waive the waiting period for all employees who are otherwise then eligible for and enrolling in the plan.

[13.10.11.26 NMAC - N, 6-1-01]

13.10.11.27 ENROLLMENT PERIODS: Applications must be received by the **alliance** office within the time period for enrollment specified above.

A. Timely enrollment. Employees and their dependents shall be entitled to enroll in an **alliance** plan during the following timely enrollment periods.

(1) New employees and their dependents may enroll in the plan within 31 days of completion of their employer's waiting period.

(2) An individual may enroll in the plan if:

(a) at the time the individual was first eligible to be covered under the small employer's plan, the individual was covered under another group health benefit plan;

(b) the individual's coverage under the other group plan terminates involuntarily except for cause; and

(c) the individual enrolls in the small employer's plan within 31 days of the effective date of termination of his or her coverage under the other group plan.

(3) A new dependent of an eligible or enrolled employee may enroll in the plan within 31 days of becoming eligible by virtue of marriage, birth, adoption or placement for adoption, or entry of a guardianship order. If the eligible employee is not then enrolled in the plan, he must also enroll in the plan within this period in order to obtain coverage for the dependent.

B. Late enrollment. Each approved health plan shall hold an annual open enrollment period for 30 days prior to an enrolled group's anniversary date, for coverage effective as of the anniversary date. Eligible employees or dependents who do not enroll within the time specified in subsection A shall be entitled to enroll during this open enrollment period without evidence of insurability. No late enrollments will be approved outside of a group's annual open enrollment period. The board of directors may require that all plans hold their annual 30-day open enrollment period at the same time, regardless of the group's anniversary date, in which case coverage shall be effective as of the first of the month following the close of the open enrollment period.

[13.10.11.27 NMAC - N, 6-1-01]

13.10.11.28 EFFECTIVE DATES:

A. If the documentation required by the **alliance** is received by the 15th of the month, coverage shall be reviewed for an effective date as of the first day of the following month. If the documentation required by the **alliance** is received after the 15th of the month, coverage shall not be effective until the first day of the month after the month following that in which the complete documentation is received. (Note: If the 15th of the month falls on a weekend or holiday, the documentation must be received by the **alliance**, or delivered to its post office box, before 5:00 p.m. on the next business day.)

B. Coverage for an eligible employee and/or dependent shall be effective as of the first day of the month

following fulfillment of enrollment and eligibility requirements, unless an earlier effective date is required by law (as in the case of newborn or adopted children). (See 13.10.11.29 NMAC.)

C. Coverage for persons eligible to enroll and enrolling during an open enrollment period held pursuant to Subsection B of 13.10.11.27 NMAC shall be effective as of the first day of the month following enrollment.

D. The small employer shall notify the **alliance** of the termination of, or cancellation of insurance for, any employee or dependent by the end of the month following the month in which the employee was terminated or his coverage cancelled. Premiums for the month following the month in which termination or cancellation is effective shall be refunded if previously paid, provided that the **alliance** has been timely notified in writing.

E. The small employer shall notify the **alliance** of its intent to terminate its group insurance through the **alliance** no later than the 10th of the month following the last month of coverage. Premiums for any month following the last intended month of coverage will not be refunded unless notice of termination is received by the **alliance** on or before the 10th of that month. (Note: If the 10th of the month falls on a weekend or holiday, the documentation must be received by the **alliance**, or delivered to its post office box, before 5:00 pm on the next business day.)

[13.10.11.28 NMAC - N, 6-1-01]

13.10.11.29 FAMILY COVERAGE:

A. Family coverage must be offered for:

(1) the employee's lawful spouse;

(2) the employee's natural-born or legally adopted unmarried child;

(3) the employee's stepchild who is living in the employee's home and is chiefly dependent on the employee for support; and

(4) a child who is living in the employee's home and for whom the employee or his or her spouse has been appointed the legal guardian by a state court of competent jurisdiction.

B. Family coverage must be offered to the family of an employee who is not eligible for coverage because of his or her eligibility for medicare, provided that the dependents enrolling meet the timely enrollment requirements set forth in 13.10.11.27 NMAC.

C. Coverage of a dependent unmarried individual terminates on the first day of the month following the date when the individual becomes 26.

(1) Attainment of the limiting age does not terminate coverage of a dependent child as a dependent when the individual continues to be incapable of self-sustaining employment by reason of mental retardation or physical handicap and is primarily dependent upon the employee or primary insured for support and maintenance.

(2) A dependent child aged 26 or older is not eligible to enroll, even if that child became disabled prior to attaining that age unless coverage is required under the "no-loss, no-gain" rules for replacement group policies set forth in 13.10.5 NMAC, Group Coverage Discontinuance and Replacement.

D. A newly born child of the family member or the individual in whose name the **alliance** coverage is issued must be covered from birth if enrolled within 31 days of birth. If payment of a specific premium is required to provide coverage for the child, the particular policy or plan may require that notification of the birth of a child and payment of the required premium shall be furnished to the carrier within 31 days after the date of birth in order to have the coverage from birth.

E. Adopted children are eligible for coverage on the same basis as other dependents. Coverage shall be effective from the date of placement (i.e., physical custody) for the purpose of adoption, if the child is enrolled and any additional premium is paid within 31 days from such date. Coverage continues unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.

F. Coverage of children is subject to all requirements of federal and state law, including but not limited to the requirements of Sections 59A-22-34.2 and 59A-46-38.1 NMSA 1978.

G. A dependent is not eligible for coverage if the dependent would be ineligible as an employee under Subsection B of 13.10.11.21 NMAC.

[13.10.11.29 NMAC - N, 6-1-01; A, 3-31-08; A, 8-15-12]

13.10.11.30 PRE-EXISTING CONDITION EXCLUSIONS:

A. Definitions. As used in this section:

(1) **pre-existing condition** 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;

(2) **creditable coverage** means, with respect to an individual, coverage of the individual pursuant to:

(a) an employment-based group health plan;

(b) health insurance coverage;

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

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

(e) 10 USCA Chapter 55 (military benefits);

(f) a medical care program of the Indian Health Service or of an Indian nation, tribe or pueblo;

(g) the Comprehensive Health Insurance Pool Act (CHIP);

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

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

(j) a health benefit plan offered pursuant to section 5(e) of the federal Peace Corps Act; and

(3) **enrollment date** means the date of enrollment of the individual in the **alliance** plan or, if earlier, the first day of the waiting period for that enrollment.

B. Allowable provisions.

(1) An **alliance** indemnity plan may include a pre-existing condition exclusion only if the exclusion relates to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was actually recommended or received within the six-month period ending on the enrollment date.

(a) The pre-existing condition exclusion cannot extend for more than six months from the enrollment date.

(b) The period of the pre-existing condition exclusion must be reduced on a day-for-day basis by the aggregate of the periods of creditable coverage applicable to the employee or dependent as of the enrollment date.

(2) An HMO plan issued through the **alliance** may not include a pre-existing condition exclusion.

C. Prohibited applications. No pre-existing condition exclusion may be imposed:

(1) on a child who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage; or

(2) on a child who is adopted or placed for adoption before his 18th birthday and who, as of the last day of the 30-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.

[13.10.11.30 NMAC - N, 6-1-01]

13.10.11.31 CONTINUATION COVERAGE:

A. In addition to continuation coverage under the act, other forms of continuation coverage may be available under federal law or other provisions of state law. Details of these other programs may be obtained from an employer, an agent, or the insurance division. With respect to continuation of coverage provided under the act:

(1) An employee is eligible for continuation coverage under the act only if the employee has been continuously covered under an **alliance** plan as an active employee for at least six months, even if the employer group ceases to do business or terminates its group coverage under the **alliance**. If the employee has family coverage, this coverage would continue as well, provided other conditions of eligibility continue to be met. An employee must apply for continuation coverage through the **alliance** within 31 days of the loss of his or her eligibility for group coverage through the **alliance**.

(2) A covered dependent is eligible for individual continuation coverage under the Alliance Act only if the dependent has been continuously covered under an **alliance** plan as a dependent of an active employee for at least six months, and then only if the dependent applies for continuation coverage within 31 days of:

(a) the death of the employee;

(b) the divorce, annulment or dissolution of marriage or legal separation of the spouse from the employee;

(c) termination of the employee's employment for any reason, including the termination of the employer's group coverage or dissolution of the group; or

(d) for covered dependent children, upon attainment of the limiting age of 26, as provided in Subsection C of 13.10.11.29 NMAC.

(e) a covered dependent may not continue coverage if, at the time of the qualifying event specified above, the employee himself is covered under continuation coverage; provided that a spouse and any dependent children may continue coverage if the qualifying event is the death of the continuee.

(3) No person is eligible to enroll or to remain on continuation coverage if he or she resides outside of the United States for a period of over six months or, if continuation coverage under this section became effective after the effective date of this rule, he or she either moves from the state of New Mexico or resides outside of the state of New Mexico for a period of over six months.

(4) Continuation coverage under the act is considered to be individual coverage for purposes of state and federal law. Persons electing to continue coverage under the act shall be subject to the provisions of 13.10.11.34 NMAC. Premiums for this continuation coverage shall be calculated at individual coverage rates.

B. An individual who is eligible for and elects COBRA continuation shall remain on the small employer's plan as required by COBRA; COBRA rights shall be administered by the small employer who shall be responsible for collecting premiums and submitting them to the **alliance**. An individual who is eligible for state six-month continuation may elect to remain on the group plan for the continuation period provided that the plan itself continues and appropriate premiums

are submitted through the small employer. The **alliance** does not list bill. An individual may move to an individual plan at any time during the continuation period; provided, however, that any COBRA continuee who moves to an individual plan after the effective date of this rule shall be deemed to be covered as an individual and not as a COBRA continuee as of the date of his or her enrollment in the individual plan.
[13.10.11.31 NMAC - N, 6-1-01; A, 8-15-12]

13.10.11.32 COVERAGE OF OUT-OF-COUNTRY SERVICES: Services provided outside of the United States will be covered only if they are for emergency treatment.
[13.10.11.32 NMAC - N, 6-1-01]

13.10.11.33 CHANGES TO COVERAGE: A group must select one carrier (member) for all participants as of the effective date of the group coverage. A group may only change carriers and plan design, (e.g., level of deductible or co-pay/co-insurance), at the group's anniversary date. All changes must be received by the **alliance** by the 15th day of the month prior to the group's anniversary date. (Note: If the 15th of the month falls on a weekend or holiday, the documentation must be received by the **alliance**, or delivered to its post office box, before 5:00 p.m. on the next business day.)
[13.10.11.33 NMAC - N, 6-1-01]

13.10.11.34 INDIVIDUAL COVERAGE:

A. Eligibility as an individual.

(1) An individual is eligible for an **alliance** plan outside of a small employer if:

(a) as of the date of application for coverage the individual is a resident of the state of New Mexico and has an aggregate of 18 or more months of creditable coverage, as defined in the act, provided that during this period the individual did not have a break in creditable coverage lasting 95 days or longer; and either

(i) the individual's most recent coverage was under a group health plan, governmental plan or church plan, or

(ii) the individual was covered by a group health plan, governmental plan or church plan less than 95 days prior to the date the individual applies for coverage through the **alliance**;

(b) the individual is a resident of the state of New Mexico and is entitled to continuation coverage under the act, as provided in 13.10.11.31 NMAC;

(c) the individual is a resident of the state of New Mexico and his coverage has been terminated pursuant to the provisions of Section 59A-23E-14 NMSA 1978 (i.e., when a carrier has withdrawn from the small group market) or Section 59A-23E-19 NMSA 1978 (i.e., when a carrier has withdrawn from the individual market).

(2) The **alliance** may require the individual to provide an affidavit, signed under oath, stating that the individual is or will be a resident of the state of New Mexico as of the effective date of coverage.

(3) Notwithstanding the foregoing, an individual is not eligible for coverage if the coverage is being paid for or reimbursed by the individual's employer, unless the individual is either self-employed or employed by his own corporation and in either case has no other employees, or if on the effective date of coverage the individual:

(a) has or is eligible for coverage under a group health plan, as defined in the Alliance Act;

(b) is eligible for coverage under medicare or medicaid;

(c) has other health insurance coverage as defined by Subsection R of Section 59A-23E-2 NMSA 1978 (which is not terminating);

(d) was terminated from the most recent coverage within the coverage period described in Paragraph 1 of Subsection A of 13.10.11.34 NMAC as a result of nonpayment of premium or fraud*;* or

(e) has been offered the option of coverage under a COBRA continuation provision or a similar state program (other than through the **alliance**), and either did not elect or did not exhaust the coverage available under the offered program.

(4) An individual may elect to obtain coverage for his or her eligible dependents under an individual plan. The requirements of 13.10.11.29 NMAC shall apply to the eligibility and enrollment of dependents under individual coverage.

(5) A covered dependent is eligible for individual continuation coverage under the act only if the dependent has been continuously covered under an **alliance** plan as a dependent of a covered individual for at least six months, and then only if the dependent applies for continuation coverage within 31 days of:

(a) the death of the individual;

(b) the divorce, annulment or dissolution of marriage or legal separation of the spouse from the individual; or

(c) for covered dependent children, upon attainment of the limiting age of 26, as provided in Subsection C of 13.10.11.29 NMAC.

(6) No person is eligible to enroll or to remain on continuation coverage if he or she resides outside of the United States for a period of over six months or, if continuation coverage under this section became effective after the effective date of this rule, he or she moves from the state of New Mexico or resides outside of the state of New Mexico for a

period of over six months.

(7) Continuation coverage under the act is considered to be individual coverage for purposes of state and federal law. Persons electing to continue coverage under the act shall be subject to the provisions of 13.10.11.34 NMAC. Premiums for this continuation coverage shall be calculated at individual coverage rates.

B. Effective date.

(1) If the documentation required by the **alliance** is received by the 15th of the month, coverage shall be reviewed for an effective as of the first day of the following month. If the complete documentation required by the **alliance** is received after the 15th of the month, coverage shall be not be effective until the first day of the month after the month following that in which the documentation is received. (If the 15th of the month falls on a weekend or holiday, the documentation must be received by the **alliance**, or delivered to its post office box, before 5:00 p.m. on the next business day.)

(2) The effective date of a continuee's individual coverage shall be the first of the month following termination of the individual's group coverage through the **alliance** provided the required documentation is received.

C. Renewability.

(1) Coverage under an **alliance** plan for an individual can be terminated or non-renewed only in the event of the following:

(a) the individual loses eligibility by residing outside of the state of New Mexico for a period of over six months, and the individual:

(i) obtained individual coverage through the **alliance** after the date on which this residency requirement first became effective; and

(ii) is not covered as a continuee under state six-month continuation; termination under this paragraph is allowed if the individual is covered under 13.10.11.31 NMAC.

(b) nonpayment of premium;

(c) fraud; or

(d) termination of the plan.

(2) If coverage under an **alliance** plan is terminated or not renewed because of termination of the plan, the individual shall have the right to transfer to any other **alliance** plan. If the individual's coverage terminates for any reason, covered dependents shall be given the opportunity to obtain conversion coverage directly from the member.

D. HMO service area requirements. In order to be eligible to enroll in an **alliance** plan offered by an HMO, an individual must live or work within the HMO's service area. The HMO may approve exceptions on an individual basis in accordance with the HMO's usual business practice. If the individual moves from the service area, the individual may enroll in the HMO's affiliated indemnity plan offered through the **alliance**.

E. Coverage of out-of-country services. Services provided outside of the United States will be covered only if they are for emergency treatment.

F. Pre-existing condition exclusions. An individual or dependent enrolling for individual coverage shall not be subject to any pre-existing condition exclusion.

G. Individual rates. Premium rates for individuals, including **alliance** continuees, shall be based on the age of the individual on the effective date of the individual or continuation coverage. Rates, excepting age-based increases or tier changes, shall be guaranteed for 12 months from that effective date and from each annual anniversary thereafter. Any applicable age-based increase shall not be considered a violation of the guarantee and shall become effective on the first of the month following the individual's birthday. Any applicable tier-change increase shall not be considered a violation of the guarantee and shall become effective on the first of the month in which the change in dependents becomes effective. Changes in premiums for renewal periods shall take effect on the anniversary of the effective date of individual or continuation coverage.

H. Plan selection. Individuals must select a carrier (member) as of the effective date of individual coverage and may not thereafter change carriers except on the annual anniversary of the effective date of individual coverage or if the carrier withdraws from participation in the **alliance**. An individual may change plan design, e.g., level of deductible or co-pay/co-insurance, as of any annual anniversary of the effective date of individual coverage.

[13.10.11.34 NMAC - N, 6-1-01; A, 3-31-08; A, 8-15-12]

13.10.11.35 CERTIFICATES OF CREDITABLE COVERAGE: Members shall be responsible for issuing certificates of creditable coverage for groups and individuals. A member may transfer this responsibility to an individual group only by means of a written agreement signed by both parties. The member may charge a reasonable fee for such service, subject to the approval of the **alliance**.

[13.10.11.35 NMAC - N, 6-1-01; A, 3-31-08]

HISTORY OF 13.10.11 NMAC:

13.10.11 NMAC, Health Insurance Alliance Plan of Operation and Eligibility Criteria, effective 6-1-01.