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AN ACT

RELATING TO INSURANCE; AMENDING SECTIONS OF THE NEW MEXICO INSURANCE CODE, THE SMALL GROUP RATE AND RENEWABILITY ACT, THE HEALTH INSURANCE PORTABILITY ACT, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO ALIGN PROVISIONS RELATING TO THE ACCESSIBILITY OF HEALTH CARE COVERAGE TO FEDERAL LAW; ENACTING NEW SECTIONS OF THE NEW MEXICO INSURANCE CODE TO REQUIRE THE SUPERINTENDENT OF INSURANCE TO SEEK FEDERAL HEALTH COVERAGE ACCESS AND AFFORDABILITY WAIVER AUTHORIZATION AND FUNDING AND TO EXCEPT CERTAIN PLANS.

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

SECTION 1. Section 59A-18-13.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 26, as amended) is amended to read:

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

A. Every insurer, fraternal benefit society, multiple employer welfare arrangement, 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, geographic area of the place of employment and smoking practices, except that for individual policies the rating factor of the individual's place of

1 residence may be used instead of the geographic area of the
2 individual's place of employment.

3 B. Separately for an insurer's individual and
4 group policies, no person's rate shall exceed the rate of any
5 other person with similar family composition by more than two
6 hundred fifty percent of the lower rate, except that the
7 rates for children under nineteen years of age or children
8 nineteen to twenty-five years of age who are full-time
9 students may have rates that are lower than the bottom rates
10 in the two hundred fifty percent band. The rating factor
11 restrictions shall not prohibit an insurer, multiple employer
12 welfare arrangement, fraternal benefit society, health
13 maintenance organization or nonprofit health care plan from
14 offering rates that differ depending upon family composition.
15 For the purposes of this subsection, "family composition"
16 refers only to whether coverage covers an individual or a
17 family.

18 C. The provisions of this section do not preclude
19 an insurer, multiple employer welfare arrangement, fraternal
20 benefit society, health maintenance organization or nonprofit
21 health care plan from using health status or occupational or
22 industry classification in establishing the amount a large
23 group health benefits plan may be charged for coverage.

24 D. As used in Subsection C of this section,
25 "health status" does not include genetic information.

1 E. The superintendent shall adopt regulations to
2 implement the provisions of this section."

3 SECTION 2. Section 59A-18-16 NMSA 1978 (being Laws
4 1984, Chapter 127, Section 345.1, as amended) is amended to
5 read:

6 "59A-18-16. CONTINUATION OF COVERAGE AND CONVERSION
7 RIGHTS--ACCIDENT AND HEALTH INSURANCE POLICIES--NOTICE.--
8 Subject to the provisions of the Health Insurance Portability
9 Act:

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

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

20 (2) if a group policy:

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

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

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

14 B. the right to a continuation of coverage or
15 conversion pursuant to this section shall not exist with
16 respect to any member or employee of the group insured or any
17 covered family member in the event the coverage terminates
18 for nonpayment of premium, nonrenewal of the policy or the
19 expiration of the term for which the policy is issued. With
20 respect to any member or employee of the group insured or any
21 covered family member who is eligible for medicare or any
22 other similar federal or state health insurance program, the
23 right to a continuation of coverage or conversion shall be
24 limited to coverage under a medicare supplement insurance
25 policy as defined by the rules and regulations adopted by the

1 superintendent;

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

19 D. at the time of inception of coverage, the
20 insurer shall furnish to each covered family member who is
21 eighteen years of age or over and to each employee or member
22 of the group insured a statement setting forth in summary
23 form the continuation of coverage and conversion provisions
24 of the policy;

25 E. the insurer shall notify in writing each

1 employee or member, upon that employee's or member's
2 termination of employment or membership with the group
3 insured, of the continuation and conversion provisions of the
4 policy. The employer may give the written notice specified
5 herein. The employer should notify the insurer of the
6 employee's or member's change of status and last known
7 address. Under no circumstances shall the employer have any
8 civil liability under the conversion provisions of the
9 Insurance Code;

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

18 G. coverage shall be provided through continuation
19 or conversion without additional evidence of insurability and
20 shall not impose any preexisting condition, limitations or
21 other contractual time limitations;

22 H. benefits otherwise payable under a converted or
23 separate policy may be reduced so they are not, during the
24 first policy year of the converted or separate policy, in
25 excess of those that would have been payable under the policy

1 from which conversion is exercised. Benefits, if any,
2 otherwise payable under a converted or separate policy are
3 not payable for a loss claimed under the policy from which
4 conversion is exercised; and

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

9 SECTION 3. Section 59A-18-16.2 NMSA 1978 (being Laws
10 2011, Chapter 144, Section 12) is amended to read:

11 "59A-18-16.2. HEALTH INSURANCE OR HEALTH PLAN FORM AND
12 RATE FILINGS--SUPERINTENDENT--RULEMAKING--COMPLIANCE WITH
13 FEDERAL LAW.--

14 A. A small group health plan and a health
15 insurance issuer or multiple employer welfare arrangement
16 offering a small group or individual health insurance plan
17 that provides benefits other than excepted benefits shall:

18 (1) provide the essential health benefits
19 defined by the superintendent under Subsection B of this
20 section;

21 (2) limit cost sharing for such coverage in
22 accordance with Subsection D of this section; and

23 (3) provide coverage without cost sharing
24 for preventive benefits in accordance with Subsection E of
25 this section.

1 B. The superintendent shall define by rule the
2 essential health benefits package to include at least the
3 following general categories and the items and services
4 covered within the categories:

- 5 (1) ambulatory patient services;
- 6 (2) emergency services;
- 7 (3) hospitalization;
- 8 (4) maternity and newborn care;
- 9 (5) mental health and substance use disorder
10 services, including behavioral health treatment;
- 11 (6) prescription drugs;
- 12 (7) rehabilitative and habilitative services
13 and devices;
- 14 (8) laboratory services;
- 15 (9) preventive and wellness services and
16 chronic disease management; and
- 17 (10) pediatric services, including oral and
18 vision care.

19 C. In defining the essential health benefits
20 pursuant to Subsection B of this section, the superintendent
21 shall:

- 22 (1) ensure that such essential health
23 benefits reflect an appropriate balance among the categories
24 described in that subsection, so that benefits are not unduly
25 weighted toward any category;

1 (2) not make coverage decisions, determine
2 reimbursement rates, establish incentive programs or design
3 benefits in ways that discriminate against individuals
4 because of their age, disability or expected length of life;

5 (3) take into account the health care needs
6 of diverse segments of the population, including women,
7 children, persons with disabilities and other groups;

8 (4) ensure that health benefits established
9 as essential not be subject to denial to individuals against
10 their wishes on the basis of the individual's age or expected
11 length of life or of the individual's present or predicted
12 disability, degree of medical dependency or quality of life;

13 (5) provide that if a plan is offered
14 through the New Mexico health insurance exchange, another
15 health insurance plan offered through the New Mexico health
16 insurance exchange shall not fail to be treated as a
17 qualified health plan solely because the plan does not offer
18 coverage of benefits offered through the standalone plan that
19 are otherwise required; and

20 (6) periodically update the essential health
21 benefits under Subsection B of this section to address any
22 gaps in access to coverage or changes in the evidence base
23 identified by the superintendent.

24 D. A group health plan and a health insurance
25 issuer offering a group or individual health insurance plan

1 shall not establish a restricted lifetime or annual limit on
2 the dollar value of benefits for any participant or
3 beneficiary with respect to benefits that are essential
4 health benefits, as determined by the superintendent. The
5 provisions of this subsection shall not be construed to
6 prevent a group health plan or health insurance plan from
7 placing annual or lifetime per-beneficiary limits on specific
8 covered benefits that are not essential health benefits, to
9 the extent that these limits are otherwise permitted under
10 federal or state law.

11 E. The superintendent shall adopt and promulgate
12 rules specifying the maximum cost-sharing amounts for which
13 an insured may be held liable for payment of covered benefits
14 under any health insurance plan that provides benefits other
15 than excepted benefits, including deductibles, coinsurance,
16 copayments or similar charge, and any other expenditure
17 required of an insured individual with respect to essential
18 health benefits covered under the plan, but not including
19 premiums, balance billing amounts for non-network providers
20 or spending for non-covered services.

21 F. Any rules that the office of superintendent of
22 insurance intends to adopt and promulgate pursuant to this
23 section shall be adopted no later than the first day of
24 February of the year prior to the first plan year for which
25 the rules would be effective.

1 G. A group health plan and a health insurance
2 issuer offering a group or individual health insurance plan
3 that provides benefits other than excepted benefits shall
4 provide coverage for and shall not impose any cost-sharing
5 requirements for:

6 (1) items or services that have in effect a
7 rating of "A" or "B" in the current recommendations of the
8 United States preventive services task force;

9 (2) immunizations that have in effect a
10 recommendation from the advisory committee on immunization
11 practices of the federal centers for disease control and
12 prevention, with respect to the insured for which
13 immunization is considered;

14 (3) with respect to infants, children and
15 adolescents, preventive care and screenings provided for in
16 the comprehensive guidelines supported by the health
17 resources and services administration of the United States
18 department of health and human services; and

19 (4) with respect to women, additional
20 preventive care and screenings to those described in
21 Paragraph (1) of this subsection, as provided for in
22 comprehensive guidelines supported by the health resources
23 and services administration of the United States department
24 of health and human services.

25 H. The provisions of Subsection G of this section

1 shall not be construed to prohibit a health insurance plan or
2 health insurance issuer from providing coverage for services
3 in addition to those recommended by the United States
4 preventive services task force or to deny coverage for
5 services that are not described in this section. The
6 superintendent shall establish by rule a minimum interval
7 between the date on which a recommendation described in
8 Paragraphs (1) and (2) of Subsection G of this section or a
9 guideline under Paragraph (3) of Subsection G of this section
10 is issued and the plan year with respect to which the
11 requirement described in Subsection G of this section is
12 effective with respect to the service described in such
13 recommendation or guideline; provided that the interval shall
14 not be less than one year from the date the federal
15 recommendation or guideline is published.

16 I. If a health insurance plan is offered as a
17 qualified health plan through the New Mexico health insurance
18 exchange, the insurer offering the qualified health plan
19 shall also offer that plan through the health insurance
20 exchange as a plan that restricts enrollment to individuals
21 who, as of the beginning of a plan year, have not attained
22 the age of twenty-one years.

23 J. The superintendent shall adopt rules:

24 (1) to define terms used regarding forms,
25 rates, reviews and blocks of business that an insurer or

1 health care plan submits in filing matters;

2 (2) to govern any additional filing
3 requirements the superintendent deems appropriate;

4 (3) to provide notice of hearings and the
5 grounds on which the hearings have been requested;

6 (4) to meet criteria for review in
7 accordance with federal law; and

8 (5) that the superintendent deems
9 appropriate to carry out the provisions of Chapter 59A,
10 Article 18 NMSA 1978.

11 K. Except as provided by state or federal rule or
12 law, nothing in this section shall be construed to prohibit a
13 health insurance carrier from appropriately using reasonable
14 health care cost management techniques.

15 L. As used in this section, "excepted benefits"
16 means benefits furnished pursuant to the following:

17 (1) coverage-only accident or disability
18 income insurance;

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

21 (3) liability insurance;

22 (4) workers' compensation or similar
23 insurance;

24 (5) automobile medical payment insurance;

25 (6) credit-only insurance;

1 (7) coverage for on-site medical clinics;

2 (8) other similar insurance coverage

3 specified in regulations under which benefits for medical

4 care are secondary or incidental to other benefits;

5 (9) the following benefits if offered

6 separately:

7 (a) limited scope dental or vision

8 benefits;

9 (b) benefits for long-term care,

10 nursing home care, home health care, community-based care or

11 any combination of those benefits; and

12 (c) other similar limited benefits

13 specified in regulations;

14 (10) the following benefits, offered as

15 independent noncoordinated benefits:

16 (a) coverage only for a specified

17 disease or illness; or

18 (b) hospital indemnity or other fixed

19 indemnity insurance; and

20 (11) the following benefits if offered as a

21 separate insurance policy:

22 (a) medicare supplemental health

23 insurance as defined pursuant to Section 1882(g)(1) of the

24 Social Security Act; and

25 (b) coverage supplemental to the

1 coverage provided pursuant to Chapter 55 of Title 10 USCA and
2 similar supplemental coverage provided to coverage pursuant
3 to a group health plan."

4 SECTION 4. Section 59A-22-5 NMSA 1978 (being Laws 1984,
5 Chapter 127, Section 426, as amended) is amended to read:

6 "59A-22-5. TIME LIMIT ON CERTAIN DEFENSES.--

7 A. There shall be a provision for comprehensive
8 major medical policies as follows: As of the date of issue
9 of this policy, no misstatements, except willful or
10 fraudulent misstatements, made by the applicant in the
11 application for this policy shall be used to void the policy
12 or to deny a claim for loss incurred or disability (as
13 defined in the policy). In the event a misstatement in an
14 application is made that is not fraudulent or willful, the
15 issuer of the policy may prospectively rate and collect from
16 the insured the premium that would have been charged to the
17 insured at the time the policy was issued had such
18 misstatement not been made.

19 B. There shall be a provision for policies other
20 than comprehensive major medical policies as follows: After
21 two years from the date of issue of this policy, no
22 misstatements, except fraudulent misstatements, made by the
23 applicant in the application for this policy shall be used to
24 void the policy or to deny a claim for loss incurred or
25 disability (as defined in the policy) commencing after the

1 expiration of such two-year period.

2 C. The foregoing policy provisions shall not be so
3 construed as to affect any initial two-year period nor to
4 limit the application of Sections 59A-22-17 through
5 59A-22-19, 59A-22-21 and 59A-22-22 NMSA 1978 in the event of
6 misstatement with respect to age or occupation or other
7 insurance.

8 D. A policy that the insured has the right to
9 continue in force subject to its terms by the timely payment
10 of premium (1) until at least age fifty or (2) in the case of
11 a policy issued after age forty-four, for at least five years
12 from its date of issue, may contain in lieu of the foregoing
13 the following provision, from which the clause in parentheses
14 may be omitted at the insurance company's option, under the
15 caption "Incontestable":

16 After this policy has been in force for a period of two
17 years during the lifetime of the insured (excluding any
18 period during which the insured is disabled), it shall become
19 incontestable as to the statements contained in the
20 application."

21 **SECTION 5.** Section 59A-23C-5.1 NMSA 1978 (being Laws
22 1994, Chapter 75, Section 33, as amended) is amended to read:

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

24 A. A health benefit plan that is offered by a
25 carrier to a small employer shall be offered without regard

1 to the health status of any individual in the group, except
2 as provided in the Small Group Rate and Renewability Act.

3 The only rating factors that may be used to determine the
4 initial year's premium charged a group, subject to the
5 maximum rate variation provided in this section for all
6 rating factors, are the group members':

7 (1) ages;

8 (2) geographic areas of the place of
9 employment; or

10 (3) smoking practices.

11 B. Separately for an insurer's individual and
12 group policies, no person's rate shall exceed the rate of
13 any other person with similar family composition by more than
14 two hundred fifty percent of the lower rate, except that the
15 rates for children under nineteen years of age or children
16 nineteen to twenty-five years of age who are full-time
17 students may have rates that are lower than the bottom rates
18 in the two hundred fifty percent band. The rating factor
19 restrictions shall not prohibit an insurer, multiple employer
20 welfare arrangement, fraternal benefit society, health
21 maintenance organization or nonprofit health care plan from
22 offering rates that differ depending upon family composition.
23 For the purposes of this subsection, "family composition"
24 refers only to whether coverage covers an individual or a
25 family.

1 C. The superintendent shall adopt and promulgate
2 rules to implement the provisions of this section."

3 **SECTION 6.** Section 59A-23C-7 NMSA 1978 (being Laws
4 1991, Chapter 153, Section 7) is amended to read:

5 "59A-23C-7. DISCLOSURE OF RATING PRACTICES AND
6 RENEWABILITY PROVISIONS.--Each small employer carrier shall
7 make reasonable disclosure in solicitation and sales
8 materials provided to small employers of the following:

9 A. the provisions concerning the carriers' right
10 to change premium rates and the factors that affect changes
11 in premium rates; and

12 B. the provisions relating to renewability of
13 coverage."

14 **SECTION 7.** Section 59A-23E-2 NMSA 1978 (being Laws
15 1997, Chapter 243, Section 2, as amended) is amended to read:

16 "59A-23E-2. DEFINITIONS.--As used in the Health
17 Insurance Portability Act:

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

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

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

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

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

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

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

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

16 D. "church plan" means that term as defined
17 pursuant to Section 3(33) of the federal Employee Retirement
18 Income Security Act of 1974;

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

21 F. "COBRA continuation provision" means:

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

25 (2) Part 6 of Subtitle B of Title 1 of the

1 federal Employee Retirement Income Security Act of 1974

2 except for Section 609 of that part; or

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

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

7 (1) a group health plan;

8 (2) health insurance coverage;

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

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

14 (5) 10 USCA Chapter 55;

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

17 (7) the Medical Insurance Pool Act;

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

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

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

24 H. "employee" means that term as defined in
25 Section 3(6) of the federal Employee Retirement Income

1 Security Act of 1974;

2 I. "employer" means:

3 (1) a person who is an employer as that term
4 is defined in Section 3(5) of the federal Employee Retirement
5 Income Security Act of 1974, and who employs two or more
6 employees; and

7 (2) a partnership in relation to a partner
8 pursuant to Section 59A-23E-17 NMSA 1978;

9 J. "employer contribution rule" means a
10 requirement relating to the minimum level or amount of
11 employer contribution toward the premium for enrollment of
12 participants and beneficiaries;

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

18 L. "excepted benefits" means benefits furnished
19 pursuant to the following:

20 (1) coverage only accident or disability
21 income insurance;

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

24 (3) liability insurance;

25 (4) workers' compensation or similar

1 insurance;

2 (5) automobile medical payment insurance;

3 (6) credit-only insurance;

4 (7) coverage for on-site medical clinics;

5 (8) other similar insurance coverage

6 specified in regulations under which benefits for medical

7 care are secondary or incidental to other benefits;

8 (9) the following benefits if offered

9 separately:

10 (a) limited scope dental or vision

11 benefits;

12 (b) benefits for long-term care,

13 nursing home care, home health care, community-based care or

14 any combination of those benefits; and

15 (c) other similar limited benefits

16 specified in regulations;

17 (10) the following benefits, offered as

18 independent noncoordinated benefits:

19 (a) coverage only for a specified

20 disease or illness; or

21 (b) hospital indemnity or other fixed

22 indemnity insurance; and

23 (11) the following benefits if offered as a

24 separate insurance policy:

25 (a) medicare supplemental health

1 insurance as defined pursuant to Section 1882(g)(1) of the
2 Social Security Act; and

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

7 M. "federal governmental plan" means a
8 governmental plan established or maintained for its employees
9 by the United States government or an instrumentality of that
10 government;

11 N. "governmental plan" means that term as defined
12 in Section 3(32) of the federal Employee Retirement Income
13 Security Act of 1974 and includes a federal governmental
14 plan;

15 O. "group health insurance coverage" means health
16 insurance coverage offered in connection with a group health
17 plan or any other health insurance subject to the provisions
18 of Chapter 59A, Article 23 NMSA 1978;

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

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

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

14 S. "health insurance issuer" means an insurance
15 company, insurance service or insurance organization,
16 including a health maintenance organization, that is licensed
17 to engage in the business of insurance in the state and that
18 is subject to state law that regulates insurance within the
19 meaning of Section 514(b)(2) of the federal Employee
20 Retirement Income Security Act of 1974, but "health insurance
21 issuer" does not include a group health plan;

22 T. "health maintenance organization" means:

23 (1) a federally qualified health maintenance
24 organization;

25 (2) an organization recognized pursuant to

1 state law as a health maintenance organization; or

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

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

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

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

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

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

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

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

6 (2) a special enrollment period pursuant to
7 Sections 59A-23E-8 and 59A-23E-9 NMSA 1978;

8 AA. "medical care" means:

9 (1) services consisting of the diagnosis,
10 cure, mitigation, treatment or prevention of human disease or
11 provided for the purpose of affecting any structure or
12 function of the human body; and

13 (2) transportation services primarily for
14 and essential to provision of the services described in
15 Paragraph (1) of this subsection;

16 BB. "network plan" means health insurance coverage
17 of a health insurance issuer under which the financing and
18 delivery of medical care are provided through a defined set
19 of providers under contract with the issuer;

20 CC. "nonfederal governmental plan" means a
21 governmental plan that is not a federal governmental plan;

22 DD. "participant" means:

23 (1) that term as defined in Section 3(7) of
24 the federal Employee Retirement Income Security Act of 1974;

25 (2) a partner in relationship to a

1 partnership in connection with a group health plan maintained
2 by the partnership; and

3 (3) a self-employed individual in connection
4 with a group health plan maintained by the self-employed
5 individual;

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

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

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

22 HH. "small employer" means, in connection with a
23 group health plan and with respect to a calendar year and a
24 plan year, an employer who employed an average of at least
25 two but not more than fifty employees on business days during

1 the preceding calendar year and who employs at least two
2 employees on the first day of the plan year;

3 II. "small group market" means the health
4 insurance market under which individuals obtain health
5 insurance coverage through a group health plan maintained by
6 a small employer;

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

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

15 SECTION 8. Section 59A-23E-3 NMSA 1978 (being Laws
16 1997, Chapter 243, Section 3, as amended) is amended to read:

17 "59A-23E-3. LIMITATION ON PREEXISTING CONDITION
18 EXCLUSION PERIOD.--A health insurance issuer or health
19 benefits plan offering group health insurance, blanket health
20 insurance or individual health insurance shall not impose any
21 preexisting condition exclusion with respect to that health
22 insurance plan or coverage. A health insurance issuer or
23 health insurance plan offering group health insurance,
24 blanket health insurance or individual health insurance shall
25 not impose a waiting period in excess of ninety days with

1 respect to a health insurance plan or coverage."

2 SECTION 9. Section 59A-23E-8 NMSA 1978 (being Laws
3 1997, Chapter 243, Section 8, as amended) is amended to read:

4 "59A-23E-8. GROUP HEALTH PLAN--GROUP HEALTH
5 INSURANCE--SPECIAL ENROLLMENT PERIODS FOR INDIVIDUALS LOSING
6 OTHER COVERAGE.--

7 A. A group health plan and a health insurance
8 issuer offering group health insurance coverage in connection
9 with a group health plan shall permit an employee who is
10 eligible but not enrolled for coverage under the terms of the
11 plan, or a dependent of the employee if the dependent is
12 eligible but not enrolled for coverage, to enroll for
13 coverage under the terms of the plan if:

14 (1) the employee or dependent was covered
15 under a group health plan or had health insurance coverage at
16 the time coverage was previously offered to the employee or
17 dependent;

18 (2) the employee stated in writing at the
19 time coverage was offered that coverage under a group health
20 plan or health insurance coverage was the reason for
21 declining enrollment, but only if the plan sponsor or issuer
22 required such a statement at the time and provided the
23 employee with notice of that requirement and the consequences
24 of the requirement at the time;

25 (3) the employee's or dependent's coverage

1 described in Paragraph (1) of this subsection was:

2 (a) under a COBRA continuation
3 provision and the coverage under that provision was
4 exhausted; or

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

12 (4) under the terms of the plan, the
13 employee requested enrollment not later than thirty days
14 after the date of exhaustion of coverage described in
15 Subparagraph (a) of Paragraph (3) of this subsection or
16 termination of coverage or employer contribution described in
17 Subparagraph (b) of Paragraph (3) of this subsection.

18 B. A group health plan or a health insurance
19 issuer offering group health insurance plan coverage shall
20 permit an eligible enrollee to enroll for coverage under the
21 terms of the plan if either of the following conditions is
22 met:

23 (1) the eligible enrollee's medical
24 assistance provided pursuant to the Public Assistance Act is
25 terminated; or

1 (2) the eligible enrollee becomes eligible
2 for medical assistance, with respect to coverage under the
3 group health plan or health insurance plan, under such
4 medicaid plan or state child health plan, including under any
5 waiver or demonstration project conducted under or in
6 relation to such a plan, if the employee requests coverage
7 under the group health plan or health insurance plan not
8 later than sixty days after the date the employee or
9 dependent is determined to be eligible for such assistance.

10 C. As used in this section, "eligible enrollee"
11 means an employee or dependent of an employee who is
12 eligible, but not enrolled, for coverage under the terms of
13 an employer's group health plan."

14 SECTION 10. Section 59A-23E-11 NMSA 1978 (being Laws
15 1997, Chapter 243, Section 11, as amended) is amended to
16 read:

17 "59A-23E-11. PROHIBITING DISCRIMINATION BASED ON HEALTH
18 STATUS AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES.--A
19 group health plan and a health insurance issuer offering
20 group or individual health insurance coverage shall not
21 establish rules for eligibility or continued eligibility of
22 any individual to enroll or continue to participate in a
23 health plan, or eligibility or continued eligibility for
24 benefits, based on any of the following factors in relation
25 to the individual or a dependent of the individual:

- 1 A. health status;
- 2 B. medical condition, including both physical and
- 3 mental illnesses;
- 4 C. claims experience;
- 5 D. receipt of health care;
- 6 E. medical history;
- 7 F. genetic information;
- 8 G. evidence of insurability, including conditions
- 9 arising out of acts of domestic violence;
- 10 H. disability;
- 11 I. gender;
- 12 J. national origin;
- 13 K. sexual orientation; or
- 14 L. any other health status-related factor that the
- 15 superintendent specifies in rules of the office of
- 16 superintendent of insurance."

17 SECTION 11. Section 59A-23E-12 NMSA 1978 (being Laws
18 1997, Chapter 243, Section 12, as amended) is amended to
19 read:

20 "59A-23E-12. PROHIBITING DISCRIMINATION BASED ON HEALTH
21 STATUS AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES IN
22 PREMIUM CONTRIBUTIONS.--

23 A. A group health plan and a health insurance
24 issuer offering group or individual health insurance coverage
25 shall not require an individual as a condition of enrollment

1 or continued enrollment under the plan to pay a premium or
2 contribution that is greater than the premium or contribution
3 for a similarly situated individual enrolled in the plan on
4 the basis of the health status related factor in relation to
5 the individual or a person enrolled under the plan as a
6 dependent of the individual.

7 B. The provisions of Subsection A of this section
8 shall not be construed to:

9 (1) restrict the amount that an employer or
10 an individual may be charged for coverage under a group
11 health plan or individual health coverage; or

12 (2) prevent a group health plan or a health
13 insurance issuer offering group health insurance coverage
14 from establishing premium discounts or rebates or modifying
15 otherwise applicable copayments or deductibles in return for
16 adherence to programs of health promotion and disease
17 prevention.

18 C. A group health benefits plan or a health
19 insurance issuer that offers group health insurance coverage
20 in connection with a group health benefits plan shall not
21 adjust premiums or contribution amounts for the group covered
22 under the plan on the basis of genetic information."

23 SECTION 12. Section 59A-23E-13 NMSA 1978 (being Laws
24 1997, Chapter 243, Section 13, as amended) is amended to
25 read:

1 "59A-23E-13. HEALTH INSURANCE ISSUERS--GUARANTEED
2 AVAILABILITY OF COVERAGE--EXCEPTIONS FOR NETWORK PLANS,
3 INSUFFICIENT FINANCIAL CAPACITY AND BONA FIDE ASSOCIATIONS--
4 EMPLOYER CONTRIBUTION RULES.--

5 A. Except as provided in Subsections C through E
6 of this section, a health insurance issuer that offers health
7 insurance coverage in the individual or small group markets
8 shall:

9 (1) accept every individual or employer that
10 applies for coverage;

11 (2) accept for enrollment under the offered
12 coverage an eligible individual who applies for enrollment
13 during the period in which the individual first becomes
14 eligible to enroll under the terms of the group health plan
15 or during an open or special enrollment period as specified
16 in rules of the office of superintendent of insurance; and

17 (3) not place a restriction on an eligible
18 individual being a participant or a beneficiary that is
19 inconsistent with Sections 59A-23E-11 and 59A-23E-12 NMSA
20 1978.

21 B. The superintendent shall adopt and promulgate
22 rules relating to enrollment periods.

23 C. A health insurance issuer that offers health
24 insurance coverage in the group or individual markets through
25 a network plan may:

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

5 (2) within the service area of the network
6 plan, deny coverage to individuals or employers within the
7 service area for the network plan if the issuer has
8 demonstrated to the superintendent that it:

9 (a) will not have the capacity to
10 deliver services adequately to enrollees of any additional
11 groups or any additional individuals because of its
12 obligations to existing individuals, group contract holders
13 and enrollees; and

14 (b) is applying this exception
15 uniformly to all employers and individuals without regard to
16 the claims experience of those individuals or those
17 employers, their employees and their dependents or any health
18 status related factor relating to those individuals,
19 employees and dependents.

20 D. A health insurance issuer, upon denying
21 insurance coverage in any service area pursuant to the
22 provisions of Subsection C of this section, shall not offer
23 coverage in the group market or individual market within the
24 service area for a period of one hundred eighty days after
25 the date coverage is denied.

1 E. A health insurance issuer may deny health
2 insurance coverage in the individual and group markets if the
3 issuer has demonstrated to the superintendent that it:

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

6 (2) is applying this exception uniformly to
7 all individuals, employers and their employees in the
8 individual and group markets in the state consistent with
9 state law and without regard to the claims experience of
10 those individuals, employers, their employees and their
11 dependents or any health status related factor relating to
12 those individuals, employees and dependents.

13 F. A health insurance issuer, upon denying health
14 insurance coverage in accordance with Paragraphs (1) and (2)
15 of Subsection E of this section, shall not offer coverage in
16 the group or individual markets in the state for a period of
17 one hundred eighty days after the date the coverage is denied
18 or until the issuer has demonstrated to the superintendent
19 that the carrier has sufficient financial reserves to
20 underwrite additional coverage, whichever is later. The
21 superintendent may provide for the application of this
22 subsection on a service-area-specific basis.

23 G. As used in this section, "eligible individual"
24 means, with respect to a health insurance issuer offering an
25 individual or group health plan, an individual whose

1 eligibility shall be determined:

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

4 (2) as provided by the issuer under the
5 rules of the issuer that are uniformly applicable in the
6 state to the individual and group markets; and

7 (3) in accordance with New Mexico Insurance
8 Code provisions governing the issuer and the small group
9 market."

10 SECTION 13. Section 59A-23E-14 NMSA 1978 (being Laws
11 1997, Chapter 243, Section 14, as amended) is amended to
12 read:

13 "59A-23E-14. HEALTH INSURANCE ISSUERS--GUARANTEED
14 AVAILABILITY OF COVERAGE.--

15 A. Except as provided in Subsections B through F
16 of this section, a health insurance issuer that offers health
17 insurance coverage in the individual or group markets shall
18 renew or continue that coverage in force at the option of the
19 plan sponsor or the individual.

20 B. A health insurance issuer may refuse to renew
21 or may discontinue health insurance coverage offered pursuant
22 to Subsection A of this section if:

23 (1) the plan sponsor or individual has
24 failed to pay premiums or contributions in accordance with
25 the terms of the health insurance coverage or the issuer has

1 not received timely premium payments;

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

6 (3) the issuer is ceasing to offer
7 coverage in the market in accordance with Subsection C of
8 this section; or

9 (4) in the case of a health insurance issuer
10 that offers health insurance coverage in the market through a
11 network plan, there is no longer any enrollee in connection
12 with that plan who lives, resides or works in the service
13 area of the issuer or the area for which the issuer is
14 authorized to do business and the issuer would deny
15 enrollment with respect to the network plan pursuant to
16 Paragraph (1) of Subsection C of Section 59A-23E-13 NMSA
17 1978.

18 C. A health insurance issuer may discontinue
19 offering a particular type of individual or group health
20 insurance coverage offered in the group or individual markets
21 only if:

22 (1) the issuer provides notice to each plan
23 sponsor or individual provided coverage of this type in the
24 market and to the participants and beneficiaries covered
25 under the coverage of the discontinuation at least ninety

1 days prior to the date of the discontinuation;

2 (2) the issuer offers to a plan sponsor or
3 individual provided coverage of this type in the market the
4 option to purchase any other health insurance plan coverage
5 currently being offered by the issuer in that market; and

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

13 D. If a health insurance issuer elects to
14 discontinue offering all health insurance coverage in the
15 individual or group markets, coverage may be discontinued
16 only if:

17 (1) the issuer provides notice to the
18 superintendent and to each plan sponsor or to the individual
19 and participants and beneficiaries covered under that
20 coverage of the discontinuation at least one hundred eighty
21 days prior to the date of discontinuation; and

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

25 E. After discontinuation pursuant to Subsection D

1 of this section, the health insurance issuer shall not
2 provide for the issuance of any health insurance coverage in
3 the market involved during the five-year period beginning on
4 the date of the discontinuation of the last health insurance
5 coverage not renewed.

6 F. At the time of coverage renewal pursuant to
7 Subsection A of this section, a health insurance issuer may
8 modify the coverage for a policy form offered to a group or
9 individual if the modification is effective on a uniform
10 basis among all groups or individuals, as applicable, with
11 that policy form."

12 SECTION 14. Section 59A-23E-15 NMSA 1978 (being Laws
13 1997, Chapter 243, Section 15, as amended) is amended to
14 read:

15 "59A-23E-15. DISCLOSURE OF INFORMATION BY HEALTH
16 INSURANCE ISSUERS.--

17 A. A health insurance issuer when offering health
18 insurance coverage to an employer or individual shall:

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

23 (2) upon request of the employer or
24 individual provide the information described.

25 B. Except as provided in Subsection D of this

1 section, a health insurance issuer offering a health plan to
2 an employer or individual shall provide information pursuant
3 to Subsection A of this section concerning:

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

7 (2) the provisions of coverage relating to
8 renewability of coverage; and

9 (3) the benefits and premiums available
10 under all health insurance coverage for which the small
11 employer is qualified.

12 C. Information furnished pursuant to this section
13 shall be provided to employers or individuals in a manner
14 determined to be understandable by the average employer or
15 individual and shall be sufficient to reasonably inform
16 employers or individuals of their rights and obligations
17 under the health insurance coverage.

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

21 SECTION 15. Section 59A-23E-16 NMSA 1978 (being Laws
22 1997, Chapter 243, Section 16, as amended) is amended to
23 read:

24 "59A-23E-16. EXCLUSIONS, LIMITATIONS AND EXCEPTIONS FOR
25 CERTAIN GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE.--

1 A. The requirements of Sections 59A-23E-3 through
2 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply
3 to any group retiree health plan and health insurance
4 coverage offered in connection with a group retiree health
5 plan if, on the first day of the plan year, the plan has
6 fewer than two employees who are current employees.

7 B. The requirements of Sections 59A-23E-3
8 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 shall
9 not apply with respect to a group health plan or group
10 retiree health plan that is a nonfederal governmental plan if
11 the plan sponsor makes an election under the provisions of
12 this subsection in conformity with regulations of the federal
13 secretary of health and human services. The period of an
14 election for exclusion made pursuant to this subsection is
15 for a single specified plan year or, in the case of a plan
16 provided pursuant to a collective bargaining agreement, for
17 the term of the agreement. The plan for which an election is
18 made shall provide under the terms of the election for:

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

22 (2) certification and disclosure of
23 creditable coverage under the plan with respect to enrollees
24 in accordance with Section 59A-23E-7 NMSA 1978.

25 C. The requirements of Sections 59A-23E-3 through

1 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply
2 to a group health plan and group health insurance coverage
3 offered in connection with a group health plan in relation to
4 its provision of excepted benefits described in Paragraph (9)
5 of Subsection L of Section 59A-23E-2 NMSA 1978 if the
6 benefits are:

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

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

11 D. The requirements of Sections 59A-23E-3 through
12 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply
13 to any group health plan and group health insurance coverage
14 offered in connection with a group health plan in relation to
15 its provision of excepted benefits described in Paragraph
16 (10) of Subsection L of Section 59A-23E-2 NMSA 1978 if:

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

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

23 (3) the benefits are paid with respect to an
24 event without regard to whether benefits are provided with
25 respect to that event under any group health plan maintained

1 by the same plan sponsor.

2 E. The requirements of Sections 59A-23E-3 through
3 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply
4 to any group health plan and group health insurance coverage
5 offered in connection with a group health plan in relation to
6 its provision of excepted benefits described in Paragraph
7 (11) of Subsection L of Section 59A-23E-2 NMSA 1978 if the
8 benefits are provided under a separate policy, certificate or
9 contract of insurance."

10 SECTION 16. Section 59A-23E-18 NMSA 1978 (being Laws
11 2000, Chapter 6, Section 1) is amended to read:

12 "59A-23E-18. REQUIREMENT FOR MENTAL HEALTH BENEFITS IN
13 AN INDIVIDUAL OR GROUP HEALTH PLAN, OR GROUP HEALTH INSURANCE
14 OFFERED IN CONNECTION WITH THE PLAN, FOR A PLAN YEAR OF AN
15 EMPLOYER.--

16 A. A group health plan or group or individual
17 health insurance shall not impose treatment limitations or
18 financial restrictions, limitations or requirements on the
19 provision of mental health benefits that are more restrictive
20 than the predominant restrictions, limitations or
21 requirements that are imposed on coverage of benefits for
22 other conditions.

23 B. A group health plan or group or individual
24 health insurance offered in connection with that plan, may:

25 (1) require pre-admission screening prior to

1 the authorization of mental health benefits whether inpatient
2 or outpatient; or

3 (2) apply limitations that restrict mental
4 health benefits provided under the plan to those that are
5 medically necessary.

6 C. As used in this section, "mental health
7 benefits" means mental health benefits as described in the
8 group health plan, or group health insurance offered in
9 connection with the plan; but does not include benefits with
10 respect to treatment of substance abuse, chemical dependency
11 or gambling addiction."

12 SECTION 17. Section 59A-46-2 NMSA 1978 (being Laws
13 1993, Chapter 266, Section 2, as amended) is amended to read:

14 "59A-46-2. DEFINITIONS.--As used in the Health
15 Maintenance Organization Law:

16 A. "basic health care services" means medically
17 necessary services consisting of preventive care, emergency
18 care, inpatient and outpatient hospital and physician care,
19 diagnostic laboratory, diagnostic and therapeutic
20 radiological services and services of pharmacists and
21 pharmacist clinicians;

22 B. "capitated basis" means fixed per member per
23 month payment or percentage of premium payment wherein the
24 provider assumes the full risk for the cost of contracted
25 services without regard to the type, value or frequency of

1 services provided and includes the cost associated with
2 operating staff model facilities;

3 C. "carrier" means a health maintenance
4 organization, an insurer, a nonprofit health care plan or
5 other entity responsible for the payment of benefits or
6 provision of services under a group contract;

7 D. "copayment" means an amount an enrollee must
8 pay in order to receive a specific service that is not fully
9 prepaid;

10 E. "credentialing" means the process of obtaining
11 and verifying information about a provider and evaluating
12 that provider when that provider seeks to become a
13 participating provider;

14 F. "deductible" means the amount an enrollee is
15 responsible to pay out-of-pocket before the health
16 maintenance organization begins to pay the costs associated
17 with treatment;

18 G. "enrollee" means an individual who is covered
19 by a health maintenance organization;

20 H. "evidence of coverage" means a policy, contract
21 or certificate showing the essential features and services of
22 the health maintenance organization coverage that is given to
23 the subscriber by the health maintenance organization or by
24 the group contract holder;

25 I. "extension of benefits" means the continuation

1 of coverage under a particular benefit provided under a
2 contract or group contract following termination with respect
3 to an enrollee who is totally disabled on the date of
4 termination;

5 J. "grievance" means a written complaint submitted
6 in accordance with the health maintenance organization's
7 formal grievance procedure by or on behalf of the enrollee
8 regarding any aspect of the health maintenance organization
9 relative to the enrollee;

10 K. "group contract" means a contract for health
11 care services that by its terms limits eligibility to members
12 of a specified group and may include coverage for dependents;

13 L. "group contract holder" means the person to
14 whom a group contract has been issued;

15 M. "health care services" means any services
16 included in the furnishing to any individual of medical,
17 mental, dental, pharmaceutical or optometric care or
18 hospitalization or nursing home care or incident to the
19 furnishing of such care or hospitalization, as well as the
20 furnishing to any person of any and all other services for
21 the purpose of preventing, alleviating, curing or healing
22 human physical or mental illness or injury;

23 N. "health maintenance organization" means any
24 person who undertakes to provide or arrange for the delivery
25 of basic health care services to enrollees on a prepaid

1 basis, except for enrollee responsibility for copayments or
2 deductibles;

3 O. "health maintenance organization agent" means a
4 person who solicits, negotiates, effects, procures, delivers,
5 renews or continues a policy or contract for health
6 maintenance organization membership or who takes or transmits
7 a membership fee or premium for such a policy or contract,
8 other than for that person, or a person who advertises or
9 otherwise makes any representation to the public as such;

10 P. "individual contract" means a contract for
11 health care services issued to and covering an individual and
12 it may include dependents of the subscriber;

13 Q. "insolvent" or "insolvency" means that the
14 organization has been declared insolvent and placed under an
15 order of liquidation by a court of competent jurisdiction;

16 R. "managed hospital payment basis" means
17 agreements in which the financial risk is related primarily
18 to the degree of utilization rather than to the cost of
19 services;

20 S. "net worth" means the excess of total admitted
21 assets over total liabilities, but the liabilities shall not
22 include fully subordinated debt;

23 T. "participating provider" means a provider as
24 defined in Subsection X of this section who, under an express
25 contract with the health maintenance organization or with its

1 contractor or subcontractor, has agreed to provide health
2 care services to enrollees with an expectation of receiving
3 payment, other than copayment or deductible, directly or
4 indirectly from the health maintenance organization;

5 U. "person" means an individual or other legal
6 entity;

7 V. "pharmacist" means a person licensed as a
8 pharmacist pursuant to the Pharmacy Act;

9 W. "pharmacist clinician" means a pharmacist who
10 exercises prescriptive authority pursuant to the Pharmacist
11 Prescriptive Authority Act;

12 X. "provider" means a physician, pharmacist,
13 pharmacist clinician, hospital or other person licensed or
14 otherwise authorized to furnish health care services;

15 Y. "replacement coverage" means the benefits
16 provided by a succeeding carrier;

17 Z. "subscriber" means an individual whose
18 employment or other status, except family dependency, is the
19 basis for eligibility for enrollment in the health
20 maintenance organization or, in the case of an individual
21 contract, the person in whose name the contract is issued;
22 and

23 AA. "uncovered expenditures" means the costs to
24 the health maintenance organization for health care services
25 that are the obligation of the health maintenance

1 organization, for which an enrollee may also be liable in the
2 event of the health maintenance organization's insolvency and
3 for which no alternative arrangements have been made that are
4 acceptable to the superintendent."

5 SECTION 18. Section 59A-46-32 NMSA 1978 (being Laws
6 1984, Chapter 127, Section 876.1) is amended to read:

7 "59A-46-32. CONTINUATION OF COVERAGE AND CONVERSION
8 RIGHTS--HEALTH CARE PLANS.--

9 A. Every individual or group contract entered into
10 by a health maintenance organization and that is delivered,
11 issued for delivery or renewed in this state on or after
12 January 1, 1985 shall provide covered family members of
13 subscribers the right to continue such coverage through a
14 converted or separate contract upon the death of the
15 subscriber or upon the divorce, annulment or dissolution of
16 marriage or legal separation of the spouse from the
17 subscriber. Where a continuation of coverage or conversion
18 is made in the name of the spouse of the subscriber, such
19 coverage may, at the option of the spouse, include coverage
20 to dependent children for whom the spouse has responsibility
21 for care and support.

22 B. The right to a continuation of coverage or
23 conversion pursuant to this section shall not exist with
24 respect to any covered family member of a subscriber in the
25 event the coverage terminates for nonpayment of premium,

1 nonrenewal of the contract or the expiration of the term for
2 which the contract is issued. With respect to any covered
3 family member who is eligible for medicare or any other
4 similar federal or state health insurance program, the right
5 to a continuation of coverage or conversion shall be limited
6 to coverage under a medicare supplement insurance contract as
7 defined by the rules and regulations adopted by the
8 superintendent of insurance.

9 C. Coverage continued through the issuance of a
10 converted or separate contract shall be provided at a
11 reasonable, nondiscriminatory rate to the insured and shall
12 consist of a form of coverage then being offered by the
13 health maintenance organization as a conversion contract.
14 Continued and converted coverages shall contain renewal
15 provisions that are not less favorable to the subscriber than
16 those contained in the contract from which the conversion is
17 made, except that the person who exercises the right of
18 conversion is entitled only to have included a right to
19 coverage under a medicare supplement insurance contract, as
20 defined by the rules and regulations adopted by the
21 superintendent of insurance, after the attainment of the age
22 of eligibility for medicare or any other similar federal or
23 state health insurance program.

24 D. At the time of inception of coverage, the
25 health maintenance organization shall provide each covered

1 family member eighteen years of age or older a statement
2 setting forth in summary form the continuation of coverage
3 and conversion provisions of the subscriber's contract.

4 E. The eligible covered family member exercising
5 the continuation or conversion right must notify the health
6 maintenance organization and make payment of the applicable
7 premium within thirty days following the date such coverage
8 otherwise terminates as specified in the contract from which
9 continuation or conversion is being exercised.

10 F. Coverage shall be provided through continuation
11 or conversion without additional evidence of insurability and
12 shall not impose any preexisting condition, limitations or
13 other contractual time limitations.

14 G. Any probationary or waiting period set forth in
15 the converted or separate contract is deemed to commence on
16 the effective date of the applicant's coverage under the
17 original contract."

18 SECTION 19. Section 59A-47-34 NMSA 1978 (being Laws
19 1984, Chapter 127, Section 879.33) is amended to read:

20 "59A-47-34. CONTINUATION OF COVERAGE AND CONVERSION
21 RIGHTS--HEALTH CARE PLANS.--

22 A. Every individual or group contract entered into
23 by a health care plan that provides for health care expense
24 payments on a service benefit basis or an indemnity benefit
25 basis or both and that is delivered, issued for delivery or

1 renewed in this state on or after July 1, 1984 shall provide
2 covered family members of subscribers the right to continue
3 such coverage through a converted or separate contract upon
4 the death of the subscriber or upon the divorce, annulment or
5 dissolution of marriage or legal separation of the spouse
6 from the subscriber. Where a continuation of coverage or
7 conversion is made in the name of the spouse of the
8 subscriber, such coverage may, at the option of the spouse,
9 include coverage to dependent children for whom the spouse
10 has responsibility for care and support.

11 B. The right to a continuation of coverage or
12 conversion pursuant to this section shall not exist with
13 respect to any covered family member of a subscriber in the
14 event the coverage terminates for nonpayment of premium,
15 nonrenewal of the contract or the expiration of the term for
16 which the contract is issued. With respect to any covered
17 family member who is eligible for medicare or any other
18 similar federal or state health insurance program, the right
19 to a continuation of coverage or conversion shall be limited
20 to coverage under a medicare supplement insurance contract as
21 defined by the rules and regulations adopted by the
22 superintendent of insurance.

23 C. Coverage continued through the issuance of a
24 converted or separate contract shall be provided at a
25 reasonable, nondiscriminatory rate to the insured and shall

1 consist of a form of coverage then being offered by the
2 health care plan as a conversion contract in the jurisdiction
3 where the person exercising the conversion right resides that
4 most nearly approximates the coverage of the contract from
5 which conversion is exercised. Continued and converted
6 coverages shall contain renewal provisions that are not less
7 favorable to the subscriber than those contained in the
8 policy from which the conversion is made, except that the
9 person who exercises the right of conversion is entitled only
10 to have included a right to coverage under a medicare
11 supplement insurance contract, as defined by the rules and
12 regulations adopted by the superintendent of insurance, after
13 the attainment of the age of eligibility for medicare or any
14 other similar federal or state health insurance program.

15 D. At the time of inception of coverage, the
16 health care plan shall provide each covered family member
17 eighteen years of age or older a statement setting forth in
18 summary form the continuation of coverage and conversion
19 provisions of the subscriber's contract.

20 E. The eligible covered family member exercising
21 the continuation or conversion right must notify the health
22 care plan and make payment of the applicable premium within
23 thirty days following the date such coverage otherwise
24 terminates as specified in the contract from which
25 continuation or conversion is being exercised.

1 F. Coverage shall be provided through continuation
2 or conversion without additional evidence of insurability and
3 shall not impose any preexisting condition, limitations or
4 other contractual time limitations.

5 G. Any probationary or waiting period set forth in
6 the converted or separate contract is deemed to commence on
7 the effective date of the applicant's coverage under the
8 original contract."

9 SECTION 20. A new section of the New Mexico Insurance
10 Code is enacted to read:

11 "STATE INNOVATION WAIVER APPLICATION.--The
12 superintendent, in consultation with and pursuant to approval
13 by the governor, is authorized to submit a state innovation
14 waiver application pursuant to Section 1332 of the federal
15 Patient Protection and Affordable Care Act to establish a
16 program relating to access and affordability of health
17 insurance coverage. In applying for a waiver pursuant to
18 Section 1332 of the federal Patient Protection and Affordable
19 Care Act, the superintendent shall seek any federal funding
20 available to implement the waiver."

21 SECTION 21. A new section of the New Mexico Insurance
22 Code is enacted to read:

23 "EXCLUSION PROHIBITION NOT APPLICABLE TO EXCEPTED
24 BENEFIT PLANS OR POLICIES.--

25 A. Notwithstanding any other provisions of law, an HB 436/a
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1 excepted benefits policy or plan shall not exclude coverage
2 for losses incurred for a preexisting condition more than
3 twelve months from the effective date of coverage. The
4 policy or plan shall not define a preexisting condition more
5 restrictively than a condition for which medical advice was
6 given or treatment recommended by or received from a
7 physician within twelve months before the effective date of
8 coverage.

9 B. As used in this section, "excepted benefits"
10 means benefits furnished pursuant to the following:

11 (1) coverage-only accident or disability
12 income insurance;

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

15 (3) liability insurance;

16 (4) workers' compensation or similar
17 insurance;

18 (5) automobile medical payment insurance;

19 (6) credit-only insurance;

20 (7) coverage for on-site medical clinics;

21 (8) other similar insurance coverage

22 specified in office of superintendent of insurance rules,
23 under which benefits for medical care are secondary or
24 incidental to other benefits;

25 (9) the following benefits if offered

1 separately:

2 (a) limited-scope dental or vision
3 benefits;

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

7 (c) other similar limited benefits
8 specified in office of superintendent of insurance rules;

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9 (10) the following benefits, offered as
10 independent, non-coordinated benefits:

11 (a) coverage-only for a specified
12 disease or illness; or

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

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

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

20 (b) coverage supplemental to the
21 coverage provided pursuant to Chapter 55 of Title 10 USCA and
22 similar supplemental coverage provided to coverage pursuant
23 to a group health plan."

24 SECTION 22. REPEAL.--Sections 59A-22-37, 59A-23B-1
25 through 59A-23B-12, 59A-23C-5, 59A-23C-7.1 and 59A-23E-4

1 through 59A-23E-7 NMSA 1978 (being Laws 1984, Chapter 127,
2 Section 459, Laws 1991, Chapter 111, Sections 1 through 10,
3 Laws 1994, Chapter 64, Section 7, Laws 1991, Chapter 111,
4 Section 11, Laws 2003, Chapter 252, Section 2, Laws 1991,
5 Chapter 153, Section 5, Laws 1994, Chapter 75, Section 32 and
6 Laws 1997, Chapter 243, Sections 4 through 7, as amended) are
7 repealed. _____

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