AN ACT

RELATING TO INSURANCE; ELIMINATING IN CERTAIN CASES THE INITIAL TWO-YEAR PERIOD WHEN A HEALTH INSURANCE POLICY MAY BE VOIDED OR A CLAIM FOR LOSS DENIED; RAISING THE MINIMUM AMOUNT OF THE MAXIMUM LIMIT OF COVERAGE FOR POLICIES UNDER THE MINIMUM HEALTHCARE PROTECTION ACT; CHANGING A REQUIREMENT FOR DETERMINING A PERIOD OF CREDITABLE COVERAGE UNDER THE HEALTH INSURANCE PORTABILITY ACT.

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

Section 1. Section 59A-22-5 NMSA 1978 (being Laws 1984, Chapter 127, Section 426, as amended) is amended to read:

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

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

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

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

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

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become

incontestable as to the statements contained in the application.

E. For individual policies that do not reimburse or pay as a result of hospitalization, medical or surgical expenses, no claim for loss incurred or disability (as defined in the policy) shall be reduced or denied on the ground that a disease or physical condition disclosed on the application and not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy. As an alternative, those policies may contain provisions under which coverage may be excluded for a period of six months following the effective date of coverage as to a given covered insured for a preexisting condition, provided that:

(1) the condition manifested itself within a period of six months prior to the effective date of coverage in a manner that would cause a reasonably prudent person to seek diagnosis, care or treatment; or

(2) medical advice or treatment relating to the condition was recommended or received within a period of six months prior to the effective date of coverage.

F. Individual policies that reimburse or pay as a result of hospitalization, medical or surgical expenses may contain provisions under which coverage is excluded during a

period of six months following the effective date of coverage as to a given covered insured for a preexisting condition, provided that:

(1) the condition manifested itself within a period of six months prior to the effective date of coverage in a manner that would cause a reasonably prudent person to seek diagnosis, care or treatment; or

(2) medical advice or treatment relating to the condition was recommended or received within a period of six months prior to the effective date of coverage.

G. The preexisting condition exclusions authorized in Subsections E and F of this section shall be waived to the extent that similar conditions have been satisfied under any prior health insurance coverage if the application for new coverage is made not later than thirty-one days following the termination of prior coverage. In that case, the new coverage shall be effective from the date on which the prior coverage terminated.

H. Nothing in this section shall be construed to require the use of preexisting conditions or prohibit the use of preexisting conditions that are more favorable to the insured than those specified in this section."

Section 2. Section 59A-23B-3 NMSA 1978 (being Laws 1991, Chapter 111, Section 3, as amended) is amended to read:

"59A-23B-3. POLICY OR PLAN--DEFINITION--CRITERIA.--

A. For purposes of the Minimum Healthcare Protection Act, "policy or plan" means a healthcare benefit policy or healthcare benefit plan that the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan chooses to offer to individuals, families or groups of fewer than twenty members formed for purposes other than obtaining insurance coverage and that meets the requirements of Subsection B of this section. For purposes of the Minimum Healthcare Protection Act, "policy or plan" shall not mean a healthcare policy or healthcare benefit plan that an insurer, health maintenance organization, fraternal benefit society or nonprofit healthcare plan chooses to offer outside the authority of the Minimum Healthcare Protection Act.

B. A policy or plan shall meet the following criteria:

(1) the individual, family or group obtaining coverage under the policy or plan has been without healthcare insurance, a health services plan or employer-sponsored healthcare coverage for the six-month period immediately preceding the effective date of its coverage under a policy or plan, provided that the six-month period shall not apply to:

(a) a group that has been in existence for less than six months and has been without healthcare

coverage since the formation of the group;

(b) an employee whose healthcare coverage has been terminated by an employer;

(c) a dependent who no longer qualifies as a dependent under the terms of the contract; or

(d) an individual and an individual's dependents who no longer have healthcare coverage as a result of termination or change in employment of the individual or by reason of death of a spouse or dissolution of a marriage, notwithstanding rights the individual or individual's dependents may have to continue healthcare coverage on a self-pay basis pursuant to the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985;

(2) the policy or plan includes the following managed care provisions to control costs:

(a) an exclusion for services that are not medically necessary or are not covered by preventive health services; and

(b) a procedure for preauthorization of elective hospital admissions by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan; and

(3) subject to a maximum limit on the cost of healthcare services covered in any calendar year of not less than fifty thousand dollars ($50,000) and, effective for

policies written or renewed on or after January 1, 2009, of not less than one hundred thousand dollars ($100,000), adjusted for changes not to exceed the medical price index component of the federal department of labor's consumer price index at intervals and in a manner established by rule pursuant to the Minimum Healthcare Protection Act, the policy or plan provides the following minimum healthcare services to covered individuals:

(a) inpatient hospitalization coverage or home care coverage in lieu of hospitalization or a combination of both, not to exceed twenty-five days of coverage inclusive of any deductibles, co-payments or co-insurance; provided that a period of inpatient hospitalization coverage shall precede any home care coverage;

(b) prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy and one office visit per week during the ninth month and until term; provided that coverage for each office visit shall also include prenatal counseling and education and necessary and appropriate screening, including history, physical examination and the laboratory and diagnostic procedures deemed appropriate by the physician based upon recognized

medical criteria for the risk group of which the patient is a member;

(c) obstetrical care, including physicians' and certified nurse midwives' services, delivery room and other medically necessary services directly associated with delivery;

(d) well-baby and well-child care, including periodic evaluation of a child's physical and emotional status, a history, a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards; provided that such evaluation and care shall be covered when performed at approximately the age intervals of birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years and six years;

(e) coverage for low-dose screening mammograms for determining the presence of breast cancer; provided that the mammogram coverage shall include one baseline mammogram for persons age thirty-five through thirty-nine years, one biennial mammogram for persons age forty through forty-nine years and one annual mammogram for persons age fifty years and over; and further provided that the mammogram coverage shall only be subject to deductibles

and co-insurance requirements consistent with those imposed on other benefits under the same policy or plan;

(f) coverage for cytologic screening, to include a Papanicolaou test and pelvic exam for asymptomatic as well as symptomatic women;

(g) a basic level of primary and preventive care, including no less than seven physician, nurse practitioner, nurse midwife or physician assistant office visits per calendar year, including any ancillary diagnostic or laboratory tests related to the office visit;

(h) coverage for childhood immunizations, in accordance with the current schedule of immunizations recommended by the American academy of pediatrics, including coverage for all medically necessary booster doses of all immunizing agents used in childhood immunizations; provided that coverage for childhood immunizations and necessary booster doses may be subject to deductibles and co-insurance consistent with those imposed on other benefits under the same policy or plan; and

(i) coverage for smoking cessation treatment.

C. A policy or plan may include the following managed care and cost control features to control costs:

(1) a panel of providers who have entered into written agreements with the insurer, fraternal benefit

society, health maintenance organization or nonprofit healthcare plan to provide covered healthcare services at specified levels of reimbursement; provided that such written agreement shall contain a provision relieving the individual, family or group covered by the policy or plan from an obligation to pay for a healthcare service performed by the provider that is determined by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan not to be medically necessary;

(2) a requirement for obtaining a second opinion before elective surgery is performed;

(3) a procedure for utilization review by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan; and

(4) a maximum limit on the cost of healthcare services covered in a calendar year of not less than fifty thousand dollars ($50,000) and, effective for policies written or renewed on or after January 1, 2009, of not less than one hundred thousand dollars ($100,000), adjusted for changes not to exceed the medical price index component of the federal department of labor's consumer price index at intervals and in a manner established by rule pursuant to the Minimum Healthcare Protection Act.

D. Nothing contained in Subsection C of this section shall prohibit an insurer, fraternal benefit society,

health maintenance organization or nonprofit healthcare plan from including in the policy or plan additional managed care and cost control provisions that the superintendent determines to have the potential for controlling costs in a manner that does not cause discriminatory treatment of individuals, families or groups covered by the policy or plan.

E. Notwithstanding any other provisions of law, a policy or plan shall not exclude coverage for losses incurred for a preexisting condition more than six months from the effective date of coverage. The policy or plan shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment recommended by or received from a physician within six months before the effective date of coverage.

F. A medical group, independent practice association or health professional employed by or contracting with an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan shall not maintain an action against an insured person, family or group member for sums owed by an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan that are higher than those agreed to pursuant to a policy or plan."

Section 3. Section 59A-23E-5 NMSA 1978 (being Laws

1997, Chapter 243, Section 5, as amended) is amended to read:

"59A-23E-5. GROUP HEALTH PLAN--RULES FOR CREDITING PREVIOUS COVERAGE.--

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

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

Section 4. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2008.