

1 SENATE BILL 290

2 **50TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2012**

3 INTRODUCED BY

4 Dede Feldman

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10 AN ACT

11 RELATING TO HEALTH COVERAGE; AMENDING AND ENACTING SECTIONS OF
12 THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE
13 ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO
14 PROHIBIT LIFETIME OR ANNUAL LIMITS; PROVIDING FOR GUARANTEED
15 ISSUE; BANNING PREEXISTING CONDITION EXCLUSIONS AND EXCESSIVE
16 WAITING PERIODS; PROHIBITING RESCISSIONS OF COVERAGE EXCEPT IN
17 CASES OF FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL
18 FACT; MANDATING COVERAGE FOR INDIVIDUALS UNDER THE AGE OF
19 TWENTY-SIX WHO SEEK COVERAGE UNDER THEIR PARENTS' COVERAGE;
20 REQUIRING THAT INSURERS MAKE REBATES TO CONSUMERS WHEN
21 ADMINISTRATIVE LOSSES EXCEED THE STATUTORY MAXIMUM; PROHIBITING
22 LIFETIME OR ANNUAL LIMITS; PROVIDING FOR SMOKING AND TOBACCO
23 CESSATION COVERAGE; ALIGNING COVERAGE FOR IMMUNIZATIONS,
24 COLORECTAL CANCER SCREENINGS AND CYTOLOGIC AND HUMAN
25 PAPILOMAVIRUS SCREENINGS WITH FEDERAL GUIDELINES; PROVIDING

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1 FOR ALCOHOL DEPENDENCY AND MISUSE COVERAGE; PROHIBITING
2 PREEXISTING CONDITION EXCLUSIONS FOR INDIVIDUALS UNDER THE AGE
3 OF NINETEEN; PROHIBITING EMPLOYER-SPONSORED PLANS FROM
4 DISCRIMINATING IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS;
5 PROVIDING FOR APPLICABILITY TO "GRANDFATHERED" HEALTH PLAN
6 COVERAGE; REQUIRING EMERGENCY SERVICES COVERAGE; PROVIDING FOR
7 EXTENDED HEALTH COVERAGE FOR DISABLED CHILDREN; PROVIDING FOR
8 OBSTETRICAL AND GYNECOLOGICAL PRIMARY CARE AND PEDIATRIC
9 PRIMARY CARE; REQUIRING COVERAGE OF CERTAIN PREVENTIVE ITEMS
10 AND SERVICES WITHOUT COST-SHARING; PROVIDING FOR RULEMAKING;
11 AMENDING SECTIONS OF THE HEALTH CARE PURCHASING ACT AND THE
12 MEDICAL CARE SAVINGS ACCOUNT ACT TO PROVIDE FOR DEPENDENT
13 COVERAGE UNTIL THE AGE OF TWENTY-SIX; AMENDING A SECTION OF THE
14 SMALL GROUP RATE AND RENEWABILITY ACT TO PROVIDE FOR
15 RENEWABILITY OF COVERAGE, TO LIMIT ADJUSTED COMMUNITY RATING
16 AND ADMINISTRATIVE LOSS RATIOS AND TO BAN PREEXISTING
17 CONDITIONS EXCLUSIONS; PROVIDING FOR THE EXPULSION OR
18 SUSPENSION OF FRATERNAL BENEFIT SOCIETY MEMBERSHIP FOR FRAUD OR
19 INTENTIONAL MISREPRESENTATION OF MATERIAL FACT; PROVIDING FOR
20 RESCISSION OR BREACH OF NONPROFIT HEALTH CARE PLAN SUBSCRIBER
21 CONTRACTS IN CASES OF FRAUD OR INTENTIONALLY MISLEADING
22 REPRESENTATIONS OF MATERIAL FACT; AMENDING THE HEALTH INSURANCE
23 PORTABILITY ACT TO PROVIDE FOR RENEWABILITY OF COVERAGE;
24 AMENDING A SECTION OF THE HEALTH INSURANCE ALLIANCE ACT TO
25 REQUIRE GUARANTEED ISSUE AND RENEWABILITY AND SPECIAL

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1 ENROLLMENT; AMENDING SECTIONS OF THE PATIENT PROTECTION ACT TO
2 EXTEND ITS PROVISIONS TO ALL HEALTH INSURANCE AND HEALTH CARE
3 PLANS IN THE STATE; PROVIDING FOR INTERNAL GRIEVANCE
4 PROCEDURES; PROVIDING FOR FORMAL HEARINGS ON VIOLATIONS OF THE
5 PATIENT PROTECTION ACT.

6
7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

8 SECTION 1. Section 13-7-8 NMSA 1978 (being Laws 2003,
9 Chapter 391, Section 2) is amended to read:

10 "13-7-8. MAXIMUM AGE OF ~~[DEPENDENT]~~ CHILD.--Any group
11 health care coverage, including any form of self-insurance,
12 offered, issued or renewed under the Health Care Purchasing Act
13 on or after July 1, 2003 that offers coverage of an insured's
14 ~~[dependent]~~ child shall not terminate coverage of ~~[an unmarried~~
15 ~~dependent]~~ a child by reason of the ~~[dependent's]~~ child's age
16 before the ~~[dependent's twenty-fifth]~~ child's twenty-sixth
17 birthday ~~[regardless of whether the dependent is enrolled in an~~
18 ~~educational institution]."~~

19 SECTION 2. Section 59A-18-13.1 NMSA 1978 (being Laws
20 1994, Chapter 75, Section 26, as amended) is amended to read:

21 "59A-18-13.1. ADJUSTED COMMUNITY RATING.--

22 A. Every insurer, fraternal benefit society, health
23 maintenance organization or nonprofit health care plan that
24 provides primary health insurance or health care coverage
25 insuring or covering major medical expenses shall, in

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1 determining the initial year's premium charged for an
2 individual, use only the rating factors of age, [~~gender~~
3 ~~pursuant to Subsection B of this section~~] geographic area of
4 the place of employment and smoking practices, except that for
5 individual policies the rating factor of the individual's place
6 of residence may be used instead of the geographic area of the
7 individual's place of employment.

8 B. In determining the initial and any subsequent
9 year's rate, [~~the difference in rates in any one age group that~~
10 ~~may be charged on the basis of a person's gender shall not~~
11 ~~exceed another person's rates in the age group by more than the~~
12 ~~following percentage of the lower rate for policies issued or~~
13 ~~delivered in the respective year; provided, however, that~~
14 ~~gender shall not be used as a rating factor for policies issued~~
15 ~~or delivered on or after January 1, 2014:~~

- 16 (1) ~~twenty percent for calendar year 2010;~~
17 (2) ~~fifteen percent for calendar year 2011;~~
18 (3) ~~ten percent for calendar year 2012; and~~
19 (4) ~~five percent for calendar year 2013.~~

20 ~~G.]~~ no person's rate shall exceed the rate of any
21 other person [~~with similar family composition~~] on the basis of
22 age by more than two hundred fifty percent of the lower rate,
23 except that the rates for children under the age of nineteen or
24 children aged nineteen to twenty-five who are full-time
25 students may be as much as three hundred percent lower than the

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1 ~~[bottom] highest age-based rates [in the two hundred fifty~~
2 ~~percent band. The rating factor restrictions shall not~~
3 ~~prohibit an insurer, fraternal benefit society, health~~
4 ~~maintenance organization or nonprofit health care plan from~~
5 ~~offering rates that differ depending upon family composition].~~

6 C. No person's rate shall exceed the rate of any
7 other person on the basis of geographic rating area by an
8 amount that the superintendent shall establish by rule, after
9 review by the United States department of health and human
10 services.

11 D. The rate difference between any one person who
12 smokes and any person who does not use tobacco shall not differ
13 by more than one hundred fifty percent.

14 ~~[D.]~~ E. The provisions of this section do not
15 preclude an insurer, fraternal benefit society, health
16 maintenance organization or nonprofit health care plan from
17 using health status or occupational or industry classification
18 in establishing:

- 19 (1) rates for individual policies; or
20 (2) the amount an employer may be charged for
21 coverage under the group health plan.

22 ~~[E. As used in Subsection D of this section,~~
23 ~~"health status" does not include genetic information.]~~

24 F. The superintendent shall adopt regulations to
25 implement the provisions of this section."

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1 SECTION 3. A new section of Chapter 59A, Article 18 NMSA
2 1978 is enacted to read:

3 "[NEW MATERIAL] UNIFORM HEALTH COVERAGE DOCUMENTS--
4 STANDARDIZED DEFINITIONS.--

5 A. A health maintenance organization that offers an
6 individual or group health care policy, plan, evidence of
7 coverage or certificate of insurance in the state shall comply
8 with the standards established by the superintendent by rule
9 for the following documents issued by each policy, plan,
10 evidence of coverage or certificate issued in the state
11 relating to:

- 12 (1) a summary of benefits;
- 13 (2) an explanation of coverage;
- 14 (3) definitions of standard insurance terms
15 and medical terms;
- 16 (4) exceptions, reductions and limitations on
17 coverage;
- 18 (5) cost-sharing provisions, including
19 deductible, coinsurance and copayment obligations;
- 20 (6) the renewability and continuation of
21 coverage provisions;
- 22 (7) a coverage facts disclosure that includes
23 examples that are based on nationally recognized clinical
24 practice guidelines to illustrate common benefits scenarios,
25 including pregnancy and serious or chronic medical conditions

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1 and related cost-sharing;

2 (8) a statement that the health care plan:

3 (a) provides minimum essential coverage,
4 as defined under Section 5000A(f) of the federal Internal
5 Revenue Code of 1986; and

6 (b) ensures that the health care plan's
7 share of the total allowed costs of benefits provided under the
8 policy, plan, evidence of coverage or certificate is not less
9 than sixty percent of those costs; and

10 (9) a contact number for the consumer to call
11 with additional questions and an internet web address where a
12 copy of the actual health care plan can be reviewed and
13 obtained.

14 B. An insurer, health maintenance organization or
15 nonprofit health care plan shall provide the following persons,
16 prior to any enrollment restriction, a summary of benefits and
17 coverage explanation required pursuant to Subsection A of this
18 section:

19 (1) an applicant, at the time of application;

20 (2) an enrollee or subscriber, prior to the
21 time of enrollment or re-enrollment, subscription or re-
22 subscription; and

23 (3) a policyholder, plan holder, evidence of
24 coverage holder, enrollee, subscriber or certificate holder, at
25 the time of issuance of the policy, plan or evidence of

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1 coverage or the delivery of the certificate."

2 SECTION 4. Section 59A-22-2 NMSA 1978 (being Laws 1984,
3 Chapter 127, Section 423) is amended to read:

4 "59A-22-2. FORM AND CONTENT OF POLICY.--

5 A. No policy of individual health insurance shall
6 be delivered or issued for delivery in this state unless the
7 policy sets forth:

8 (1) a summary of benefits;

9 (2) an explanation of coverage;

10 (3) definitions of standard insurance terms
11 and medical terms;

12 (4) exceptions, reductions of indemnity and
13 limitations on coverage;

14 (5) cost-sharing provisions, including
15 deductible, coinsurance and copayment obligations;

16 (6) the renewability and continuation of
17 coverage provisions;

18 (7) a coverage facts disclosure that includes
19 examples that are based on nationally recognized clinical
20 practice guidelines to illustrate common benefits scenarios,
21 including pregnancy and serious or chronic medical conditions
22 and related cost-sharing;

23 (8) a statement of whether the policy:

24 (a) provides minimum essential coverage,
25 as defined under Section 5000A(f) of the federal Internal

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1 Revenue Code of 1986; and

2 (b) ensures that the plan or coverage
3 share of the total allowed costs of benefits provided under the
4 policy is not less than sixty percent of those costs; and

5 (9) a contact number for the consumer to call
6 with additional questions and an internet web address where a
7 copy of the actual individual health coverage policy can be
8 reviewed and obtained.

9 B. An insurer shall provide the following persons,
10 prior to any enrollment restriction, a summary of benefits and
11 coverage explanation required pursuant to Subsection A of this
12 section:

13 (1) an applicant, at the time of application;

14 (2) an enrollee or subscriber, prior to the
15 time of enrollment or re-enrollment, subscription or re-
16 subscription; and

17 (3) a policyholder at the time of issuance of
18 the policy.

19 C. No policy of individual health insurance shall
20 be delivered or issued for delivery in this state unless:

21 [A.] (1) the entire money and other
22 considerations therefor are expressed therein; [and

23 B.] (2) the time at which insurance takes
24 effect and terminates is expressed therein; [and

25 G.] (3) it purports to insure only one person,

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1 except as provided in Chapter 59A, Article 23 [~~of the Insurance~~
2 ~~Code~~] NMSA 1978, and except that a policy or contract may be
3 issued upon application of the head of a family, who shall be
4 deemed the policyholder, covering members of any one family,
5 including husband, wife, [~~dependent~~] children [~~or any children~~]
6 under the age of [~~nineteen (19)~~] twenty-six and [~~other~~] any
7 dependents living with the family; [~~and~~

8 D.] (4) every printed portion of the text
9 matter and of any endorsements or attached papers shall be
10 printed in uniform type of which the face shall be not less
11 than ten [~~(10)~~] point (the "text" shall include all printed
12 matter except the name and address of the insurer, name and
13 title of the policy, captions, subcaptions and form numbers),
14 but notwithstanding any provision of this law, the
15 superintendent shall not disapprove any such policy on the
16 ground that every printed portion of its text matter or of any
17 endorsement or attached paper is not printed in uniform type if
18 it shall be shown that the type used is required to conform to
19 the laws of another state in which the insurer is authorized;
20 [~~and~~

21 ~~E. the exceptions and reductions of indemnity are~~
22 ~~adequately captioned and clearly set forth in the policy or~~
23 ~~contract; and~~

24 F.] (5) each [~~such~~] form, including riders and
25 endorsements, shall be identified by a form number in the lower

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1 left-hand corner of the first page thereof; and

2 [6-] (6) if any policy is issued by an insurer
3 domiciled in this state for delivery to a person residing in
4 another state, and if the official having responsibility for
5 the administration of insurance laws of such other state shall
6 have advised the superintendent that any such policy is not
7 subject to approval or disapproval by such official, the
8 superintendent may by ruling require that such policy meet the
9 standards set forth in Sections [~~424 through 446 of this~~
10 ~~article]~~ 59A-22-3 through 59A-22-25 NMSA 1978."

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

13 "59A-22-5. TIME LIMIT ON CERTAIN DEFENSES.--

14 A. There shall be a provision for individual and
15 group comprehensive major medical policies and plans as
16 follows: As of the date of issue of this policy [~~no~~
17 ~~misstatements, except willful or fraudulent misstatements, made~~
18 ~~by the applicant in the application for this policy, shall be~~
19 ~~used to void the]~~ or plan, a policy or [to deny] plan shall not
20 be rescinded, nor shall a claim for loss incurred or disability
21 [~~as defined in the policy]~~ be denied, except when a covered
22 individual:

23 (1) engages in conduct that constitutes fraud;

24 or

25 (2) makes an intentional misrepresentation of

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1 material fact that is prohibited by the terms of the policy.

2 B. In the event [~~a misstatement in an application~~
3 ~~is made that is not fraudulent or willful~~] a misrepresentation
4 of a material fact that is not intentional is made in an
5 application, the issuer of the policy or plan may prospectively
6 rate and collect from the insured the premium that would have
7 been charged to the insured at the time the policy or plan was
8 issued had [~~such misstatement~~] the misrepresentation not been
9 made.

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

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

24 D. A policy or plan that the insured has the right
25 to continue in force subject to its terms by the timely payment

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1 of premium [~~(1)~~] until at least age fifty or [~~(2)~~], in the case
2 of a policy or plan issued after age forty-four, for at least
3 five years from its date of issue, may contain in lieu of the
4 foregoing the following provision, from which the clause in
5 parentheses may be omitted at the insurance company's option,
6 under the caption "Incontestable" [~~After this policy has been~~
7 ~~in force for a period of two years during the lifetime of the~~
8 ~~insured, excluding any period during which the insured is~~
9 ~~disabled, it shall become incontestable as to the statements~~
10 ~~contained in the application.~~

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

23 ~~(1) the condition manifested itself within a~~
24 ~~period of six months prior to the effective date of coverage in~~
25 ~~a manner that would cause a reasonably prudent person to seek~~

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1 ~~diagnosis, care or treatment; or~~

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

5 ~~F. Individual policies that reimburse or pay as a~~
6 ~~result of hospitalization, medical or surgical expenses may~~
7 ~~contain provisions under which coverage is excluded during a~~
8 ~~period of six months following the effective date of coverage~~
9 ~~as to a given covered insured for a preexisting condition,~~
10 ~~provided that:~~

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

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

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

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

5 SECTION 6. Section 59A-22-6 NMSA 1978 (being Laws 1984,
6 Chapter 127, Section 427) is amended to read:

7 "59A-22-6. GRACE PERIOD.--There shall be a provision as
8 follows:

9 A grace period of..... (insert a number not
10 less than "7" for weekly premium policies, "10" for
11 monthly premium policies and "31" for all other
12 policies) days will be granted for the payment of
13 each premium falling due after the first premium,
14 during which grace period the policy shall continue
15 in force.

16 ~~[A policy in which the insurer reserves the right to~~
17 ~~refuse any renewal shall have, at the beginning of the above~~
18 ~~provision, "Unless not less than five days prior to the premium~~
19 ~~due date the insurance company has delivered to the insured or~~
20 ~~has mailed to his last address as shown by the records of the~~
21 ~~insurer written notice of its intention not to renew this~~
22 ~~policy beyond the period for which the premium has been~~
23 ~~accepted.".]"~~

24 SECTION 7. Section 59A-22-30.1 NMSA 1978 (being Laws
25 2005, Chapter 41, Section 1) is amended to read:

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1 "59A-22-30.1. MAXIMUM AGE OF ~~[DEPENDENT]~~ CHILD.--An
2 individual or group health plan, policy or certificate of
3 insurance delivered, issued for delivery or renewed in New
4 Mexico that provides coverage for an insured's ~~[dependent]~~
5 child shall not terminate coverage of ~~[an unmarried dependent]~~
6 a child by reason of the ~~[dependent's]~~ child's age before the
7 ~~[dependent's twenty-fifth]~~ child's twenty-sixth birthday
8 ~~[regardless of whether the dependent is enrolled in an~~
9 ~~educational institution]."~~

10 SECTION 8. Section 59A-22-33 NMSA 1978 (being Laws 1984,
11 Chapter 127, Section 455) is amended to read:

12 "59A-22-33. ~~[HANDICAPPED]~~ DISABLED CHILDREN--COVERAGE
13 CONTINUED.--

14 A. An individual or group hospital or medical
15 expense insurance policy or plan delivered or issued for
16 delivery in this state ~~[which]~~ that provides that coverage of a
17 ~~[dependent]~~ child of an insured, or of an employee or other
18 member of the covered group, shall terminate upon attainment of
19 the limiting age for ~~[dependent]~~ children specified in the
20 policy or plan shall also provide, in substance, that
21 attainment of the limiting age shall not operate to terminate
22 the coverage of a child while the child is, and continues to
23 be, both incapable of self-sustaining employment, by reason of
24 ~~[mental retardation]~~ cognitive or physical ~~[handicap]~~
25 disability, and chiefly dependent upon the policyholder or plan

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1 holder for support and maintenance. However, proof of the
2 incapacity and dependency of the child must be furnished to the
3 insurer by the insured employee or member within thirty-one
4 [~~(31)~~] days of the child's attainment of the limiting age and
5 subsequently, as may be required by the insurer, but not more
6 frequently than annually after the two-year period following
7 the child's attainment of the limiting age.

8 B. No limiting age shall be set before age twenty-
9 six."

10 SECTION 9. Section 59A-22-34.2 NMSA 1978 (being Laws
11 1994, Chapter 64, Section 2, as amended) is amended to read:

12 "59A-22-34.2. COVERAGE OF CHILDREN.--

13 A. An insurer shall not deny enrollment of a child
14 under the health plan or policy of the child's parent on the
15 grounds that the child:

16 (1) was born out of wedlock;

17 (2) is not claimed as a dependent on the
18 parent's federal tax return; or

19 (3) does not reside with the parent or in the
20 insurer's service area.

21 B. When a child has health coverage through an
22 insurer of a noncustodial parent, the insurer shall:

23 (1) provide such information to the custodial
24 parent as may be necessary for the child to obtain benefits
25 through that coverage;

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1 (2) permit the custodial parent or the
2 provider, with the custodial parent's approval, to submit
3 claims for covered services without the approval of the
4 noncustodial parent; and

5 (3) make payments on claims submitted in
6 accordance with Paragraph (2) of this subsection directly to
7 the custodial parent, the provider or the state medicaid
8 agency.

9 C. When a parent is required by a court or
10 administrative order to provide health coverage for a child and
11 the parent is eligible for family health coverage, the insurer
12 shall be required:

13 (1) to permit the parent to enroll, under the
14 family coverage, a child who is otherwise eligible for the
15 coverage without regard to any enrollment season restrictions;

16 (2) if the parent is enrolled but fails to
17 make application to obtain coverage for the child, to enroll
18 the child under family coverage upon application of the child's
19 other parent, the state agency administering the medicaid
20 program or the state agency administering 42 U.S.C. Sections
21 651 through 669, the child support enforcement program; and

22 (3) not to disenroll or eliminate coverage of
23 the child unless the insurer is provided satisfactory written
24 evidence that:

25 (a) the court or administrative order is

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1 no longer in effect; or

2 (b) the child is or will be enrolled in
3 comparable health coverage through another insurer that will
4 take effect not later than the effective date of disenrollment.

5 D. An insurer shall not impose requirements on a
6 state agency that has been assigned the rights of an individual
7 eligible for medical assistance under the medicaid program and
8 covered for health benefits from the insurer that are different
9 from requirements applicable to an agent or assignee of any
10 other individual so covered.

11 E. An insurer shall provide coverage for children,
12 from birth through three years of age, for or under the family,
13 infant, toddler program administered by the department of
14 health, provided that eligibility criteria are met [~~for a~~
15 ~~maximum benefit of three thousand five hundred dollars (\$3,500)~~
16 ~~annually~~] for medically necessary early intervention services
17 provided as part of an individualized family service plan and
18 delivered by certified and licensed personnel as defined in
19 7.30.8 NMAC who are working in early intervention programs
20 approved by the department of health. [~~No payment under this~~
21 ~~subsection shall be applied against any maximum lifetime or~~
22 ~~annual limits specified in the policy, health benefits plan or~~
23 ~~contract.~~]"

24 SECTION 10. A new section of Chapter 59A, Article 22 NMSA
25 1978, is enacted to read:

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1 "[NEW MATERIAL] ALCOHOL DEPENDENCY AND MISUSE COVERAGE.--

2 A. Each insurer that delivers or issues for
3 delivery in this state a group health insurance policy shall
4 offer and make available benefits for the necessary care and
5 treatment of alcohol dependency and misuse. These benefits
6 shall provide necessary care and treatment in an alcohol
7 dependency and misuse treatment center and outpatient visits
8 for alcohol dependency and misuse treatment.

9 B. For purposes of this section, "alcohol
10 dependency and misuse treatment center" means a facility that
11 provides a program for the treatment of alcohol dependency and
12 misuse pursuant to a written treatment plan approved and
13 monitored by a physician or meeting the quality standards of
14 the behavioral health services division of the human services
15 department and which facility also:

16 (1) is affiliated with a hospital under a
17 contractual agreement with an established system for patient
18 referral;

19 (2) is accredited as such a facility by the
20 joint commission; or

21 (3) meets at least the minimum standards
22 adopted by the behavioral health services division for
23 treatment of alcohol dependency and misuse in regional
24 treatment centers.

25 C. This section applies to policies delivered or

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1 issued for delivery or renewed, extended or amended in this
2 state on or after July 1, 1983 or upon expiration of a
3 collective bargaining agreement applicable to a particular
4 policyholder, whichever is later; provided that this section
5 does not apply to blanket, short-term travel, accident-only,
6 limited or specified disease or individual conversion policies
7 or policies designed for issuance to persons eligible for
8 coverage under Title 18 of the federal Social Security Act,
9 known as medicare, or any other similar coverage under state or
10 federal governmental plans. With respect to any policy forms
11 approved by the insurance division of the commission prior to
12 the effective date of this section, an insurer is authorized to
13 comply with this section by the use of endorsements or riders;
14 provided that such endorsements or riders are approved by the
15 insurance division as being in compliance with this section and
16 applicable provisions of the Insurance Code.

17 D. If an organization offering group health
18 benefits to its members makes more than one health insurance
19 policy or nonprofit health care plan available to its members
20 on a member option basis, the organization shall not require
21 alcohol dependency and misuse coverage from one health insurer
22 or health care plan without requiring the same level of alcohol
23 dependency and misuse coverage for all other health insurance
24 policies or health care plans that the organization makes
25 available to its members."

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1 SECTION 11. Section 59A-22-34.3 NMSA 1978 (being Laws
2 1997, Chapter 250, Section 1) is amended to read:

3 "59A-22-34.3. CHILDHOOD IMMUNIZATION COVERAGE REQUIRED.--

4 A. Each individual and group health insurance
5 policy, health care plan and certificate of health insurance
6 delivered or issued for delivery in this state shall provide
7 coverage for childhood immunizations, as well as coverage for
8 medically necessary booster doses of all immunizing agents used
9 in child immunizations, in accordance with the current schedule
10 of immunizations recommended by the American academy of
11 pediatrics or the advisory committee on immunization practices
12 of the federal centers for disease control and prevention,
13 whichever provides greater coverage.

14 B. The provisions of this section shall not apply
15 to short-term travel, accident-only or limited or specified
16 disease policies.

17 ~~[G. Coverage for childhood immunizations and~~
18 ~~necessary booster doses may be subject to deductibles and co-~~
19 ~~insurance consistent with those imposed on other benefits under~~
20 ~~the same policy, plan or certificate.]"~~

21 SECTION 12. Section 59A-22-40 NMSA 1978 (being Laws 1992,
22 Chapter 56, Section 2, as amended) is amended to read:

23 "59A-22-40. COVERAGE FOR CYTOLOGIC AND HUMAN
24 PAPILOMAVIRUS SCREENING.--

25 A. Each individual and group health insurance

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1 policy, health care plan and certificate of health insurance
2 delivered or issued for delivery in this state shall provide
3 coverage for cytologic and human papillomavirus screening for
4 determining the presence of precancerous or cancerous
5 conditions and other health problems. The coverage shall make
6 available cytologic screening, as determined by the health care
7 provider in accordance with national medical standards and
8 United States preventive services task force "A"-rated and "B"-
9 rated recommendations, whichever provides greater coverage, for
10 women who are eighteen years of age or older and for women who
11 are at risk of cancer or at risk of other health conditions
12 that can be identified through cytologic screening. The
13 coverage shall make available human papillomavirus screening
14 once every three years for women aged thirty and older.

15 B. Coverage for cytologic and human papillomavirus
16 screening may be subject to deductibles and coinsurance
17 consistent with those imposed on other benefits under the same
18 policy, plan or certificate.

19 C. The provisions of this section shall not apply
20 to short-term travel, accident-only or limited or specified-
21 disease policies.

22 D. For the purposes of this section:

23 (1) "cytologic screening" means a Papanicolaou
24 test and a pelvic exam for asymptomatic as well as symptomatic
25 women;

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1 (2) "health care provider" means any person
2 licensed within the scope of [~~his~~] the person's practice to
3 perform cytologic and human papillomavirus screening, including
4 physicians, physician assistants, certified nurse-midwives and
5 certified nurse practitioners; and

6 (3) "human papillomavirus screening" means a
7 test approved by the federal food and drug administration for
8 detection of the human papillomavirus."

9 SECTION 13. Section 59A-22-44 NMSA 1978 (being Laws 2003,
10 Chapter 337, Section 1) is amended to read:

11 "59A-22-44. COVERAGE FOR SMOKING CESSATION TREATMENT.--

12 A. An individual or group health insurance policy,
13 health care plan or certificate of health insurance that is
14 delivered or issued for delivery in this state and that offers
15 maternity benefits shall offer coverage for smoking cessation
16 treatment and shall offer augmented counseling tailored to
17 pregnant women who smoke.

18 [~~B. Coverage for smoking cessation treatment may be~~
19 ~~subject to deductibles and coinsurance consistent with those~~
20 ~~imposed on other benefits under the same policy, plan or~~
21 ~~certificate.]~~

22 B. An individual or group health insurance policy,
23 health care plan or certificate of health insurance that is
24 delivered or issued for delivery in this state shall:

25 (1) offer tobacco cessation intervention

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1 coverage for those who use tobacco products;

2 (2) provide for screening of pregnant women
3 for tobacco use in accordance with the United States preventive
4 services task force guidelines; and

5 (3) provide diagnostic, therapy and counseling
6 services and pharmacotherapy, including the coverage of
7 prescription and nonprescription tobacco cessation agents
8 approved by the federal food and drug administration for
9 cessation of tobacco use by pregnant women.

10 C. The provisions of this section shall not apply
11 to short-term travel, accident-only or limited or specified-
12 disease policies."

13 SECTION 14. Section 59A-22-47 NMSA 1978 (being Laws 2007,
14 Chapter 17, Section 1) is amended to read:

15 "59A-22-47. COVERAGE OF COLORECTAL CANCER SCREENING.--

16 A. An individual or group health insurance policy,
17 health care plan and certificate of health insurance that is
18 delivered, issued for delivery or renewed in this state shall
19 provide coverage for colorectal screening for determining the
20 presence of precancerous or cancerous conditions and other
21 health problems. The coverage shall make available colorectal
22 cancer screening, as determined by the health care provider in
23 accordance with ~~[the evidence-based recommendations established~~
24 ~~by]~~ practices that have, in effect, a rating of "A" or "B" in
25 the current recommendations of the United States preventive

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1 services task force.

2 [B. Coverage for colorectal screening may be
3 subject to deductibles and coinsurance consistent with those
4 imposed on other benefits under the same policy, plan or
5 certificate.]

6 G.] B. The provisions of this section shall not
7 apply to short-term travel, accident-only or limited or
8 specified-disease policies or plans."

9 SECTION 15. Section 59A-22-49 NMSA 1978 (being Laws 2009,
10 Chapter 74, Section 1) is amended to read:

11 "59A-22-49. COVERAGE FOR AUTISM SPECTRUM DISORDER
12 DIAGNOSIS AND TREATMENT.--

13 A. An individual or group health insurance policy,
14 health care plan or certificate of health insurance that is
15 delivered, issued for delivery or renewed in this state shall
16 provide coverage to an eligible individual who is nineteen
17 years of age or younger or an eligible individual who is
18 twenty-two years of age or younger and is enrolled in high
19 school for:

20 (1) well-baby and well-child screening for
21 diagnosing the presence of autism spectrum disorder; and

22 (2) treatment of autism spectrum disorder
23 through speech therapy, occupational therapy, physical therapy
24 and applied behavioral analysis.

25 B. Coverage required pursuant to Subsection A of

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1 this section:

2 (1) shall be limited to treatment that is
3 prescribed by the insured's treating physician in accordance
4 with a treatment plan;

5 ~~[(2) shall be limited to thirty-six thousand~~
6 ~~dollars (\$36,000) annually and shall not exceed two hundred~~
7 ~~thousand dollars (\$200,000) in total lifetime benefits.~~

8 ~~Beginning January 1, 2011, the maximum benefit shall be~~
9 ~~adjusted annually on January 1 to reflect any change from the~~
10 ~~previous year in the medical component of the then-current~~
11 ~~consumer price index for all urban consumers published by the~~
12 ~~bureau of labor statistics of the United States department of~~
13 ~~labor;~~

14 ~~(3)]~~ (2) shall not be denied on the basis that
15 the services are habilitative or rehabilitative in nature;

16 ~~[(4)]~~ (3) may be subject to other general
17 exclusions and limitations of the insurer's policy or plan,
18 including, but not limited to, coordination of benefits,
19 participating provider requirements, restrictions on services
20 provided by family or household members and utilization review
21 of health care services, including the review of medical
22 necessity, case management and other managed care provisions;
23 and

24 ~~[(5)]~~ (4) may be limited to exclude coverage
25 for services received under the federal Individuals with

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1 Disabilities Education Improvement Act of 2004 and related
2 state laws that place responsibility on state and local school
3 boards for providing specialized education and related services
4 to children three to twenty-two years of age who have autism
5 spectrum disorder.

6 C. The coverage required pursuant to Subsection A
7 of this section shall not be subject to dollar limits,
8 deductibles or coinsurance provisions that are less favorable
9 to an insured than the dollar limits, deductibles or
10 coinsurance provisions that apply to physical illnesses that
11 are generally covered under the individual or group health
12 insurance policy, health care plan or certificate of health
13 insurance, except as otherwise provided in Subsection B of this
14 section.

15 D. An insurer shall not deny or refuse to issue
16 health insurance coverage for medically necessary services or
17 refuse to contract with, renew, reissue or otherwise terminate
18 or restrict health insurance coverage for an individual because
19 the individual is diagnosed as having autism spectrum disorder.

20 E. The treatment plan required pursuant to
21 Subsection B of this section shall include all elements
22 necessary for the health insurance policy or plan to pay claims
23 appropriately. These elements include, but are not limited to:

- 24 (1) the diagnosis;
25 (2) the proposed treatment by types;

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- 1 (3) the frequency and duration of treatment;
2 (4) the anticipated outcomes stated as goals;
3 (5) the frequency with which the treatment
4 plan will be updated; and
5 (6) the signature of the treating physician.

6 F. This section shall not be construed as limiting
7 benefits and coverage otherwise available to an insured under a
8 health insurance policy or plan.

9 G. The provisions of this section shall not apply
10 to policies or plans intended to supplement major medical
11 group-type coverages such as medicare supplement, long-term
12 care, disability income, specified disease, accident-only,
13 hospital indemnity, other limited-benefit health insurance
14 policies or plans.

15 H. As used in this section:

16 (1) "autism spectrum disorder" means a
17 condition that meets the diagnostic criteria for the pervasive
18 developmental disorders published in the *Diagnostic and*
19 *Statistical Manual of Mental Disorders*, fourth edition, text
20 revision, also known as DSM-IV-TR, published by the American
21 psychiatric association, including autistic disorder;
22 Asperger's disorder; pervasive development disorder not
23 otherwise specified; Rett's disorder; and childhood
24 disintegrative disorder;

25 (2) "habilitative or rehabilitative services"

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1 means treatment programs that are necessary to develop,
2 maintain and restore to the maximum extent practicable the
3 functioning of an individual; and

4 (3) "high school" means a school providing
5 instruction for any of the grades nine through twelve."

6 SECTION 16. Section 59A-22-50 NMSA 1978 (being Laws 2010,
7 Chapter 94, Section 1) is amended to read:

8 "59A-22-50. HEALTH INSURERS--DIRECT SERVICES.--

9 A. A health insurer shall make reimbursement for
10 direct services at a level not less than eighty-five percent of
11 premiums across all health product lines, except individually
12 underwritten health insurance policies, contracts or plans,
13 that are governed by the provisions of Chapter 59A, Article 22
14 NMSA 1978, the Health Maintenance Organization Law and the
15 Nonprofit Health Care Plan Law. Reimbursement shall be made
16 for direct services provided over the preceding three calendar
17 years, but not earlier than calendar year 2010, as determined
18 by reports filed with the insurance division of the commission.
19 Nothing in this subsection shall be construed to preclude a
20 purchaser from negotiating an agreement with a health insurer
21 that requires a higher amount of premiums paid to be used for
22 reimbursement for direct services for one or more products or
23 for one or more years.

24 B. For individually underwritten health care
25 policies, plans or contracts, the superintendent shall

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1 establish, after notice and informal hearing, the level of
2 reimbursement for direct services, as determined by the reports
3 filed with the insurance division, as a percent of premiums.
4 Additional informal hearings may be held at the
5 superintendent's discretion. In establishing the level of
6 reimbursement for direct services, the superintendent shall
7 consider the costs associated with the individual marketing and
8 medical underwriting of these policies, plans or contracts at a
9 level not less than seventy-five percent of premiums. A health
10 insurer writing these policies, plans or contracts shall make
11 reimbursement for direct services at a level not less than that
12 level established by the superintendent pursuant to this
13 subsection over the three calendar years preceding the date
14 upon which that rate is established, but not earlier than
15 calendar year 2010. Nothing in this subsection shall be
16 construed to preclude a purchaser of one of these policies,
17 plans or contracts from negotiating an agreement with a health
18 insurer that requires a higher amount of premiums paid to be
19 used for reimbursement for direct services.

20 C. An insurer that fails to comply with the
21 reimbursement requirements pursuant to this section shall issue
22 a ~~[dividend or credit against future premiums]~~ rebate to all
23 policyholders or plan holders in ~~[an amount sufficient to~~
24 ~~assure that the benefits paid in the preceding three calendar~~
25 ~~years plus the amount of the dividends or credits are equal to~~

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1 ~~the required direct services reimbursement level pursuant to~~
2 ~~Subsection A of this section for group health coverage and~~
3 ~~blanket health coverage or the required direct services~~
4 ~~reimbursement level pursuant to Subsection B of this section~~
5 ~~for individually underwritten health policies, contracts or~~
6 ~~plans for the preceding three calendar years] accordance with~~
7 ~~rules that the superintendent has promulgated.~~ If the insurer
8 fails to issue the [~~dividend or credit~~] rebate in accordance
9 with the requirements of this section, the superintendent shall
10 enforce these requirements and may pursue any other penalties
11 as provided by law, including general penalties pursuant to
12 Section 59A-1-18 NMSA 1978.

13 D. After notice and hearing, the superintendent
14 [~~may~~] shall adopt and promulgate reasonable rules necessary and
15 proper to carry out the provisions of this section.

16 E. For the purposes of this section:

17 (1) "direct services" means services rendered
18 to an individual by a health insurer or a health care
19 practitioner, facility or other provider, including case
20 management, disease management, health education and promotion,
21 preventive services, quality incentive payments to providers
22 and any portion of an assessment that covers services rather
23 than administration and for which an insurer does not receive a
24 tax credit pursuant to the Medical Insurance Pool Act or the
25 Health Insurance Alliance Act; provided, however, that "direct

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1 services" does not include care coordination, utilization
2 review or management or any other activity designed to manage
3 utilization or services;

4 (2) "health insurer" means a person duly
5 authorized to transact the business of health insurance in the
6 state pursuant to the Insurance Code but does not include a
7 person that only issues a limited-benefit policy intended to
8 supplement major medical coverage, including medicare
9 supplement, vision, dental, disease-specific, accident-only or
10 hospital indemnity-only insurance policies, or that only issues
11 policies for long-term care or disability income; and

12 (3) "premium" means all income received from
13 individuals and private and public payers or sources for the
14 procurement of health coverage, including capitated payments,
15 self-funded administrative fees, self-funded claim
16 reimbursements, recoveries from third parties or other insurers
17 and interests less any premium tax paid pursuant to Section
18 59A-6-2 NMSA 1978 and fees associated with participating in a
19 health insurance exchange that serves as a clearinghouse for
20 insurance."

21 SECTION 17. A new section of Chapter 59A, Article 22 NMSA
22 1978 is enacted to read:

23 "[NEW MATERIAL] CHILD DEFINED.--As used in Chapter 59A,
24 Article 22 NMSA 1978, "child" means an individual under twenty-
25 six years of age whom the principal insured covers or whom the

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1 applicant for coverage applies to cover, regardless of the
2 individual's financial dependency, residency with a parent,
3 student status, employment and marital status."

4 SECTION 18. A new section of Chapter 59A, Article 22 NMSA
5 1978 is enacted to read:

6 "[NEW MATERIAL] GRANDFATHERED HEALTH PLAN OR GRANDFATHERED
7 HEALTH POLICY COVERAGE.--

8 A. For the purposes of Chapter 59A, Article 22 NMSA
9 1978, "grandfathered health plan" or "grandfathered health
10 policy coverage" means individual coverage provided by a health
11 insurer, health maintenance organization or nonprofit health
12 plan that was in effect on March 23, 2010 and that remains in
13 effect through the original term of coverage or through renewal
14 of the original term.

15 B. A dependent of an individual enrolled in a
16 grandfathered health plan may enroll in a grandfathered health
17 plan or policy if the terms of the plan in effect as of March
18 23, 2010 permitted the dependent to enroll.

19 C. A group health plan that provides coverage on
20 March 23, 2010 may provide for the enrolling of new employees
21 and their dependents in that grandfathered health plan.

22 D. Coverage provided by a health insurer, health
23 maintenance organization or nonprofit health plan pursuant to
24 one or more collective bargaining agreements between employee
25 representatives and one or more employers that was ratified

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1 before March 23, 2010 constitutes a grandfathered health plan
2 until the date on which the last of the collective bargaining
3 agreements relating to the coverage terminates. Any coverage
4 amendment made pursuant to a collective bargaining agreement
5 that relates to the coverage and amends the coverage solely to
6 conform to any requirement of Chapter 59A, Article 22 NMSA 1978
7 shall not be treated as a termination of the collective
8 bargaining agreement."

9 SECTION 19. A new section of Chapter 59A, Article 22 NMSA
10 1978 is enacted to read:

11 "[NEW MATERIAL] GUARANTEED ISSUE--GUARANTEED
12 RENEWABILITY--MAXIMUM WAITING PERIOD--BAN ON PREEXISTING
13 CONDITION EXCLUSIONS.--

14 A. A health insurer shall issue coverage to any
15 individual who requests and offers to purchase the coverage
16 without permanent exclusion of preexisting conditions.

17 B. A health insurer shall renew any policy or plan
18 at the individual's option, except as provided pursuant to
19 rules that the superintendent has promulgated.

20 C. A health insurer may impose a waiting period not
21 to exceed ninety days before payment for any service related to
22 a preexisting condition.

23 D. A health insurer shall offer or make a referral
24 to a transition product to provide coverage during the waiting
25 period due to a preexisting condition.

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1 E. A health insurer may continue and renew a
2 grandfathered plan or policy that has a permanent exclusion of
3 payment for preexisting conditions.

4 F. A health insurer may restrict enrollment in
5 coverage described in Subsection A of this section to open or
6 special enrollment periods; provided that any special
7 enrollment period shall comply with the provisions of Section
8 21 of this 2012 act and rules the superintendent has
9 promulgated.

10 G. For the purposes of this section:

11 (1) "coverage" means a health insurance
12 policy, health care plan, health maintenance organization
13 contract or certificate of insurance issued for delivery in the
14 state. "Coverage" does not mean a short-term, accident, fixed
15 indemnity or specified disease policy; disability income;
16 limited benefit insurance; credit insurance; workers'
17 compensation; or automobile or medical insurance under which
18 benefits are payable with or without regard to fault and that
19 is required by law to be contained in any liability insurance
20 policy; and

21 (2) "preexisting condition" means a physical
22 or mental condition for which medical advice, medication,
23 diagnosis, care or treatment was recommended for or received by
24 an applicant for health insurance within six months before the
25 effective date of coverage, except that pregnancy is not

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1 considered a preexisting condition for federally defined
2 individuals."

3 SECTION 20. A new section of Chapter 59A, Article 22 NMSA
4 1978 is enacted to read:

5 "[NEW MATERIAL] PROHIBITION ON LIFETIME OR ANNUAL LIMITS.--

6 A. Notwithstanding any other provision of law, a
7 group health plan, health insurance issuer offering group or
8 individual health insurance coverage, health maintenance
9 organization, fraternal benefit society or nonprofit
10 organization shall not establish:

11 (1) lifetime limits on the dollar value of
12 benefits for any participant or beneficiary; or

13 (2) except as provided in Subsection B of this
14 section, annual limits on the dollar value of benefits for any
15 participant or beneficiary.

16 B. With respect to plan years beginning prior to
17 January 1, 2014, a group health plan, health insurance issuer
18 offering group or individual health insurance coverage, health
19 maintenance organization, fraternal benefit society or
20 nonprofit organization shall establish a restricted annual
21 limit on the dollar value of benefits for any participant or
22 beneficiary only with respect to the scope of benefits that are
23 essential health benefits, as the superintendent defines
24 "essential health benefits" by rule.

25 C. Subsection A of this section shall not be

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1 construed to prevent a group health plan, health insurance
2 issuer offering group or individual health insurance coverage,
3 health maintenance organization, fraternal benefit society or
4 nonprofit organization from placing annual or lifetime per
5 beneficiary limits on specific covered benefits that are not
6 essential health benefits to the extent that these limits are
7 otherwise permitted under federal or state law.

8 D. The provisions of this section shall not apply
9 to policies or plans intended to supplement major medical
10 group-type coverages such as medicare supplement, long-term
11 care, disability income, specified disease, accident-only,
12 hospital indemnity or other limited-benefit health insurance
13 policies or plans."

14 SECTION 21. A new section of Chapter 59A, Article 22 NMSA
15 1978 is enacted to read:

16 "[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY
17 REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--
18 OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

19 A. For plan or policy years beginning on or after
20 September 23, 2010, if a child's coverage ended or did not
21 begin for the reasons described in Subsection E of this
22 section, a health insurer shall provide the child an
23 opportunity to enroll in a health plan or policy for which
24 coverage continues for at least sixty days and provide written
25 notice of the opportunity to enroll as described in Subsection

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1 B of this section no later than the first day of the plan or
2 policy year.

3 B. A written notice of the opportunity to enroll
4 provided pursuant to this section shall include a statement
5 that children whose coverage ended, who were denied coverage or
6 who were not eligible for coverage because dependent coverage
7 of children was unavailable before the child reached twenty-six
8 years of age, are eligible to enroll in coverage. This notice
9 may be provided to a principal insured on behalf of the
10 principal insured's child.

11 C. For an individual who enrolls in an individual
12 health insurance policy or health plan, the coverage shall take
13 effect not later than the first day of the first plan or policy
14 year.

15 D. A child enrolling pursuant to this section in a
16 group health insurance policy or health plan shall be
17 considered a "special enrollee" pursuant to Section 59A-23E-8
18 NMSA 1978. The child and the principal insured shall be
19 offered all of the benefit packages available to similarly
20 situated individuals who were denied coverage or whose coverage
21 ended by reason of cessation of dependent status. Any
22 difference in benefits or cost-sharing requirements constitutes
23 a different benefit package. The child shall not be required
24 to pay more for coverage than similarly situated individuals
25 who did not lose coverage by reason of cessation of dependent

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1 status.

2 E. The provisions of this section shall apply to a
3 child:

4 (1) whose coverage ended, or who was denied
5 coverage or was not eligible for coverage under an individual
6 or a group health insurance policy or health plan because,
7 under the terms of coverage, the availability of dependent
8 coverage of a child ended before the child reached the age of
9 twenty-six; or

10 (2) who became eligible, or is required to
11 become eligible, for coverage on the first day of the first
12 plan or policy year, beginning on or after September 23, 2010
13 by reason of the provisions of this section."

14 SECTION 22. A new section of Chapter 59A, Article 22 NMSA
15 1978 is enacted to read:

16 "[NEW MATERIAL] GRANDFATHERED HEALTH PLANS--ADULT CHILD
17 DEPENDENT ELIGIBLE FOR EMPLOYER-SPONSORED HEALTH BENEFIT PLAN--
18 EXCLUSION FROM DEPENDENT COVERAGE ELIGIBILITY PERMITTED.--

19 A. For plan years beginning before January 1, 2014,
20 a group health plan providing group health insurance coverage
21 that is a grandfathered health plan and makes available
22 dependent coverage of children may exclude an adult child under
23 twenty-six years of age from coverage only if the adult child
24 is eligible to enroll in an eligible employer-sponsored health
25 benefit plan, as defined in Section 5000A(f)(2) of the federal

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1 Internal Revenue Code of 1986, other than the group health plan
2 of a parent.

3 B. For the purposes of this section "adult child"
4 means an individual eighteen to twenty-six years of age."

5 SECTION 23. A new section of Chapter 59A, Article 22 NMSA
6 1978 is enacted to read:

7 "[NEW MATERIAL] PROHIBITION ON PREEXISTING CONDITION
8 EXCLUSIONS FOR INDIVIDUALS UNDER THE AGE OF NINETEEN.--

9 A. An individual or group health insurance policy,
10 health care plan or certificate of health insurance that is
11 delivered or issued for delivery in this state shall not limit
12 or exclude coverage under an individual or group health benefit
13 plan for an individual under the age of nineteen by imposing a
14 preexisting condition exclusion on that individual.

15 B. When a health insurer offers individual or group
16 health insurance coverage that only covers individuals under
17 age nineteen, that insurer shall offer the coverage
18 continuously throughout the year or during one or more open
19 enrollment periods as the superintendent prescribes by rule.

20 C. During an open enrollment period, a health
21 insurer shall not deny or unreasonably delay the issuance of a
22 policy, plan or certificate, refuse to issue a policy, plan or
23 certificate or issue a policy, plan or certificate with any
24 preexisting condition exclusion rider or endorsement to an
25 applicant or insured who is under the age of nineteen on the

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1 basis of a preexisting condition.

2 D. Coverage shall be effective for those applying
3 during an open enrollment period on the same basis as any
4 applicant qualifying for coverage on an underwritten basis.

5 E. Each health insurer shall provide prior
6 prominent public notice on its web site and written notice to
7 each of its policyholders or plan holders annually at least
8 ninety days before any open enrollment period of the open
9 enrollment rights for individuals under the age of nineteen and
10 shall provide information as to how an individual eligible for
11 this open enrollment right may apply for coverage with the
12 insurer during an open enrollment period."

13 SECTION 24. A new section of Chapter 59A, Article 22 NMSA
14 1978 is enacted to read:

15 "[NEW MATERIAL] EMERGENCY SERVICES.--

16 A. An individual or group health insurance policy,
17 health care plan or certificate of health insurance that is
18 delivered or issued for delivery in this state and that
19 provides or covers any benefits with respect to services in an
20 emergency department of a hospital shall cover emergency
21 services:

22 (1) without the need for any prior
23 authorization determination; and

24 (2) whether or not the health care provider
25 furnishing emergency services is a participating provider with

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1 respect to emergency services.

2 B. If emergency services are provided to a covered
3 individual by a nonparticipating health care provider with or
4 without prior authorization, the services shall be provided
5 without imposing any requirement under the policy, plan or
6 certificate for prior authorization of services or any
7 limitation on coverage where the provider of services does not
8 have a contractual relationship with the insurer for the
9 provision of services that is more restrictive than the
10 requirements or limitations that apply to emergency department
11 services received from providers who do have such a contractual
12 relationship with the health insurer.

13 C. If emergency services are provided out of
14 network, the cost-sharing requirement, expressed as a copayment
15 amount or coinsurance rate, shall be the same requirement that
16 would apply if the emergency services were provided in-network
17 and without regard to any other term or condition of such
18 coverage, other than exclusion or coordination of benefits, or
19 an affiliation or waiting period other than the applicable
20 cost-sharing otherwise permitted pursuant to state or federal
21 law.

22 D. The provisions of this section shall not apply
23 to:

24 (1) policies or plans intended to supplement
25 major medical group-type coverages such as medicare supplement,

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1 long-term care, disability income, specified disease, accident-
2 only, hospital indemnity or other limited-benefit health
3 insurance policies or plans; or

4 (2) health insurance policies, plans,
5 certificates or subscriber agreements that are governed by the
6 provisions of Section 59A-22A-5 NMSA 1978.

7 E. As used in this section:

8 (1) "emergency medical condition" means a
9 medical condition manifesting itself by acute symptoms of
10 sufficient severity, including severe pain, such that a prudent
11 layperson who possesses an average knowledge of health and
12 medicine could reasonably expect the absence of immediate
13 medical attention to result in one of the following conditions:

14 (a) placing the health of the individual
15 or, with respect to a pregnant woman, the health of the woman
16 or her unborn child, in serious jeopardy;

17 (b) serious impairment to bodily
18 functions; or

19 (c) serious dysfunction of any bodily
20 organ or part;

21 (2) "emergency services" means, with respect
22 to an emergency medical condition:

23 (a) a medical screening examination that
24 is within the capability of the emergency department of a
25 hospital, including ancillary services routinely available to

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1 the emergency department to evaluate the emergency medical
2 condition; and

3 (b) according to the capabilities of the
4 staff and facilities available at the hospital, further medical
5 examination and treatment required to stabilize the patient's
6 emergency medical condition or safe transfer of the patient to
7 another medical facility capable of providing the medical
8 examination or treatment required to stabilize the patient's
9 emergency medical condition; and

10 (3) "stabilize" means:

11 (a) to provide medical treatment of an
12 emergency medical condition as necessary to ensure, within
13 reasonable medical probability, that no material deterioration
14 of the condition is likely to result from or occur during the
15 transfer of the individual from a facility; or

16 (b) with respect to a pregnant woman who
17 is having contractions, to deliver, including a placenta."

18 SECTION 25. A new section of Chapter 59A, Article 22 NMSA
19 1978 is enacted to read:

20 "[NEW MATERIAL] OPTION FOR PEDIATRICIAN AS PRIMARY CARE
21 PHYSICIAN.--

22 A. An individual or group health insurance policy,
23 health care plan or certificate of health insurance that is
24 delivered or issued for delivery in this state that requires or
25 provides for the designation of a participating primary care

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1 provider shall allow a principal insured to designate for the
2 principal insured's dependent child who is a covered individual
3 an allopathic or osteopathic physician who specializes in
4 pediatrics as the principal insured child's primary care
5 provider if the provider participates in the network of the
6 plan or issuer.

7 B. Nothing in Subsection A of this section shall be
8 construed to waive any exclusions of coverage under the terms
9 and conditions of the plan or health insurance policy with
10 respect to coverage of pediatric care.

11 C. As used in this section, "primary care provider"
12 means a health care practitioner acting within the scope of the
13 health care practitioner's license who provides the first level
14 of basic or general health care for a covered individual's
15 health needs, including diagnostic and treatment services, who
16 initiates referrals to other health care practitioners and who
17 maintains the continuity of care when appropriate."

18 SECTION 26. A new section of Chapter 59A, Article 22 NMSA
19 1978 is enacted to read:

20 "[NEW MATERIAL] OBSTETRICAL AND GYNECOLOGICAL PRIMARY CARE
21 OPTION.--

22 A. An individual or group health insurance policy,
23 health care plan or certificate of health insurance that is
24 delivered or issued for delivery in this state that provides
25 coverage for obstetrical and gynecological care and that

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1 requires that covered individuals designate a primary care
2 provider shall not require authorization or referral by the
3 plan or issuer or any person, including a primary care
4 provider, when a female covered individual seeks coverage for
5 obstetrical or gynecological care provided by a participating
6 health care professional who specializes in obstetrics or
7 gynecology. The obstetrical or gynecological health care
8 provider shall agree otherwise to adhere to the plan's or
9 issuer's policies and procedures, including procedures
10 regarding referrals, obtaining prior authorization and
11 providing services pursuant to a treatment plan approved by the
12 plan or issuer.

13 B. A health insurer shall treat the provision of
14 obstetrical and gynecological care, and the ordering of related
15 obstetrical and gynecological items and services by a
16 participating health care professional who specializes in
17 obstetrics or gynecology, as the authorization of the primary
18 care provider.

19 C. Nothing in Subsection A of this section shall be
20 construed to:

21 (1) waive any exclusions of coverage under the
22 terms and conditions of the plan or health insurance policy
23 with respect to coverage of obstetrical or gynecological care;
24 or

25 (2) preclude the health insurer from requiring

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1 that the obstetrical or gynecological provider notify the
2 covered individual's primary care health care professional or
3 the plan or issuer of treatment decisions.

4 D. As used in this section, "primary care provider"
5 means a health care practitioner acting within the scope of the
6 health care practitioner's license who provides the first level
7 of basic or general health care for a person's health needs,
8 including diagnostic and treatment services, who initiates
9 referrals to other health care practitioners and who maintains
10 the continuity of care when appropriate."

11 SECTION 27. A new section of Chapter 59A, Article 22 NMSA
12 1978 is enacted to read:

13 "[NEW MATERIAL] PREVENTIVE ITEMS AND SERVICES--PROHIBITION
14 ON COST-SHARING.--

15 A. A health insurer providing coverage under an
16 individual health benefit policy or plan, except for a
17 grandfathered health policy or plan, shall provide coverage for
18 items and services pursuant to Sections 59A-22-34.3, 59A-22-40,
19 59A-22-44 and 59A-22-47 NMSA 1978 and Sections 28 through 30 of
20 this 2012 act and shall not impose any cost-sharing
21 requirements, such as a copayment, coinsurance or deductible.

22 B. A health insurer is not required to provide
23 coverage for any items or services specified in any
24 recommendation or guideline described in Subsection A of this
25 section after the recommendation or guideline is no longer

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1 described by a source listed in that subsection.

2 C. Other provisions of state or federal law may
3 apply in connection with a health insurer's ceasing to provide
4 coverage for any such items or services.

5 D. To the extent that a preventive care provision
6 in this section conflicts with any other preventive health care
7 law in New Mexico, the provision providing the greatest level
8 of coverage shall apply. The preventive care provisions in
9 this section are intended to supplement rather than supplant
10 existing preventive health care provisions in this state.

11 E. The superintendent shall at least annually
12 revise the preventive services standards established pursuant
13 to Sections 59A-22-44 and 59A-22-47 NMSA 1978 and Sections 28
14 through 30 of this 2012 act to ensure that they are
15 respectively consistent with the current "A"-rated and "B"-
16 rated recommendations of the United States preventive services
17 task force, the advisory committee on immunization practices of
18 the federal centers for disease control and prevention and the
19 guidelines with respect to infants, children, adolescents and
20 women of evidence-based preventive care and screenings by the
21 federal health resources and services administration. When
22 changes are made to any of these guidelines or recommendations,
23 the superintendent shall make recommendations to the
24 legislature for legislative changes to conform these standards
25 to current guidelines and recommendations.

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1 F. An insurer may impose cost-sharing requirements
2 with respect to an office visit if a preventive item or service
3 provided pursuant to this section is billed separately or is
4 tracked as individual encounter data separately from the office
5 visit.

6 G. An insurer shall not impose cost-sharing
7 requirements with respect to an office visit for an item or
8 service provided pursuant to this section if an item or service
9 is not billed separately or is not tracked as individual
10 encounter data separately from the office visit and the primary
11 purpose of the office visit is the delivery of the preventive
12 item or service.

13 H. An insurer may impose cost-sharing requirements
14 with respect to an office visit if a preventive item or service
15 provided pursuant to this section is not billed separately or
16 is not tracked as individual encounter data separately from the
17 office visit and the primary purpose of the office visit is not
18 the delivery of the preventive item or service.

19 I. The provisions of this section shall not apply
20 to policies or plans intended to supplement major medical
21 group-type coverages such as medicare supplement, long-term
22 care, disability income, specified disease, accident-only,
23 hospital indemnity or other limited-benefit health insurance
24 policies or plans."

25 **SECTION 28.** A new section of Chapter 59A, Article 22 NMSA

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1 1978 is enacted to read:

2 "[NEW MATERIAL] PREVENTIVE SERVICES BENEFITS--ASPIRIN
3 REGIMEN--HIGH BLOOD PRESSURE SCREENING--BREAST CANCER
4 SCREENING--LIPID DISORDERS SCREENING--COLORECTAL CANCER
5 SCREENING--DEPRESSION SCREENING--BEHAVIORAL DIETARY
6 COUNSELING--OBESITY COUNSELING AND SCREENING--OSTEOPOROSIS
7 SCREENING.--

8 A. An individual or group health insurance policy,
9 health care plan or certificate of health insurance that is
10 delivered or issued for delivery in this state shall provide
11 the following benefits that have, in effect, a rating of "A" or
12 "B" in the current recommendations of the United States
13 preventive services task force, for:

14 (1) a one-time screening for abdominal aortic
15 aneurysm by ultrasonography in men who have ever smoked and who
16 are between the ages of sixty-five and seventy-five;

17 (2) an aspirin regimen for men between the
18 ages of forty-five and seventy-nine when the potential benefit
19 due to a reduction in myocardial infarctions outweighs the
20 potential harm due to an increase in gastrointestinal
21 hemorrhage;

22 (3) an aspirin regimen for women between the
23 ages of fifty-five and seventy-nine when the potential benefit
24 of a reduction in ischemic strokes outweighs the potential harm
25 due to an increase in gastrointestinal hemorrhage;

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1 (4) screening for high blood pressure in
2 adults aged eighteen and older;

3 (5) genetic counseling and evaluation for
4 breast cancer BRCA-gene testing for women whose family
5 histories are associated with an increased risk for deleterious
6 mutations in BRCA1 or BRCA2 genes. Nothing in this section
7 shall be construed as a waiver or exception to the Genetic
8 Information Privacy Act;

9 (6) screening of lipid disorders for:

10 (a) men who are thirty-five years of age
11 or older; and

12 (b) women who are twenty years of age or
13 older who are at increased risk of coronary heart disease;

14 (7) screening of individuals over eighteen
15 years of age for colorectal cancer using fecal occult blood
16 testing, sigmoidoscopy or colonoscopy;

17 (8) screening of individuals eighteen years of
18 age or older for depression;

19 (9) screening of individuals twelve to
20 eighteen years of age for major depressive disorder;

21 (10) behavioral dietary counseling for adults
22 with hyperlipidemia and other known risk factors for
23 cardiovascular and diet-related chronic disease;

24 (11) screening and counseling for obesity for:

25 (a) individuals eighteen years of age

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1 and older who are obese; and

2 (b) individuals six to eighteen years of
3 age; and

4 (12) screening for osteoporosis for:

5 (a) women who are sixty-five years of
6 age and older; and

7 (b) women who are sixty to sixty-five
8 years of age who are at increased risk for osteoporotic
9 fractures.

10 B. The provisions of this section shall not apply
11 to policies or plans intended to supplement major medical
12 group-type coverages such as medicare supplement, long-term
13 care, disability income, specified disease, accident-only,
14 hospital indemnity or other limited-benefit health insurance
15 policies or plans."

16 SECTION 29. A new section of Chapter 59A, Article 22 NMSA
17 1978 is enacted to read:

18 "[NEW MATERIAL] PREVENTIVE SERVICES FOR CHILDREN.--

19 A. An individual or group health insurance policy,
20 health care plan or certificate of health insurance that is
21 delivered or issued for delivery in this state shall provide
22 the following benefits that have, in effect, a rating of "A" or
23 "B" in the current recommendations of the United States
24 preventive services task force, for:

25 (1) oral fluoride supplementation at currently

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1 recommended doses to children six months of age to five years
2 of age whose primary water sources are deficient in fluoride;

3 (2) prophylactic ocular topical medication
4 against gonococcal ophthalmia neonatorum for newborns;

5 (3) screening for hearing loss in newborns;

6 (4) screening for sickle cell disease for
7 newborns;

8 (5) screening for congenital hypothyroidism
9 for newborns;

10 (6) iron supplementation for asymptomatic
11 children six to twelve months of age who are at increased risk
12 for iron deficiency anemia;

13 (7) screening for phenylketonuria in newborns;
14 and

15 (8) screening to detect amblyopia, strabismus
16 and defects in visual acuity in children less than five years
17 of age.

18 B. The provisions of this section shall not apply
19 to policies or plans intended to supplement major medical
20 group-type coverages such as medicare supplement, long-term
21 care, disability income, specified disease, accident-only,
22 hospital indemnity or other limited-benefit health insurance
23 policies or plans."

24 SECTION 30. A new section of Chapter 59A, Article 22 NMSA
25 1978 is enacted to read:

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1 "[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--
2 REPRODUCTIVE HEALTH.--

3 A. An individual or group health insurance policy,
4 health care plan or certificate of health insurance that is
5 delivered or issued for delivery in this state shall provide
6 the following benefits that have, in effect, a rating of "A" or
7 "B" in the current recommendations of the United States
8 preventive services task force, for:

9 (1) screening for asymptomatic bacteriuria
10 with a urine culture for pregnant women;

11 (2) interventions during pregnancy and after
12 birth to promote and support breastfeeding;

13 (3) screening for cervical cancer in women who
14 have been sexually active and have a cervix;

15 (4) screening for chlamydial infection for:

16 (a) all sexually active young women
17 twenty-four years of age and younger; and

18 (b) older women who are at increased
19 risk of chlamydial infection;

20 (5) a daily supplement containing four hundred
21 to eight hundred micrograms of folic acid for any woman
22 planning a pregnancy or capable of pregnancy;

23 (6) screening of all sexually active women who
24 are at increased risk for infection, including those who are
25 pregnant, for gonorrheal infection;

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1 (7) screening for iron deficiency anemia in
2 asymptomatic pregnant women;

3 (8) Rh (D) blood typing and antibody testing
4 for:

5 (a) all pregnant women; and

6 (b) all unsensitized Rh (D) negative
7 women at twenty-four to twenty-eight weeks' gestation;

8 (9) behavioral counseling to prevent sexually
9 transmitted infections in:

10 (a) all sexually active adolescents; and

11 (b) individuals aged eighteen years and
12 older at increased risk for sexually transmitted infections;

13 (10) screening for hepatitis B virus infection
14 in pregnant women;

15 (11) screening for human immunodeficiency
16 virus for individuals twelve years of age and older who are at
17 risk of human immunodeficiency virus infection;

18 (12) screening for iron deficiency anemia in
19 asymptomatic pregnant women; and

20 (13) screening for syphilis for:

21 (a) any individual at increased risk for
22 syphilis infection; and

23 (b) any pregnant woman.

24 B. The provisions of this section shall not apply
25 to policies or plans intended to supplement major medical

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1 group-type coverages such as medicare supplement, long-term
2 care, disability income, specified disease, accident-only,
3 hospital indemnity or other limited-benefit health insurance
4 policies or plans."

5 SECTION 31. Section 59A-23-6 NMSA 1978 (being Laws 1983,
6 Chapter 64, Section 1, as amended) is amended to read:

7 "59A-23-6. ALCOHOL DEPENDENCY AND MISUSE COVERAGE.--

8 A. Each insurer that delivers or issues for
9 delivery in this state a group health insurance policy shall
10 offer and make available benefits for the necessary care and
11 treatment of alcohol dependency [~~Such~~] and misuse. These
12 benefits shall

13 [~~(1) be subject to annual deductibles and~~
14 ~~coinsurance consistent with those imposed on other benefits~~
15 ~~within the same policy;~~

16 (2)] provide [~~no less than thirty days~~]
17 necessary care and treatment in an alcohol dependency and
18 misuse treatment center and [~~thirty~~] outpatient visits for
19 alcohol dependency and misuse treatment [~~and~~

20 (3) ~~be offered for benefit periods of no more~~
21 ~~than one year and may be limited to a lifetime maximum of no~~
22 ~~less than two benefit periods. Such offer of benefits shall be~~
23 ~~subject to the rights of the group health insurance holder to~~
24 ~~reject the coverage or to select any alternative level of~~
25 ~~benefits if that right is offered by or negotiated with that~~

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1 ~~insurer~~].

2 B. For purposes of this section, "alcohol
3 dependency and misuse treatment center" means a facility that
4 provides a program for the treatment of alcohol dependency and
5 misuse pursuant to a written treatment plan approved and
6 monitored by a physician or meeting the quality standards of
7 the behavioral health services division of the human services
8 department and which facility also:

9 (1) is affiliated with a hospital under a
10 contractual agreement with an established system for patient
11 referral;

12 (2) is accredited as such a facility by the
13 joint commission [~~on accreditation of hospitals~~]; or

14 (3) meets at least the minimum standards
15 adopted by the behavioral health services division for
16 treatment of [~~alcoholism~~] alcohol dependency and misuse in
17 regional treatment centers.

18 C. This section applies to policies delivered or
19 issued for delivery or renewed, extended or amended in this
20 state on or after July 1, 1983 or upon expiration of a
21 collective bargaining agreement applicable to a particular
22 policyholder, whichever is later; provided that this section
23 does not apply to blanket, short-term travel, accident-only,
24 limited or specified disease, individual conversion policies or
25 policies designed for issuance to persons eligible for coverage

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1 under Title 18 of the Social Security Act, known as medicare,
2 or any other similar coverage under state or federal
3 governmental plans. With respect to any policy forms approved
4 by the insurance division of the public regulation commission
5 prior to the effective date of this section, an insurer is
6 authorized to comply with this section by the use of
7 endorsements or riders, provided such endorsements or riders
8 are approved by the insurance division as being in compliance
9 with this section and applicable provisions of the Insurance
10 Code.

11 D. If an organization offering group health
12 benefits to its members makes more than one health insurance
13 policy or nonprofit health care plan available to its members
14 on a member option basis, the organization shall not require
15 alcohol dependency and misuse coverage from one health insurer
16 or health care plan without requiring the same level of alcohol
17 dependency and misuse coverage for all other health insurance
18 policies or health care plans that the organization makes
19 available to its members."

20 SECTION 32. Section 59A-23-7.2 NMSA 1978 (being Laws
21 1994, Chapter 64, Section 5, as amended) is amended to read:

22 "59A-23-7.2. COVERAGE OF CHILDREN.--

23 A. An insurer shall not deny enrollment of a child
24 under the health plan or policy of the child's parent on the
25 grounds that the child:

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1 (1) was born out of wedlock;

2 (2) is not claimed as a dependent on the
3 parent's federal tax return; or

4 (3) does not reside with the parent or in the
5 insurer's service area.

6 B. When a child has health coverage through an
7 insurer of a noncustodial parent, the insurer shall:

8 (1) provide such information to the custodial
9 parent as may be necessary for the child to obtain benefits
10 through that coverage;

11 (2) permit the custodial parent or the
12 provider, with the custodial parent's approval, to submit
13 claims for covered services without the approval of the
14 noncustodial parent; and

15 (3) make payments on claims submitted in
16 accordance with Paragraph (2) of this subsection directly to
17 the custodial parent, the provider or the state medicaid
18 agency.

19 C. When a parent is required by a court or
20 administrative order to provide health coverage for a child and
21 the parent is eligible for family health coverage, the insurer
22 shall be required:

23 (1) to permit the parent to enroll, under the
24 family coverage, a child who is otherwise eligible for the
25 coverage without regard to any enrollment season restrictions;

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1 (2) if the parent is enrolled but fails to
2 make application to obtain coverage for the child, to enroll
3 the child under family coverage upon application of the child's
4 other parent, the state agency administering the medicaid
5 program or the state agency administering 42 U.S.C. Sections
6 651 through 669, the child support enforcement program; and

7 (3) not to disenroll or eliminate coverage of
8 the child unless the insurer is provided satisfactory written
9 evidence that:

10 (a) the court or administrative order is
11 no longer in effect; or

12 (b) the child is or will be enrolled in
13 comparable health coverage through another insurer or plan that
14 will take effect not later than the effective date of
15 disenrollment.

16 D. An insurer shall not impose requirements on a
17 state agency that has been assigned the rights of an individual
18 eligible for medical assistance under the medicaid program and
19 covered for health benefits from the insurer that are different
20 from requirements applicable to an agent or assignee of any
21 other individual so covered.

22 E. An insurer shall provide coverage for children,
23 from birth through three years of age, for or under the family,
24 infant, toddler program administered by the department of
25 health, provided that eligibility criteria are met [~~for a~~

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1 ~~maximum benefit of three thousand five hundred dollars (\$3,500)~~
2 ~~annually]~~ for medically necessary early intervention services
3 provided as part of an individualized family service plan and
4 delivered by certified and licensed personnel as defined in
5 7.30.8 NMAC who are working in early intervention programs
6 approved by the department of health. ~~[No payment under this~~
7 ~~subsection shall be applied against any maximum lifetime or~~
8 ~~annual limits specified in the policy, health benefits plan or~~
9 ~~contract.]"~~

10 SECTION 33. Section 59A-23-7.3 NMSA 1978 (being Laws
11 2003, Chapter 391, Section 3) is amended to read:

12 "59A-23-7.3. MAXIMUM AGE OF ~~[DEPENDENT]~~ CHILD.--Each
13 blanket or group health policy or certificate of insurance
14 delivered, issued for delivery or renewed in New Mexico on or
15 after July 1, 2003 that provides coverage for an insured's
16 ~~[dependent]~~ child shall not terminate coverage of ~~[an unmarried~~
17 ~~dependent]~~ a child by reason of the ~~[dependent's]~~ child's age
18 before the ~~[dependent's twenty-fifth]~~ child's twenty-sixth
19 birthday ~~[regardless of whether the dependent is enrolled in an~~
20 ~~educational institution]."~~

21 SECTION 34. Section 59A-23-7.9 NMSA 1978 (being Laws
22 2009, Chapter 74, Section 2) is amended to read:

23 "59A-23-7.9. COVERAGE FOR AUTISM SPECTRUM DISORDER
24 DIAGNOSIS AND TREATMENT.--

25 A. A blanket or group health insurance policy or

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1 contract that is delivered, issued for delivery or renewed in
2 this state shall provide coverage to an eligible individual who
3 is nineteen years of age or younger or an eligible individual
4 who is twenty-two years of age or younger and is enrolled in
5 high school for:

6 (1) well-baby and well-child screening for
7 diagnosing the presence of autism spectrum disorder; and

8 (2) treatment of autism spectrum disorder
9 through speech therapy, occupational therapy, physical therapy
10 and applied behavioral analysis.

11 B. Coverage required pursuant to Subsection A of
12 this section:

13 (1) shall be limited to treatment that is
14 prescribed by the insured's treating physician in accordance
15 with a treatment plan;

16 ~~[(2) shall be limited to thirty-six thousand~~
17 ~~dollars (\$36,000) annually and shall not exceed two hundred~~
18 ~~thousand dollars (\$200,000) in total lifetime benefits.~~

19 ~~Beginning January 1, 2011, the maximum benefit shall be~~
20 ~~adjusted annually on January 1 to reflect any change from the~~
21 ~~previous year in the medical component of the then-current~~
22 ~~consumer price index for all urban consumers published by the~~
23 ~~bureau of labor statistics of the United States department of~~
24 ~~labor;~~

25 ~~(3)]~~ (2) shall not be denied on the basis that

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1 the services are habilitative or rehabilitative in nature;
2 [~~(4)~~] (3) may be subject to other general
3 exclusions and limitations of the insurer's policy or plan,
4 including, but not limited to, coordination of benefits,
5 participating provider requirements, restrictions on services
6 provided by family or household members and utilization review
7 of health care services, including the review of medical
8 necessity, case management and other managed care provisions;
9 and

10 [~~(5)~~] (4) may be limited to exclude coverage
11 for services received under the federal Individuals with
12 Disabilities Education Improvement Act of 2004 and related
13 state laws that place responsibility on state and local school
14 boards for providing specialized education and related services
15 to children three to twenty-two years of age who have autism
16 spectrum disorder.

17 C. The coverage required pursuant to Subsection A
18 of this section shall not be subject to dollar limits,
19 deductibles or coinsurance provisions that are less favorable
20 to an insured than the dollar limits, deductibles or
21 coinsurance provisions that apply to physical illnesses that
22 are generally covered under the blanket or group health
23 insurance policy or contract, except as otherwise provided in
24 Subsection B of this section.

25 D. An insurer shall not deny or refuse to issue

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1 health insurance coverage for medically necessary services or
2 refuse to contract with, renew, reissue or otherwise terminate
3 or restrict health insurance coverage for an individual because
4 the individual is diagnosed as having autism spectrum disorder.

5 E. The treatment plan required pursuant to
6 Subsection B of this section shall include all elements
7 necessary for the health insurance plan or policy to pay claims
8 appropriately. These elements include, but are not limited to:

- 9 (1) the diagnosis;
10 (2) the proposed treatment by types;
11 (3) the frequency and duration of treatment;
12 (4) the anticipated outcomes stated as goals;
13 (5) the frequency with which the treatment
14 plan will be updated; and
15 (6) the signature of the treating physician.

16 F. This section shall not be construed as limiting
17 benefits and coverage otherwise available to an insured under a
18 health insurance plan or policy.

19 G. The provisions of this section shall not apply
20 to plans or policies intended to supplement major medical
21 group-type coverages such as medicare supplement, long-term
22 care, disability income, specified disease, accident-only,
23 hospital indemnity or other limited-benefit health insurance
24 plans or policies.

25 H. As used in this section:

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1 (1) "autism spectrum disorder" means a
2 condition that meets the diagnostic criteria for the pervasive
3 developmental disorders published in the *Diagnostic and*
4 *Statistical Manual of Mental Disorders*, fourth edition, text
5 revision, also known as DSM-IV-TR, published by the American
6 psychiatric association, including autistic disorder;
7 Asperger's disorder; pervasive development disorder not
8 otherwise specified; Rett's disorder; and childhood
9 disintegrative disorder;

10 (2) "habilitative or rehabilitative services"
11 means treatment programs that are necessary to develop,
12 maintain and restore to the maximum extent practicable the
13 functioning of an individual; and

14 (3) "high school" means a school providing
15 instruction for any of the grades nine through twelve."

16 SECTION 35. A new section of Chapter 59A, Article 23 NMSA
17 1978 is enacted to read:

18 "[NEW MATERIAL] PROHIBITION ON LIFETIME OR ANNUAL
19 LIMITS.--

20 A. Notwithstanding any other provision of law, a
21 group or blanket health policy, plan or certificate of
22 insurance that is issued or delivered in the state shall not
23 establish:

24 (1) a lifetime limit on the dollar value of
25 any benefits for any participant or beneficiary; or

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1 (2) except as provided in Subsection B of this
2 section, annual limits on the dollar value of benefits for any
3 participant or beneficiary.

4 B. With respect to policy or plan years beginning
5 prior to January 1, 2014, a group health plan or health
6 insurance issuer offering group or blanket coverage shall
7 establish a restricted annual limit on the dollar value of
8 benefits for any participant or beneficiary only with respect
9 to the scope of benefits that are essential health benefits, as
10 the superintendent defines "essential health benefits" by rule.

11 C. Subsection A of this section shall not be
12 construed to prevent a group or blanket insurer offering group
13 or blanket health insurance coverage from placing annual or
14 lifetime per beneficiary limits on specific covered benefits
15 that are not essential health benefits to the extent that these
16 limits are otherwise permitted under federal or state law.

17 D. The provisions of this section shall not apply
18 to policies or plans intended to supplement major medical
19 group-type coverages such as medicare supplement, long-term
20 care, disability income, specified disease, accident only,
21 hospital indemnity or other limited-benefit health insurance
22 policies or plans."

23 SECTION 36. A new section of Chapter 59A, Article 23 NMSA
24 1978 is enacted to read:

25 "[NEW MATERIAL] CHILD DEFINED.--For the purposes of

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1 Chapter 59A, Article 23 NMSA 1978, "child" means an individual
2 under twenty-six years of age whom the principal insured covers
3 or whom the applicant for coverage applies to cover, regardless
4 of the individual's financial dependency, residency with a
5 parent, student status, employment or marital status."

6 SECTION 37. A new section of Chapter 59A, Article 23 NMSA
7 1978 is enacted to read:

8 "[NEW MATERIAL] GRANDFATHERED HEALTH PLAN OR GRANDFATHERED
9 HEALTH POLICY COVERAGE.--

10 A. For the purposes of Chapter 59A, Article 23 NMSA
11 1978, "grandfathered health plan" or "grandfathered health
12 policy coverage" means individual coverage provided by a health
13 insurer, health maintenance organization or nonprofit health
14 plan that was in effect on March 23, 2010 and that remains in
15 effect through the original term of coverage or through renewal
16 of the original term.

17 B. A dependent of an individual enrolled in a
18 grandfathered health plan may enroll in a grandfathered health
19 plan or policy if the terms of the plan in effect as of March
20 23, 2010 permitted the dependent to enroll.

21 C. A group health plan that provides coverage on
22 March 23, 2010 may provide for the enrolling of new employees
23 and their dependents in that grandfathered health plan.

24 D. Coverage provided by a health insurer, health
25 maintenance organization or nonprofit health plan pursuant to

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1 one or more collective bargaining agreements between employee
2 representatives and one or more employers that was ratified
3 before March 23, 2010 constitutes a grandfathered health plan
4 until the date on which the last of the collective bargaining
5 agreements relating to the coverage terminates. Any coverage
6 amendment made pursuant to a collective bargaining agreement
7 that relates to the coverage and amends the coverage solely to
8 conform to any requirement of Chapter 59A, Article 23 NMSA 1978
9 shall not be treated as a termination of the collective
10 bargaining agreement."

11 SECTION 38. A new section of Chapter 59A, Article 23 NMSA
12 1978 is enacted to read:

13 "[NEW MATERIAL] DIRECT SERVICES.--

14 A. A health insurer shall make reimbursement for
15 direct services at a level not less than eighty-five percent of
16 premiums across all health product lines over the preceding
17 three calendar years, but not earlier than calendar year 2010,
18 as determined by reports filed with the insurance division of
19 the commission. Nothing in this subsection shall be construed
20 to preclude a purchaser from negotiating an agreement with a
21 health insurer that requires a higher amount of premiums paid
22 to be used for reimbursement for direct services for one or
23 more products or for one or more years.

24 B. An insurer that fails to comply with the
25 eighty-five percent reimbursement requirement in Subsection A

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1 of this section shall issue a dividend or credit against future
2 premiums to all policyholders in an amount sufficient to assure
3 that the benefits paid in the preceding three calendar years
4 plus the amount of the dividends or credits equal eighty-five
5 percent of the premiums collected in the preceding three
6 calendar years. If the insurer fails to issue the dividend or
7 credit in accordance with the requirements of this section, the
8 superintendent shall enforce the requirements and may pursue
9 any other penalties as provided by law, including general
10 penalties pursuant to Section 59A-1-18 NMSA 1978.

11 C. After notice and hearing, the superintendent may
12 adopt and promulgate reasonable rules necessary and proper to
13 carry out the provisions of this section.

14 D. For the purposes of this section:

15 (1) "direct services" means services rendered
16 to an individual by a health insurer or a health care
17 practitioner, facility or other provider, including case
18 management, disease management, health education and promotion,
19 preventive services, quality incentive payments to providers
20 and any portion of an assessment that covers services rather
21 than administration and for which an insurer does not receive a
22 tax credit pursuant to the Medical Insurance Pool Act or the
23 Health Insurance Alliance Act; provided, however, that "direct
24 services" does not include care coordination, utilization
25 review or management or any other activity designed to manage

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1 utilization or services;

2 (2) "health insurer" means a person duly
3 authorized to transact the business of health insurance in the
4 state pursuant to the Insurance Code but does not include a
5 person that only issues a limited-benefit policy intended to
6 supplement major medical coverage, including medicare
7 supplement, vision, dental, disease-specific, accident-only or
8 hospital indemnity-only insurance policies, or that only issues
9 policies for long-term care or disability income; and

10 (3) "premium" means all income received from
11 individuals and private and public payers or sources for the
12 procurement of health coverage, including capitated payments,
13 self-funded administrative fees, self-funded claim
14 reimbursements, recoveries from third parties or other insurers
15 and interests less any premium tax paid pursuant to Section
16 59A-6-2 NMSA 1978 and fees associated with participating in a
17 health insurance exchange that serves as a clearinghouse for
18 insurance."

19 SECTION 39. A new section of Chapter 59A, Article 23 NMSA
20 1978 is enacted to read:

21 "[NEW MATERIAL] PROHIBITION ON RESCISSIONS OF COVERAGE.--

22 A. A health insurer or insurer providing coverage
23 under a group or blanket health benefit plan or policy or a
24 grandfathered health plan shall not rescind coverage under a
25 group or blanket health benefit policy or with respect to an

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1 individual, including a group to which the individual belongs
2 or family coverage in which the individual is included, after
3 the individual is covered under the plan or policy, unless a
4 covered individual:

5 (1) engages in conduct that constitutes fraud;

6 or

7 (2) makes an intentional misrepresentation of
8 material fact, as prohibited by the terms of the plan or
9 coverage.

10 B. A health insurer shall provide at least thirty
11 days' advance written notice to each plan or policy enrollee,
12 or for individual health insurance coverage, to each primary
13 subscriber, who would be affected by the proposed rescission of
14 coverage before coverage under the plan or policy may be
15 rescinded in accordance with Subsection A of this section,
16 regardless, in the case of group health insurance coverage, of
17 whether the rescission applies to the entire group or only to
18 an individual within the group.

19 C. The provisions of this section apply regardless
20 of any applicable contestability period."

21 SECTION 40. A new section of Chapter 59A, Article 23 NMSA
22 1978 is enacted to read:

23 "[NEW MATERIAL] GUARANTEED ISSUE--MAXIMUM WAITING PERIOD--
24 BAN ON PREEXISTING CONDITION EXCLUSIONS.--

25 A. Except as provided pursuant to Subsection B of

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1 this section, a health insurer that offers a health benefit
2 plan providing group health insurance coverage in the state
3 shall issue any health benefit plan to any employer that
4 applies for such plan and agrees to make the required premium
5 payments and to satisfy the other reasonable provisions of the
6 health policy or plan. An insurer:

7 (1) shall offer coverage to all of the
8 eligible employees of the employer and their children and
9 dependents who apply for enrollment during the period in which
10 the employee first becomes eligible to enroll under the terms
11 of the plan; and

12 (2) shall not offer coverage to only certain
13 individuals or certain children or dependents of employees in
14 the group or to only part of the group.

15 B. A health insurer that offers coverage through a
16 network plan shall not be required to offer coverage under that
17 plan or accept applications for that plan pursuant to
18 Subsection A of this section under the following circumstances:

19 (1) to an employer, where the employer is not
20 physically located in the insurer's established geographic
21 service area for the network plan;

22 (2) to an employee, when the employee does not
23 live, work or reside within the insurer's established
24 geographic service area for the network plan; or

25 (3) within the geographic service area for the

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1 network plan where the insurer reasonably anticipates, and
2 demonstrates to the satisfaction of the superintendent, that it
3 will not have the capacity within its established geographic
4 service area to deliver service adequately to the members of
5 the groups because of its obligations to existing group
6 policyholders and enrollees.

7 C. A health insurer may restrict enrollment in
8 coverage described in Subsection A of this section to open or
9 special enrollment periods; provided that any special
10 enrollment period shall comply with the provisions of Section
11 41 of this 2012 act and rules that the superintendent has
12 promulgated.

13 D. A health insurer may impose a waiting period not
14 to exceed ninety days before payment for any service related to
15 a preexisting condition. A health insurer shall offer or make
16 a referral to a transition product to provide coverage during
17 the waiting period due to a preexisting condition.

18 E. A health insurer may continue and renew a
19 grandfathered plan or policy that has a permanent exclusion of
20 payment for preexisting conditions.

21 F. A health insurer shall renew any health benefit
22 plan at the option of the employer, except as the
23 superintendent has provided by rule.

24 G. For the purposes of this section:

25 (1) "coverage" means a health insurance

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1 policy, health care plan, health maintenance organization
2 contract or certificate of insurance issued for delivery in the
3 state. "Coverage" does not mean a short-term, accident, fixed
4 indemnity or specified disease policy; disability income;
5 limited benefit insurance; credit insurance; workers'
6 compensation; or automobile or medical insurance under which
7 benefits are payable with or without regard to fault and that
8 is required by law to be contained in any liability insurance
9 policy; and

10 (2) "preexisting condition" means a physical
11 or mental condition for which medical advice, medication,
12 diagnosis, care or treatment was recommended for or received by
13 an applicant for health insurance within six months before the
14 effective date of coverage, except that pregnancy is not
15 considered a preexisting condition for federally defined
16 individuals."

17 SECTION 41. A new section of Chapter 59A, Article 23 NMSA
18 1978 is enacted to read:

19 "[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY
20 REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--
21 OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

22 A. For plan or policy years beginning on or after
23 September 23, 2010, if a child's coverage ended or did not
24 begin for the reasons described in Subsection E of this
25 section, a health insurer shall provide the child an

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1 opportunity to enroll in a health plan or policy for which
2 coverage continues for at least sixty days and provide written
3 notice of the opportunity to enroll, as described in Subsection
4 B of this section, no later than the first day of the plan or
5 policy year.

6 B. A written notice of the opportunity to enroll
7 provided pursuant to this section shall include a statement
8 that children whose coverage ended, who were denied coverage or
9 who were not eligible for coverage because dependent coverage
10 of children was unavailable before the child reached twenty-six
11 years of age are eligible to enroll in coverage. This notice
12 may be provided to a principal insured on behalf of the
13 principal insured's child. For a group plan or policy, the
14 notice may be included with other enrollment materials that the
15 health insurer distributes to employees, provided the statement
16 is prominent. If the notice is provided to an employee whose
17 child is entitled to an enrollment opportunity under Subsection
18 A of this section, the obligation to provide the notice of
19 enrollment opportunity under this subsection is satisfied for
20 both the individual or group health insurance policy, health
21 care plan or certificate of health insurance and the health
22 insurer.

23 C. For an individual who enrolls in a group health
24 insurance policy, health care plan or certificate of health
25 insurance pursuant to Subsection A of this section, the

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1 coverage shall take effect not later than the first day of the
2 first plan or policy year.

3 D. A child enrolling pursuant to this section in a
4 group health insurance policy, health care plan or certificate
5 of health insurance shall be considered a "special enrollee"
6 pursuant to Section 59A-23E-8 NMSA 1978. The child and the
7 principal insured shall be offered all of the benefit packages
8 available to similarly situated individuals who were denied
9 coverage or whose coverage ended by reason of cessation of
10 dependent status. Any difference in benefits or cost-sharing
11 requirements constitutes a different benefit package. The
12 child shall not be required to pay more for coverage than
13 similarly situated individuals who did not lose coverage by
14 reason of cessation of dependent status.

15 E. The provisions of this section shall apply to a
16 child:

17 (1) whose coverage ended, or who was denied
18 coverage or was not eligible for coverage under a group health
19 insurance policy, health care plan or certificate of health
20 insurance, because under the terms of coverage the availability
21 of dependent coverage of a child ended before the child reached
22 the age of twenty-six; or

23 (2) who became eligible, or is required to
24 become eligible, for coverage on the first day of the first
25 plan or policy year, beginning on or after September 23, 2010,

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1 by reason of the provisions of this section."

2 SECTION 42. A new section of Chapter 59A, Article 23 NMSA
3 1978 is enacted to read:

4 "[NEW MATERIAL] PROHIBITION OF DISCRIMINATION IN FAVOR OF
5 HIGHLY COMPENSATED INDIVIDUALS--EXCLUSIONS.--

6 A. A blanket or group health insurance policy, plan
7 or contract that is delivered, issued for delivery or renewed
8 in this state on behalf of an employer shall not discriminate
9 in favor of highly compensated individuals as to eligibility to
10 participate or as to the benefits offered. The benefits
11 provided for participants who are highly compensated
12 individuals shall be provided for all other participants.

13 B. An employer shall ensure that any employer-
14 sponsored group health coverage it offers is offered to:

15 (1) seventy percent or more of all of that
16 employer's employees;

17 (2) eighty percent or more of all of that
18 employer's employees who are eligible to benefit under the
19 policy, plan or contract if seventy percent or more of all
20 employees are eligible to benefit; or

21 (3) any employees that qualify under a
22 classification that the employer has established and that the
23 secretary of the United States department of health and human
24 services has approved.

25 C. An employer may exclude the following types of

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1 employees from an offering of health coverage under Subsections
2 A and B of this section:

3 (1) employees who have not completed three
4 years of service;

5 (2) employees who have not attained twenty-
6 five years of age;

7 (3) part-time or seasonal employees;

8 (4) employees not included in the plan who are
9 included in a unit of employees covered by an agreement between
10 employee representatives and one or more employers that the
11 secretary of the United States department of health and human
12 services has found to be a collective bargaining agreement, if
13 accident and health benefits were the subject of good-faith
14 bargaining between these employee representatives and the
15 employer or employers; and

16 (5) employees who are nonresident aliens of
17 the United States and who receive no earned income, within the
18 meaning of Section 911(d)(2) of the federal Internal Revenue
19 Code of 1986, from the employer, that constitutes income from
20 sources within the United States, as defined in Section
21 861(a)(3) of the federal Internal Revenue Code of 1986.

22 D. As used in this section, "highly compensated
23 individual" means an individual who is:

24 (1) one of the five highest paid officers of
25 an employer;

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1 (2) a shareholder who owns more than ten
2 percent in the value of the employer's stock, pursuant to
3 Section 318 of the federal Internal Revenue Code of 1986; or

4 (3) among the highest paid twenty-five percent
5 of all employees who do not belong to any category listed in
6 Subsection C of this section."

7 SECTION 43. A new section of Chapter 59A, Article 23 NMSA
8 1978 is enacted to read:

9 "[NEW MATERIAL] GRANDFATHERED HEALTH PLANS--ADULT CHILD
10 DEPENDENT ELIGIBLE FOR EMPLOYER-SPONSORED HEALTH BENEFIT
11 PLAN--EXCLUSION FROM DEPENDENT COVERAGE ELIGIBILITY
12 PERMITTED.--

13 A. For plan years beginning before January 1, 2014,
14 a group health plan providing group health insurance coverage
15 that is a grandfathered health plan and makes available
16 dependent coverage of children may exclude an adult child under
17 twenty-six years of age from coverage only if the adult child
18 is eligible to enroll in an eligible employer-sponsored health
19 benefit plan, as defined in Section 5000A(f)(2) of the federal
20 Internal Revenue Code of 1986, other than the group health plan
21 of a parent.

22 B. For the purposes of this section, "adult child"
23 means an individual eighteen to twenty-six years of age."

24 SECTION 44. A new section of Chapter 59A, Article 23 NMSA
25 1978 is enacted to read:

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1 "[NEW MATERIAL] PROHIBITION ON PREEXISTING CONDITION

2 EXCLUSIONS FOR INDIVIDUALS UNDER THE AGE OF NINETEEN.--

3 A. A group health insurance policy, health care
4 plan or certificate of health insurance that is delivered or
5 issued for delivery in this state shall not limit or exclude
6 coverage under a group health benefit plan for an individual
7 under the age of nineteen by imposing a preexisting condition
8 exclusion on that individual.

9 B. When a health insurer offers individual or group
10 health insurance coverage that only covers individuals under
11 the age of nineteen, that insurer shall offer the coverage
12 continuously throughout the year or during one or more open
13 enrollment periods as the superintendent prescribes by rule.

14 C. During an open enrollment period, a health
15 insurer shall not deny or unreasonably delay the issuance of a
16 policy, plan or certificate, refuse to issue a policy, plan or
17 certificate or issue a policy, plan or certificate with any
18 preexisting condition exclusion rider or endorsement to an
19 applicant or insured who is under the age of nineteen on the
20 basis of a preexisting condition.

21 D. Coverage shall be effective for those applying
22 during an open enrollment period on the same basis as any
23 applicant qualifying for coverage on an underwritten basis.

24 E. Each health insurer shall provide prior
25 prominent public notice on its web site and written notice to

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1 each of its policyholders or plan holders annually at least
2 ninety days before any open enrollment period of the open
3 enrollment rights for individuals under the age of nineteen and
4 shall provide information as to how an individual eligible for
5 this open enrollment right may apply for coverage with the
6 insurer during an open enrollment period."

7 SECTION 45. A new section of Chapter 59A, Article 23 NMSA
8 1978 is enacted to read:

9 "[NEW MATERIAL] EMERGENCY SERVICES.--

10 A. A group health insurance policy, health care
11 plan or certificate of health insurance that is delivered or
12 issued for delivery in this state and that provides or covers
13 any benefits with respect to services in an emergency
14 department of a hospital shall cover emergency services:

15 (1) without the need for any prior
16 authorization determination; and

17 (2) whether or not the health care provider
18 furnishing emergency services is a participating provider with
19 respect to emergency services.

20 B. If emergency services are provided to a covered
21 individual by a nonparticipating health care provider with or
22 without prior authorization, the services shall be provided
23 without imposing any requirement under the policy, plan or
24 certificate for prior authorization of services or any
25 limitation on coverage where the provider of services does not

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1 have a contractual relationship with the insurer for the
2 provision of services that is more restrictive than the
3 requirements or limitations that apply to emergency department
4 services received from providers who do have such a contractual
5 relationship with the health insurer.

6 C. If emergency services are provided out of
7 network, the cost-sharing requirement, expressed as a copayment
8 amount or coinsurance rate, shall be the same requirement that
9 would apply if the emergency services were provided in-network
10 and without regard to any other term or condition of such
11 coverage, other than exclusion or coordination of benefits, or
12 an affiliation or waiting period other than the applicable
13 cost-sharing otherwise permitted pursuant to state or federal
14 law.

15 D. The provisions of this section shall not apply
16 to:

17 (1) policies or plans intended to supplement
18 major medical group-type coverages such as medicare supplement,
19 long-term care, disability income, specified disease, accident-
20 only, hospital indemnity or other limited-benefit health
21 insurance policies or plans; or

22 (2) health insurance policies, plans,
23 certificates or subscriber agreements that are governed by the
24 provisions of Section 59A-22A-5 NMSA 1978.

25 E. As used in this section:

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1 (1) "emergency medical condition" means a
2 medical condition manifesting itself by acute symptoms of
3 sufficient severity, including severe pain, such that a prudent
4 layperson who possesses an average knowledge of health and
5 medicine could reasonably expect the absence of immediate
6 medical attention to result in one of the following conditions:

7 (a) placing the health of the individual
8 or, with respect to a pregnant woman, the health of the woman
9 or her unborn child, in serious jeopardy;

10 (b) serious impairment to bodily
11 functions; or

12 (c) serious dysfunction of any bodily
13 organ or part;

14 (2) "emergency services" means, with respect
15 to an emergency medical condition:

16 (a) a medical screening examination that
17 is within the capability of the emergency department of a
18 hospital, including ancillary services routinely available to
19 the emergency department to evaluate the emergency medical
20 condition; and

21 (b) according to the capabilities of the
22 staff and facilities available at the hospital, further medical
23 examination and treatment required to stabilize the patient's
24 emergency medical condition or safe transfer of the patient to
25 another medical facility capable of providing the medical

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1 examination or treatment required to stabilize the patient's
2 emergency medical condition; and

3 (3) "stabilize" means:

4 (a) to provide medical treatment of an
5 emergency medical condition as necessary to ensure, within
6 reasonable medical probability, that no material deterioration
7 of the condition is likely to result from or occur during the
8 transfer of the individual from a facility; or

9 (b) with respect to a pregnant woman who
10 is having contractions, to deliver, including a placenta."

11 SECTION 46. A new section of Chapter 59A, Article 23 NMSA
12 1978 is enacted to read:

13 "[NEW MATERIAL] OPTION FOR PEDIATRICIAN AS PRIMARY CARE
14 PROVIDER.--

15 A. A group health insurance policy, health care
16 plan or certificate of health insurance that is delivered or
17 issued for delivery in this state that requires or provides for
18 the designation of a participating primary care provider shall
19 allow a principal insured to designate for the principal
20 insured's dependent child who is a covered individual an
21 allopathic or osteopathic physician who specializes in
22 pediatrics as the principal insured child's primary care
23 provider if the provider participates in the network of the
24 plan or issuer.

25 B. Nothing in Subsection A of this section shall be

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1 construed to waive any exclusions of coverage under the terms
2 and conditions of the plan or health insurance policy with
3 respect to coverage of pediatric care.

4 C. As used in this section, "primary care provider"
5 means a health care practitioner acting within the scope of the
6 health care practitioner's license who provides the first level
7 of basic or general health care for a covered individual's
8 health needs, including diagnostic and treatment services, who
9 initiates referrals to other health care practitioners and who
10 maintains the continuity of care when appropriate."

11 SECTION 47. A new section of Chapter 59A, Article 23 NMSA
12 1978 is enacted to read:

13 "[NEW MATERIAL] OBSTETRICAL AND GYNECOLOGICAL CARE
14 OPTION.--

15 A. A group health insurance policy, health care
16 plan or certificate of health insurance that is delivered or
17 issued for delivery in this state that provides coverage for
18 obstetrical and gynecological care and that requires that
19 covered individuals designate a primary care provider shall not
20 require authorization or referral by the plan or issuer or any
21 person, including a primary care provider, when a female
22 covered individual seeks coverage for obstetrical or
23 gynecological care provided by a participating health care
24 professional who specializes in obstetrics or gynecology. The
25 obstetrical or gynecological health care provider shall agree

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1 otherwise to adhere to the plan's or issuer's policies and
2 procedures, including procedures regarding referrals, obtaining
3 prior authorization and providing services pursuant to a
4 treatment plan approved by the plan or issuer.

5 B. A health insurer shall treat the provision of
6 obstetrical and gynecological care, and the ordering of related
7 obstetrical and gynecological items and services by a
8 participating health care professional who specializes in
9 obstetrics or gynecology, as the authorization of the primary
10 care provider.

11 C. Nothing in Subsection A of this section shall be
12 construed to:

13 (1) waive any exclusions of coverage under the
14 terms and conditions of the plan or health insurance policy
15 with respect to coverage of obstetrical or gynecological care;
16 or

17 (2) preclude the health insurer from requiring
18 that the obstetrical or gynecological provider notify the
19 covered individual's primary care health care professional or
20 the plan or issuer of treatment decisions.

21 D. As used in this section, "primary care provider"
22 means a health care practitioner acting within the scope of the
23 health care practitioner's license who provides the first level
24 of basic or general health care for a person's health needs,
25 including diagnostic and treatment services, who initiates

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1 referrals to other health care practitioners and who maintains
2 the continuity of care when appropriate."

3 SECTION 48. A new section of Chapter 59A, Article 23 NMSA
4 1978 is enacted to read:

5 "[NEW MATERIAL] COVERAGE FOR PREVENTIVE ITEMS AND
6 SERVICES--PROHIBITION ON COST-SHARING.--

7 A. A health insurer providing coverage under a
8 group or blanket health insurance policy, plan or certificate
9 of coverage, except for a grandfathered health plan, shall
10 provide coverage for all of the preventive items and services
11 pursuant to Sections 49 through 53 of this 2012 act, and shall
12 not impose any cost-sharing requirements, such as a copayment,
13 coinsurance or deductible.

14 B. A health insurer is not required to provide
15 coverage for any items or services specified in any
16 recommendation or guideline described in Subsection A of this
17 section after the recommendation or guideline is no longer
18 described by a source listed in that subsection.

19 C. Other provisions of state or federal law may
20 apply in connection with a health insurer's ceasing to provide
21 coverage for any such items or services.

22 D. To the extent that a preventive care provision
23 in this section conflicts with any other preventive health care
24 law in New Mexico, the provision providing the greatest level
25 of coverage shall apply. The preventive care provisions in

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1 this section are intended to supplement rather than supplant
2 existing preventive health care provisions in this state.

3 E. The superintendent shall at least annually
4 revise the preventive services standards established pursuant
5 to Sections 49 through 53 of this 2012 act to ensure that they
6 are consistent with the recommendations of the United States
7 preventive services task force, the advisory committee on
8 immunization practices of the federal centers for disease
9 control and prevention and the guidelines with respect to
10 infants, children, adolescents and women of evidence-based
11 preventive care and screenings by the federal health resources
12 and services administration. When changes are made to any of
13 these guidelines or recommendations, the superintendent shall
14 make recommendations to the legislature for legislative changes
15 to conform these standards to current guidelines and
16 recommendations.

17 F. An insurer may impose cost-sharing requirements
18 with respect to an office visit if a preventive item or service
19 provided pursuant to this section is billed separately or is
20 tracked as individual encounter data separately from the office
21 visit.

22 G. An insurer shall not impose cost-sharing
23 requirements with respect to an office visit for an item or
24 service provided pursuant to this section if an item or service
25 is not billed separately or is not tracked as individual

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1 encounter data separately from the office visit and the primary
2 purpose of the office visit is the delivery of the preventive
3 item or service.

4 H. An insurer may impose cost-sharing requirements
5 with respect to an office visit if a preventive item or service
6 provided pursuant to this section is not billed separately or
7 is not tracked as individual encounter data separately from the
8 office visit and the primary purpose of the office visit is not
9 the delivery of the preventive item or service.

10 I. The provisions of this section shall not apply
11 to policies or plans intended to supplement major medical
12 group-type coverages such as medicare supplement, long-term
13 care, disability income, specified disease, accident-only,
14 hospital indemnity or other limited-benefit health insurance
15 policies or plans."

16 SECTION 49. A new section of Chapter 59A, Article 23 NMSA
17 1978 is enacted to read:

18 "[NEW MATERIAL] COVERAGE FOR SMOKING AND TOBACCO CESSATION
19 TREATMENT.--

20 A. A group or blanket health insurance policy,
21 health care plan or certificate of health insurance that is
22 delivered or issued for delivery in this state and that offers
23 maternity benefits shall offer coverage for smoking cessation
24 treatment and shall offer augmented counseling tailored to
25 pregnant women who smoke.

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1 B. A group or blanket health insurance policy,
2 health care plan or certificate of health insurance that is
3 delivered or issued for delivery in this state shall:

4 (1) offer tobacco cessation intervention
5 coverage for those who use tobacco products;

6 (2) provide for screening of pregnant women
7 for tobacco use in accordance with the United States preventive
8 services task force guidelines; and

9 (3) provide diagnostic, therapy and counseling
10 services and pharmacotherapy, including the coverage of
11 prescription and nonprescription tobacco cessation agents
12 approved by the federal food and drug administration for
13 cessation of tobacco use by pregnant women.

14 C. The provisions of this section shall not apply
15 to short-term travel, accident-only or limited or specified-
16 disease policies, plans, contracts or certificates."

17 **SECTION 50.** A new section of Chapter 59A, Article 23 NMSA
18 1978 is enacted to read:

19 "[NEW MATERIAL] PREVENTIVE SERVICES BENEFITS--ASPIRIN
20 REGIMEN--HIGH BLOOD PRESSURE SCREENING--BREAST CANCER
21 SCREENING--LIPID DISORDERS SCREENING--COLORECTAL CANCER
22 SCREENING--DEPRESSION SCREENING--BEHAVIORAL DIETARY
23 COUNSELING--OBESITY COUNSELING AND SCREENING--OSTEOPOROSIS
24 SCREENING.--

25 A. A group health insurance policy, health care
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1 plan or certificate of health insurance that is delivered or
2 issued for delivery in this state shall provide the following
3 benefits that have, in effect, a rating of "A" or "B" in the
4 current recommendations of the United States preventive
5 services task force, for:

6 (1) a one-time screening for abdominal aortic
7 aneurysm by ultrasonography in men who have ever smoked and who
8 are between the ages of sixty-five and seventy-five;

9 (2) an aspirin regimen for men between the
10 ages of forty-five and seventy-nine when the potential benefit
11 due to a reduction in myocardial infarctions outweighs the
12 potential harm due to an increase in gastrointestinal
13 hemorrhage;

14 (3) an aspirin regimen for women between the
15 ages of fifty-five and seventy-nine when the potential benefit
16 of a reduction in ischemic strokes outweighs the potential harm
17 due to an increase in gastrointestinal hemorrhage;

18 (4) screening for high blood pressure in
19 adults aged eighteen and older;

20 (5) genetic counseling and evaluation for
21 breast cancer BRCA-gene testing for women whose family
22 histories are associated with an increased risk for deleterious
23 mutations in BRCA1 or BRCA2 genes. Nothing in this subsection
24 shall be construed as a waiver or exception to the Genetic
25 Information Privacy Act;

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- 1 (6) screening of lipid disorders for:
2 (a) men who are thirty-five years of age
3 or older; and
4 (b) women who are twenty years of age or
5 older who are at increased risk of coronary heart disease;
6 (7) screening of individuals over eighteen
7 years of age for colorectal cancer using fecal occult blood
8 testing, sigmoidoscopy or colonoscopy;
9 (8) screening of individuals eighteen years of
10 age or older for depression;
11 (9) screening of individuals twelve to
12 eighteen years of age for major depressive disorder;
13 (10) behavioral dietary counseling for adults
14 with hyperlipidemia and other known risk factors for
15 cardiovascular and diet-related chronic disease;
16 (11) screening and counseling for obesity for:
17 (a) individuals eighteen years of age
18 and older who are obese; and
19 (b) individuals six to eighteen years of
20 age; and
21 (12) screening for osteoporosis for:
22 (a) women who are sixty-five years of
23 age and older; and
24 (b) women who are sixty to sixty-five
25 years of age who are at increased risk for osteoporotic

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1 fractures.

2 B. The provisions of this section shall not apply
3 to policies or plans intended to supplement major medical
4 group-type coverages such as medicare supplement, long-term
5 care, disability income, specified disease, accident-only,
6 hospital indemnity or other limited-benefit health insurance
7 policies or plans."

8 SECTION 51. A new section of Chapter 59A, Article 23 NMSA
9 1978 is enacted to read:

10 "[NEW MATERIAL] PREVENTIVE SERVICES FOR CHILDREN.--

11 A. A group health insurance policy, health care
12 plan or certificate of health insurance that is delivered or
13 issued for delivery in this state shall provide the following
14 benefits that have, in effect, a rating of "A" or "B" in the
15 current recommendations of the United States preventive
16 services task force, for:

17 (1) oral fluoride supplementation at currently
18 recommended doses to children six months of age to five years
19 of age whose primary water sources are deficient in fluoride;

20 (2) prophylactic ocular topical medication
21 against gonococcal ophthalmia neonatorum for newborns;

22 (3) screening for hearing loss in newborns;

23 (4) screening for sickle cell disease for
24 newborns;

25 (5) screening for congenital hypothyroidism

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1 for newborns;

2 (6) iron supplementation for asymptomatic
3 children six to twelve months of age who are at increased risk
4 for iron deficiency anemia;

5 (7) screening for phenylketonuria in newborns;
6 and

7 (8) screening to detect amblyopia, strabismus
8 and defects in visual acuity in children less than five years
9 of age.

10 B. The provisions of this section shall not apply
11 to policies or plans intended to supplement major medical
12 group-type coverages such as medicare supplement, long-term
13 care, disability income, specified disease, accident-only,
14 hospital indemnity or other limited-benefit health insurance
15 policies or plans."

16 SECTION 52. A new section of Chapter 59A, Article 23 NMSA
17 1978 is enacted to read:

18 "[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--
19 REPRODUCTIVE HEALTH.--

20 A. A group health insurance policy, health care
21 plan or certificate of health insurance that is delivered or
22 issued for delivery in this state shall provide the following
23 benefits that have, in effect, a rating of "A" or "B" in the
24 current recommendations of the United States preventive
25 services task force, for:

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- 1 (1) screening for asymptomatic bacteriuria
- 2 with a urine culture for pregnant women;
- 3 (2) interventions during pregnancy and after
- 4 birth to promote and support breastfeeding;
- 5 (3) screening for cervical cancer in women who
- 6 have been sexually active and have a cervix;
- 7 (4) screening for chlamydial infection for:
- 8 (a) all sexually active young women
- 9 twenty-four years of age and younger; and
- 10 (b) older women who are at increased
- 11 risk of chlamydial infection;
- 12 (5) a daily supplement containing four hundred
- 13 to eight hundred micrograms of folic acid for any woman
- 14 planning a pregnancy or capable of pregnancy;
- 15 (6) screening of all sexually active women who
- 16 are at increased risk for infection, including those who are
- 17 pregnant, for gonorrheal infection;
- 18 (7) screening for iron deficiency anemia in
- 19 asymptomatic pregnant women;
- 20 (8) Rh (D) blood typing and antibody testing
- 21 for:
- 22 (a) all pregnant women; and
- 23 (b) all unsensitized Rh (D) negative
- 24 women at twenty-four to twenty-eight weeks' gestation;
- 25 (9) behavioral counseling to prevent sexually

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1 transmitted infections in:

2 (a) all sexually active adolescents; and

3 (b) individuals aged eighteen years and
4 older at increased risk for sexually transmitted infections;

5 (10) screening for hepatitis B virus infection
6 in pregnant women;

7 (11) screening for human immunodeficiency
8 virus for individuals twelve years of age and older who are at
9 risk of human immunodeficiency virus infection;

10 (12) screening for iron deficiency anemia in
11 asymptomatic pregnant women; and

12 (13) screening for syphilis for:

13 (a) any individual at increased risk for
14 syphilis infection; and

15 (b) any pregnant woman.

16 B. The provisions of this section shall not apply
17 to policies or plans intended to supplement major medical
18 group-type coverages such as medicare supplement, long-term
19 care, disability income, specified disease, accident-only,
20 hospital indemnity or other limited-benefit health insurance
21 policies or plans."

22 SECTION 53. A new section of Chapter 59A, Article 23 NMSA
23 1978 is enacted to read:

24 "[NEW MATERIAL] CHILDHOOD IMMUNIZATION COVERAGE

25 REQUIRED.--

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1 A. Each group or blanket health insurance policy,
2 plan and certificate of health insurance delivered or issued
3 for delivery in this state shall provide coverage for childhood
4 immunizations, as well as coverage for medically necessary
5 booster doses of all immunizing agents used in child
6 immunizations, in accordance with the current schedule of
7 immunizations recommended by the American academy of
8 pediatrics, the advisory committee on immunization practices of
9 the federal centers for disease control and prevention or the
10 United States preventive services task force "A"-rated and "B"-
11 rated recommendations, whichever provides greater coverage.

12 B. The provisions of this section shall not apply
13 to short-term travel, accident-only or limited or specified
14 disease policies."

15 SECTION 54. Section 59A-23B-6 NMSA 1978 (being Laws 1991,
16 Chapter 111, Section 6, as amended) is amended to read:

17 "59A-23B-6. FORMS AND RATES--APPROVAL OF THE
18 SUPERINTENDENT--UNIFORM HEALTH COVERAGE DOCUMENTS--STANDARDIZED
19 DEFINITIONS--ADJUSTED COMMUNITY RATING.--

20 A. All policy or plan forms, including
21 applications, enrollment forms, policies, plans, certificates,
22 evidences of coverage, riders, amendments, endorsements and
23 disclosure forms, shall be submitted to the superintendent for
24 approval prior to use.

25 B. No policy or plan may be issued in the state

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1 unless the rates have first been filed with and approved by the
2 superintendent. This subsection shall not apply to policies or
3 plans subject to the Small Group Rate and Renewability Act.

4 C. A health insurer, health maintenance
5 organization or nonprofit health care plan that offers an
6 individual policy, plan, evidence of coverage or certificate of
7 insurance issued for delivery in the state shall comply with
8 the standards that the superintendent has established by the
9 superintendent by rule uniform standards for the following
10 documents issued by each policy, plan, evidence of coverage or
11 certificate issued in the state relating to:

12 (1) a summary of benefits;

13 (2) an explanation of coverage;

14 (3) definitions of standard insurance terms
15 and medical terms;

16 (4) exceptions, reductions and limitations on
17 coverage;

18 (5) cost-sharing provisions, including
19 deductible, coinsurance and copayment obligations;

20 (6) the renewability and continuation of
21 coverage provisions;

22 (7) a coverage facts disclosure that includes
23 examples that are based on nationally recognized clinical
24 practice guidelines to illustrate common benefits scenarios,
25 including pregnancy and serious or chronic medical conditions

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1 and related cost-sharing;

2 (8) a statement of whether the policy, plan,
3 evidence of coverage or certificate:

4 (a) provides minimum essential coverage,
5 as defined under Section 5000A(f) of the federal Internal
6 Revenue Code of 1986; and

7 (b) ensures that the plan or coverage
8 share of the total allowed costs of benefits provided under the
9 policy, plan, evidence of coverage or certificate is not less
10 than sixty percent of those costs; and

11 (9) a contact number for the consumer to call
12 with additional questions and an internet web address where a
13 copy of the actual individual or group health coverage policy,
14 plan, evidence of coverage or certificate can be reviewed and
15 obtained.

16 D. An insurer, health maintenance organization or
17 nonprofit health care plan shall provide the following persons,
18 prior to any enrollment restriction, a summary of benefits and
19 coverage explanation required pursuant to Subsection A of this
20 section:

21 (1) an applicant, at the time of application;
22 (2) an enrollee or subscriber, prior to the
23 time of enrollment or re-enrollment, subscription or re-
24 subscription; and

25 (3) a policyholder, plan holder, evidence of

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1 coverage holder, subscriber or certificate holder, at the time
2 of issuance of the policy, plan or evidence of coverage or the
3 delivery of the certificate.

4 ~~[G.]~~ E. In determining the initial year's premium
5 or rate charged for coverage under a policy or plan, the only
6 rating factors that may be used are age, ~~[gender pursuant to~~
7 ~~this subsection]~~ geographic area of the place of employment and
8 smoking practices, except that for individual policies the
9 rating factor of the individual's place of residence may be
10 used instead of the geographic area of the individual's place
11 of employment. ~~[In determining the initial and any subsequent~~
12 ~~year's rate, the difference in rates in any one age group that~~
13 ~~may be charged on the basis of a person's gender shall not~~
14 ~~exceed another person's rate in the age group by more than the~~
15 ~~following percentage of the lower rate for policies issued or~~
16 ~~delivered in the respective year; provided, however, that~~
17 ~~gender shall not be used as a rating factor for policies issued~~
18 ~~or delivered on or after January 1, 2014:~~

- 19 (1) ~~twenty percent for calendar year 2010;~~
20 (2) ~~fifteen percent for calendar year 2011;~~
21 (3) ~~ten percent for calendar year 2012; and~~
22 (4) ~~five percent for calendar year 2013.~~

23 ~~D.]~~ F. No person's rate shall exceed the rate of
24 any other person ~~[with similar family composition]~~ by more than
25 two hundred fifty percent of the lower rate, except that the

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1 rates for children under the age of nineteen or children aged
2 nineteen to twenty-five who are full-time students may be as
3 much as three hundred percent lower than the ~~[bottom]~~ highest
4 age-based rates ~~[in the two hundred fifty percent band. The~~
5 ~~rating factor restrictions shall not prohibit an insurer,~~
6 ~~society, organization or plan from offering rates that differ~~
7 ~~depending upon family composition].~~

8 G. No person's rate shall exceed the rate of any
9 other person on the basis of geographic rating area by an
10 amount that the superintendent shall establish by rule, after
11 review by the United States department of health and human
12 services.

13 H. The rate difference between any one person who
14 smokes and any person who does not use tobacco shall not differ
15 by more than one hundred fifty percent.

16 ~~[E.]~~ I. The provisions of this section do not
17 preclude an insurer, fraternal benefit society, health
18 maintenance organization or nonprofit health care plan from
19 using health status or occupational or industry classification
20 in establishing:

- 21 (1) rates for individual policies; or
22 (2) the amount an employer may be charged for
23 coverage under a group health plan.

24 ~~[F. As used in Subsection E of this section,~~
25 ~~"health status" does not include genetic information.~~

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

3 SECTION 55. Section 59A-23C-5.1 NMSA 1978 (being Laws
4 1994, Chapter 75, Section 33, as amended) is amended to read:

5 "59A-23C-5.1. ADJUSTED COMMUNITY RATING.--

6 A. A health benefit plan that is offered by a
7 carrier to a small employer shall be offered without regard to
8 the health status of any individual in the group, except as
9 provided in the Small Group Rate and Renewability Act. The
10 only rating factors that may be used to determine the initial
11 year's premium charged a group, subject to the maximum rate
12 variation provided in this section for all rating factors, are
13 the group members':

14 (1) ages;

15 [~~(2)~~] ~~genders pursuant to Subsection B of this~~
16 ~~section;~~

17 ~~(3)]~~ (2) geographic areas of the place of
18 employment; or

19 [~~(4)]~~ (3) smoking practices.

20 ~~[B. In determining the initial and any subsequent~~
21 ~~year's rate, the difference in rates in any one age group that~~
22 ~~may be charged on the basis of a person's gender shall not~~
23 ~~exceed another person's rate in the age group by more than the~~
24 ~~following percentage of the lower rate for policies issued or~~
25 ~~delivered in the respective year; provided, however, that~~

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1 ~~gender shall not be used as a rating factor for policies issued~~
2 ~~or delivered on or after January 1, 2014:~~

- 3 ~~(1) twenty percent for calendar year 2010;~~
4 ~~(2) fifteen percent for calendar year 2011;~~
5 ~~(3) ten percent for calendar year 2012; and~~
6 ~~(4) five percent for calendar year 2013.~~

7 ~~G.]~~ B. No person's rate shall exceed the rate of
8 any other person [~~with similar family composition~~] on the basis
9 of age by more than two hundred fifty percent of the lower
10 rate, except that the rates for children under the age of
11 nineteen or children aged nineteen to twenty-five who are full-
12 time students may be as much as three hundred percent lower
13 than the [~~bottom~~] highest age-based rates [~~in the two hundred~~
14 ~~fifty percent band~~]. ~~The rating factor restrictions shall not~~
15 ~~prohibit a carrier from offering rates that differ depending~~
16 ~~upon family composition~~].

17 C. No person's rate shall exceed the rate of any
18 other person on the basis of geographic rating area by an
19 amount that the superintendent shall establish by rule, after
20 review by the United States department of health and human
21 services.

22 D. The rate difference between any one person who
23 smokes and any person who does not use tobacco shall not differ
24 by more than one hundred fifty percent.

25 ~~[D.]~~ E. The provisions of this section do not

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1 preclude a carrier from using health status or occupational or
2 industry classification in establishing the amount an employer
3 may be charged for coverage under a group health plan.

4 ~~[E. As used in Subsection D of this section,~~
5 ~~"health status" does not include genetic information.]~~

6 F. The superintendent shall adopt regulations to
7 implement the provisions of this section."

8 SECTION 56. Section 59A-23C-6 NMSA 1978 (being Laws 1991,
9 Chapter 153, Section 6) is amended to read:

10 "59A-23C-6. PROVISIONS ON RENEWABILITY OF COVERAGE.--

11 A. Except as provided in Subsection B of this
12 section, a health benefit plan subject to the Small Group Rate
13 and Renewability Act shall be renewable to all eligible
14 employees and dependents at the option of the small employer,
15 except for the following reasons:

16 (1) nonpayment of required premiums;

17 (2) ~~[fraud or misrepresentation of the small~~
18 ~~employer, or with respect to coverage of an insured individual,~~
19 ~~fraud or misrepresentation by the insured individual or that~~
20 ~~individual's representative] an act by a covered employee or~~
21 ~~dependent that constitutes:~~

22 (a) fraud; or

23 (b) an intentional misrepresentation of
24 material fact that is prohibited by the terms of the plan;

25 (3) noncompliance with plan provisions;

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1 (4) the number of individuals covered under
2 the plan is less than the number or percentage of eligible
3 individuals required by percentage requirements under the plan;
4 or

5 (5) the small employer is no longer actively
6 engaged in the business in which it was engaged on the
7 effective date of the plan.

8 Eligibility classifications may not be changed if any
9 individual is eliminated, due to the change, who was insured
10 immediately prior to the change without first receiving the
11 approval of the superintendent.

12 B. A small employer carrier may cease to renew all
13 plans under a class of business. The carrier shall provide
14 notice to all affected health benefit plans and to the
15 superintendent in each state in which an affected insured
16 individual is known to reside at least ninety days prior to
17 termination of coverage. A carrier [~~which~~] that exercises its
18 right to cease to renew all plans in a class of business shall
19 not:

20 (1) establish a new class of business for a
21 period of five years after the nonrenewal of the plans without
22 prior approval of the superintendent; or

23 (2) transfer or otherwise provide coverage to
24 any of the employers from the nonrenewed class of business
25 unless the insurer offers to transfer or provide coverage to

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1 all affected employers and eligible employees and dependents
2 without regard to case characteristics, claim experience,
3 health status or duration of coverage.

4 C. A small employer carrier may not change
5 eligibility classifications upon renewal or replacement within
6 twelve months of its termination of its own coverage if the
7 change in classification eliminates from coverage any
8 individual who was insured previous to the change and would
9 have continued to be insured if the change in eligibility had
10 not occurred."

11 SECTION 57. Section 59A-23C-10 NMSA 1978 (being Laws
12 2010, Chapter 94, Section 2) is amended to read:

13 "59A-23C-10. HEALTH INSURERS--DIRECT SERVICES.--

14 A. A health insurer shall make reimbursement for
15 direct services at a level not less than eighty-five percent of
16 premiums across all health product lines, except individually
17 underwritten health insurance policies, contracts or plans,
18 that are governed by the provisions of Chapter 59A, Article 22
19 NMSA 1978, the Health Maintenance Organization Law and the
20 Nonprofit Health Care Plan Law. Reimbursement shall be made
21 for direct services provided over the preceding three calendar
22 years, but not earlier than calendar year 2010, as determined
23 by reports filed with the insurance division of the commission.
24 Nothing in this subsection shall be construed to preclude a
25 purchaser from negotiating an agreement with a health insurer

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1 that requires a higher amount of premiums paid to be used for
2 reimbursement for direct services for one or more products or
3 for one or more years.

4 B. For individually underwritten health care
5 policies, plans or contracts, the superintendent shall
6 establish, after notice and informal hearing, the level of
7 reimbursement for direct services, as determined by the reports
8 filed with the insurance division, as a percent of premiums.
9 Additional informal hearings may be held at the
10 superintendent's discretion. In establishing the level of
11 reimbursement for direct services, the superintendent shall
12 consider the costs associated with the individual marketing and
13 medical underwriting of these policies, plans or contracts at a
14 level not less than seventy-five percent of premiums. A health
15 insurer writing these policies shall make reimbursement for
16 direct services at a level not less than that level established
17 by the superintendent pursuant to this subsection over the
18 three calendar years preceding the date upon which that rate is
19 established, but not earlier than calendar year 2010. Nothing
20 in this subsection shall be construed to preclude a purchaser
21 of one of these policies, plans or contracts from negotiating
22 an agreement with a health insurer that requires a higher
23 amount of premiums paid to be used for reimbursement for direct
24 services.

25 C. An insurer that fails to comply with the

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1 reimbursement requirements pursuant to this section shall issue
2 a [~~dividend or credit against future premiums~~] rebate to all
3 policyholders in [~~an amount sufficient to assure that the~~
4 ~~benefits paid in the preceding three calendar years plus the~~
5 ~~amount of the dividends or credits are equal to the required~~
6 ~~direct services reimbursement level pursuant to Subsection A of~~
7 ~~this section for group health coverage and blanket health~~
8 ~~coverage or the required direct services reimbursement level~~
9 ~~pursuant to Subsection B of this section for individually~~
10 ~~underwritten health policies, contracts or plans for the~~
11 ~~preceding three calendar years~~] accordance with rules that the
12 superintendent has promulgated. If the insurer fails to issue
13 the [~~dividend or credit~~] rebate in accordance with the
14 requirements of this section, the superintendent shall enforce
15 these requirements and may pursue any other penalties as
16 provided by law, including general penalties pursuant to
17 Section 59A-1-18 NMSA 1978.

18 D. After notice and hearing, the superintendent
19 [~~may~~] shall adopt and promulgate reasonable rules necessary and
20 proper to carry out the provisions of this section.

21 E. For the purposes of this section:

22 (1) "direct services" means services rendered
23 to an individual by a health insurer or a health care
24 practitioner, facility or other provider, including case
25 management, disease management, health education and promotion,

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1 preventive services, quality incentive payments to providers
2 and any portion of an assessment that covers services rather
3 than administration and for which an insurer does not receive a
4 tax credit pursuant to the Medical Insurance Pool Act or the
5 Health Insurance Alliance Act; provided, however, that "direct
6 services" does not include care coordination, utilization
7 review or management or any other activity designed to manage
8 utilization or services;

9 (2) "health insurer" means a person duly
10 authorized to transact the business of health insurance in the
11 state pursuant to the Insurance Code but does not include a
12 person that only issues a limited-benefit policy intended to
13 supplement major medical coverage, including medicare
14 supplement, vision, dental, disease-specific, accident-only or
15 hospital indemnity-only insurance policies, or that only issues
16 policies for long-term care or disability income; and

17 (3) "premium" means all income received from
18 individuals and private and public payers or sources for the
19 procurement of health coverage, including capitated payments,
20 self-funded administrative fees, self-funded claim
21 reimbursements, recoveries from third parties or other insurers
22 and interests less any premium tax paid pursuant to Section
23 59A-6-2 NMSA 1978 and fees associated with participating in a
24 health insurance exchange that serves as a clearinghouse for
25 insurance."

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1 SECTION 58. Section 59A-23D-2 NMSA 1978 (being Laws 1995,
2 Chapter 93, Section 2, as amended) is amended to read:

3 "59A-23D-2. DEFINITIONS.--As used in the Medical Care
4 Savings Account Act:

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

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

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

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

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

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

20 C. "department" means the insurance division of the
21 public regulation commission;

22 D. "dependent" means:

23 (1) a spouse;

24 (2) [~~an unmarried or unemancipated~~] a child of
25 the employee who is [~~a minor~~] under the age of twenty-six and

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1 who is:

2 (a) a natural child;

3 (b) a legally adopted child;

4 (c) a stepchild living in the same

5 household who is primarily dependent on the employee for
6 maintenance and support;

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

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

14 [~~(3) an unmarried child described in~~
15 ~~Subparagraphs (a) through (e) of Paragraph (2) of this~~
16 ~~subsection who is between the ages of eighteen and twenty-five]~~
17 or

18 [~~(4)~~] (3) a child over the age of [~~eighteen~~
19 twenty-six who is incapable of self-sustaining employment by
20 reason of [~~mental retardation~~] cognitive or physical [~~handicap~~]
21 disability and who is chiefly dependent on the employee for
22 support and maintenance;

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

25 (1) is covered under a qualified higher

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1 deductible health plan as of the first day of that month;

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

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

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

10 (3) is covered by a qualified higher
11 deductible health plan that is established and maintained by
12 the employer of the individual or of the spouse of the
13 individual;

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

19 G. "employee" includes a self-employed individual;

20 H. "employer" includes a self-employed individual;

21 I. "medical care savings account" or "savings
22 account" means an account established by an employer in the
23 United States exclusively for the purpose of paying the
24 eligible medical expenses of the employee or dependent, but
25 only if the written governing instrument creating the trust

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1 meets the following requirements:

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

4 (a) unless it is in cash; or

5 (b) to the extent the contribution, when
6 added to previous contributions to the trust for the calendar
7 year, exceeds seventy-five percent of the highest annual limit
8 deductible permitted pursuant to the Medical Care Savings
9 Account Act;

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

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

15 (4) the interest of an individual in the
16 balance in [~~his~~] the individual's account is nonforfeitable;

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

19 K. "qualified higher deductible health plan" means
20 a health coverage policy, certificate or contract that provides
21 for payments for covered health care benefits that exceed the
22 policy, certificate or contract deductible, that is purchased
23 by an employer for the benefit of an employee and that has the
24 following deductible provisions:

25 (1) self-only coverage with an annual

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

5 (2) family coverage with an annual deductible
6 of not less than three thousand dollars (\$3,000) or more than
7 four thousand five hundred dollars (\$4,500) and a maximum
8 annual out-of-pocket expense requirement of five thousand five
9 hundred dollars (\$5,500), not including premiums; and

10 (3) preventive care coverage may be provided
11 within the policies without the preventive care being subjected
12 to the qualified higher deductibles."

13 SECTION 59. Section 59A-23E-19 NMSA 1978 (being Laws
14 1998, Chapter 41, Section 23) is amended to read:

15 "59A-23E-19. INDIVIDUAL HEALTH INSURANCE COVERAGE--
16 GUARANTEED RENEWABILITY--EXCEPTIONS.--

17 A. Except as otherwise provided in this section, a
18 health insurance issuer that provides individual health
19 insurance coverage to an individual shall renew or continue
20 that coverage in force at the option of the individual.

21 B. A health insurance issuer may refuse to renew or
22 discontinue health insurance coverage of an individual in the
23 individual market if:

24 (1) the individual has failed to pay premiums
25 or contributions in accordance with the terms of the health

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1 insurance coverage or the issuer has not received timely
2 premium payments;

3 (2) the individual has [~~performed an act or~~
4 ~~practice~~] engaged in conduct that constitutes:

5 (a) fraud; or [~~has made~~]

6 (b) an intentional misrepresentation of
7 a material fact [~~under~~] as prohibited by the terms of the plan
8 or coverage;

9 (3) the issuer is ceasing to offer coverage in
10 the individual market in accordance with Subsection C of this
11 section;

12 (4) in the case of a health insurance issuer
13 that offers health insurance coverage in the market through a
14 network plan, the individual no longer lives, resides or works
15 in the service area of the issuer or the area for which the
16 issuer is authorized to do business, but only if the coverage
17 is terminated pursuant to this paragraph uniformly without
18 regard to any health status related factor of covered
19 individuals; and

20 (5) in the case of health insurance coverage
21 that is made available to the individual market only through
22 one or more bona fide associations, the membership of the
23 individual in the association on the basis of which the
24 coverage is provided ceases, but only if the coverage is
25 terminated pursuant to this paragraph uniformly without regard

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1 to any health status related factor of covered individuals.

2 C. A health insurance issuer may discontinue
3 offering a particular type of group health insurance coverage
4 offered in the individual market only if:

5 (1) the issuer provides notice to each covered
6 individual provided coverage of this type in the market of the
7 discontinuation at least ninety days prior to the date of the
8 discontinuation;

9 (2) the issuer offers to each individual in
10 the individual market provided coverage of this type the option
11 to purchase any other individual health insurance coverage
12 currently being offered by the issuer for individuals in that
13 market; and

14 (3) in exercising the option to discontinue
15 coverage of this type and in offering the option of coverage
16 pursuant to Paragraph (2) of this subsection, the issuer acts
17 uniformly without regard to any health status related factor of
18 enrolled individuals or individuals who may become eligible for
19 that coverage.

20 D. If a health insurance issuer elects to
21 discontinue offering all health insurance coverage, the
22 individual coverage may be discontinued only if:

23 (1) the issuer provides notice to the
24 superintendent and to each individual of the discontinuation at
25 least one hundred eighty days prior to the date of the

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1 expiration of the coverage; and

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

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

11 F. At the time of coverage renewal pursuant to
12 Subsection A of this section, a health insurance issuer may
13 modify the coverage for a policy form offered to individuals in
14 the individual market if the modification is consistent with
15 law and effective on a uniform basis among all individuals with
16 that policy form.

17 G. If health insurance coverage is made available
18 by a health insurance issuer in the individual market to an
19 individual only through one or more associations, a reference
20 to an "individual" is deemed to include a reference to that
21 association."

22 SECTION 60. Section 59A-44-19 NMSA 1978 (being Laws 1989,
23 Chapter 388, Section 19) is amended to read:

24 "59A-44-19. THE BENEFIT CONTRACT.--

25 A. Every society authorized to do business in this

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1 state shall issue to each owner of a benefit contract a
2 certificate specifying the amount of benefits provided thereby.
3 The certificate, together with any riders or endorsements
4 attached thereto, the laws of the society, the application for
5 membership, the application for insurance and declaration of
6 insurability, if any, signed by the applicant, and all
7 amendments to each thereof, shall constitute the benefit
8 contract, as of the date of issuance, between the society and
9 the owner, and the certificate shall so state. A copy of the
10 application for insurance and declaration of insurability, if
11 any, shall be endorsed upon or attached to the certificate.
12 All statements on the application shall be representations and
13 not warranties. Any waiver of this provision shall be void.

14 B. Any changes, additions or amendments to the laws
15 of the society duly made or enacted subsequent to the issuance
16 of the certificate shall bind the owner and the beneficiaries
17 and shall govern and control the benefit contract in all
18 respects the same as though such changes, additions or
19 amendments had been made prior to and were in force at the time
20 of the application for insurance, except that no change,
21 addition or amendment shall destroy or diminish benefits
22 [~~which~~] that the society contracted to give the owner as of the
23 date of issuance.

24 C. Any person upon whose life a certificate is
25 issued prior to attaining the age of majority shall be bound by

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1 the terms of the application and certificate and by all the
2 laws and rules of the society to the same extent as though the
3 age of majority had been attained at the time of application.

4 D. A society shall provide in its laws that if its
5 reserves as to all or any class of certificates become
6 impaired, its board of directors or corresponding body shall
7 require that there shall be paid by the owner to the society
8 the amount of the owner's equitable proportion of such
9 deficiency as ascertained by its board, and that if the payment
10 is not made, either:

11 (1) it shall stand as an indebtedness against
12 the certificate and draw interest not to exceed the rate
13 specified for certificate loans under the certificates; or

14 (2) in lieu of or in combination with the
15 provisions of Paragraph (1) of this subsection, the owner may
16 accept a proportionate reduction in benefits under the
17 certificate. The society may specify the manner of the
18 election and which alternative is to be presumed if no election
19 is made.

20 E. Copies of any of the documents mentioned in this
21 section, certified by the secretary or corresponding officer of
22 the society, shall be received in evidence of the terms and
23 conditions thereof.

24 F. No certificate shall be delivered or issued for
25 delivery in this state unless a copy of the form and rates and

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1 rate increases applicable to accident and health insurance have
2 been filed with and approved by the superintendent in
3 accordance with Sections 59A-18-12, 59A-18-13 and 59A-18-14
4 NMSA 1978. Every life or accident and health insurance
5 certificate and every annuity certificate issued on or after
6 one year from ~~[the effective date of this act]~~ January 1, 1990
7 shall meet the standard contract provision requirements
8 consistent with Chapter 59A, Article 44 NMSA 1978, as specified
9 in Chapter 59A, Articles 20 and 22 NMSA 1978, except that a
10 society may provide for a grace period for payment of premiums
11 of one full month in its certificates. The certificate shall
12 also contain a provision stating the amount of premiums ~~[which]~~
13 that are payable under the certificate and a provision reciting
14 or setting forth the substance of any sections of the society's
15 laws or rules in force at the time of issuance of the
16 certificate ~~[which]~~ that, if violated, will result in the
17 termination or reduction of benefits payable under the
18 certificate. If the laws of the society provide for expulsion
19 or suspension of a member, the certificate shall also contain a
20 provision that any member so expelled or suspended, except for
21 nonpayment of a premium or within the contestable period for
22 engaging in conduct that constitutes fraud or an intentional
23 material misrepresentation ~~[in the application for membership~~
24 ~~or insurance]~~ that is prohibited by the terms of membership,
25 shall have the privilege of maintaining the certificate in

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1 force by continuing payment of the required premium.

2 G. Certificates issued on the lives of persons below
3 the society's minimum age for adult membership may provide for
4 transfer of control of ownership to the insured at an age
5 specified in the certificate. A society may require approval
6 of an application for membership in order to effect this
7 transfer and may provide in all other respects for the
8 regulation, government and control of such certificates and all
9 rights, obligations and liabilities incident thereto and
10 connected therewith. Ownership rights prior to such transfer
11 shall be specified in the certificate.

12 H. A society may specify the terms and conditions on
13 which certificates may be assigned."

14 SECTION 61. Section 59A-46-2 NMSA 1978 (being Laws 1993,
15 Chapter 266, Section 2, as amended) is amended to read:

16 "59A-46-2. DEFINITIONS.--As used in the Health
17 Maintenance Organization Law:

18 A. "basic health care services":

19 (1) means medically necessary services
20 consisting of preventive care, emergency care, inpatient and
21 outpatient hospital and physician care, diagnostic laboratory,
22 diagnostic and therapeutic radiological services and services
23 of pharmacists and pharmacist clinicians; but

24 (2) does not include mental health services or
25 services for alcohol or drug abuse, dental or vision services

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1 or long-term rehabilitation treatment;

2 B. "capitated basis" means fixed per member per month
3 payment or percentage of premium payment wherein the provider
4 assumes the full risk for the cost of contracted services
5 without regard to the type, value or frequency of services
6 provided and includes the cost associated with operating staff
7 model facilities;

8 C. "carrier" means a health maintenance organization,
9 an insurer, a nonprofit health care plan or other entity
10 responsible for the payment of benefits or provision of
11 services under a group contract;

12 D. "child" means an individual who is related to a
13 principal enrollee or applicant for insurance or other coverage
14 pursuant to the Health Maintenance Organization Law by birth or
15 adoption;

16 [~~D.~~] E. "copayment" means an amount an enrollee must
17 pay in order to receive a specific service that is not fully
18 prepaid;

19 [~~E.~~] F. "deductible" means the amount an enrollee is
20 responsible to pay out-of-pocket before the health maintenance
21 organization begins to pay the costs associated with treatment;

22 [~~F.~~] G. "enrollee" means an individual who is covered
23 by a health maintenance organization;

24 [~~G.~~] H. "evidence of coverage" means a policy,
25 contract or certificate showing the essential features and

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1 services of the health maintenance organization coverage that
2 is given to the subscriber by the health maintenance
3 organization or by the group contract holder;

4 [~~H.~~] I. "extension of benefits" means the
5 continuation of coverage under a particular benefit provided
6 under a contract or group contract following termination with
7 respect to an enrollee who is totally disabled on the date of
8 termination;

9 [~~F.~~] J. "grievance" means a written complaint
10 submitted in accordance with the health maintenance
11 organization's formal grievance procedure by or on behalf of
12 the enrollee regarding any aspect of the health maintenance
13 organization relative to the enrollee;

14 [~~J.~~] K. "group contract" means a contract for health
15 care services that by its terms limits eligibility to members
16 of a specified group and may include coverage for dependents;

17 [~~K.~~] L. "group contract holder" means the person to
18 whom a group contract has been issued;

19 [~~F.~~] M. "health care services" means any services
20 included in the furnishing to any individual of medical,
21 mental, dental, pharmaceutical or optometric care or
22 hospitalization or nursing home care or incident to the
23 furnishing of such care or hospitalization, as well as the
24 furnishing to any person of any and all other services for the
25 purpose of preventing, alleviating, curing or healing human

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1 physical or mental illness or injury;

2 [M-] N. "health maintenance organization" means any
3 person who undertakes to provide or arrange for the delivery of
4 basic health care services to enrollees on a prepaid basis,
5 except for enrollee responsibility for copayments or
6 deductibles;

7 [N-] O. "health maintenance organization agent" means
8 a person who solicits, negotiates, effects, procures, delivers,
9 renews or continues a policy or contract for health maintenance
10 organization membership or who takes or transmits a membership
11 fee or premium for such a policy or contract, other than for
12 [~~himself~~] that person, or a person who advertises or otherwise
13 [~~holds himself out~~] makes any representation to the public as
14 such;

15 [O-] P. "individual contract" means a contract for
16 health care services issued to and covering an individual, and
17 it may include dependents of the subscriber;

18 [P-] Q. "insolvent" or "insolvency" means that the
19 organization has been declared insolvent and placed under an
20 order of liquidation by a court of competent jurisdiction;

21 [Q-] R. "managed hospital payment basis" means
22 agreements in which the financial risk is related primarily to
23 the degree of utilization rather than to the cost of services;

24 [R-] S. "net worth" means the excess of total
25 admitted assets over total liabilities, but the liabilities

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1 shall not include fully subordinated debt;

2 ~~[S.]~~ T. "participating provider" means a provider as
3 defined in Subsection ~~[U]~~ V of this section who, under an
4 express contract with the health maintenance organization or
5 with its contractor or subcontractor, has agreed to provide
6 health care services to enrollees with an expectation of
7 receiving payment, other than copayment or deductible, directly
8 or indirectly from the health maintenance organization;

9 ~~[F.]~~ U. "person" means an individual or other legal
10 entity;

11 ~~[U.]~~ V. "provider" means a physician, pharmacist,
12 pharmacist clinician, hospital or other person licensed or
13 otherwise authorized to furnish health care services;

14 ~~[V.]~~ W. "replacement coverage" means the benefits
15 provided by a succeeding carrier;

16 ~~[W.]~~ X. "subscriber" means an individual whose
17 employment or other status, except family dependency, is the
18 basis for eligibility for enrollment in the health maintenance
19 organization or, in the case of an individual contract, the
20 person in whose name the contract is issued;

21 ~~[X.]~~ Y. "uncovered expenditures" means the costs to
22 the health maintenance organization for health care services
23 that are the obligation of the health maintenance organization,
24 for which an enrollee may also be liable in the event of the
25 health maintenance organization's insolvency and for which no

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1 alternative arrangements have been made that are acceptable to
2 the superintendent;

3 [~~Y.~~] Z. "pharmacist" means a person licensed as a
4 pharmacist pursuant to the Pharmacy Act; and

5 [~~Z.~~] AA. "pharmacist clinician" means a pharmacist
6 who exercises prescriptive authority pursuant to the Pharmacist
7 Prescriptive Authority Act."

8 SECTION 62. Section 59A-46-38.1 NMSA 1978 (being Laws
9 1994, Chapter 64, Section 9, as amended) is amended to read:

10 "59A-46-38.1. COVERAGE OF CHILDREN.--

11 A. [~~An insurer~~] A health maintenance organization
12 shall not deny enrollment of a child under the health plan or
13 membership of the child's parent on the grounds that the child:

14 (1) was born out of wedlock;

15 (2) is not claimed as a dependent on the
16 parent's federal tax return; or

17 (3) does not reside with the parent or in the
18 insurer's service area.

19 B. When a child has health coverage through [~~an~~
20 ~~insurer~~] a health maintenance organization of a noncustodial
21 parent, the [~~insurer~~] health maintenance organization shall:

22 (1) provide such information to the custodial
23 parent as may be necessary for the child to obtain benefits
24 through that coverage;

25 (2) permit the custodial parent or the provider,

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1 with the custodial parent's approval, to submit claims for
2 covered services without the approval of the noncustodial
3 parent; and

4 (3) make payments on claims submitted in
5 accordance with Paragraph (2) of this subsection directly to
6 the custodial parent, the provider or the state medicaid
7 agency.

8 C. When a parent is required by a court or
9 administrative order to provide health coverage for a child and
10 the parent is eligible for family health coverage, the
11 ~~[insurer]~~ health maintenance organization shall be required:

12 (1) to permit the parent to enroll, under the
13 family coverage, a child who is otherwise eligible for the
14 coverage without regard to any enrollment season restrictions;

15 (2) if the parent is enrolled but fails to make
16 application to obtain coverage for the child, to enroll the
17 child under family coverage upon application of the child's
18 other parent, the state agency administering the medicaid
19 program or the state agency administering 42 U.S.C. Sections
20 651 through 669, the child support enforcement program; and

21 (3) not to disenroll or eliminate coverage of
22 the child unless the insurer is provided satisfactory written
23 evidence that:

24 (a) the court or administrative order is no
25 longer in effect; or

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1 (b) the child is or will be enrolled in
2 comparable health coverage through another insurer or plan that
3 will take effect not later than the effective date of
4 disenrollment.

5 D. ~~[An insurer]~~ A health maintenance organization
6 shall not impose requirements on a state agency that has been
7 assigned the rights of an individual eligible for medical
8 assistance under the medicaid program and covered for health
9 benefits from the insurer that are different from requirements
10 applicable to an agent or assignee of any other individual so
11 covered.

12 E. ~~[An insurer]~~ A health maintenance organization
13 shall provide coverage for children, from birth through three
14 years of age, for or under the family, infant, toddler program
15 administered by the department of health, provided that
16 eligibility criteria are met [~~for a maximum benefit of three~~
17 ~~thousand five hundred dollars (\$3,500) annually]~~ for medically
18 necessary early intervention services provided as part of an
19 individualized family service plan and delivered by certified
20 and licensed personnel as defined in 7.30.8 NMAC who are
21 working in early intervention programs approved by the
22 department of health. [~~No payment under this subsection shall~~
23 ~~be applied against any maximum lifetime or annual limits~~
24 ~~specified in the policy, health benefits plan or contract.]"~~

25 SECTION 63. Section 59A-46-38.2 NMSA 1978 (being Laws
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1 1997, Chapter 250, Section 4) is amended to read:

2 "59A-46-38.2. CHILDHOOD IMMUNIZATION COVERAGE REQUIRED.--

3 A. Each individual and group health maintenance
4 contract delivered or issued for delivery in this state shall
5 provide coverage for childhood immunizations in accordance with
6 the current schedule of immunizations recommended by the
7 American academy of pediatrics, [~~including coverage for all~~
8 ~~medically necessary booster doses of all immunizing agents used~~
9 ~~in childhood immunizations]~~ the advisory committee on
10 immunization practices of the federal centers for disease
11 control and prevention or the United States preventive services
12 task force "A"-rated and "B"-rated recommendations, whichever
13 provides greater coverage.

14 B. The provisions of this section shall not apply to
15 short-term travel, accident-only or limited or specified
16 disease policies.

17 [~~B. Coverage for childhood immunizations and~~
18 ~~necessary booster doses may be subject to deductibles and~~
19 ~~coinsurance consistent with those imposed on other benefits~~
20 ~~under the same contract.]"~~

21 SECTION 64. Section 59A-46-38.3 NMSA 1978 (being Laws
22 2003, Chapter 391, Section 5, as amended) is amended to read:

23 "59A-46-38.3. MAXIMUM AGE OF [~~DEPENDENT~~] CHILD.--Each
24 individual or group health maintenance organization contract
25 delivered or issued for delivery or renewed in New Mexico that

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1 provides coverage for an enrollee's [~~dependents~~] child shall
2 not terminate coverage of [~~an unmarried dependent~~] a child by
3 reason of the [~~dependent's~~] child's age before the [~~dependent's~~
4 ~~twenty-fifth~~] child's twenty-sixth birthday [~~regardless of~~
5 ~~whether the dependent is enrolled in an educational~~
6 ~~institution~~]; provided that this requirement does not apply to
7 the medicaid managed care system."

8 SECTION 65. Section 59A-46-42 NMSA 1978 (being Laws 1992,
9 Chapter 56, Section 1, as amended) is amended to read:

10 "59A-46-42. COVERAGE FOR CYTOLOGIC AND HUMAN
11 PAPILOMAVIRUS SCREENING.--

12 A. Each individual and group health maintenance
13 organization contract delivered or issued for delivery in this
14 state shall provide coverage for cytologic and human
15 papillomavirus screening to determine the presence of
16 precancerous or cancerous conditions and other health problems.
17 The coverage shall make available cytologic screening, as
18 determined by the health care provider, in accordance with
19 national medical standards and United States preventive
20 services task force "A"-rated and "B"-rated recommendations,
21 whichever provides greater coverage, for women who are eighteen
22 years of age or older and for women who are at risk of cancer
23 or at risk of other health conditions that can be identified
24 through cytologic screening. The coverage shall make available
25 human papillomavirus screening once every three years for women

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1 aged thirty and older.

2 B. Coverage for cytologic and human papillomavirus
3 screening may be subject to deductibles and coinsurance
4 consistent with those imposed on other benefits under the same
5 contract.

6 C. For the purposes of this section:

7 (1) "cytologic screening" means a Papanicolaou
8 test and pelvic exam for asymptomatic as well as symptomatic
9 women;

10 (2) "health care provider" means any person
11 licensed within the scope of [~~his~~] the person's practice to
12 perform cytologic and human papillomavirus screening, including
13 physicians, physician assistants, certified nurse-midwives and
14 certified nurse practitioners; and

15 (3) "human papillomavirus screening" means a
16 test approved by the federal food and drug administration for
17 detection of the human papillomavirus."

18 SECTION 66. Section 59A-46-45 NMSA 1978 (being Laws 2003,
19 Chapter 337, Section 4) is amended to read:

20 "59A-46-45. COVERAGE FOR SMOKING CESSATION TREATMENT.--

21 A. An individual or group health maintenance
22 organization contract that is delivered or issued for delivery
23 in this state and that offers maternity benefits shall offer
24 coverage for smoking cessation treatment and shall offer
25 augmented counseling tailored to pregnant women who smoke.

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1 ~~[B. Coverage for smoking cessation treatment may be~~
2 ~~subject to deductibles and coinsurance consistent with those~~
3 ~~imposed on other benefits under the same contract.]~~

4 B. An individual or group health insurance policy,
5 health care plan or certificate of health insurance that is
6 delivered or issued for delivery in this state shall:

7 (1) offer tobacco cessation intervention
8 coverage for those who use tobacco products;

9 (2) provide for screening of pregnant women for
10 tobacco use in accordance with the United States preventive
11 services task force guidelines; and

12 (3) provide diagnostic, therapy and counseling
13 services and pharmacotherapy, including the coverage of
14 prescription and nonprescription tobacco cessation agents
15 approved by the federal food and drug administration for
16 cessation of tobacco use by pregnant women.

17 C. The provisions of this section shall not apply to
18 short-term travel, accident-only or limited or specified-
19 disease policies, plans, contracts or certificates."

20 SECTION 67. Section 59A-46-50 NMSA 1978 (being Laws 2009,
21 Chapter 74, Section 3) is amended to read:

22 "59A-46-50. COVERAGE FOR AUTISM SPECTRUM DISORDER
23 DIAGNOSIS AND TREATMENT.--

24 A. An individual or group health maintenance contract
25 that is delivered, issued for delivery or renewed in this state

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1 shall provide coverage to an eligible individual who is
2 nineteen years of age or younger, or an eligible individual who
3 is twenty-two years of age or younger and is enrolled in high
4 school, for:

5 (1) well-baby and well-child screening for
6 diagnosing the presence of autism spectrum disorder; and

7 (2) treatment of autism spectrum disorder
8 through speech therapy, occupational therapy, physical therapy
9 and applied behavioral analysis.

10 B. Coverage required pursuant to Subsection A of this
11 section:

12 (1) shall be limited to treatment that is
13 prescribed by the insured's treating physician in accordance
14 with a treatment plan;

15 ~~[(2) shall be limited to thirty-six thousand~~
16 ~~dollars (\$36,000) annually and shall not exceed two hundred~~
17 ~~thousand dollars (\$200,000) in total lifetime benefits.~~
18 ~~Beginning January 1, 2011, the maximum benefit shall be~~
19 ~~adjusted annually on January 1 to reflect any change from the~~
20 ~~previous year in the medical component of the then-current~~
21 ~~consumer price index for all urban consumers published by the~~
22 ~~bureau of labor statistics of the United States department of~~
23 ~~labor;~~

24 ~~(3)]~~ (2) shall not be denied on the basis that
25 the services are habilitative or rehabilitative in nature;

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1 [~~(4)~~] (3) may be subject to other general
2 exclusions and limitations of the insurer's policy or plan,
3 including, but not limited to, coordination of benefits,
4 participating provider requirements, restrictions on services
5 provided by family or household members and utilization review
6 of health care services, including the review of medical
7 necessity, case management and other managed care provisions;
8 and

9 [~~(5)~~] (4) may be limited to exclude coverage for
10 services received under the federal Individuals with
11 Disabilities Education Improvement Act of 2004 and related
12 state laws that place responsibility on state and local school
13 boards for providing specialized education and related services
14 to children three to twenty-two years of age who have autism
15 spectrum disorder.

16 C. The coverage required pursuant to Subsection A of
17 this section shall not be subject to dollar limits, deductibles
18 or coinsurance provisions that are less favorable to an insured
19 than the dollar limits, deductibles or coinsurance provisions
20 that apply to physical illnesses that are generally covered
21 under the individual or group health maintenance contract,
22 except as otherwise provided in Subsection B of this section.

23 D. [~~An insurer~~] A carrier shall not deny or refuse to
24 issue health insurance coverage for medically necessary
25 services or refuse to contract with, renew, reissue or

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1 otherwise terminate or restrict health insurance coverage for
2 an individual because the individual is diagnosed as having
3 autism spectrum disorder.

4 E. The treatment plan required pursuant to Subsection
5 B of this section shall include all elements necessary for the
6 health insurance plan to pay claims appropriately. These
7 elements include, but are not limited to:

- 8 (1) the diagnosis;
9 (2) the proposed treatment by types;
10 (3) the frequency and duration of treatment;
11 (4) the anticipated outcomes stated as goals;
12 (5) the frequency with which the treatment plan
13 will be updated; and
14 (6) the signature of the treating physician.

15 F. This section shall not be construed as limiting
16 benefits and coverage otherwise available to an insured under a
17 health insurance plan or policy.

18 G. The provisions of this section shall not apply to
19 plans or policies intended to supplement major medical
20 group-type coverages such as medicare supplement, long-term
21 care, disability income, specified disease, accident-only,
22 hospital indemnity or other limited-benefit health insurance
23 plans or policies.

24 H. As used in this section:

- 25 (1) "autism spectrum disorder" means a condition

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1 that meets the diagnostic criteria for the pervasive
2 developmental disorders published in the *Diagnostic and*
3 *Statistical Manual of Mental Disorders*, fourth edition, text
4 revision, also known as DSM-IV-TR, published by the American
5 psychiatric association, including autistic disorder;
6 Asperger's disorder; pervasive development disorder not
7 otherwise specified; Rett's disorder; and childhood
8 disintegrative disorder;

9 (2) "habilitative or rehabilitative services"
10 means treatment programs that are necessary to develop,
11 maintain and restore to the maximum extent practicable the
12 functioning of an individual; and

13 (3) "high school" means a school providing
14 instruction for any of the grades nine through twelve."

15 **SECTION 68.** Section 59A-46-51 NMSA 1978 (being Laws 2010,
16 Chapter 94, Section 3) is amended to read:

17 "59A-46-51. HEALTH MAINTENANCE ORGANIZATIONS--DIRECT
18 SERVICES.--

19 A. A health maintenance organization shall make
20 reimbursement for direct services at a level not less than
21 eighty-five percent of premiums across all health product
22 lines, except individually underwritten health insurance
23 policies, contracts or plans, that are governed by the
24 provisions of Chapter 59A, Article 22 NMSA 1978, the Health
25 Maintenance Organization Law and the Nonprofit Health Care Plan

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1 Law. Reimbursement shall be made for direct services provided
2 over the preceding three calendar years, but not earlier than
3 calendar year 2010, as determined by reports filed with the
4 insurance division of the commission. Nothing in this
5 subsection shall be construed to preclude a purchaser from
6 negotiating an agreement with a health maintenance organization
7 that requires a higher amount of premiums paid to be used for
8 reimbursement for direct services for one or more products or
9 for one or more years.

10 B. For individually underwritten health care
11 policies, plans or contracts, the superintendent shall
12 establish, after notice and informal hearing, the level of
13 reimbursement for direct services, as determined by the reports
14 filed with the insurance division, as a percent of premiums.
15 Additional informal hearings may be held at the
16 superintendent's discretion. In establishing the level of
17 reimbursement for direct services, the superintendent shall
18 consider the costs associated with the individual marketing and
19 medical underwriting of these policies, plans or contracts at a
20 level not less than seventy-five percent of premiums. A health
21 insurer or health maintenance organization writing these
22 policies, plans or contracts shall make reimbursement for
23 direct services at a level not less than that level established
24 by the superintendent pursuant to this subsection over the
25 three calendar years preceding the date upon which that rate is

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1 established, but not earlier than calendar year 2010. Nothing
2 in this subsection shall be construed to preclude a purchaser
3 of one of these policies, plans or contracts from negotiating
4 an agreement with a health insurer or health maintenance
5 organization that requires a higher amount of premiums paid to
6 be used for reimbursement for direct services.

7 C. A health maintenance organization that fails to
8 comply with the reimbursement requirements pursuant to this
9 section shall issue a [~~dividend or credit against future~~
10 ~~premiums~~] rebate to all policy, plan or contract holders in [~~an~~
11 ~~amount sufficient to assure that the benefits paid in the~~
12 ~~preceding three calendar years plus the amount of the dividends~~
13 ~~or credits are equal to the required direct services~~
14 ~~reimbursement level pursuant to Subsection A of this section~~
15 ~~for group health coverage and blanket health coverage or the~~
16 ~~required direct services reimbursement level pursuant to~~
17 ~~Subsection B of this section for individually underwritten~~
18 ~~health policies, contracts or plans for the preceding three~~
19 ~~calendar years~~] accordance with rules the superintendent has
20 promulgated. If the [~~insurer~~] health maintenance organization
21 fails to issue the [~~dividend or credit~~] rebate in accordance
22 with the requirements of this section, the superintendent shall
23 enforce these requirements and may pursue any other penalties
24 as provided by law, including general penalties pursuant to
25 Section 59A-1-18 NMSA 1978.

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1 D. After notice and hearing, the superintendent [~~may~~]
2 shall adopt and promulgate reasonable rules necessary and
3 proper to carry out the provisions of this section.

4 E. For the purposes of this section:

5 (1) "direct services" means services rendered to
6 an individual by a health maintenance organization or a health
7 care practitioner, facility or other provider, including case
8 management, disease management, health education and promotion,
9 preventive services, quality incentive payments to providers
10 and any portion of an assessment that covers services rather
11 than administration and for which an insurer does not receive a
12 tax credit pursuant to the Medical Insurance Pool Act or the
13 Health Insurance Alliance Act; provided, however, that "direct
14 services" does not include care coordination, utilization
15 review or management or any other activity designed to manage
16 utilization or services;

17 (2) "health maintenance organization" means any
18 person who undertakes to provide or arrange for the delivery of
19 basic health care services to enrollees on a prepaid basis,
20 except for enrollee responsibility for copayments or
21 deductibles, but does not include a person that only issues a
22 limited-benefit policy or contract intended to supplement major
23 medical coverage, including medicare supplement, vision,
24 dental, disease-specific, accident-only or hospital indemnity-
25 only insurance policies, or that only issues policies for long-

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1 term care or disability income; and

2 (3) "premium" means all income received from
3 individuals and private and public payers or sources for the
4 procurement of health coverage, including capitated payments,
5 self-funded administrative fees, self-funded claim
6 reimbursements, recoveries from third parties or other insurers
7 and interests less any premium tax paid pursuant to Section
8 59A-6-2 NMSA 1978 and fees associated with participating in a
9 health insurance exchange that serves as a clearinghouse for
10 insurance."

11 SECTION 69. A new section of the Health Maintenance
12 Organization Law is enacted to read:

13 "[NEW MATERIAL] GRANDFATHERED HEALTH PLAN OR GRANDFATHERED
14 HEALTH POLICY COVERAGE.--

15 A. For the purposes of the Health Maintenance
16 Organization Law, "grandfathered health plan" or "grandfathered
17 health policy coverage" means individual coverage provided by a
18 health maintenance organization that was in effect on March 23,
19 2010 and that remains in effect through the original term of
20 coverage or through renewal of the original term.

21 B. A dependent of an individual enrolled in a
22 grandfathered health plan may enroll in a grandfathered health
23 plan or policy if the terms of the plan in effect as of March
24 23, 2010 permitted the dependent to enroll.

25 C. A group health maintenance organization plan that

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1 provides coverage on March 23, 2010 may provide for the
2 enrolling of new employees and their dependents in that
3 grandfathered health plan.

4 D. Coverage provided by a health maintenance
5 organization pursuant to one or more collective bargaining
6 agreements between employee representatives and one or more
7 employers that was ratified before March 23, 2010 constitutes a
8 grandfathered health plan until the date on which the last of
9 the collective bargaining agreements relating to the coverage
10 terminates. Any coverage amendment made pursuant to a
11 collective bargaining agreement that relates to the coverage
12 and amends the coverage solely to conform to any requirement of
13 the Health Maintenance Organization Law shall not be treated as
14 a termination of the collective bargaining agreement."

15 SECTION 70. A new section of the Health Maintenance
16 Organization Law is enacted to read:

17 "[NEW MATERIAL] GUARANTEED ISSUE--GUARANTEED
18 RENEWABILITY--MAXIMUM WAITING PERIOD--BAN ON PREEXISTING
19 CONDITION EXCLUSIONS.--

20 A. A carrier shall issue coverage to any individual
21 who requests and offers to purchase the coverage without
22 permanent exclusion of preexisting conditions.

23 B. Except as provided in to Subsection C of this
24 section, a health maintenance organization that offers a health
25 benefit plan or contract providing group health insurance

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1 coverage in the state shall issue any health benefit plan to
2 any employer that applies for such plan and agrees to make the
3 required premium payments and satisfy the other reasonable
4 provisions of the health plan or contract. A carrier:

5 (1) shall offer coverage to all of the eligible
6 employees of the employer and the employees' children and
7 dependents who apply for enrollment during the period in which
8 the employee first becomes eligible to enroll under the terms
9 of the plan; and

10 (2) shall not offer coverage to only certain
11 individuals or certain children or dependents of employees in
12 the group or to only part of the group.

13 C. A carrier that offers through a network plan or
14 contract shall not be required to offer coverage under that
15 plan or accept applications for that plan or contract pursuant
16 to Subsection A of this section under the following
17 circumstances:

18 (1) to an employer, where the employer is not
19 physically located in the insurer's established geographic
20 service area for the network plan or contract;

21 (2) to an employee, when the employee does not
22 live, work or reside within the carrier's established
23 geographic service area for the network plan or contract; or

24 (3) within the geographic service area for the
25 network plan or contract where the carrier reasonably

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1 anticipates, and demonstrates to the satisfaction of the
2 superintendent, that it will not have the capacity within its
3 established geographic service area to deliver service
4 adequately to the members of the groups because of its
5 obligations to existing group plan holders and enrollees.

6 D. A carrier may restrict enrollment in coverage
7 described in Subsection B of this section to open or special
8 enrollment periods; provided that any special enrollment period
9 shall comply with the provisions of Section 74 of this 2012 act
10 and rules the superintendent has promulgated.

11 E. A carrier may impose a waiting period not to
12 exceed ninety days before payment for any service related to a
13 preexisting condition. A carrier shall offer or make a
14 referral to a transition product to provide coverage during the
15 waiting period due to a preexisting condition.

16 F. A carrier shall renew any health benefit plan or
17 contract at the option of the employer, except as the
18 superintendent has provided by rule.

19 G. A carrier may continue and renew a grandfathered
20 plan or policy that has a permanent exclusion of payment for
21 preexisting conditions.

22 H. For the purposes of this section:

23 (1) "coverage" means a health insurance policy,
24 health care plan, health maintenance organization contract or
25 certificate of insurance issued for delivery in the state.

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1 "Coverage" does not mean a short-term, accident, fixed
2 indemnity or specified disease policy; disability income;
3 limited benefit insurance; credit insurance; workers'
4 compensation; or automobile or medical insurance under which
5 benefits are payable with or without regard to fault and that
6 is required by law to be contained in any liability insurance
7 policy; and

8 (2) "preexisting condition" means a physical or
9 mental condition for which medical advice, medication,
10 diagnosis, care or treatment was recommended for or received by
11 an applicant for health insurance within six months before the
12 effective date of coverage, except that pregnancy is not
13 considered a preexisting condition for federally defined
14 individuals."

15 SECTION 71. A new section of the Health Maintenance
16 Organization Law is enacted to read:

17 "[NEW MATERIAL] PROHIBITION ON LIFETIME OR ANNUAL LIMITS.--

18 A. Notwithstanding any other provision of law, a
19 health maintenance organization shall not establish:

20 (1) lifetime limits on the dollar value of
21 benefits for any enrollee; or

22 (2) except as provided in Subsection B of this
23 section, annual limits on the dollar value of benefits for any
24 enrollee.

25 B. With respect to contract years beginning prior to

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1 January 1, 2014, a health maintenance organization shall
2 establish a restricted annual limit on the dollar value of
3 benefits for any enrollee only with respect to the scope of
4 benefits that are essential health benefits, as the
5 superintendent defines "essential health benefits" by rule.

6 C. Subsection A of this section shall not be
7 construed to prevent a health maintenance organization from
8 placing annual or lifetime per enrollee limits on specific
9 covered benefits that are not essential health benefits to the
10 extent that these limits are otherwise permitted under federal
11 or state law.

12 D. The provisions of this section shall not apply to
13 policies or plans intended to supplement major medical group-
14 type coverages such as medicare supplement, long-term care,
15 disability income, specified disease, accident-only, hospital
16 indemnity or other limited-benefit health insurance policies or
17 plans."

18 SECTION 72. A new section of the Health Maintenance
19 Organization Law is enacted to read:

20 "[NEW MATERIAL] PROHIBITION ON RESCISSIONS OF COVERAGE.--

21 A. A health maintenance organization contract or a
22 grandfathered health maintenance organization contract offered
23 shall not rescind coverage under a contract with respect to an
24 individual, including a group to which the individual belongs
25 or family coverage in which the individual is included, after

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1 the individual is covered under the contract, unless:

2 (1) the individual or a person seeking coverage
3 on behalf of the individual engages in conduct that constitutes
4 fraud; or

5 (2) the individual makes an intentional
6 misrepresentation of material fact, as prohibited by the terms
7 of the contract or coverage.

8 B. For purposes of Paragraph (1) of Subsection A of
9 this section, a person seeking coverage on behalf of an
10 individual does not include an insurance producer or an
11 employee or authorized representative of the carrier.

12 C. A health maintenance organization shall provide at
13 least thirty days' advance written notice to each health
14 maintenance organization enrollee, or for individual health
15 maintenance organization coverage, to each primary subscriber,
16 who would be affected by the proposed rescission of coverage
17 before coverage under the contract may be rescinded in
18 accordance with Subsection A of this section, regardless, in
19 the case of group health maintenance organization coverage, of
20 whether the rescission applies to the entire group or only to
21 an individual within the group.

22 D. The provisions of this section apply regardless of
23 any applicable contestability period."

24 **SECTION 73.** A new section of the Health Maintenance
25 Organization Law is enacted to read:

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1 "[NEW MATERIAL] PROHIBITION OF DISCRIMINATION IN FAVOR OF
2 HIGHLY COMPENSATED INDIVIDUALS--EXCLUSIONS.--

3 A. A group health maintenance organization contract
4 that is delivered, issued for delivery or renewed in this state
5 on behalf of an employer shall not discriminate in favor of
6 highly compensated individuals as to eligibility to participate
7 or as to the benefits offered. The benefits provided for
8 participants who are highly compensated individuals shall be
9 provided for all other participants.

10 B. An employer shall ensure that any employer-
11 sponsored group health coverage it offers is offered to:

12 (1) seventy percent or more of all of that
13 employer's employees;

14 (2) eighty percent or more of all of that
15 employer's employees who are eligible to benefit under the
16 policy, plan or contract if seventy percent or more of all
17 employees are eligible to benefit; or

18 (3) any employees who qualify under a
19 classification that the employer has established and that the
20 secretary of the United States department of health and human
21 services has approved.

22 C. An employer may exclude the following types of
23 employees from an offering of health coverage under Subsections
24 A and B of this section:

25 (1) employees who have not completed three years

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1 of service;

2 (2) employees who have not attained twenty-five
3 years of age;

4 (3) part-time or seasonal employees;

5 (4) employees not included in the plan who are
6 included in a unit of employees covered by an agreement between
7 employee representatives and one or more employers that the
8 secretary of the United States department of health and human
9 services has found to be a collective bargaining agreement, if
10 accident and health benefits were the subject of good faith
11 bargaining between these employee representatives and the
12 employer or employers; and

13 (5) employees who are nonresident aliens of the
14 United States and who receive no earned income, within the
15 meaning of section 911(d)(2) of the federal Internal Revenue
16 Code of 1986, from the employer that constitutes income from
17 sources within the United States, as defined in Section
18 861(a)(3) of the federal Internal Revenue Code of 1986.

19 D. As used in this section, "highly compensated
20 individual" means an individual who is:

21 (1) one of the five highest paid officers of an
22 employer;

23 (2) a shareholder who owns more than ten percent
24 in the value of the employer's stock, pursuant to Section 318
25 of the federal Internal Revenue Code of 1986; or

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1 (3) among the highest paid twenty-five percent
2 of all employees who do not belong to any category listed in
3 Subsection C of this section."

4 **SECTION 74.** A new section of the Health Maintenance
5 Organization Law is enacted to read:

6 "[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY
7 REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--
8 OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

9 A. For individual or group health maintenance
10 organization contract years beginning on or after September 23,
11 2010, if a child's health maintenance organization coverage
12 ended or did not begin for the reasons described in Subsection
13 E of this section, a health maintenance organization shall
14 provide the child an opportunity to enroll in a health
15 maintenance organization contract for which coverage continues
16 for at least sixty days and provide written notice of the
17 opportunity to enroll as described in Subsection B of this
18 section no later than the first day of the contract year.

19 B. A written notice of the opportunity to enroll
20 provided pursuant to this section shall include a statement
21 that children whose coverage ended, who were denied coverage or
22 who were not eligible for coverage because dependent coverage
23 of children was unavailable before the child reached twenty-six
24 years of age, are eligible to enroll in coverage. This notice
25 may be provided to a principal insured on behalf of the

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1 principal insured's child. For a group health maintenance
2 organization contract, the notice may be included with other
3 enrollment materials that the carrier distributes to employees,
4 provided the statement is prominent. If the notice is provided
5 to an employee whose child is entitled to an enrollment
6 opportunity under Subsection A of this section, the obligation
7 to provide the notice of enrollment opportunity under this
8 subsection is satisfied for both the individual or group health
9 maintenance organization contract.

10 C. For an individual who enrolls in an individual or
11 a group health maintenance organization contract pursuant to
12 Subsection A of this section, the coverage shall take effect
13 not later than the first day of the first contract year.

14 D. A child enrolling pursuant to this section in a
15 group health maintenance organization contract shall be
16 considered a "special enrollee" pursuant to Section 59A-23E-8
17 NMSA 1978. The child and the principal insured shall be
18 offered all of the benefit packages available to similarly
19 situated individuals who were denied coverage or whose coverage
20 ended by reason of cessation of dependent status. Any
21 difference in benefits or cost-sharing requirements constitutes
22 a different benefit package. The child shall not be required
23 to pay more for coverage than similarly situated individuals
24 who did not lose coverage by reason of cessation of dependent
25 status.

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1 E. The provisions of this section shall apply to a
2 child:

3 (1) whose coverage ended, or who was denied
4 coverage or was not eligible for coverage under an individual
5 or group health maintenance organization contract delivered,
6 issued for delivery or renewed in this state because, under the
7 terms of coverage, the availability of dependent coverage of a
8 child ended before the child reached the age of twenty-six; or

9 (2) who became eligible, or is required to
10 become eligible, for coverage on the first day of the first
11 contract year, beginning on or after September 23, 2010 by
12 reason of the provisions of this section."

13 **SECTION 75.** A new section of the Health Maintenance
14 Organization Law is enacted to read:

15 "[NEW MATERIAL] GRANDFATHERED HEALTH MAINTENANCE
16 ORGANIZATION CONTRACTS--ADULT CHILD DEPENDENT ELIGIBLE FOR
17 EMPLOYER-SPONSORED HEALTH BENEFIT CONTRACTS--EXCLUSION FROM
18 DEPENDENT COVERAGE ELIGIBILITY PERMITTED.--

19 A. For contract years beginning before January 1,
20 2014, a group health maintenance organization contract
21 delivered, issued for delivery or renewed in this state that
22 provides group health maintenance organization coverage that is
23 a grandfathered health maintenance organization contract and
24 makes available dependent coverage of children may exclude an
25 adult child under twenty-six years of age from coverage only if

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1 the adult child is eligible to enroll in an eligible employer-
2 sponsored health benefit plan, as defined in Section
3 5000A(f)(2) of the federal Internal Revenue Code of 1986, other
4 than the group contract of a parent.

5 B. For the purposes of this section, "adult child"
6 means an individual eighteen to twenty-six years of age."

7 SECTION 76. A new section of the Health Maintenance
8 Organization Law is enacted to read:

9 "[NEW MATERIAL] PROHIBITION ON PREEXISTING CONDITION
10 EXCLUSIONS FOR INDIVIDUALS UNDER THE AGE OF NINETEEN.--

11 A. An individual or group health maintenance
12 organization contract delivered, issued for delivery or renewed
13 in this state shall not limit or exclude coverage under an
14 individual or group contract for an individual under the age of
15 nineteen by imposing a preexisting condition exclusion on that
16 individual.

17 B. When a carrier offers individual or group health
18 insurance coverage that only covers individuals under age
19 nineteen, that insurer shall offer the coverage continuously
20 throughout the year or during one or more open enrollment
21 periods as the superintendent prescribes by rule.

22 C. During an open enrollment period, a carrier shall
23 not deny or unreasonably delay the issuance of a policy, refuse
24 to issue a policy or issue a policy with any preexisting
25 condition exclusion rider or endorsement to an applicant or

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1 insured who is under the age of nineteen on the basis of a
2 preexisting condition.

3 D. Coverage shall be effective for those applying
4 during an open enrollment period on the same basis as any
5 applicant qualifying for coverage on an underwritten basis.

6 E. Each carrier shall provide prior prominent public
7 notice on its web site and written notice to each of its
8 policyholders annually at least ninety days before any open
9 enrollment period of the open enrollment rights for individuals
10 under the age of nineteen and shall provide information as to
11 how an individual eligible for this open enrollment right may
12 apply for coverage with the insurer during an open enrollment
13 period."

14 SECTION 77. A new section of the Health Maintenance
15 Organization Law is enacted to read:

16 "[NEW MATERIAL] EMERGENCY SERVICES.--

17 A. An individual or group health maintenance
18 organization contract delivered, issued for delivery or renewed
19 in this state and that provides or covers any benefits with
20 respect to services in an emergency department of a hospital
21 shall cover emergency services:

22 (1) without the need for any prior authorization
23 determination; and

24 (2) whether or not the health care provider
25 furnishing emergency services is a participating provider with

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1 respect to emergency services.

2 B. If emergency services are provided to a covered
3 individual by a nonparticipating health care provider with or
4 without prior authorization, the services shall be provided
5 without imposing any requirement under the contract for prior
6 authorization of services or any limitation on coverage where
7 the provider of services does not have a contractual
8 relationship with the carrier for the provision of services
9 that is more restrictive than the requirements or limitations
10 that apply to emergency department services received from
11 providers who do have such a contractual relationship with the
12 carrier.

13 C. If emergency services are provided out of network,
14 the cost-sharing requirement, expressed as a copayment amount
15 or coinsurance rate, shall be the same requirement that would
16 apply if the emergency services were provided in-network and
17 without regard to any other term or condition of such coverage,
18 other than exclusion or coordination of benefits, or an
19 affiliation or waiting period other than the applicable
20 cost-sharing otherwise permitted pursuant to state or federal
21 law.

22 D. The provisions of this section shall not apply to:

23 (1) policies or plans intended to supplement
24 major medical group-type coverages such as medicare supplement,
25 long-term care, disability income, specified disease, accident-

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1 only, hospital indemnity or other limited-benefit health
2 insurance policies or plans; or

3 (2) health insurance policies, plans,
4 certificates or subscriber agreements that are governed by the
5 provisions of Section 59A-22A-5 NMSA 1978.

6 E. As used in this section:

7 (1) "emergency medical condition" means a
8 medical condition manifesting itself by acute symptoms of
9 sufficient severity, including severe pain, such that a prudent
10 layperson who possesses an average knowledge of health and
11 medicine could reasonably expect the absence of immediate
12 medical attention to result in one of the following conditions:

13 (a) placing the health of the individual or,
14 with respect to a pregnant woman, the health of the woman or
15 her unborn child, in serious jeopardy;

16 (b) serious impairment to bodily functions;
17 or

18 (c) serious dysfunction of any bodily organ
19 or part;

20 (2) "emergency services" means, with respect to
21 an emergency medical condition:

22 (a) a medical screening examination that is
23 within the capability of the emergency department of a
24 hospital, including ancillary services routinely available to
25 the emergency department to evaluate the emergency medical

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1 condition; and

2 (b) according to the capabilities of the
3 staff and facilities available at the hospital, further medical
4 examination and treatment required to stabilize the patient's
5 emergency medical condition or safe transfer of the patient to
6 another medical facility capable of providing the medical
7 examination or treatment required to stabilize the patient's
8 emergency medical condition; and

9 (3) "stabilize" means:

10 (a) to provide medical treatment of an
11 emergency medical condition as necessary to ensure, within
12 reasonable medical probability, that no material deterioration
13 of the condition is likely to result from or occur during the
14 transfer of the individual from a facility; or

15 (b) with respect to a pregnant woman who is
16 having contractions, to deliver, including a placenta."

17 **SECTION 78.** A new section of the Health Maintenance
18 Organization Law is enacted to read:

19 "[NEW MATERIAL] OPTION FOR PEDIATRICIAN AS PRIMARY CARE
20 PHYSICIAN.--

21 A. An individual or group health maintenance
22 organization contract delivered, issued for delivery or renewed
23 in this state that requires or provides for the designation of
24 a participating primary care provider shall allow a principal
25 insured to designate for the principal insured's dependent

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1 child who is a covered individual an allopathic or osteopathic
2 physician who specializes in pediatrics as the principal
3 insured child's primary care provider if the provider
4 participates in the network of the carrier.

5 B. Nothing in Subsection A of this section shall be
6 construed to waive any exclusions of coverage under the terms
7 and conditions of the contract with respect to coverage of
8 pediatric care.

9 C. As used in this section, "primary care provider"
10 means a health care practitioner acting within the scope of the
11 health care practitioner's license who provides the first level
12 of basic or general health care for a covered individual's
13 health needs, including diagnostic and treatment services, who
14 initiates referrals to other health care practitioners and who
15 maintains the continuity of care when appropriate."

16 SECTION 79. A new section of the Health Maintenance
17 Organization Law is enacted to read:

18 "[NEW MATERIAL] ACCESS TO OBSTETRICAL AND GYNECOLOGICAL
19 CARE.--

20 A. An individual or group health maintenance
21 organization contract delivered, issued for delivery or renewed
22 in this state that provides coverage for obstetrical and
23 gynecological care and that requires that covered individuals
24 designate a primary care provider shall not require
25 authorization or referral by the carrier or any person,

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1 including a primary care provider, when a female covered
2 individual seeks coverage for obstetrical or gynecological care
3 provided by a participating health care professional who
4 specializes in obstetrics or gynecology. The obstetrical or
5 gynecological health care provider shall agree otherwise to
6 adhere to the contract's or issuer's policies and procedures,
7 including procedures regarding referrals, obtaining prior
8 authorization and providing services pursuant to a treatment
9 plan approved by the carrier.

10 B. A health maintenance organization shall treat the
11 provision of obstetrical and gynecological care, and the
12 ordering of related obstetrical and gynecological items and
13 services by a participating health care professional who
14 specializes in obstetrics or gynecology, as the authorization
15 of the primary care provider.

16 C. Nothing in Subsection A of this section shall be
17 construed to:

18 (1) waive any exclusions of coverage under the
19 terms and conditions of the contract with respect to coverage
20 of obstetrical or gynecological care; or

21 (2) preclude the carrier from requiring that the
22 obstetrical or gynecological provider notify the covered
23 individual's primary care health care professional or the
24 carrier of treatment decisions.

25 D. As used in this section, "primary care provider"

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1 means a health care practitioner acting within the scope of the
2 health care practitioner's license who provides the first level
3 of basic or general health care for a person's health needs,
4 including diagnostic and treatment services, who initiates
5 referrals to other health care practitioners and who maintains
6 the continuity of care when appropriate."

7 **SECTION 80.** A new section of the Health Maintenance
8 Organization Law is enacted to read:

9 "[NEW MATERIAL] COST-SHARING FOR PREVENTIVE ITEMS AND
10 SERVICES.--

11 A. An individual or group health maintenance
12 organization contract delivered, issued for delivery or renewed
13 in this state, except for grandfathered health maintenance
14 organization coverage, shall provide coverage for all of the
15 following items and services required under Sections
16 59A-46-38.2, 59A-46-42 and 59A-46-45 NMSA 1978 and Sections 81
17 through 83 of this 2012 act, and shall not impose any
18 cost-sharing requirements, such as a copayment, coinsurance or
19 deductible.

20 B. A carrier is not required to provide coverage for
21 any items or services specified in any recommendation or
22 guideline described in Subsection A of this section after the
23 recommendation or guideline is no longer described by a source
24 listed in that subsection.

25 C. Other provisions of state or federal law may apply

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1 in connection with a carrier's ceasing to provide coverage for
2 any such items or services.

3 D. To the extent that a preventive care provision in
4 this section conflicts with any other preventive health care
5 law in New Mexico, the provision providing the greatest level
6 of coverage shall apply. The preventive care provisions in
7 this section are intended to supplement rather than supplant
8 existing preventive health care provisions in this state.

9 E. The superintendent shall at least annually revise
10 the preventive services standards established pursuant to
11 Sections 59A-46-38.2, 59A-46-42 and 59A-46-45 NMSA 1978 and
12 Sections 81 through 83 of this 2012 act to ensure that they are
13 consistent with the "A"-rated and "B"-rated recommendations of
14 the United States preventive services task force, the advisory
15 committee on immunization practices of the federal centers for
16 disease control and prevention and the guidelines with respect
17 to infants, children, adolescents and women of evidence-based
18 preventive care and screenings by the federal health resources
19 and services administration. When changes are made to any of
20 these guidelines or recommendations, the superintendent shall
21 make recommendations to the legislature for legislative changes
22 to conform these standards to current guidelines and
23 recommendations.

24 F. A health maintenance organization may impose
25 cost-sharing requirements with respect to an office visit if a

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1 preventive item or service provided pursuant to this section is
2 billed separately or is tracked as individual encounter data
3 separately from the office visit.

4 G. A health maintenance organization shall not impose
5 cost-sharing requirements with respect to an office visit for
6 an item or service provided pursuant to this section if an item
7 or service is not billed separately or is not tracked as
8 individual encounter data separately from the office visit and
9 the primary purpose of the office visit is the delivery of the
10 preventive item or service.

11 H. A health maintenance organization may impose
12 cost-sharing requirements with respect to an office visit if a
13 preventive item or service provided pursuant to this section is
14 not billed separately or is not tracked as individual encounter
15 data separately from the office visit and the primary purpose
16 of the office visit is not the delivery of the preventive item
17 or service.

18 I. The provisions of this section shall not apply to
19 policies or plans intended to supplement major medical group-
20 type coverages such as medicare supplement, long-term care,
21 disability income, specified disease, accident-only, hospital
22 indemnity or other limited-benefit health insurance policies or
23 plans."

24 SECTION 81. A new section of the Health Maintenance
25 Organization Law is enacted to read:

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1 "[NEW MATERIAL] PREVENTIVE SERVICES BENEFITS--ASPIRIN
2 REGIMEN--HIGH BLOOD PRESSURE SCREENING--BREAST CANCER
3 SCREENING--LIPID DISORDERS SCREENING--COLORECTAL CANCER
4 SCREENING--DEPRESSION SCREENING--BEHAVIORAL DIETARY
5 COUNSELING--OBESITY COUNSELING AND SCREENING--OSTEOPOROSIS
6 SCREENING.--

7 A. An individual or group health maintenance
8 organization contract delivered, issued for delivery or renewed
9 in this state shall provide the following benefits that have,
10 in effect, a rating of "A" or "B" in the current
11 recommendations of the United States preventive services task
12 force, for:

13 (1) a one-time screening for abdominal aortic
14 aneurysm by ultrasonography in men who have ever smoked and who
15 are between the ages of sixty-five and seventy-five;

16 (2) an aspirin regimen for men between the ages
17 of forty-five and seventy-nine when the potential benefit due
18 to a reduction in myocardial infarctions outweighs the
19 potential harm due to an increase in gastrointestinal
20 hemorrhage;

21 (3) an aspirin regimen for women between the
22 ages of fifty-five and seventy-nine when the potential benefit
23 of a reduction in ischemic strokes outweighs the potential harm
24 due to an increase in gastrointestinal hemorrhage;

25 (4) screening for high blood pressure in adults

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1 aged eighteen and older;

2 (5) genetic counseling and evaluation for breast
3 cancer BRCA-gene testing for women whose family histories are
4 associated with an increased risk for deleterious mutations in
5 BRCA1 or BRCA2 genes. Nothing in this subsection shall be
6 construed as a waiver or exception to the Genetic Information
7 Privacy Act;

8 (6) screening of lipid disorders for:

9 (a) men who are thirty-five years of age or
10 older; and

11 (b) women who are twenty years of age or
12 older who are at increased risk of coronary heart disease;

13 (7) screening of individuals over eighteen years
14 of age for colorectal cancer using fecal occult blood testing,
15 sigmoidoscopy or colonoscopy;

16 (8) screening of individuals eighteen years of
17 age or older for depression;

18 (9) screening of individuals twelve to eighteen
19 years of age for major depressive disorder;

20 (10) behavioral dietary counseling for adults
21 with hyperlipidemia and other known risk factors for
22 cardiovascular and diet-related chronic disease;

23 (11) screening and counseling for obesity for:

24 (a) individuals eighteen years of age and
25 older who are obese; and

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1 (b) individuals six to eighteen years of
2 age; and

3 (12) screening for osteoporosis for:

4 (a) women who are sixty-five years of age
5 and older; and

6 (b) women who are sixty to sixty-five years
7 of age who are at increased risk for osteoporotic fractures.

8 B. The provisions of this section shall not apply to
9 policies or plans intended to supplement major medical group-
10 type coverages such as medicare supplement, long-term care,
11 disability income, specified disease, accident-only, hospital
12 indemnity or other limited-benefit health insurance policies or
13 plans."

14 SECTION 82. A new section of the Health Maintenance
15 Organization Law is enacted to read:

16 "[NEW MATERIAL] PREVENTIVE SERVICES FOR CHILDREN.--

17 A. An individual or group health maintenance
18 organization contract that is delivered or issued for delivery
19 in this state shall provide the following benefits that have,
20 in effect, a rating of "A" or "B" in the current
21 recommendations of the United States preventive services task
22 force, for:

23 (1) oral fluoride supplementation at currently
24 recommended doses to children six months of age to five years
25 of age whose primary water sources are deficient in fluoride;

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- 1 (2) prophylactic ocular topical medication
2 against gonococcal ophthalmia neonatorum for newborns;
3 (3) screening for hearing loss in newborns;
4 (4) screening for sickle cell disease for
5 newborns;
6 (5) screening for congenital hypothyroidism for
7 newborns;
8 (6) iron supplementation for asymptomatic
9 children six to twelve months of age who are at increased risk
10 for iron deficiency anemia;
11 (7) screening for phenylketonuria in newborns;
12 and
13 (8) screening to detect amblyopia, strabismus
14 and defects in visual acuity in children less than five years
15 of age.

16 B. The provisions of this section shall not apply to
17 policies or plans intended to supplement major medical group-
18 type coverages such as medicare supplement, long-term care,
19 disability income, specified disease, accident-only, hospital
20 indemnity or other limited-benefit health insurance policies or
21 plans."

22 **SECTION 83.** A new section of the Health Maintenance
23 Organization Law is enacted to read:

24 "[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--
25 REPRODUCTIVE HEALTH.--

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1 A. An individual or group health maintenance
2 organization contract delivered, issued for delivery or renewed
3 in this state shall provide the following benefits that have,
4 in effect, a rating of "A" or "B" in the current
5 recommendations of the United States preventive services task
6 force, for:

7 (1) screening for asymptomatic bacteriuria with
8 a urine culture for pregnant women;

9 (2) interventions during pregnancy and after
10 birth to promote and support breastfeeding;

11 (3) screening for cervical cancer in women who
12 have been sexually active and have a cervix;

13 (4) screening for chlamydial infection for:

14 (a) all sexually active young women
15 twenty-four years of age and younger; and

16 (b) older women who are at increased risk of
17 chlamydial infection;

18 (5) a daily supplement containing four hundred
19 to eight hundred micrograms of folic acid for any woman
20 planning a pregnancy or capable of pregnancy;

21 (6) screening of all sexually active women who
22 are at increased risk for infection, including those who are
23 pregnant, for gonorrheal infection;

24 (7) screening for iron deficiency anemia in
25 asymptomatic pregnant women;

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1 (8) Rh (D) blood typing and antibody testing

2 for:

3 (a) all pregnant women; and

4 (b) all unsensitized Rh (D) negative women

5 at twenty-four to twenty-eight weeks' gestation;

6 (9) behavioral counseling to prevent sexually
7 transmitted infections in:

8 (a) all sexually active adolescents; and

9 (b) individuals aged eighteen years and
10 older at increased risk for sexually transmitted infections;

11 (10) screening for hepatitis B virus infection
12 in pregnant women;

13 (11) screening for human immunodeficiency virus
14 for individuals twelve years of age and older who are at risk
15 of human immunodeficiency virus infection;

16 (12) screening for iron deficiency anemia in
17 asymptomatic pregnant women; and

18 (13) screening for syphilis for:

19 (a) any individual at increased risk for
20 syphilis infection; and

21 (b) any pregnant woman.

22 B. The provisions of this section shall not apply to
23 policies or plans intended to supplement major medical group-
24 type coverages such as medicare supplement, long-term care,
25 disability income, specified disease, accident-only, hospital

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1 indemnity or other limited-benefit health insurance policies or
2 plans."

3 SECTION 84. Section 59A-47-3 NMSA 1978 (being Laws 1984,
4 Chapter 127, Section 879.1, as amended) is amended to read:

5 "59A-47-3. DEFINITIONS.--As used in Chapter 59A, Article
6 47 NMSA 1978:

7 A. "health care" means the treatment of persons for
8 the prevention, cure or correction of any illness or physical
9 or mental condition, including optometric services;

10 B. "item of health care" includes any services or
11 materials used in health care;

12 C. "health care expense payment" means a payment for
13 health care to a purveyor on behalf of a subscriber, or such a
14 payment to the subscriber;

15 D. "purveyor" means a person who furnishes any item
16 of health care and charges for that item;

17 E. "service benefit" means a payment that the
18 purveyor has agreed to accept as payment in full for health
19 care furnished the subscriber;

20 F. "indemnity benefit" means a payment that the
21 purveyor has not agreed to accept as payment in full for health
22 care furnished the subscriber;

23 G. "subscriber" means any individual who, because of
24 a contract with a health care plan entered into by or for the
25 individual, is entitled to have health care expense payments

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1 made on the individual's behalf or to the individual by the
2 health care plan;

3 H. "underwriting manual" means the health care plan's
4 written criteria, approved by the superintendent, that defines
5 the terms and conditions under which subscribers may be
6 selected. The underwriting manual may be amended from time to
7 time, but amendment will not be effective until approved by the
8 superintendent. The superintendent shall notify the health
9 care plan filing the underwriting manual or the amendment
10 thereto of the superintendent's approval or disapproval thereof
11 in writing within thirty days after filing or within sixty days
12 after filing if the superintendent shall so extend the time.
13 If the superintendent fails to act within such period, the
14 filing shall be deemed to be approved;

15 I. "acquisition expenses" includes all expenses
16 incurred in connection with the solicitation and enrollment of
17 subscribers;

18 J. "administration expenses" means all expenses of
19 the health care plan other than the cost of health care expense
20 payments and acquisition expenses;

21 K. "health care plan" means a nonprofit corporation
22 authorized by the superintendent to enter into contracts with
23 subscribers and to make health care expense payments;

24 L. "agent" means a person appointed by a health care
25 plan authorized to transact business in this state to act as

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1 its representative in any given locality for soliciting health
2 care policies and other related duties as may be authorized;

3 M. "solicitor" means a person employed by the
4 licensed agent of a health care plan for the purpose of
5 soliciting health care policies and other related duties in
6 connection with the handling of the business of the agent as
7 may be authorized and paid for the person's services either on
8 a commission basis or salary basis or part by commission and
9 part by salary;

10 N. "chiropractor" means any person holding a license
11 provided for in the Chiropractic Physician Practice Act;

12 O. "doctor of oriental medicine" means any person
13 licensed as a doctor of oriental medicine under the Acupuncture
14 and Oriental Medicine Practice Act;

15 P. "pharmacist" means a person licensed as a
16 pharmacist pursuant to the Pharmacy Act; ~~and~~

17 Q. "pharmacist clinician" means a pharmacist who
18 exercises prescriptive authority pursuant to the Pharmacist
19 Prescriptive Authority Act; and

20 R. "child" means an individual under twenty-six
21 years of age whom the principal insured covers or whom the
22 applicant for coverage applies to cover, regardless of the
23 individual's financial dependency, residency with a parent,
24 student status, employment or marital status."

25 SECTION 85. Section 59A-47-24 NMSA 1978 (being Laws

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1 1984, Chapter 127, Section 879.22) is amended to read:

2 "59A-47-24. SUBSCRIBER CONTRACTS--REQUIREMENTS AND
3 PROVISIONS.--

4 A. Every health care expense payments contract
5 issued under [~~this article~~] the Nonprofit Health Care Plan
6 Law shall be in writing and shall comply with [~~requirements~~
7 ~~and~~] standards that the superintendent has established by
8 rule pursuant to United States department of health and human
9 services regulations on uniform standards for the following
10 documents issued by each contract relating to:

11 (1) a summary of benefits;

12 (2) an explanation of coverage;

13 (3) definitions of standard insurance terms
14 and medical terms;

15 (4) exceptions, reductions and limitations on
16 coverage;

17 (5) cost-sharing provisions, including
18 deductible, coinsurance and copayment obligations;

19 (6) the renewability and continuation of
20 coverage provisions;

21 (7) a coverage facts disclosure that includes
22 examples that are based on nationally recognized clinical
23 practice guidelines to illustrate common benefits scenarios,
24 including pregnancy and serious or chronic medical conditions
25 and related cost-sharing;

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1 (8) a statement of whether the contract:

2 (a) provides minimum essential coverage,
3 as defined under Section 5000A(f) of the federal Internal
4 Revenue Code of 1986; and

5 (b) ensures that the coverage share of the
6 total allowed costs of benefits provided under the contract
7 is not less than sixty percent of those costs; and

8 (9) a contact number for the consumer to call
9 with additional questions and an internet web address where a
10 copy of the actual individual or group health coverage
11 contract can be reviewed and obtained.

12 B. A health care expense payments contract shall
13 contain provisions in substance as follows:

14 [~~A-~~] (1) a provision that the policy, the
15 application of the policyholder (if it or a copy thereof is
16 attached to the policy) and the individual applications, if
17 any, submitted in connection with [~~such~~] the policy by the
18 employees or members constitutes the entire contract between
19 the parties, that no statement therein is a warranty in the
20 absence of fraud and that no such statement shall avoid the
21 obligation of the health care plan provided in the policy or
22 reduce benefits thereunder unless contained in a written
23 application for [~~such~~] the contract, attached to and made
24 part of the policy;

25 [~~B-~~] (2) if [~~such~~] the contract is a group

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1 contract, a provision that the health care plan will furnish
2 to the subscriber, for delivery to each employee or member of
3 any covered group, an individual certificate, ~~[or]~~ an
4 identification card or other evidence of such coverage,
5 setting forth in summary form a statement of the essential
6 features of the contract of all persons included in the
7 coverage;

8 ~~[G.]~~ (3) if ~~[such]~~ the contract is a group
9 contract, a provision that eligible new employees or members
10 or dependents, as the case may be, may be added from time to
11 time to the group originally covered, in accordance with the
12 terms of the contract;

13 ~~[D.]~~ (4) the amount payable to the health care
14 plan by the subscriber and the time at which and manner in
15 which ~~[such]~~ the amount is to be paid;

16 ~~[E. the nature of the benefits which will be
17 furnished and the period during which they will be furnished
18 and, if there are any benefits to be excepted, a detailed
19 statement of such exceptions;~~

20 ~~F.]~~ (5) any specific term or condition to the
21 effect that the contract may be canceled or otherwise
22 terminated by the health care plan, including the manner and
23 time of ~~[such]~~ the termination; provided that a contract may
24 not be canceled during the period for which the premium has
25 been paid unless written notice is delivered to the insured,

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1 or mailed to [~~his~~] the insured's last address as shown by the
2 records of the health care plan, stating when, not less than
3 five days thereafter [~~such~~] the cancellation shall be
4 effective;

5 [~~G.~~] (6) that the contract includes the
6 endorsements thereon and attached papers, if any, and
7 constitutes the entire contract;

8 [~~H.~~] (7) that [~~after two years no statement,~~
9 ~~except a fraudulent statement, by the subscriber in the~~
10 ~~application for a contract shall void the contract or~~] once
11 the subscriber is covered under the contract, only an act by
12 a subscriber that constitutes fraud or an intentional
13 misrepresentation of material fact that is prohibited by the
14 terms of the contract shall rescind the contract;

15 (8) that no statement, except a fraudulent
16 statement by the subscriber in the application for a
17 contract, shall be used against the subscriber in any legal
18 action or proceedings relating to the contract unless [~~such~~]
19 the application or a true copy thereof is included in or
20 attached to [~~such~~] the contract; a statement that no change
21 in the contract shall be valid until approved by an executive
22 officer of the health care plan and unless [~~such~~] the
23 approval and countersignature be endorsed on or attached to
24 [~~such~~] the contract; and a statement that no agent has
25 authority to change the contract or waive any of its

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1 provisions. No claim for loss incurred or disability, as
2 defined in the policy, shall be reduced or denied on the
3 ground that a disease or physical condition not excluded from
4 coverage by name or a specific description effective on the
5 date of loss had existed prior to the effective date of
6 coverage of ~~[such]~~ the policy;

7 ~~[F.]~~ (9) that if the subscriber defaults in
8 making any payment under the contract, the subsequent
9 acceptance of an application for reinstatement and
10 accompanying payment or its failure to take any action with
11 respect thereto within thirty days following receipt of
12 ~~[such]~~ the application for reinstatement, by ~~[such]~~ the
13 health care plan or any duly authorized agent thereof,
14 reinstates the contract. The reinstated policy shall cover
15 only loss resulting from such accidental injury as may be
16 sustained after the date of reinstatement and loss due to
17 such sickness as may begin more than ten days after ~~[such]~~
18 that date. In all other respects, the subscriber and the
19 health care plan shall have the same rights thereunder as
20 they had under the policy immediately before the due date of
21 the defaulted premium, subject to any provisions endorsed
22 thereon or attached thereto in connection with the
23 reinstatement. Any premium accepted in connection with a
24 reinstatement shall be applied to a period for which a
25 premium has not been previously paid, but not to any period

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1 more than sixty days prior to the date of reinstatement.

2 (The last sentence of the above provision may be omitted from
3 any policy [~~which~~] that the insured has the right to continue
4 in force subject to its terms by the timely payment of
5 premiums:

6 [~~(1)~~] (a) until at least age fifty [~~(50)~~];
7 or

8 [~~(2)~~] (b) in the case of a policy issued
9 after age forty-four [~~(44)~~], for at least five [~~(5)~~] years
10 from the date of its issue); and

11 [~~(J)~~] (10) the period of grace [~~which~~] that
12 will be allowed the subscriber for making any payment due
13 under the contract, which period shall not be less than ten
14 [~~(10)~~] days.

15 C. A health care expense payments contract shall
16 provide the following persons, prior to any enrollment
17 restriction, a summary of benefits and coverage explanation
18 required pursuant to Subsection A of this section:

19 (1) an applicant, at the time of application;
20 (2) a subscriber, prior to the time of
21 enrollment or re-enrollment, subscription or re-subscription;
22 and

23 (3) a subscriber, at the time of issuance of
24 the health care expense payments contract."

25 SECTION 86. Section 59A-47-35 NMSA 1978 (being Laws

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1 1984, Chapter 127, Section 879.34, as amended) is amended to
2 read:

3 "59A-47-35. ALCOHOL DEPENDENCY AND MISUSE COVERAGE.--

4 A. Each health care plan that delivers or issues
5 for delivery in this state a group contract providing for
6 health care expense payments on a service benefit basis or an
7 indemnity benefit basis or both shall offer and make
8 available benefits for the necessary care and treatment of
9 alcohol dependency [~~Such~~] and misuse. These benefits shall

10 [~~(1) be subject to annual deductibles and~~
11 ~~coinsurance consistent with those imposed on other benefits~~
12 ~~within the same contract;~~

13 ~~(2)] provide [no less than thirty days]~~
14 necessary care and treatment in an alcohol dependency and
15 misuse treatment center and [~~thirty~~] outpatient visits for
16 alcohol dependency and misuse treatment [~~and~~

17 ~~(3) be offered for benefit periods of no more~~
18 ~~than one year and may be limited to a lifetime maximum of no~~
19 ~~less than two benefit periods.~~

20 ~~Such offer of benefits shall be subject to the rights of~~
21 ~~the group contract holder to reject the coverage or to select~~
22 ~~any alternative level of benefits if that right is offered by~~
23 ~~or negotiated with that health care plan].~~

24 B. For purposes of this section, "alcohol
25 dependency and misuse treatment center" means a facility that

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1 contracts with the health care plan and that provides a
2 program for the treatment of alcohol dependency and misuse
3 pursuant to a written treatment plan approved and monitored
4 by a physician or meeting the quality standards of the
5 department of health and which facility also:

6 (1) is affiliated with a hospital under a
7 contractual agreement with an established system for patient
8 referral;

9 (2) is accredited as such a facility by the
10 joint commission on accreditation of hospitals; or

11 (3) meets at least the minimum standards for
12 treatment of alcohol dependency and misuse adopted by the
13 department of health.

14 C. This section applies to contracts delivered or
15 issued for delivery or renewed, extended or amended in this
16 state on or after July 1, 1983 or upon expiration of a
17 collective bargaining agreement applicable to a particular
18 contract holder, whichever is later; provided that this
19 section does not apply to blanket, short-term travel,
20 accident-only, limited or specified disease, individual
21 conversion contracts or contracts designed for issuance to
22 persons eligible for coverage under Title 18 of the Social
23 Security Act, known as medicare, or any other similar
24 coverage under state or federal governmental plans. With
25 respect to any contract forms approved by the insurance

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1 division prior to the effective date of this section, an
2 insurer is authorized to comply with this section by the use
3 of endorsements or riders, provided such endorsements or
4 riders are approved by the insurance division as being in
5 compliance with this section and applicable provisions of the
6 Insurance Code.

7 D. If an organization offering group health
8 benefits to its members makes more than one health care plan
9 or health insurance plan policy available to its members on a
10 member option basis, the organization shall not require
11 alcohol dependency and misuse coverage from one health care
12 plan or health insurer without requiring the same level of
13 alcohol dependency and misuse coverage for all other health
14 care plans or health insurance policies that the organization
15 makes available to its members."

16 SECTION 87. Section 59A-47-37 NMSA 1978 (being Laws
17 1994, Chapter 64, Section 12, as amended) is amended to read:

18 "59A-47-37. COVERAGE OF CHILDREN.--

19 A. ~~[An insurer]~~ A health care plan shall not deny
20 enrollment of a child under the ~~[health]~~ plan of the child's
21 parent on the grounds that the child:

22 (1) was born out of wedlock;

23 (2) is not claimed as a dependent on the
24 parent's federal tax return; or

25 (3) does not reside with the parent or in the

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1 insurer's service area.

2 B. When a child has health coverage through an
3 insurer of a noncustodial parent, the ~~[insurer]~~ health care
4 plan shall:

5 (1) provide such information to the custodial
6 parent as may be necessary for the child to obtain benefits
7 through that coverage;

8 (2) permit the custodial parent or the
9 provider, with the custodial parent's approval, to submit
10 claims for covered services without the approval of the
11 noncustodial parent; and

12 (3) make payments on claims submitted in
13 accordance with Paragraph (2) of this subsection directly to
14 the custodial parent, the provider or the state medicaid
15 agency.

16 C. When a parent is required by a court or
17 administrative order to provide health coverage for a child,
18 and the parent is eligible for family health coverage, the
19 ~~[insurer]~~ health care plan shall be required:

20 (1) to permit the parent to enroll, under the
21 family coverage, a child who is otherwise eligible for the
22 coverage without regard to any enrollment season
23 restrictions;

24 (2) if the parent is enrolled but fails to
25 make application to obtain coverage for the child, to enroll

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1 the child under family coverage upon application of the
2 child's other parent, the state agency administering the
3 medicaid program or the state agency administering 42 U.S.C.
4 Sections 651 through 669, the child support enforcement
5 program; and

6 (3) not to disenroll or eliminate coverage of
7 the child unless the insurer is provided satisfactory written
8 evidence that:

9 (a) the court or administrative order is
10 no longer in effect; or

11 (b) the child is or will be enrolled in
12 comparable health coverage through another insurer or plan
13 that will take effect not later than the effective date of
14 disenrollment.

15 D. ~~[An insurer]~~ A health care plan shall not impose
16 requirements on a state agency that has been assigned the
17 rights of an individual eligible for medical assistance under
18 the medicaid program and covered for health benefits from the
19 ~~[insurer]~~ health care plan that are different from
20 requirements applicable to an agent or assignee of any other
21 individual so covered.

22 E. ~~[An insurer]~~ A health care plan shall provide
23 coverage for children, from birth through three years of age,
24 for or under the family, infant, toddler program administered
25 by the department of health, provided eligibility criteria

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1 are met [~~for a maximum benefit of three thousand five hundred~~
2 ~~dollars (\$3,500) annually~~] for medically necessary early
3 intervention services provided as part of an individualized
4 family service plan and delivered by certified and licensed
5 personnel as defined in 7.30.8 NMAC who are working in early
6 intervention programs approved by the department of health.
7 No payment under this subsection shall be applied against any
8 maximum lifetime or annual limits specified in the policy,
9 health benefits plan or contract."

10 SECTION 88. Section 59A-47-40 NMSA 1978 (being Laws
11 2003, Chapter 391, Section 7, as amended) is amended to read:

12 "59A-47-40. MAXIMUM AGE OF ~~[DEPENDENT]~~ CHILD.--An
13 individual or group health care coverage, including any form
14 of self-insurance, offered, issued or renewed under the
15 Health Care Purchasing Act that offers coverage of an
16 insured's ~~[dependent]~~ child shall not terminate coverage of
17 ~~[an unmarried dependent]~~ a child by reason of the
18 ~~[dependent's]~~ child's age before the ~~[dependent's twenty-~~
19 ~~fifth]~~ child's twenty-sixth birthday ~~[regardless of whether~~
20 ~~the dependent is enrolled in an educational institution]."~~

21 SECTION 89. Section 59A-47-45 NMSA 1978 (being Laws
22 2009, Chapter 74, Section 4) is amended to read:

23 "59A-47-45. COVERAGE FOR AUTISM SPECTRUM DISORDER
24 DIAGNOSIS AND TREATMENT.--

25 A. An individual or group health insurance policy,

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1 health care plan or certificate of health insurance delivered
2 or issued for delivery in this state shall provide coverage
3 to an eligible individual who is nineteen years of age or who
4 is twenty-two years of age or younger and is enrolled in high
5 school, for:

6 (1) well-baby and well-child screening for
7 diagnosing the presence of autism spectrum disorder; and

8 (2) treatment of autism spectrum disorder
9 through speech therapy, occupational therapy, physical
10 therapy and applied behavioral analysis.

11 B. Coverage required pursuant to Subsection A of
12 this section:

13 (1) shall be limited to treatment that is
14 prescribed by the insured's treating physician in accordance
15 with a treatment plan;

16 ~~[(2) shall be limited to thirty-six thousand~~
17 ~~dollars (\$36,000) annually and shall not exceed two hundred~~
18 ~~thousand dollars (\$200,000) in total lifetime benefits.~~
19 ~~Beginning January 1, 2011, the maximum benefit shall be~~
20 ~~adjusted annually on January 1 to reflect any change from the~~
21 ~~previous year in the medical component of the then-current~~
22 ~~consumer price index for all urban consumers published by the~~
23 ~~bureau of labor statistics of the United States department of~~
24 ~~labor;~~

25 ~~(3)]~~ (2) shall not be denied on the basis that

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1 the services are habilitative or rehabilitative in nature;
2 [~~(4)~~] (3) may be subject to other general
3 exclusions and limitations of the insurer's policy or plan,
4 including, but not limited to, coordination of benefits,
5 participating provider requirements, restrictions on services
6 provided by family or household members and utilization
7 review of health care services, including the review of
8 medical necessity, case management and other managed care
9 provisions; and

10 [~~(5)~~] (4) may be limited to exclude coverage
11 for services received under the federal Individuals with
12 Disabilities Education Improvement Act of 2004 and related
13 state laws that place responsibility on state and local
14 school boards for providing specialized education and related
15 services to children three to twenty-two years of age who
16 have autism spectrum disorder.

17 C. The coverage required pursuant to Subsection A
18 of this section shall not be subject to dollar limits,
19 deductibles or coinsurance provisions that are less favorable
20 to an insured than the dollar limits, deductibles or
21 coinsurance provisions that apply to physical illnesses that
22 are generally covered under the individual or group health
23 maintenance contract, except as otherwise provided in
24 Subsection B of this section.

25 D. An insurer shall not deny or refuse to issue

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1 health insurance coverage for medically necessary services or
2 refuse to contract with, renew, reissue or otherwise
3 terminate or restrict health insurance coverage for an
4 individual because the individual is diagnosed as having
5 autism spectrum disorder.

6 E. The treatment plan required pursuant to
7 Subsection B of this section shall include all elements
8 necessary for the health insurance policy or plan to pay
9 claims appropriately. These elements include, but are not
10 limited to:

- 11 (1) the diagnosis;
- 12 (2) the proposed treatment by types;
- 13 (3) the frequency and duration of treatment;
- 14 (4) the anticipated outcomes stated as goals;
- 15 (5) the frequency with which the treatment
16 plan will be updated; and
- 17 (6) the signature of the treating physician.

18 F. This section shall not be construed as limiting
19 benefits and coverage otherwise available to an insured under
20 a health insurance plan.

21 G. The provisions of this section shall not apply
22 to policies intended to supplement major medical group-type
23 coverages such as medicare supplement, long-term care,
24 disability income, specified disease, accident-only, hospital
25 indemnity or other limited-benefit health insurance policies.

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1 H. As used in this section:

2 (1) "autism spectrum disorder" means a
3 condition that meets the diagnostic criteria for the
4 pervasive developmental disorders published in the *Diagnostic*
5 *and Statistical Manual of Mental Disorders*, fourth edition,
6 text revision, also known as DSM-IV-TR, published by the
7 American psychiatric association, including autistic
8 disorder; Asperger's disorder; pervasive development disorder
9 not otherwise specified; Rett's disorder; and childhood
10 disintegrative disorder;

11 (2) "habilitative or rehabilitative services"
12 means treatment programs that are necessary to develop,
13 maintain and restore to the maximum extent practicable the
14 functioning of an individual; and

15 (3) "high school" means a school providing
16 instruction for any of the grades nine through twelve."

17 **SECTION 90.** Section 59A-47-46 NMSA 1978 (being Laws
18 2010, Chapter 94, Section 4) is amended to read:

19 "59A-47-46. HEALTH [~~INSURERS~~] CARE PLANS--DIRECT
20 SERVICES.--

21 A. A health care plan shall make reimbursement for
22 direct services at a level not less than eighty-five percent
23 of premiums across all health product lines, except
24 individually underwritten health care policies, contracts or
25 plans, that are governed by the provisions of Chapter 59A,

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1 Article 22 NMSA 1978, the Health Maintenance Organization Law
2 and the Nonprofit Health Care Plan Law. Reimbursement shall
3 be made for direct services provided over the preceding three
4 calendar years, but not earlier than calendar year 2010, as
5 determined by reports filed with the insurance division of
6 the commission. Nothing in this subsection shall be
7 construed to preclude a purchaser from negotiating an
8 agreement with a health insurer that requires a higher amount
9 of premiums paid to be used for reimbursement for direct
10 services for one or more products or for one or more years.

11 B. For individually underwritten health care
12 policies, plans or contracts, the superintendent shall
13 establish, after notice and informal hearing, the level of
14 reimbursement for direct services as determined as a percent
15 of premiums. Additional hearings may be held at the
16 superintendent's discretion. In establishing the level of
17 reimbursement for direct services, the superintendent shall
18 consider the costs associated with the individual marketing
19 and medical underwriting of these policies, plans or
20 contracts at a level not less than seventy-five percent of
21 premiums. A health insurer writing these policies, plans or
22 contracts shall make reimbursement for direct services at a
23 level not less than that level established by the
24 superintendent pursuant to this subsection over the three
25 calendar years preceding the date upon which that rate is

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1 established, but not earlier than calendar year 2010.

2 Nothing in this subsection shall be construed to preclude a
3 purchaser of one of these policies, plans or contracts from
4 negotiating an agreement with a health insurer that requires
5 a higher amount of premiums paid to be used for reimbursement
6 for direct services.

7 C. A health care plan that fails to comply with the
8 reimbursement requirements pursuant to this section shall
9 issue a ~~[dividend or credit against future premiums]~~ rebate
10 to all policyholders in ~~[an amount sufficient to assure that~~
11 ~~the benefits paid in the preceding three calendar years plus~~
12 ~~the amount of the dividends or credits are equal to the~~
13 ~~required direct services reimbursement level pursuant to~~
14 ~~Subsection A of this section for group health coverage and~~
15 ~~blanket health coverage or the required direct services~~
16 ~~reimbursement level pursuant to Subsection B of this section~~
17 ~~for individually underwritten health policies, contracts or~~
18 ~~plans for the preceding three calendar years]~~ accordance with
19 rules the superintendent has promulgated. If the insurer
20 fails to issue the ~~[dividend or credit]~~ rebate in accordance
21 with the requirements of this section, the superintendent
22 shall enforce these requirements and may pursue any other
23 penalties as provided by law, including general penalties
24 pursuant to Section 59A-1-18 NMSA 1978.

25 D. After notice and hearing, the superintendent

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1 ~~may~~ shall adopt and promulgate reasonable rules necessary
2 and proper to carry out the provisions of this section.

3 E. For the purposes of this section:

4 (1) "direct services" means services rendered
5 to an individual by a health care plan, health insurer or a
6 health care practitioner, facility or other provider,
7 including case management, disease management, health
8 education and promotion, preventive services, quality
9 incentive payments to providers and any portion of an
10 assessment that covers services rather than administration
11 and for which a health care plan or a health insurer does not
12 receive a tax credit pursuant to the Medical Insurance Pool
13 Act or the Health Insurance Alliance Act; provided, however,
14 that "direct services" does not include care coordination,
15 utilization review or management or any other activity
16 designed to manage utilization or services;

17 (2) "health care plan" means a nonprofit
18 corporation authorized by the superintendent to enter into
19 contracts with subscribers and to make health care expense
20 payments but does not include a person that only issues a
21 limited-benefit policy intended to supplement major medical
22 coverage, including medicare supplement, vision, dental,
23 disease-specific, accident-only or hospital indemnity-only
24 insurance policies, or that only issues policies for long-
25 term care or disability income; and

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1 (3) "premium" means all income received from
2 individuals and private and public payers or sources for the
3 procurement of health coverage, including capitated payments,
4 self-funded administrative fees, self-funded claim
5 reimbursements, recoveries from third parties or other
6 insurers and interests less any premium tax paid pursuant to
7 Section 59A-6-2 NMSA 1978 and fees associated with
8 participating in a health insurance exchange that serves as a
9 clearinghouse for insurance."

10 **SECTION 91.** A new section of the Nonprofit Health Care
11 Plan Law is enacted to read:

12 "[NEW MATERIAL] PROHIBITION ON LIFETIME OR ANNUAL LIMITS.--

13 A. Notwithstanding any other provision of law, a
14 group individual or group health care plan or certificate of
15 health insurance shall not establish:

16 (1) lifetime limits on the dollar value of
17 benefits for any enrollee; or

18 (2) except as provided in Subsection B of this
19 section, annual limits on the dollar value of benefits for
20 any enrollee.

21 B. With respect to plan years beginning prior to
22 January 1, 2014, an individual or group health care plan
23 shall establish a restricted annual limit on the dollar value
24 of benefits for any enrollee only with respect to the scope
25 of benefits that are essential health benefits, as the

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1 superintendent defines "essential health benefits" by rule.

2 C. Subsection A of this section shall not be
3 construed to prevent a group health care plan from placing
4 annual or lifetime per enrollee limits on specific covered
5 benefits that are not essential health benefits to the extent
6 that these limits are otherwise permitted under federal or
7 state law.

8 D. The provisions of this section shall not apply
9 to policies or plans intended to supplement major medical
10 group-type coverages such as medicare supplement, long-term
11 care, disability income, specified disease, accident-only,
12 hospital indemnity, other limited-benefit health insurance
13 policies or plans."

14 SECTION 92. A new section of the Nonprofit Health Care
15 Plan Law is enacted to read:

16 "[NEW MATERIAL] PROHIBITION ON RESCISSIONS OF
17 COVERAGE.--

18 A. A nonprofit health care plan providing coverage
19 under an individual health benefit plan or policy or a
20 grandfathered health care plan shall not rescind coverage
21 under a health benefit plan with respect to an individual,
22 including a group to which the individual belongs or family
23 coverage in which the individual is included, after the
24 individual is covered under the plan, unless:

25 (1) the individual engages in conduct that

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1 constitutes fraud; or

2 (2) the individual makes an intentional
3 misrepresentation of material fact that is prohibited by the
4 terms of the plan or coverage.

5 B. For purposes of Paragraph (1) of Subsection A of
6 this section, a person seeking coverage on behalf of an
7 individual does not include an insurance producer or an
8 employee or authorized representative of the health care
9 plan.

10 C. A health care plan shall provide at least thirty
11 days' advance written notice to each plan enrollee, or for
12 individual health insurance coverage, to each primary
13 subscriber, who would be affected by the proposed rescission
14 of coverage before coverage under the plan may be rescinded
15 in accordance with Subsection A of this section, regardless,
16 in the case of group health insurance coverage, of whether
17 the rescission applies to the entire group or only to an
18 individual within the group.

19 D. The provisions of this section apply regardless
20 of any applicable contestability period."

21 **SECTION 93.** A new section of the Nonprofit Health Care
22 Plan Law is enacted to read:

23 "[NEW MATERIAL] GRANDFATHERED HEALTH CARE PLAN.--

24 A. For the purposes of the Nonprofit Health Care
25 Plan Law, "grandfathered health care plan" means a nonprofit

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1 health care plan that was in effect on March 23, 2010 and
2 that remains in effect through the original term of coverage
3 or through renewal of the original term.

4 B. A dependent of a subscriber enrolled in a
5 grandfathered health care plan may enroll in a grandfathered
6 health care plan if the terms of the plan in effect as of
7 March 23, 2010 permitted the dependent to enroll.

8 C. A group health plan that provides coverage on
9 March 23, 2010 may provide for the enrolling of new employees
10 and their dependents in that grandfathered health care plan.

11 D. Coverage provided by a nonprofit health plan
12 pursuant to one or more collective bargaining agreements
13 between employee representatives and one or more employers
14 that was ratified before March 23, 2010 constitutes a
15 grandfathered health care plan until the date on which the
16 last of the collective bargaining agreements relating to the
17 coverage terminates. Any coverage amendment made pursuant to
18 a collective bargaining agreement that relates to the
19 coverage and amends the coverage solely to conform to any
20 requirement of the Nonprofit Health Care Plan Law shall not
21 be treated as a termination of the collective bargaining
22 agreement."

23 SECTION 94. A new section of the Nonprofit Health Care
24 Plan Law is enacted to read:

25 "[NEW MATERIAL] GUARANTEED ISSUE--GUARANTEED

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1 RENEWABILITY--MAXIMUM WAITING PERIOD--BAN ON PREEXISTING
2 CONDITION EXCLUSIONS.--

3 A. A nonprofit health care plan shall issue
4 coverage to any individual who requests and offers to
5 purchase the coverage without permanent exclusion of
6 preexisting conditions.

7 B. Except as provided in Subsection C of this
8 section, a health care plan that offers a group health
9 benefit plan in the state shall issue any health benefit plan
10 to any employer that applies for such plan and agrees to make
11 the required premium payments and satisfy the other
12 reasonable provisions of the health care plan. A health care
13 plan:

14 (1) shall offer coverage to all of the
15 eligible employees of the employer and the employees'
16 children and dependents who apply for enrollment during the
17 period in which the employee first becomes eligible to enroll
18 under the terms of the plan; and

19 (2) shall not offer coverage to only certain
20 individuals or certain children or dependents of employees in
21 the group or to only part of the group.

22 C. A health care plan that offers through a network
23 plan shall not be required to offer coverage under that plan
24 or accept applications for that plan pursuant to Subsection B
25 of this section under the following circumstances:

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1 (1) to an employer, where the employer is not
2 physically located in the insurer's established geographic
3 service area for the network plan;

4 (2) to an employee, when the employee does not
5 live, work or reside within the insurer's established
6 geographic service area for the network plan; or

7 (3) within the geographic service area for the
8 network plan where the insurer reasonably anticipates, and
9 demonstrates to the satisfaction of the superintendent, that
10 it will not have the capacity within its established
11 geographic service area to deliver service adequately to the
12 members of the groups because of its obligations to existing
13 group plan holders and enrollees.

14 D. A health care plan may restrict enrollment in
15 coverage described in Subsection B of this section to open or
16 special enrollment periods; provided that any special
17 enrollment period shall comply with the provisions of Section
18 95 of this 2012 act and rules the superintendent has
19 promulgated.

20 E. A health care plan may impose a waiting period
21 not to exceed ninety days before payment for any service
22 related to a preexisting condition.

23 F. A health care plan shall offer or make a
24 referral to a transition product to provide coverage during
25 the waiting period due to a preexisting condition.

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1 G. A health insurer shall renew any health benefit
2 plan at the option of the employer, except as the
3 superintendent has provided by rule.

4 H. A health care plan may continue and renew a
5 grandfathered plan that has a permanent exclusion of payment
6 for preexisting conditions.

7 I. For the purposes of this section:

8 (1) "coverage" means a health insurance
9 policy, health care plan, health maintenance organization
10 contract or certificate of insurance issued for delivery in
11 the state. "Coverage" does not mean a short-term, accident,
12 fixed indemnity or specified disease policy; disability
13 income; limited benefit insurance; credit insurance; workers'
14 compensation; or automobile or medical insurance under which
15 benefits are payable with or without regard to fault and that
16 is required by law to be contained in any liability insurance
17 policy; and

18 (2) "preexisting condition" means a physical
19 or mental condition for which medical advice, medication,
20 diagnosis, care or treatment was recommended for or received
21 by an applicant for health insurance within six months before
22 the effective date of coverage, except that pregnancy is not
23 considered a preexisting condition for federally defined
24 individuals."

25 **SECTION 95.** A new section of the Nonprofit Health Care

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1 Plan Law is enacted to read:

2 "[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY
3 REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--
4 OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

5 A. For health care plan years beginning on or after
6 September 23, 2010, if a child's coverage ended or did not
7 begin for the reasons described in Subsection E of this
8 section, a health care plan shall provide the child an
9 opportunity to enroll in a health care plan or policy for
10 which coverage continues for at least sixty days and provide
11 written notice of the opportunity to enroll as described in
12 Subsection B of this section no later than the first day of
13 the plan or policy year.

14 B. A written notice of the opportunity to enroll
15 provided pursuant to this section shall include a statement
16 that children whose coverage ended, who were denied coverage
17 or who were not eligible for coverage because dependent
18 coverage of children was unavailable before the child reached
19 twenty-six years of age, are eligible to enroll in coverage.
20 This notice may be provided to a principal insured on behalf
21 of the principal insured's child. For a group plan, the
22 notice may be included with other enrollment materials that
23 the health care plan distributes to employees, provided that
24 the statement is prominent. If the notice is provided to an
25 employee whose child is entitled to an enrollment opportunity

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1 under Subsection A of this section, the obligation to provide
2 the notice of enrollment opportunity under this subsection is
3 satisfied for both the individual or group health insurance
4 policy, health care plan or certificate of health insurance
5 and the health care plan.

6 C. For a subscriber who enrolls in an individual or
7 a group health care plan pursuant to Subsection A of this
8 section, the coverage shall take effect not later than the
9 first day of the first plan or policy year.

10 D. A child enrolling pursuant to this section in a
11 group health care plan shall be considered a "special
12 enrollee" pursuant to Section 59A-23E-8 NMSA 1978. The child
13 and the principal insured shall be offered all of the benefit
14 packages available to similarly situated individuals who were
15 denied coverage or whose coverage ended by reason of
16 cessation of dependent status. Any difference in benefits or
17 cost-sharing requirements constitutes a different benefit
18 package. The child shall not be required to pay more for
19 coverage than similarly situated individuals who did not lose
20 coverage by reason of cessation of dependent status.

21 E. The provisions of this section shall apply to a
22 child:

23 (1) whose coverage ended, or who was denied
24 coverage or was not eligible for coverage under an individual
25 or a group health insurance policy, health care plan or

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1 certificate of health insurance because, under the terms of
2 coverage, the availability of dependent coverage of a child
3 ended before the child reached the age of twenty-six; or

4 (2) who became eligible, or is required to
5 become eligible, for coverage on the first day of the first
6 plan or policy year, beginning on or after September 23, 2010
7 by reason of the provisions of this section."

8 SECTION 96. A new section of the Nonprofit Health Care
9 Plan Law is enacted to read:

10 "[NEW MATERIAL] PROHIBITION OF DISCRIMINATION IN FAVOR
11 OF HIGHLY COMPENSATED INDIVIDUALS--EXCLUSIONS.--

12 A. A group health care plan that is delivered,
13 issued for delivery or renewed in this state on behalf of an
14 employer shall not discriminate in favor of highly
15 compensated individuals as to eligibility to participate or
16 as to the benefits offered. Benefits provided for
17 participants who are highly compensated individuals shall be
18 provided for all other participants.

19 B. An employer shall ensure that any employer-
20 sponsored group health coverage it offers is offered to:

21 (1) seventy percent or more of all of that
22 employer's employees;

23 (2) eighty percent or more of all of that
24 employer's employees who are eligible to benefit under the
25 policy, plan or contract if seventy percent or more of all

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1 employees are eligible to benefit; or

2 (3) any employees who qualify under a
3 classification that the employer has established and that the
4 secretary of the United States department of health and human
5 services has approved.

6 C. An employer may exclude the following types of
7 employees from an offering of health coverage under
8 Subsections A and B of this section:

9 (1) employees who have not completed three
10 years of service;

11 (2) employees who have not attained age
12 twenty-five years of age;

13 (3) part-time or seasonal employees;

14 (4) employees not included in the plan who are
15 included in a unit of employees covered by an agreement
16 between employee representatives and one or more employers
17 that the secretary of the United States department of health
18 and human services has found to be a collective bargaining
19 agreement, if accident and health benefits were the subject
20 of good faith bargaining between these employee
21 representatives and the employer or employers; and

22 (5) employees who are nonresident aliens of
23 the United States and who receive no earned income, within
24 the meaning of Section 911(d)(2) of the federal Internal
25 Revenue Code of 1986, from the employer which constitutes

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1 income from sources within the United States, as defined in
2 Section 861(a)(3) of the federal Internal Revenue Code of
3 1986.

4 D. As used in this section, "highly compensated
5 individual" means an individual who is:

6 (1) one of the five highest paid officers of
7 an employer;

8 (2) a shareholder who owns more than ten
9 percent in the value of the employer's stock, pursuant to
10 Section 318 of the federal Internal Revenue Code of 1986; or

11 (3) among the highest paid twenty-five percent
12 of all employees who do not belong to any category listed in
13 Subsection C of this section."

14 SECTION 97. A new section of the Nonprofit Health Care
15 Plan Law is enacted to read:

16 "[NEW MATERIAL] GRANDFATHERED HEALTH CARE PLANS--ADULT
17 CHILD DEPENDENT ELIGIBLE FOR EMPLOYER-SPONSORED HEALTH
18 BENEFIT PLAN--EXCLUSION FROM DEPENDENT COVERAGE ELIGIBILITY
19 PERMITTED.--

20 A. For plan years beginning before January 1, 2014,
21 a group health care plan providing group health coverage that
22 makes available dependent coverage of children may exclude an
23 adult child under twenty-six years of age from coverage only
24 if the adult child is eligible to enroll in an eligible
25 employer-sponsored health benefit plan, as defined in Section

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1 5000A(f)(2) of the federal Internal Revenue Code of 1986,
2 other than the group health care plan of a parent.

3 B. For the purposes of this section, "adult child"
4 means an individual eighteen to twenty-six years of age."

5 SECTION 98. A new section of the Nonprofit Health Care
6 Plan Law is enacted to read:

7 "[NEW MATERIAL] PROHIBITION ON PREEXISTING CONDITION
8 EXCLUSIONS FOR INDIVIDUALS UNDER THE AGE OF NINETEEN.--

9 A. An individual or group health care plan that is
10 delivered or issued for delivery in this state shall not
11 limit or exclude coverage under an individual or group health
12 benefit plan for an individual under the age of nineteen by
13 imposing a preexisting condition exclusion on that
14 individual.

15 B. When a health care plan offers individual or
16 group health insurance coverage that only covers individuals
17 under age nineteen, that plan shall offer the coverage
18 continuously throughout the year or during one or more open
19 enrollment periods as the superintendent prescribes by rule.

20 C. During an open enrollment period, a health care
21 plan shall not deny or unreasonably delay the issuance of a
22 health care plan, refuse to issue a policy or issue a policy
23 with any preexisting condition exclusion rider or endorsement
24 to an applicant or insured who is under the age of nineteen
25 on the basis of a preexisting condition.

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1 D. Coverage shall be effective for those applying
2 during an open enrollment period on the same basis as any
3 applicant qualifying for coverage on an underwritten basis.

4 E. Each health care plan shall provide prior
5 prominent public notice on its web site and written notice to
6 each of its policyholders annually at least ninety days
7 before any open enrollment period of the open enrollment
8 rights for individuals under the age of nineteen and shall
9 provide information as to how an individual eligible for this
10 open enrollment right may apply for coverage with the plan
11 during an open enrollment period."

12 **SECTION 99.** A new section of the Nonprofit Health Care
13 Plan Law is enacted to read:

14 "[NEW MATERIAL] EMERGENCY SERVICES.--

15 A. An individual or group health care plan that is
16 delivered or issued for delivery in this state and that
17 provides or covers any benefits with respect to services in
18 an emergency department of a hospital shall cover emergency
19 services:

20 (1) without the need for any prior
21 authorization determination; and

22 (2) whether or not the health care provider
23 furnishing emergency services is a participating provider
24 with respect to emergency services.

25 B. If emergency services are provided to a covered

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1 individual by a nonparticipating health care provider with or
2 without prior authorization, the services shall be provided
3 without imposing any requirement under the policy, plan or
4 certificate for prior authorization of services or any
5 limitation on coverage where the provider of services does
6 not have a contractual relationship with the plan for the
7 provision of services that is more restrictive than the
8 requirements or limitations that apply to emergency
9 department services received from providers who do have such
10 a contractual relationship with the health care plan.

11 C. If emergency services are provided out of
12 network, the cost-sharing requirement, expressed as a
13 copayment amount or coinsurance rate, shall be the same
14 requirement that would apply if the emergency services were
15 provided in-network and without regard to any other term or
16 condition of such coverage, other than exclusion or
17 coordination of benefits, or an affiliation or waiting period
18 other than the applicable cost-sharing otherwise permitted
19 pursuant to state or federal law.

20 D. The provisions of this section shall not apply
21 to:

22 (1) policies or plans intended to supplement
23 major medical group-type coverages such as medicare
24 supplement, long-term care, disability income, specified
25 disease, accident-only, hospital indemnity or other limited-

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1 benefit health insurance policies or plans; or

2 (2) health insurance policies, plans,
3 certificates or subscriber agreements that are governed by
4 the provisions of Section 59A-22A-5 NMSA 1978.

5 E. As used in this section:

6 (1) "emergency medical condition" means a
7 medical condition manifesting itself by acute symptoms of
8 sufficient severity, including severe pain, such that a
9 prudent layperson who possesses an average knowledge of
10 health and medicine could reasonably expect the absence of
11 immediate medical attention to result in one of the following
12 conditions:

13 (a) placing the health of the individual
14 or, with respect to a pregnant woman, the health of the woman
15 or her unborn child, in serious jeopardy;

16 (b) serious impairment to bodily
17 functions; or

18 (c) serious dysfunction of any bodily
19 organ or part;

20 (2) "emergency services" means, with respect
21 to an emergency medical condition:

22 (a) a medical screening examination that
23 is within the capability of the emergency department of a
24 hospital, including ancillary services routinely available to
25 the emergency department to evaluate the emergency medical

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1 condition; and

2 (b) according to the capabilities of the
3 staff and facilities available at the hospital, further
4 medical examination and treatment required to stabilize the
5 patient's emergency medical condition or safe transfer of the
6 patient to another medical facility capable of providing the
7 medical examination or treatment required to stabilize the
8 patient's emergency medical condition; and

9 (3) "stabilize" means:

10 (a) to provide medical treatment of an
11 emergency medical condition as necessary to ensure, within
12 reasonable medical probability, that no material
13 deterioration of the condition is likely to result from or
14 occur during the transfer of the individual from a facility;
15 or

16 (b) with respect to a pregnant woman who
17 is having contractions, to deliver, including a placenta."

18 **SECTION 100.** A new section of the Nonprofit Health Care
19 Plan Law is enacted to read:

20 "[NEW MATERIAL] OPTION TO CHOOSE PEDIATRICIAN AS PRIMARY
21 CARE PHYSICIAN.--

22 A. An individual or group health care plan that is
23 delivered or issued for delivery in this state that requires
24 or provides for the designation of a participating primary
25 care provider shall allow a principal insured to designate

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1 for the principal insured's dependent child who is a covered
2 individual an allopathic or osteopathic physician who
3 specializes in pediatrics as the principal insured child's
4 primary care provider if the provider participates in the
5 network of the plan or issuer.

6 B. Nothing in Subsection A of this section shall be
7 construed to waive any exclusions of coverage under the terms
8 and conditions of the plan or health insurance policy with
9 respect to coverage of pediatric care.

10 C. As used in this section, "primary care provider"
11 means a health care practitioner acting within the scope of
12 the health care practitioner's license who provides the first
13 level of basic or general health care for a covered
14 individual's health needs, including diagnostic and treatment
15 services, who initiates referrals to other health care
16 practitioners and who maintains the continuity of care when
17 appropriate."

18 SECTION 101. A new section of the Nonprofit Health Care
19 Plan Law is enacted to read:

20 "[NEW MATERIAL] ACCESS TO OBSTETRICAL AND GYNECOLOGICAL
21 CARE.--

22 A. An individual or group health care plan that is
23 delivered or issued for delivery in this state that provides
24 coverage for obstetrical and gynecological care and that
25 requires that covered individuals designate a primary care

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1 provider shall not require authorization or referral by the
2 plan or issuer or any person, including a primary care
3 provider, when a female covered individual seeks coverage for
4 obstetrical or gynecological care provided by a participating
5 health care professional who specializes in obstetrics or
6 gynecology. The obstetrical or gynecological health care
7 provider shall agree otherwise to adhere to the plan's or
8 issuer's policies and procedures, including procedures
9 regarding referrals, obtaining prior authorization and
10 providing services pursuant to a treatment plan approved by
11 the plan or issuer.

12 B. A health care plan shall treat the provision of
13 obstetrical and gynecological care, and the ordering of
14 related obstetrical and gynecological items and services by a
15 participating health care professional who specializes in
16 obstetrics or gynecology, as the authorization of the primary
17 care provider.

18 C. Nothing in Subsection A of this section shall be
19 construed to:

20 (1) waive any exclusions of coverage under the
21 terms and conditions of the plan or health insurance policy
22 with respect to coverage of obstetrical or gynecological
23 care; or

24 (2) preclude the health care plan from
25 requiring that the obstetrical or gynecological provider

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1 notify the covered individual's primary care health care
2 professional or the plan or issuer of treatment decisions.

3 D. As used in this section, "primary care provider"
4 means a health care practitioner acting within the scope of
5 the health care practitioner's license who provides the first
6 level of basic or general health care for a person's health
7 needs, including diagnostic and treatment services, who
8 initiates referrals to other health care practitioners and
9 who maintains the continuity of care when appropriate."

10 SECTION 102. A new section of the Nonprofit Health Care
11 Plan Law is enacted to read:

12 "[NEW MATERIAL] COST-SHARING FOR PREVENTIVE ITEMS AND
13 SERVICES.--

14 A. A health care plan providing coverage under an
15 individual or group health benefit plan, except for
16 grandfathered health care plan coverage, shall provide
17 coverage for all of the following items and services pursuant
18 to Sections 103 through 107 of this 2012 act, and shall not
19 impose any cost-sharing requirements, such as a copayment,
20 coinsurance or deductible.

21 B. A health care plan is not required to provide
22 coverage for any items or services specified in any
23 recommendation or guideline described in Subsection A of this
24 section after the recommendation or guideline is no longer
25 described by a source listed in that subsection.

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1 C. Other provisions of state or federal law may
2 apply in connection with a health care plan's ceasing to
3 provide coverage for any such items or services.

4 D. To the extent that a preventive care provision
5 in this section conflicts with any other preventive health
6 care law in New Mexico, the provision providing the greatest
7 level of coverage shall apply. The preventive care
8 provisions in this section are intended to supplement rather
9 than supplant existing preventive health care provisions in
10 this state.

11 E. The superintendent shall at least annually
12 revise the preventive services standards established pursuant
13 to Sections 103 through 107 of this 2012 act to ensure that
14 they are consistent with the recommendations of the United
15 States preventive services task force, the advisory committee
16 on immunization practices of the federal centers for disease
17 control and prevention and the guidelines with respect to
18 infants, children, adolescents and women of evidence-based
19 preventive care and screenings by the federal health
20 resources and services administration. When changes are made
21 to any of these guidelines or recommendations, the
22 superintendent shall make recommendations to the legislature
23 for legislative changes to conform these standards to current
24 guidelines and recommendations.

25 F. A health care plan may impose cost-sharing

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1 requirements with respect to an office visit if a preventive
2 item or service provided pursuant to this section is billed
3 separately or is tracked as individual encounter data
4 separately from the office visit.

5 G. A health care plan shall not impose cost-sharing
6 requirements with respect to an office visit for an item or
7 service provided pursuant to this section if an item or
8 service is not billed separately or is not tracked as
9 individual encounter data separately from the office visit
10 and the primary purpose of the office visit is the delivery
11 of the preventive item or service.

12 H. A health care plan may impose cost-sharing
13 requirements with respect to an office visit if a preventive
14 item or service provided pursuant to this section is not
15 billed separately or is not tracked as individual encounter
16 data separately from the office visit and the primary purpose
17 of the office visit is not the delivery of the preventive
18 item or service.

19 I. The provisions of this section shall not apply
20 to policies or plans intended to supplement major medical
21 group-type coverages such as medicare supplement, long-term
22 care, disability income, specified disease, accident-only,
23 hospital indemnity or other limited-benefit health insurance
24 policies or plans."

25 SECTION 103. A new section of the Nonprofit Health Care

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1 Plan Law is enacted to read:

2 "[NEW MATERIAL] COVERAGE FOR SMOKING AND TOBACCO
3 CESSATION TREATMENT.--

4 A. A health care plan or contract that is delivered
5 or issued for delivery in this state and that offers
6 maternity benefits shall offer coverage for smoking cessation
7 treatment and shall offer augmented counseling tailored to
8 pregnant women who smoke.

9 B. A health care plan shall:

10 (1) offer tobacco cessation intervention
11 coverage for those who use tobacco products;

12 (2) provide for screening of pregnant women
13 for tobacco use in accordance with the United States
14 preventive services task force guidelines; and

15 (3) provide diagnostic, therapy and counseling
16 services and pharmacotherapy, including the coverage of
17 prescription and nonprescription tobacco cessation agents
18 approved by the federal food and drug administration for
19 cessation of tobacco use by pregnant women.

20 C. The provisions of this section shall not apply
21 to short-term travel, accident-only or limited or specified-
22 disease health care plans, policies, contracts or
23 certificates of insurance."

24 **SECTION 104.** A new section of the Nonprofit Health Care
25 Plan Law is enacted to read:

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1 "[NEW MATERIAL] CHILDHOOD IMMUNIZATION COVERAGE
2 REQUIRED.--

3 A. A health care plan shall provide coverage for
4 childhood immunizations, as well as coverage for medically
5 necessary booster doses of all immunizing agents used in
6 child immunizations, in accordance with the current schedule
7 of immunizations recommended by the American academy of
8 pediatrics, the advisory committee on immunization practices
9 of the federal centers for disease control and prevention or
10 the United States preventive services task force "A"-rated
11 and "B"-rated recommendations, whichever provides greater
12 coverage.

13 B. The provisions of this section shall not apply
14 to short-term travel, accident-only or limited or specified
15 disease plans or policies."

16 SECTION 105. A new section of the Nonprofit Health Care
17 Plan Law is enacted to read:

18 "[NEW MATERIAL] PREVENTIVE SERVICES BENEFITS--ASPIRIN
19 REGIMEN--HIGH BLOOD PRESSURE SCREENING--BREAST CANCER
20 SCREENING--LIPID DISORDERS SCREENING--COLORECTAL CANCER
21 SCREENING--DEPRESSION SCREENING--BEHAVIORAL DIETARY
22 COUNSELING--OBESITY COUNSELING AND SCREENING--OSTEOPOROSIS
23 SCREENING.--

24 A. A health care plan that is delivered or issued
25 for delivery in this state shall provide the following

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1 benefits that have, in effect, a rating of "A" or "B" in the
2 current recommendations of the United States preventive
3 services task force, for:

4 (1) a one-time screening for abdominal aortic
5 aneurysm by ultrasonography in men who have ever smoked and
6 who are between the ages of sixty-five and seventy-five;

7 (2) an aspirin regimen for men between the
8 ages of forty-five and seventy-nine when the potential
9 benefit due to a reduction in myocardial infarctions
10 outweighs the potential harm due to an increase in
11 gastrointestinal hemorrhage;

12 (3) an aspirin regimen for women between the
13 ages of fifty-five and seventy-nine when the potential
14 benefit of a reduction in ischemic strokes outweighs the
15 potential harm due to an increase in gastrointestinal
16 hemorrhage;

17 (4) screening for high blood pressure in
18 adults aged eighteen and older;

19 (5) genetic counseling and evaluation for
20 breast cancer BRCA-gene testing for women whose family
21 histories are associated with an increased risk for
22 deleterious mutations in BRCA1 or BRCA2 genes. Nothing in
23 this subsection shall be construed as a waiver or exception
24 to the Genetic Information Privacy Act;

25 (6) screening of lipid disorders for:

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1 (a) men who are thirty-five years of age
2 or older; and

3 (b) women who are twenty years of age or
4 older who are at increased risk of coronary heart disease;

5 (7) screening of individuals over eighteen
6 years of age for colorectal cancer using fecal occult blood
7 testing, sigmoidoscopy or colonoscopy;

8 (8) screening of individuals eighteen years of
9 age or older for depression;

10 (9) screening of individuals twelve to
11 eighteen years of age for major depressive disorder;

12 (10) behavioral dietary counseling for adults
13 with hyperlipidemia and other known risk factors for
14 cardiovascular and diet-related chronic disease;

15 (11) screening and counseling for obesity for:

16 (a) individuals eighteen years of age and
17 older who are obese; and

18 (b) individuals six to eighteen years of
19 age; and

20 (12) screening for osteoporosis for:

21 (a) women who are sixty-five years of age
22 and older; and

23 (b) women who are sixty to sixty-five
24 years of age who are at increased risk for osteoporotic
25 fractures.

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1 B. The provisions of this section shall not apply
2 to policies or plans intended to supplement major medical
3 group-type coverages such as medicare supplement, long-term
4 care, disability income, specified disease, accident-only,
5 hospital indemnity or other limited-benefit health insurance
6 policies or plans."

7 **SECTION 106.** A new section of the Nonprofit Health Care
8 Plan Law is enacted to read:

9 "[NEW MATERIAL] PREVENTIVE SERVICES FOR CHILDREN.--

10 A. An individual or group health care plan that is
11 delivered or issued for delivery in this state shall provide
12 the following benefits that have, in effect, a rating of "A"
13 or "B" in the current recommendations of the United States
14 preventive services task force, for:

15 (1) oral fluoride supplementation at currently
16 recommended doses to children six months of age to five years
17 of age whose primary water sources are deficient in fluoride;

18 (2) prophylactic ocular topical medication
19 against gonococcal ophthalmia neonatorum for newborns;

20 (3) screening for hearing loss in newborns;

21 (4) screening for sickle cell disease for
22 newborns;

23 (5) screening for congenital hypothyroidism
24 for newborns;

25 (6) iron supplementation for asymptomatic

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1 children six to twelve months of age who are at increased
2 risk for iron deficiency anemia;
3 (7) screening for phenylketonuria in newborns;
4 and
5 (8) screening to detect amblyopia, strabismus
6 and defects in visual acuity in children less than five years
7 of age.

8 B. The provisions of this section shall not apply
9 to policies or plans intended to supplement major medical
10 group-type coverages such as medicare supplement, long-term
11 care, disability income, specified disease, accident-only,
12 hospital indemnity or other limited-benefit health insurance
13 policies or plans."

14 SECTION 107. A new section of the Nonprofit Health Care
15 Plan Law is enacted to read:

16 "[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--
17 REPRODUCTIVE HEALTH.--

18 A. An individual or group health care plan that is
19 delivered or issued for delivery in this state shall provide
20 the following benefits that have, in effect, a rating of "A"
21 or "B" in the current recommendations of the United States
22 preventive services task force, for:

23 (1) screening for asymptomatic bacteriuria
24 with a urine culture for pregnant women;
25 (2) interventions during pregnancy and after

1 birth to promote and support breastfeeding;

2 (3) screening for cervical cancer in women who
3 have been sexually active and have a cervix;

4 (4) screening for chlamydial infection for:

5 (a) all sexually active young women
6 twenty-four years of age and younger; and

7 (b) older women who are at increased risk
8 of chlamydial infection;

9 (5) a daily supplement containing four hundred
10 to eight hundred micrograms of folic acid for any woman
11 planning a pregnancy or capable of pregnancy;

12 (6) screening of all sexually active women who
13 are at increased risk for infection, including those who are
14 pregnant, for gonorrheal infection;

15 (7) screening for iron deficiency anemia in
16 asymptomatic pregnant women;

17 (8) Rh (D) blood typing and antibody testing
18 for:

19 (a) all pregnant women; and

20 (b) all unsensitized Rh (D) negative women
21 at twenty-four to twenty-eight weeks' gestation;

22 (9) behavioral counseling to prevent sexually
23 transmitted infections in:

24 (a) all sexually active adolescents; and

25 (b) individuals aged eighteen years and

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1 older at increased risk for sexually transmitted infections;

2 (10) screening for hepatitis B virus infection
3 in pregnant women;

4 (11) screening for human immunodeficiency
5 virus for individuals twelve years of age and older who are
6 at risk of human immunodeficiency virus infection;

7 (12) screening for iron deficiency anemia in
8 asymptomatic pregnant women; and

9 (13) screening for syphilis for:

10 (a) any individual at increased risk for
11 syphilis infection; and

12 (b) any pregnant woman.

13 B. The provisions of this section shall not apply
14 to policies or plans intended to supplement major medical
15 group-type coverages such as medicare supplement, long-term
16 care, disability income, specified disease, accident-only,
17 hospital indemnity or other limited-benefit health insurance
18 policies or plans."

19 **SECTION 108.** Section 59A-56-3 NMSA 1978 (being Laws
20 1994, Chapter 75, Section 3, as amended) is amended to read:

21 "59A-56-3. DEFINITIONS.--As used in the Health
22 Insurance Alliance Act:

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

25 B. "approved health plan" means any arrangement for

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1 the provisions of health insurance offered through and
2 approved by the alliance;

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

5 D. "child" means [~~a dependent unmarried~~] an
6 individual who is less than [~~twenty-five~~] twenty-six years of
7 age;

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

- 10 (1) a group health plan;
- 11 (2) health insurance coverage;
- 12 (3) Part A or Part B of Title 18 of the
13 federal Social Security Act;
- 14 (4) Title 19 of the federal Social Security
15 Act except coverage consisting solely of benefits pursuant to
16 Section 1928 of that title;
- 17 (5) 10 USCA Chapter 55;
- 18 (6) a medical care program of the Indian
19 health service or of an Indian nation, tribe or pueblo;
- 20 (7) the Medical Insurance Pool Act;
- 21 (8) a health plan offered pursuant to 5 USCA
22 Chapter 89;
- 23 (9) a public health plan as defined in federal
24 regulations; or
- 25 (10) a health benefit plan offered pursuant to

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1 Section 5(e) of the federal Peace Corps Act;

2 F. "department" means the insurance division of the
3 commission;

4 G. "director" means an individual who serves on the
5 board;

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

11 I. "eligible expenses" means the allowable charges
12 for a health care service covered under an approved health
13 plan;

14 J. "eligible individual":

15 (1) means an individual who:

16 (a) as of the date of the individual's
17 application for coverage under an approved health plan, has
18 an aggregate of eighteen or more months of creditable
19 coverage, the most recent of which was under a group health
20 plan, governmental plan or church plan as those plans are
21 defined in Subsections P, N and D of Section 59A-23E-2 NMSA
22 1978, respectively, or health insurance offered in connection
23 with any of those plans, but for the purposes of aggregating
24 creditable coverage, a period of creditable coverage shall
25 not be counted with respect to enrollment of an individual

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1 for coverage under an approved health plan if, after that
2 period and before the enrollment date, there was a sixty-
3 three-day or longer period during all of which the individual
4 was not covered under any creditable coverage; or

5 (b) is entitled to continuation coverage
6 pursuant to Section 59A-56-20 or 59A-23E-19 NMSA 1978; and

7 (2) does not include an individual who:

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

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

13 (c) has health insurance coverage as
14 defined in Subsection R of Section 59A-23E-2 NMSA 1978;

15 (d) during the most recent coverage within
16 the coverage period described in Subparagraph (a) of
17 Paragraph (1) of this subsection was terminated from coverage
18 as a result of nonpayment of premium or fraud; or

19 (e) has been offered the option of
20 coverage under a COBRA continuation provision as that term is
21 defined in Subsection F of Section 59A-23E-2 NMSA 1978, or
22 under a similar state program, except for continuation
23 coverage under Section 59A-56-20 NMSA 1978, and did not
24 exhaust the coverage available under the offered program;

25 K. "enrollment date" means, with respect to an

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1 individual covered under a group health plan or health
2 insurance coverage, the date of enrollment of the individual
3 in the plan or coverage or, if earlier, the first day of the
4 waiting period for that enrollment;

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

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

15 N. "health care service" means a service or product
16 furnished an individual for the purpose of preventing,
17 alleviating, curing or healing human illness or injury and
18 includes services and products incidental to furnishing the
19 described services or products;

20 O. "health insurance" means "health" insurance as
21 defined in Section 59A-7-3 NMSA 1978; any hospital and
22 medical expense-incurred policy; nonprofit health care plan
23 service contract; health maintenance organization subscriber
24 contract; short-term, accident, fixed indemnity, specified
25 disease policy or disability income insurance contracts and

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1 limited health benefit or credit health insurance; coverage
2 for health care services under uninsured arrangements of
3 group or group-type contracts, including employer self-
4 insured, cost-plus or other benefits methodologies not
5 involving insurance or not subject to New Mexico premium
6 taxes; coverage for health care services under group-type
7 contracts that are not available to the general public and
8 can be obtained only because of connection with a particular
9 organization or group; coverage by medicare or other
10 governmental programs providing health care services; but
11 "health insurance" does not include insurance issued pursuant
12 to provisions of the Workers' Compensation Act or similar
13 law, automobile medical payment insurance or provisions by
14 which benefits are payable with or without regard to fault
15 and are required by law to be contained in any liability
16 insurance policy;

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

20 Q. "incurred claims" means claims paid during a
21 calendar year plus claims incurred in the calendar year and
22 paid prior to April 1 of the succeeding year, less claims
23 incurred previous to the current calendar year and paid prior
24 to April 1 of the current year;

25 R. "insured" means a small employer or its employee

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1 and an individual covered by an approved health plan, a
2 former employee of a small employer who is covered by an
3 approved health plan through conversion or an individual
4 covered by an approved health plan that allows individual
5 enrollment;

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

8 T. "member" means a member of the alliance;

9 U. "nonprofit health care plan" means a health care
10 plan as defined in Subsection K of Section 59A-47-3 NMSA
11 1978;

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

15 W. "small employer" means a person that is a
16 resident of this state, that has employees at least fifty
17 percent of whom are residents of this state, that is actively
18 engaged in business and that, on at least fifty percent of
19 its working days during either of the two preceding calendar
20 years, employed no fewer than two and no more than fifty
21 eligible employees; provided that:

22 (1) in determining the number of eligible
23 employees, the spouse or dependent of an employee may, at the
24 employer's discretion, be counted as a separate employee;

25 (2) companies that are affiliated companies or

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1 that are eligible to file a combined tax return for purposes
2 of state income taxation shall be considered one employer;
3 and

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

10 X. "superintendent" means the superintendent of
11 insurance;

12 Y. "total premiums" means the total premiums for
13 business written in the state received during a calendar
14 year; and

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

18 SECTION 109. Section 59A-56-14 NMSA 1978 (being Laws
19 1994, Chapter 75, Section 14, as amended) is amended to read:

20 "59A-56-14. ELIGIBILITY--GUARANTEED ISSUE--PLAN
21 PROVISIONS.--

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

24 (1) at least fifty percent of its employees
25 not otherwise insured elect to be covered under the approved

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1 health plan;

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

6 (3) the small employer does not offer other
7 general group health insurance coverage to its employees.
8 For the purposes of this paragraph, general group health
9 insurance coverage excludes coverage that:

10 (a) is offered by a state or federal
11 agency to a small employer's employee whose eligibility for
12 alternative coverage is based on the employee's income; or

13 (b) provides only a specific limited form
14 of health insurance such as accident or disability income
15 insurance coverage or a specific health care service such as
16 dental care.

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

21 C. An approved health plan shall provide in
22 substance that attainment of the limiting age by an unmarried
23 dependent individual does not operate to terminate coverage
24 when the individual continues to be incapable of self-
25 sustaining employment by reason of developmental disability

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1 or physical handicap and the individual is primarily
2 dependent for support and maintenance upon the employee.
3 Proof of incapacity and dependency shall be furnished to the
4 alliance and the member that offered the approved health plan
5 within one hundred twenty days of attainment of the limiting
6 age. The board may require subsequent proof annually after a
7 two-year period following attainment of the limiting age.

8 D. An approved health plan shall provide that the
9 health insurance benefits applicable for eligible dependents
10 are payable with respect to a newly born child of the family
11 member or the individual in whose name the contract is issued
12 from the moment of birth, including the necessary care and
13 treatment of medically diagnosed congenital defects and birth
14 abnormalities. If payment of a specific premium is required
15 to provide coverage for the child, the contract may require
16 that notification of the birth of a child and payment of the
17 required premium shall be furnished to the member within
18 thirty-one days after the date of birth in order to have the
19 coverage from birth. An approved health plan shall provide
20 that the health insurance benefits applicable for eligible
21 dependents are payable for an adopted child in accordance
22 with the provisions of Section 59A-22-34.1 NMSA 1978.

23 E. ~~[Except as provided in Subsections G, H and I of~~
24 ~~this section]~~ An approved health plan offered to a small
25 employer shall not contain a preexisting condition exclusion

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1 that relates to an individual under nineteen years of age.
2 An approved health plan may contain a preexisting condition
3 exclusion that relates to an individual over nineteen years
4 of age only if:

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

10 (2) the exclusion extends for a period of not
11 more than six months after the enrollment date; and

12 (3) the period of the exclusion is reduced by
13 the aggregate of the periods of creditable coverage
14 applicable to the participant or beneficiary as of the
15 enrollment date.

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

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

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

6 [~~(2) that excludes a child who is adopted or~~
7 ~~placed for adoption before the child's eighteenth birthday~~
8 ~~and who, as of the last day of the thirty-day period~~
9 ~~beginning on and following the date of the adoption or~~
10 ~~placement for adoption, is covered under creditable coverage]~~

11 or

12 [~~(3)~~] (2) that relates to or includes
13 pregnancy as a preexisting condition.

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

19 I. The preexisting condition exclusions described
20 in Subsection E of this section shall be waived to the extent
21 to which similar exclusions have been satisfied under any
22 prior health insurance coverage if the effective date of
23 coverage for health insurance through the alliance is made
24 not later than sixty-three days following the termination of
25 the prior coverage. In that case, coverage through the

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

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

9 K. An individual is not eligible for coverage by
10 the alliance under an approved health plan issued to a small
11 employer if the individual:

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

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

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

22 L. The alliance shall provide for an open
23 enrollment period of sixty days from the initial offering of
24 an approved health plan. Individuals enrolled during the
25 open enrollment period shall not be subject to the

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1 preexisting conditions limitation.

2 M. If an insured covered by an approved health plan
3 switches to another approved health plan that provides
4 increased or additional benefits such as lower deductible or
5 copayment requirements, the member offering the approved
6 health plan with increased or additional benefits may require
7 the six-month period for preexisting conditions provided in
8 Subsection E of this section to be satisfied prior to receipt
9 of the additional benefits."

10 SECTION 110. A new section of the Health Insurance
11 Alliance Act is enacted to read:

12 "[NEW MATERIAL] ELIGIBILITY--GUARANTEED ISSUE--
13 GUARANTEED RENEWABILITY--MAXIMUM WAITING PERIOD--PLAN
14 PROVISIONS.--

15 A. A small employer who applies for an approved
16 health plan and agrees to make the required premium payments
17 and to satisfy the other reasonable provisions of the
18 approved health plan is eligible for an approved health plan.
19 The alliance shall:

20 (1) offer coverage to all of the eligible
21 employees of the employer and their children and dependents
22 who apply for enrollment during the period in which the
23 employee first becomes eligible to enroll under the terms of
24 the plan; and

25 (2) not offer coverage only to certain

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1 individuals or certain children or dependents of employees in
2 the group or only to part of the group.

3 B. An approved health plan that offers coverage
4 through a network plan shall not be required to offer
5 coverage under that plan or accept applications for that plan
6 pursuant to Subsection A of this section under the following
7 circumstances:

8 (1) to an employer, where the employer is not
9 physically located in the insurer's established geographic
10 service area for the network plan;

11 (2) to an employee, when the employee does not
12 live, work or reside within the insurer's established
13 geographic service area for the network plan; or

14 (3) within the geographic service area for the
15 network plan where the insurer reasonably anticipates, and
16 demonstrates to the satisfaction of the superintendent, that
17 it will not have the capacity within its established
18 geographic service area to deliver service adequately to the
19 members of the groups because of its obligations to existing
20 group policyholders and enrollees.

21 C. An approved health plan may restrict enrollment
22 in coverage described in Subsection A of this section to open
23 or special enrollment periods; provided that any special
24 enrollment period shall comply with the provisions of Section
25 111 of this 2012 act and rules that the superintendent has

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1 promulgated.

2 D. An approved health plan may impose a waiting
3 period not to exceed ninety days before payment for any
4 service related to a preexisting condition. An approved
5 health plan shall offer or make a referral to a transition
6 product to provide coverage during the waiting period due to
7 a preexisting condition.

8 E. An approved health plan may continue and renew a
9 grandfathered approved health plan that has a permanent
10 exclusion of payment for preexisting conditions.

11 F. An approved health plan shall renew any health
12 benefit plan at the option of the employer, except as the
13 superintendent has provided by rule.

14 G. An approved health plan shall provide in
15 substance that attainment of the limiting age by an unmarried
16 dependent individual does not operate to terminate coverage
17 when the individual continues to be incapable of
18 self-sustaining employment by reason of developmental
19 disability or physical handicap and the individual is
20 primarily dependent for support and maintenance upon the
21 employee. Proof of incapacity and dependency shall be
22 furnished to the alliance and the member that offered the
23 approved health plan within one hundred twenty days of
24 attainment of the limiting age. The board may require
25 subsequent proof annually after a two-year period following

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1 attainment of the limiting age.

2 H. An approved health plan shall provide that the
3 health insurance benefits applicable for eligible dependents
4 are payable with respect to a newly born child of the family
5 member or the individual in whose name the contract is issued
6 from the moment of birth, including the necessary care and
7 treatment of medically diagnosed congenital defects and birth
8 abnormalities. If payment of a specific premium is required
9 to provide coverage for the child, the contract may require
10 that notification of the birth of a child and payment of the
11 required premium shall be furnished to the member within
12 thirty-one days after the date of birth in order to have the
13 coverage from birth. An approved health plan shall provide
14 that the health insurance benefits applicable for eligible
15 dependents are payable for an adopted child in accordance
16 with the provisions of Section 59A-22-34.1 NMSA 1978.

17 I. If an insured covered by an approved health plan
18 switches to another approved health plan that provides
19 increased or additional benefits such as lower deductible or
20 copayment requirements, the member offering the approved
21 health plan with increased or additional benefits may require
22 the ninety-day period for preexisting conditions provided in
23 Subsection E of this section to be satisfied prior to receipt
24 of the additional benefits.

25 J. For the purposes of this section:

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1 (1) "coverage" means a health insurance
2 policy, health care plan, health maintenance organization
3 contract or certificate of insurance issued for delivery in
4 the state. "Coverage" does not mean a short-term, accident,
5 fixed indemnity or specified disease policy; disability
6 income; limited benefit insurance; credit insurance; workers'
7 compensation; or automobile or medical insurance under which
8 benefits are payable with or without regard to fault and that
9 is required by law to be contained in any liability insurance
10 policy;

11 (2) "grandfathered approved health plan" means
12 an approved health plan that was in effect on March 23, 2010
13 and that remains in effect through the original term of
14 coverage or through renewal of the original term; and

15 (3) "preexisting condition" means a physical
16 or mental condition for which medical advice, medication,
17 diagnosis, care or treatment was recommended for or received
18 by an applicant for health insurance within six months before
19 the effective date of coverage, except that pregnancy is not
20 considered a preexisting condition for federally defined
21 individuals."

22 SECTION 111. A new section of the Health Insurance
23 Alliance Act is enacted to read:

24 "[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY
25 REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--

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1 OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

2 A. For plan or policy years beginning on or after
3 September 23, 2010, if a child's coverage ended or did not
4 begin for the reasons described in Subsection E of this
5 section, an approved health plan shall provide the child an
6 opportunity to enroll in the approved health plan for which
7 coverage continues for at least sixty days and provide
8 written notice of the opportunity to enroll, as described in
9 Subsection B of this section, no later than the first day of
10 the plan year.

11 B. A written notice of the opportunity to enroll
12 provided pursuant to this section shall include a statement
13 that children whose coverage ended, who were denied coverage
14 or who were not eligible for coverage because dependent
15 coverage of children was unavailable before the child reached
16 twenty-six years of age are eligible to enroll in coverage.
17 This notice may be provided to a principal insured on behalf
18 of the principal insured's child. The notice may be included
19 with other enrollment materials that the approved health plan
20 distributes to employees, provided the statement is
21 prominent. If the notice is provided to an employee whose
22 child is entitled to an enrollment opportunity under
23 Subsection A of this section, the obligation to provide the
24 notice of enrollment opportunity under this subsection is
25 satisfied for the approved health plan.

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1 C. For an individual who enrolls in an approved
2 health plan pursuant to Subsection A of this section, the
3 coverage shall take effect not later than the first day of
4 the first plan year.

5 D. A child enrolling pursuant to this section in an
6 approved health plan shall be considered a "special enrollee"
7 pursuant to Section 59A-23E-8 NMSA 1978. The child and the
8 principal insured shall be offered all of the benefit
9 packages available to similarly situated individuals who were
10 denied coverage or whose coverage ended by reason of
11 cessation of dependent status. Any difference in benefits or
12 cost-sharing requirements constitutes a different benefit
13 package. The child shall not be required to pay more for
14 coverage than similarly situated individuals who did not lose
15 coverage by reason of cessation of dependent status.

16 E. The provisions of this section shall apply to a
17 child:

18 (1) whose coverage ended, or who was denied
19 coverage or was not eligible for coverage under an approved
20 health plan, because under the terms of coverage the
21 availability of dependent coverage of a child ended before
22 the child reached the age of twenty-six; or

23 (2) who became eligible, or is required to
24 become eligible, for coverage on the first day of the first
25 plan year, beginning on or after September 23, 2010, by

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1 reason of the provisions of this section."

2 SECTION 112. Section 59A-57-2 NMSA 1978 (being Laws
3 1998, Chapter 107, Section 2) is amended to read:

4 "59A-57-2. PURPOSE OF ACT.--The purpose of the Patient
5 Protection Act is to regulate aspects of health insurance by
6 specifying patient and provider rights and confirming and
7 clarifying the authority of the department to adopt
8 regulations to provide protections to persons enrolled in
9 ~~[managed]~~ health insurance policies or health care plans.

10 The insurance protections should ensure that ~~[managed]~~ health
11 insurance policies or health care plans treat patients fairly
12 and arrange for the delivery of good quality services."

13 SECTION 113. Section 59A-57-3 NMSA 1978 (being Laws
14 1998, Chapter 107, Section 3) is amended to read:

15 "59A-57-3. DEFINITIONS.--As used in the Patient
16 Protection Act:

17 A. "continuous quality improvement" means an
18 ongoing and systematic effort to measure, evaluate and
19 improve a ~~[managed]~~ health insurance policy's or health care
20 plan's process in order to improve continually the quality of
21 health care services provided to enrollees;

22 B. "covered person", "enrollee", "patient" or
23 "consumer" means an individual who is entitled to receive
24 health care benefits provided by a ~~[managed]~~ health insurance
25 policy or health care plan;

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1 C. "department" means the insurance department;

2 D. "emergency care" means health care procedures,
3 treatments or services delivered to a covered person after
4 the sudden onset of what reasonably appears to be a medical
5 condition that manifests itself by symptoms of sufficient
6 severity, including severe pain, that the absence of
7 immediate medical attention could be reasonably expected by a
8 reasonable layperson to result in jeopardy to a person's
9 health, serious impairment of bodily functions, serious
10 dysfunction of a bodily organ or part or disfigurement to a
11 person;

12 E. "health care facility" means an institution
13 providing health care services, including a hospital or other
14 licensed inpatient center; an ambulatory surgical or
15 treatment center; a skilled nursing center; a residential
16 treatment center; a home health agency; a diagnostic,
17 laboratory or imaging center; and a rehabilitation or other
18 therapeutic health setting;

19 F. "health care insurer" means a person that has a
20 valid certificate of authority in good standing under the
21 Insurance Code to act as an insurer, health maintenance
22 organization, nonprofit health care plan or prepaid dental
23 plan;

24 G. "health care professional" means a physician or
25 other health care practitioner, including a pharmacist, who

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1 is licensed, certified or otherwise authorized by the state
2 to provide health care services consistent with state law;

3 H. "health care provider" or "provider" means a
4 person that is licensed or otherwise authorized by the state
5 to furnish health care services and includes health care
6 professionals and health care facilities;

7 I. "health care services" includes, to the extent
8 offered by the health insurance policy or health care plan,
9 physical health or community-based mental health or
10 developmental disability services, including services for
11 developmental delay;

12 J. "managed health care plan" [~~or "plan"~~] means a
13 health care insurer or a provider service network when
14 offering a benefit that either requires a covered person to
15 use, or creates incentives, including financial incentives,
16 for a covered person to use, health care providers managed,
17 owned, under contract with or employed by the health care
18 insurer or provider service network; [~~"Managed health care
19 plan" or "plan" does not include a health care insurer or
20 provider service network offering a traditional fee-for-
21 service indemnity benefit or a benefit that covers only
22 short-term travel, accident-only, limited benefit, student
23 health plan or specified disease policies]~~]

24 K. "health insurance policy" or "health care plan"
25 means a hospital, surgical and medical expense-incurred

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1 policy, plan or contract offered by a health insurer,
2 nonprofit health service provider, health maintenance
3 organization, managed care organization or provider service
4 organization; "health insurance policy" or "health care plan"
5 does not include a policy or plan intended to supplement
6 major medical group-type coverage, such as medicare, long-
7 term care, disability income, specified disease, accident-
8 only, hospital indemnity or any other limited-benefit health
9 insurance policy or health care plan;

10 [K.] L. "person" means an individual or other legal
11 entity;

12 [L.] M. "point-of-service plan" or "open plan"
13 means a [~~managed~~] health care plan that allows enrollees to
14 use health care providers other than providers under direct
15 contract with or employed by the health care plan, even if
16 the plan provides incentives, including financial incentives,
17 for covered persons to use the plan's designated
18 participating providers;

19 [M.] N. "provider service network" means two or
20 more health care providers affiliated for the purpose of
21 providing health care services to covered persons on a
22 capitated or similar prepaid flat-rate basis that hold a
23 certificate of authority pursuant to the Provider Service
24 Network Act;

25 [N.] O. "superintendent" means the superintendent

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1 of insurance; and

2 [Θ.] P. "utilization review" means a system for
3 reviewing the appropriate and efficient allocation of health
4 care services given or proposed to be given to a patient or
5 group of patients."

6 SECTION 114. Section 59A-57-4 NMSA 1978 (being Laws
7 1998, Chapter 107, Section 4) is amended to read:

8 "59A-57-4. PATIENT RIGHTS--DISCLOSURES--RIGHTS TO BASIC
9 AND COMPREHENSIVE HEALTH CARE SERVICES--GRIEVANCE PROCEDURE--
10 UTILIZATION REVIEW PROGRAM--CONTINUOUS QUALITY PROGRAM.--

11 A. Each covered person enrolled in a [~~managed~~]
12 health insurance policy or health care plan has the right to
13 be treated fairly. A [~~managed~~] health insurance policy or
14 health care plan shall arrange for the delivery of good
15 quality and appropriate health care services to enrollees as
16 defined in the particular subscriber agreement. The
17 department shall adopt regulations to implement the
18 provisions of the Patient Protection Act and shall monitor
19 and oversee a [~~managed~~] health insurance policy or health
20 care plan to ensure that each covered person enrolled in a
21 health insurance policy or plan is treated fairly and in
22 accordance with the requirements of the Patient Protection
23 Act. In adopting regulations to implement the provisions of
24 Subparagraphs (a) and (b) of Paragraph (3) and Paragraphs (5)
25 and (6) of Subsection B of this section regarding health care

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1 standards and specialists, utilization review programs and
2 continuous quality improvement programs, the department shall
3 cooperate with and seek advice from the department of health.

4 B. The regulations adopted by the department to
5 protect patient rights shall provide at a minimum that:

6 (1) prior to or at the time of enrollment, a
7 ~~[managed]~~ health insurance policy or health care plan shall
8 provide a summary of benefits and exclusions, premium
9 information and a provider listing. Within a reasonable time
10 after enrollment and at subsequent periodic times as
11 appropriate, a ~~[managed]~~ health insurance policy or health
12 care plan shall provide written material that contains, in a
13 clear, conspicuous and readily understandable form, a full
14 and fair disclosure of the policy's or plan's benefits,
15 limitations, exclusions, conditions of eligibility, prior
16 authorization requirements, enrollee financial responsibility
17 for payments, grievance procedures, appeal rights and the
18 patients' rights generally available to all covered persons;

19 (2) a ~~[managed]~~ health insurance policy or
20 health care plan shall provide health care services that are
21 reasonably accessible and available in a timely manner to
22 each covered person;

23 (3) in providing reasonably accessible health
24 care services that are available in a timely manner, a
25 ~~[managed]~~ health insurance policy or health care plan shall

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1 ensure that:

2 (a) the policy or plan offers sufficient
3 numbers and types of qualified and adequately staffed health
4 care providers at reasonable hours of service to provide
5 health care services to the policy's or plan's enrollees;

6 (b) health care providers that are
7 specialists may act as primary care providers for patients
8 with chronic medical conditions, provided the specialists
9 offer all basic health care services that are required of
10 them by a ~~managed~~ health insurance policy or health care
11 plan;

12 (c) reasonable access is provided to
13 out-of-network health care providers if medically necessary
14 covered services are not reasonably available through
15 participating health care providers or if necessary to
16 provide continuity of care during brief transition periods;

17 (d) emergency care is immediately
18 available without prior authorization requirements, and
19 appropriate out-of-network emergency care is not subject to
20 additional costs; and

21 (e) the policy or plan, through provider
22 selection, provider education, the provision of additional
23 resources or other means, reasonably addresses the cultural
24 and linguistic diversity of its enrollee population;

25 (4) a ~~managed~~ health insurance policy or

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1 health care plan shall adopt and implement a prompt and fair
2 grievance procedure for resolving patient complaints and
3 addressing patient questions and concerns regarding any
4 aspect of the policy or plan, including the quality of and
5 access to health care, the choice of health care provider or
6 treatment and the adequacy of the policy's or plan's provider
7 network. The grievance procedure shall notify patients of
8 their right to obtain review by the policy or plan, their
9 right to obtain review by the superintendent, their right to
10 expedited review of emergent utilization decisions and their
11 rights under the Patient Protection Act;

12 (5) a [~~managed~~] health insurance policy or
13 health care plan shall adopt and implement a comprehensive
14 utilization review program. The basis of a decision to deny
15 care shall be disclosed to an affected enrollee. The
16 decision to approve or deny care to an enrollee shall be made
17 in a timely manner, and the final decision shall be made by a
18 qualified health care professional. A policy's or plan's
19 utilization review program shall ensure that enrollees have
20 proper access to health care services, including referrals to
21 necessary specialists. A decision made in a policy's or
22 plan's utilization review program shall be subject to the
23 policy's or plan's grievance procedure and appeal to the
24 superintendent; and

25 (6) a [~~managed~~] health insurance policy or

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1 health care plan shall adopt and implement a continuous
2 quality improvement program that monitors the quality and
3 appropriateness of the health care services provided by the
4 policy or plan."

5 SECTION 115. Section 59A-57-5 NMSA 1978 (being Laws
6 1998, Chapter 107, Section 5) is amended to read:

7 "59A-57-5. CONSUMER ASSISTANCE--CONSUMER ADVISORY
8 BOARDS [~~OMBUDSMAN OFFICE~~]~~--REPORTS TO CONSUMERS--~~
9 SUPERINTENDENT'S ORDERS TO PROTECT CONSUMERS.--

10 A. Each [~~managed~~] health insurance policy or health
11 care plan shall establish and adequately staff a consumer
12 assistance office. The purpose of the consumer assistance
13 office is to respond to consumer questions and concerns and
14 assist patients in exercising their rights and protecting
15 their interests as consumers of health care.

16 B. Each [~~managed~~] health insurance policy or health
17 care plan shall establish a consumer advisory board. The
18 board shall meet at least quarterly and shall advise the
19 policy or plan about the policy's or plan's general
20 operations from the perspective of the insured or enrollee as
21 a consumer of health care. The board shall also review the
22 operations of and be advisory to the plan's consumer
23 assistance office.

24 [~~D.~~] C. The department shall prepare an annual
25 report assessing the operations of [~~managed~~] health insurance

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1 policies or health care plans subject to the department's
2 oversight, including information about consumer complaints.

3 ~~[E.]~~ D. A person adversely affected may file a
4 complaint with the superintendent regarding a violation of
5 the Patient Protection Act. Prior to issuing any remedial
6 order regarding violations of the Patient Protection Act or
7 its regulations, the superintendent shall hold a hearing in
8 accordance with the provisions of Chapter 59A, Article 4 NMSA
9 1978. The superintendent may issue any order ~~[he]~~ the
10 superintendent deems necessary or appropriate, including
11 ordering the delivery of appropriate care, to protect
12 consumers and enforce the provisions of the Patient
13 Protection Act. The superintendent shall adopt special
14 procedures to govern the submission of emergency appeals to
15 ~~[him]~~ the superintendent in health emergencies."

16 **SECTION 116.** Section 59A-57-6 NMSA 1978 (being Laws
17 1998, Chapter 107, Section 6) is amended to read:

18 "59A-57-6. FAIRNESS TO HEALTH CARE PROVIDERS--GAG RULES
19 PROHIBITED--GRIEVANCE PROCEDURE FOR PROVIDERS.--

20 A. ~~[No managed]~~ A health insurance policy or health
21 care plan ~~[may]~~ shall not:

22 (1) adopt a gag rule or practice that
23 prohibits a health care provider from discussing a treatment
24 option with an insured or enrollee even if the plan does not
25 approve of the option;

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1 (2) include in any of its contracts with
2 health care providers any provisions that offer an
3 inducement, financial or otherwise, to provide less than
4 medically necessary services to an enrollee; or

5 (3) require a health care provider to violate
6 any recognized fiduciary duty of [~~his~~] the provider's
7 profession or place [~~his~~] the provider's license in jeopardy.

8 B. A health insurance policy or health care plan
9 that proposes to terminate a health care provider from the
10 [~~managed health care~~] policy or plan shall explain in writing
11 the rationale for its proposed termination and deliver
12 reasonable advance written notice to the provider prior to
13 the proposed effective date of the termination.

14 C. A [~~managed~~] health insurance policy or health
15 care plan shall adopt and implement a process pursuant to
16 which health care providers may raise with the policy or plan
17 concerns that they may have regarding operation of the policy
18 or plan, including concerns regarding quality of and access
19 to health care services, the choice of [~~health care~~]
20 providers and the adequacy of the policy's or plan's provider
21 network. The process shall include, at a minimum, the right
22 of the provider to present the provider's concerns to a
23 policy or plan committee responsible for the substantive area
24 addressed by the concern and the assurance that the concern
25 will be conveyed to the policy's or plan's governing body.

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1 In addition, a ~~[managed]~~ health insurance policy or health
2 care plan shall adopt and implement a fair hearing plan that
3 permits a health care provider to dispute the existence of
4 adequate cause to terminate the provider's participation with
5 the policy or plan to the extent that the relationship is
6 terminated for cause and shall include in each provider
7 contract a dispute resolution mechanism."

8 SECTION 117. Section 59A-57-8 NMSA 1978 (being Laws
9 1998, Chapter 107, Section 8) is amended to read:

10 "59A-57-8. ADMINISTRATIVE COSTS AND BENEFIT COSTS
11 DISCLOSURES.--The department shall adopt regulations to
12 ensure that both the administrative costs and the direct
13 costs of providing health care services of each ~~[managed]~~
14 health insurance policy or health care plan are fully and
15 fairly disclosed to consumers in a uniform manner that allows
16 meaningful cost comparisons among plans."

17 SECTION 118. Section 59A-57-9 NMSA 1978 (being Laws
18 1998, Chapter 107, Section 9) is amended to read:

19 "59A-57-9. PRIVATE REMEDIES TO ENFORCE PATIENT AND
20 PROVIDER INSURANCE RIGHTS--ENROLLEE AS THIRD-PARTY
21 BENEFICIARY TO ENFORCE RIGHTS.--

22 A. A person who suffers a loss as a result of a
23 violation of a right protected pursuant to the provisions of
24 the Patient Protection Act, its regulations or a ~~[managed]~~
25 health insurance policy or health care plan may bring an

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1 action to recover actual damages or the sum of one hundred
2 dollars (\$100), whichever is greater.

3 B. A person likely to be damaged by a denial of a
4 right protected pursuant to the provisions of the Patient
5 Protection Act or its regulations may be granted an
6 injunction under the principles of equity and on terms that
7 the court considers reasonable. Proof of monetary damage or
8 intent to violate a right is not required.

9 C. To protect and enforce an enrollee's rights in a
10 ~~[managed]~~ health insurance policy or health care plan, an
11 individual enrollee participating in or eligible to
12 participate in a ~~[managed]~~ health insurance policy or health
13 care plan shall be treated as a third-party beneficiary of
14 the ~~[managed]~~ health insurance policy or health care plan
15 contract between the policy or plan and the party with which
16 the policy or plan directly contracts. An individual
17 enrollee may sue to enforce the rights provided in the
18 contract that governs the ~~[managed]~~ health insurance policy
19 or health care plan; provided, however, that the policy or
20 plan and the party to the contract may amend the terms of, or
21 terminate the provisions of, the contract without the
22 insured's or enrollee's consent.

23 D. The relief provided pursuant to this section is
24 in addition to other remedies available against the same
25 conduct under the common law or other statutes of this state.

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1 E. In any class action filed pursuant to this
2 section, the court may award damages to the named plaintiffs
3 as provided in this section and may award members of the
4 class the actual damages suffered by each member of the class
5 as a result of the unlawful practice.

6 F. Nothing in the Patient Protection Act is
7 intended to make a policy or plan vicariously liable for the
8 actions of independent contractor health care providers."

9 **SECTION 119.** Section 59A-57-11 NMSA 1978 (being Laws
10 1998, Chapter 107, Section 11) is amended to read:

11 "59A-57-11. PENALTY.--In addition to any other
12 penalties provided by law, a civil administrative penalty of
13 up to ten thousand dollars (\$10,000) may be imposed for each
14 violation of the Patient Protection Act. An administrative
15 penalty shall be imposed by written order of the
16 superintendent made after holding a formal hearing as
17 provided for in Chapter 59A, Article 4 NMSA 1978."

18 **SECTION 120.** A new section of the Patient Protection
19 Act is enacted to read:

20 "[NEW MATERIAL] INTERNAL GRIEVANCE PROCEDURE.--

21 A. A health insurer, health maintenance
22 organization or nonprofit health care plan shall establish
23 and maintain a written internal grievance procedure that has
24 been approved by the superintendent to provide procedures for
25 the resolution of internal grievances initiated by insureds,

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1 covered individuals, enrollees or subscribers.

2 B. The superintendent or the superintendent's
3 designee may examine the health insurer's, health maintenance
4 organization's or nonprofit health care plan's written
5 internal grievance procedures and any records relating to
6 internal grievances filed with the health insurer, health
7 maintenance organization or nonprofit health care plan.

8 C. The health insurer, health maintenance
9 organization or nonprofit health care plan shall maintain
10 records regarding internal grievances it has received since
11 the last date on which the superintendent or the
12 superintendent's designee examined the records of internal
13 grievances filed with the health insurer, health maintenance
14 organization or nonprofit health care plan.

15 D. The provisions of this section shall not apply
16 to policies, plans or evidence of coverage intended to
17 supplement major medical group-type coverages such as
18 medicare supplement, long-term care, disability income,
19 specified disease, accident-only, hospital indemnity or other
20 limited-benefit health insurance policies, plans or evidence
21 of coverage."

22 SECTION 121. TEMPORARY PROVISION--RULEMAKING.--The
23 superintendent of insurance shall adopt and promulgate rules
24 pursuant to the provisions of this act.

25 SECTION 122. DELAYED REPEAL.--Effective January 1,

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1 2014, Sections 23, 44, 76, 98 and 109 of this act are
2 repealed.

3 SECTION 123. EFFECTIVE DATE.--

4 A. The effective date of the provisions of Sections
5 1, 3 through 5, 7 through 18, 20 through 39, 41, 43 through
6 54, 56 through 69, 71, 72, 74 through 93, 95, 97 through 109
7 and 111 through 121 of this act is May 16, 2012.

8 B. The effective date of the provisions of Sections
9 2, 6, 19, 40, 42, 55, 70, 73, 94, 96 and 110 of this act is
10 January 1, 2014.