

HOUSE BILL 366

51ST LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2013

INTRODUCED BY

Jeff Steinborn

AN ACT

RELATING TO HEALTH COVERAGE; AMENDING A SECTION OF THE HEALTH CARE PURCHASING ACT TO PROVIDE COVERAGE FOR INDIVIDUALS UNDER THE AGE OF TWENTY-SIX WHO SEEK COVERAGE UNDER THEIR PARENTS' COVERAGE; AMENDING AND ENACTING SECTIONS OF THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO PROHIBIT LIFETIME OR ANNUAL LIMITS; PROVIDING FOR GUARANTEED ISSUE; BANNING PREEXISTING CONDITION EXCLUSIONS AND EXCESSIVE WAITING PERIODS; PROHIBITING RESCISSIONS OF COVERAGE EXCEPT IN CASES OF FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT; MANDATING COVERAGE FOR INDIVIDUALS UNDER THE AGE OF TWENTY-SIX WHO SEEK COVERAGE UNDER THEIR PARENTS' COVERAGE; REQUIRING THAT INSURERS MAKE REBATES TO CONSUMERS WHEN ADMINISTRATIVE LOSSES EXCEED THE STATUTORY MAXIMUM; PROVIDING FOR SMOKING AND TOBACCO CESSATION COVERAGE; ALIGNING COVERAGE FOR IMMUNIZATIONS, COLORECTAL CANCER

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

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

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

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

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

20 SECTION 2. Section 59A-18-13.1 NMSA 1978 (being Laws
21 1994, Chapter 75, Section 26, as amended) is amended to read:

22 "59A-18-13.1. ADJUSTED COMMUNITY RATING.--
23 A. Every insurer, fraternal benefit society, health
24 maintenance organization or nonprofit health care plan that
25 provides primary health insurance or health care coverage

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

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

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

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

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

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

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

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

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

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

25 F. The superintendent shall adopt regulations to

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1 implement the provisions of this section."

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

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

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

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

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1 including pregnancy and serious or chronic medical conditions
2 and related cost-sharing;

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

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

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

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

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

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

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1 (3) a policyholder, plan holder, evidence of
2 coverage holder, enrollee, subscriber or certificate holder, at
3 the time of issuance of the policy, plan or evidence of
4 coverage or the delivery of the certificate."

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

7 "59A-22-2. FORM AND CONTENT OF POLICY.--

8 A. No policy of individual health insurance shall
9 be delivered or issued for delivery in this state unless the
10 policy sets forth:

- 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 of indemnity and
16 limitations on coverage;
- 17 (5) cost-sharing provisions, including
18 deductible, coinsurance and copayment obligation provisions;
- 19 (6) renewability and continuation of coverage
20 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 policy:
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 plan or policy's
6 share of the total allowed costs of benefits provided under the
7 policy 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 health coverage policy can be
11 reviewed and obtained.

12 B. Prior to any enrollment restriction, an insurer
13 shall provide a summary of benefits and coverage explanation
14 required pursuant to Subsection A of this section to the
15 following persons:

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

17 (2) an enrollee or subscriber, prior to the
18 time of enrollment or re-enrollment, subscription or re-
19 subscription; and

20 (3) a policyholder at the time of issuance of
21 the policy.

22 C. No policy or contract of individual health
23 insurance shall be delivered or issued for delivery in this
24 state unless:

25 ~~[A.]~~ (1) the entire money and other

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1 considerations therefor are expressed therein; [~~and~~

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

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

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

25 ~~E. the exceptions and reductions of indemnity are~~

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1 ~~adequately captioned and clearly set forth in the policy or~~
2 ~~contract; and~~

3 ~~F.]~~ (5) each ~~[such]~~ form, including riders and
4 endorsements, shall be identified by a form number in the lower
5 left-hand corner of the first page thereof; and

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

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

17 "59A-22-5. TIME LIMIT ON CERTAIN DEFENSES.--

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

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1 individual:

2 (1) engages in conduct that constitutes fraud;

3 or

4 (2) makes an intentional misrepresentation of
5 material fact that is prohibited by the terms of the policy or
6 plan.

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

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

23 C. The foregoing policy and plan provisions shall
24 not be so construed as to affect any initial two-year period
25 nor to limit the application of Sections 59A-22-17 through

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1 59A-22-19, 59A-22-21 and 59A-22-22 NMSA 1978 in the event of
2 misstatement with respect to age or occupation or other
3 insurance.

4 ~~[D. A policy that the insured has the right to~~
5 ~~continue in force subject to its terms by the timely payment of~~
6 ~~premium:~~

7 ~~(1) until at least age fifty; or~~

8 ~~(2) in the case of a policy issued after age~~
9 ~~forty-four, for at least five years from its date of issue, may~~
10 ~~contain in lieu of the foregoing the following provision, from~~
11 ~~which the clause in parentheses may be omitted at the insurance~~
12 ~~company's option, under the caption "Incontestable". After~~
13 ~~this policy has been in force for a period of two years during~~
14 ~~the lifetime of the insured, excluding any period during which~~
15 ~~the insured is disabled, it shall become incontestable as to~~
16 ~~the statements contained in the application.~~

17 ~~E. For individual policies that do not reimburse or~~
18 ~~pay as a result of hospitalization, medical or surgical~~
19 ~~expenses, no claim for loss incurred or disability (as defined~~
20 ~~in the policy) shall be reduced or denied on the ground that a~~
21 ~~disease or physical condition disclosed on the application and~~
22 ~~not excluded from coverage by name or a specific description~~
23 ~~effective on the date of loss had existed prior to the~~
24 ~~effective date of coverage of this policy. As an alternative,~~
25 ~~those policies may contain provisions under which coverage may~~

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1 ~~be excluded for a period of six months following the effective~~
2 ~~date of coverage as to a given covered insured for a~~
3 ~~preexisting condition, provided that:~~

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

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

11 ~~F. Individual policies that reimburse or pay as a~~
12 ~~result of hospitalization, medical or surgical expenses may~~
13 ~~contain provisions under which coverage is excluded during a~~
14 ~~period of six months following the effective date of coverage~~
15 ~~as to a given covered insured for a preexisting condition,~~
16 ~~provided that:~~

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

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

24 ~~G. The preexisting condition exclusions authorized~~
25 ~~in Subsections E and F of this section shall be waived to the~~

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1 ~~extent that similar conditions have been satisfied under any~~
2 ~~prior health insurance coverage if the application for new~~
3 ~~coverage is made not later than thirty-one days following the~~
4 ~~termination of prior coverage. In that case, the new coverage~~
5 ~~shall be effective from the date on which the prior coverage~~
6 ~~terminated.~~

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

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

13 "59A-22-6. GRACE PERIOD.--There shall be a provision as
14 follows:

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

22 ~~[A policy in which the insurer reserves the right to~~
23 ~~refuse any renewal shall have, at the beginning of the above~~
24 ~~provision, "Unless not less than five days prior to the premium~~
25 ~~due date the insurance company has delivered to the insured or~~

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1 ~~has mailed to his last address as shown by the records of the~~
2 ~~insurer written notice of its intention not to renew this~~
3 ~~policy beyond the period for which the premium has been~~
4 ~~accepted.".]"~~

5 SECTION 7. Section 59A-22-30.1 NMSA 1978 (being Laws
6 2005, Chapter 41, Section 1) is amended to read:

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

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

18 "59A-22-33. ~~[HANDICAPPED]~~ DISABLED CHILDREN--COVERAGE
19 CONTINUED.--

20 A. An individual or group hospital or medical
21 expense insurance policy or plan delivered or issued for
22 delivery in this state ~~[which]~~ that provides that coverage of a
23 ~~[dependent]~~ child of an insured, or of an employee or other
24 member of the covered group, shall terminate upon attainment of
25 the limiting age for ~~[dependent]~~ children specified in the

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1 policy or plan shall also provide, in substance, that
2 attainment of the limiting age shall not operate to terminate
3 the coverage of a child while the child is, and continues to
4 be, both incapable of self-sustaining employment, by reason of
5 [~~mental retardation~~] cognitive or physical [~~handicap~~]
6 disability, and chiefly dependent upon the policyholder or plan
7 holder for support and maintenance. However, proof of the
8 incapacity and dependency of the child must be furnished to the
9 insurer by the insured employee or member within thirty-one
10 [~~(31)~~] days of the child's attainment of the limiting age and
11 subsequently, as may be required by the insurer, but not more
12 frequently than annually after the two-year period following
13 the child's attainment of the limiting age.

14 B. No limiting age shall be set before age twenty-
15 six."

16 SECTION 9. Section 59A-22-34.2 NMSA 1978 (being Laws
17 1994, Chapter 64, Section 2, as amended) is amended to read:

18 "59A-22-34.2. COVERAGE OF CHILDREN.--

19 A. An insurer shall not deny enrollment of a child
20 under the health plan or policy of the child's parent on the
21 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 shall:

4 (1) provide such information to the custodial
5 parent as may be necessary for the child to obtain benefits
6 through that coverage;

7 (2) permit the custodial parent or the
8 provider, with the custodial parent's approval, to submit
9 claims for covered services without the approval of the
10 noncustodial parent; and

11 (3) make payments on claims submitted in
12 accordance with Paragraph (2) of this subsection directly to
13 the custodial parent, the provider or the state medicaid
14 agency.

15 C. When a parent is required by a court or
16 administrative order to provide health coverage for a child and
17 the parent is eligible for family health coverage, the insurer
18 shall be required:

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

22 (2) if the parent is enrolled but fails to
23 make application to obtain coverage for the child, to enroll
24 the child under family coverage upon application of the child's
25 other parent, the state agency administering the medicaid

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1 program or the state agency administering 42 U.S.C. Sections
2 651 through 669, the child support enforcement program; and

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

6 (a) the court or administrative order is
7 no longer in effect; or

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

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

17 E. An insurer shall provide coverage for children,
18 from birth through three years of age, for or under the family,
19 infant, toddler program administered by the department of
20 health; provided that eligibility criteria are met [~~for a~~
21 ~~maximum benefit of three thousand five hundred dollars (\$3,500)~~
22 ~~annually~~] for medically necessary early intervention services
23 provided as part of an individualized family service plan and
24 delivered by certified and licensed personnel as defined in
25 7.30.8 NMAC who are working in early intervention programs

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1 approved by the department of health. [~~No payment under this~~
2 ~~subsection shall be applied against any maximum lifetime or~~
3 ~~annual limits specified in the policy, health benefits plan or~~
4 ~~contract.]"~~

5 SECTION 10. A new section of Chapter 59A, Article 22 NMSA
6 1978 is enacted to read:

7 "[NEW MATERIAL] SUBSTANCE ABUSE TREATMENT 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 substance abuse. These benefits shall provide
12 necessary care and treatment in a substance abuse treatment
13 center and outpatient visits for substance abuse treatment.

14 B. For purposes of this section, "substance abuse
15 treatment center" means a facility that provides a program that
16 offers behavioral health services and substance abuse treatment
17 pursuant to a written treatment plan approved and monitored by
18 a physician or meeting the quality standards of the behavioral
19 health services division of the human services department. The
20 facility shall also:

21 (1) be affiliated with a hospital under a
22 contractual agreement with an established system for patient
23 referral;

24 (2) be accredited as a substance abuse
25 treatment facility by the joint commission; or

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1 (3) meet at least the minimum standards
2 adopted by the behavioral health services division for the
3 provision of behavioral health services and the treatment of
4 substance abuse in regional treatment centers.

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

23 D. If an organization offering group health
24 benefits to its members makes more than one health insurance
25 policy or nonprofit health care plan available to its members

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1 on a member option basis, the organization shall not require
2 substance abuse treatment coverage from one health insurer or
3 health care plan without requiring the same level of substance
4 abuse treatment coverage for all other health insurance
5 policies or health care plans that the organization makes
6 available to its members."

7 SECTION 11. Section 59A-22-34.3 NMSA 1978 (being Laws
8 1997, Chapter 250, Section 1) is amended to read:

9 "59A-22-34.3. CHILDHOOD IMMUNIZATION COVERAGE REQUIRED.--

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

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

23 ~~[G. Coverage for childhood immunizations and~~
24 ~~necessary booster doses may be subject to deductibles and co-~~
25 ~~insurance consistent with those imposed on other benefits under~~

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1 ~~the same policy, plan or certificate.]"~~

2 SECTION 12. Section 59A-22-39.1 NMSA 1978 (being Laws
3 1997, Chapter 249, Section 1) is amended to read:

4 "59A-22-39.1. MASTECTOMIES, BREAST RECONSTRUCTION AND
5 LYMPH NODE DISSECTION--MINIMUM HOSPITAL STAY COVERAGE
6 REQUIRED.--

7 A. Each individual and group health insurance
8 policy, health care plan and certificate of health insurance
9 delivered or issued for delivery in this state shall provide
10 coverage for not less than forty-eight hours of inpatient care
11 following a mastectomy and not less than twenty-four hours of
12 inpatient care following a lymph node dissection for the
13 treatment of breast cancer.

14 B. Nothing in this section shall be construed as
15 requiring the provision of inpatient coverage where the
16 attending physician and patient determine that a shorter period
17 of hospital stay is appropriate.

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

21 D. Coverage for minimum inpatient hospital stays
22 for mastectomies and lymph node dissections for the treatment
23 of breast cancer may be subject to deductibles and co-insurance
24 consistent with those imposed on other benefits under the same
25 policy, plan or certificate.

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1 E. Each individual and group health insurance
2 policy, health care plan and certificate of insurance delivered
3 or issued for delivery in the state shall provide coverage for
4 breast reconstruction in connection with a mastectomy,
5 including coverage for:

6 (1) all stages of reconstruction of the breast
7 on which the mastectomy was performed;

8 (2) surgery and reconstruction of the other
9 breast to produce a symmetrical appearance;

10 (3) prostheses; and

11 (4) treatment of any physical complications at
12 all stages of mastectomy, including lymphedemas, in a manner
13 determined in consultation with the attending physician and the
14 patient."

15 SECTION 13. Section 59A-22-40 NMSA 1978 (being Laws 1992,
16 Chapter 56, Section 2, as amended) is amended to read:

17 "59A-22-40. COVERAGE FOR CYTOLOGIC AND HUMAN
18 PAPILOMAVIRUS SCREENING.--

19 A. Each individual and group health insurance
20 policy, health care plan and certificate of health insurance
21 delivered or issued for delivery in this state shall provide
22 coverage for cytologic and human papillomavirus screening for
23 determining the presence of precancerous or cancerous
24 conditions and other health problems. The coverage shall make
25 available cytologic screening, as determined by the health care

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1 provider in accordance with national medical standards and
2 United States preventive services task force "A"-rated and "B"-
3 rated recommendations, whichever provides greater coverage, for
4 women who are eighteen years of age or older and for women who
5 are at risk of cancer or at risk of other health conditions
6 that can be identified through cytologic screening. The
7 coverage shall make available human papillomavirus screening
8 once every three years for women aged thirty and older.

9 B. Coverage for cytologic and human papillomavirus
10 screening may be subject to deductibles and coinsurance
11 consistent with those imposed on other benefits under the same
12 policy, plan or certificate.

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

16 D. For the purposes of this section:

17 (1) "cytologic screening" means a Papanicolaou
18 test and a pelvic exam for asymptomatic as well as symptomatic
19 women;

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

25 (3) "human papillomavirus screening" means a

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1 test approved by the federal food and drug administration for
2 detection of the human papillomavirus."

3 SECTION 14. Section 59A-22-44 NMSA 1978 (being Laws 2003,
4 Chapter 337, Section 1) is amended to read:

5 "59A-22-44. COVERAGE FOR SMOKING CESSATION TREATMENT.--

6 A. An individual or group health insurance policy,
7 health care plan or certificate of health insurance that is
8 delivered or issued for delivery in this state and that offers
9 maternity benefits shall offer coverage for smoking cessation
10 treatment and shall offer augmented counseling tailored to
11 pregnant women who smoke.

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

16 B. 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 shall:

19 (1) offer tobacco cessation intervention
20 coverage for those who use tobacco products;

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

24 (3) provide diagnostic, therapy and counseling
25 services and pharmacotherapy, including the coverage of

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1 prescription and nonprescription tobacco cessation agents
2 approved by the federal food and drug administration for
3 cessation of tobacco use by pregnant women.

4 C. The provisions of this section shall not apply
5 to short-term travel, accident-only or limited or specified-
6 disease policies or plans."

7 SECTION 15. Section 59A-22-47 NMSA 1978 (being Laws 2007,
8 Chapter 17, Section 1) is amended to read:

9 "59A-22-47. COVERAGE OF COLORECTAL CANCER SCREENING.--

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

21 ~~[B. Coverage for colorectal screening may be~~
22 ~~subject to deductibles and coinsurance consistent with those~~
23 ~~imposed on other benefits under the same policy, plan or~~
24 ~~certificate.~~

25 ~~G.]~~ B. The provisions of this section shall not

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1 apply to short-term travel, accident-only or limited or
2 specified-disease policies or plans."

3 SECTION 16. Section 59A-22-49 NMSA 1978 (being Laws 2009,
4 Chapter 74, Section 1) is amended to read:

5 "59A-22-49. COVERAGE FOR AUTISM SPECTRUM DISORDER
6 DIAGNOSIS AND TREATMENT.--

7 A. An individual or group health insurance policy,
8 health care plan or certificate of health insurance that is
9 delivered, issued for delivery or renewed in this state shall
10 provide coverage to an eligible individual who is nineteen
11 years of age or younger or an eligible individual who is
12 twenty-two years of age or younger and is enrolled in high
13 school for:

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

16 (2) treatment of autism spectrum disorder
17 through speech therapy, occupational therapy, physical therapy
18 and applied behavioral analysis.

19 B. Coverage required pursuant to Subsection A of
20 this section:

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

24 ~~(2) shall be limited to thirty-six thousand~~
25 ~~dollars (\$36,000) annually and shall not exceed two hundred~~

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1 ~~thousand dollars (\$200,000) in total lifetime benefits.~~
2 ~~Beginning January 1, 2011, the maximum benefit shall be~~
3 ~~adjusted annually on January 1 to reflect any change from the~~
4 ~~previous year in the medical component of the then-current~~
5 ~~consumer price index for all urban consumers published by the~~
6 ~~bureau of labor statistics of the United States department of~~
7 ~~labor;~~

8 ~~(3)]~~ (2) shall not be denied on the basis that
9 the services are habilitative or rehabilitative in nature;

10 [~~(4)]~~ (3) may be subject to other general
11 exclusions and limitations of the insurer's policy or plan,
12 including, but not limited to, coordination of benefits,
13 participating provider requirements, restrictions on services
14 provided by family or household members and utilization review
15 of health care services, including the review of medical
16 necessity, case management and other managed care provisions;
17 and

18 [~~(5)]~~ (4) may be limited to exclude coverage
19 for services received under the federal Individuals with
20 Disabilities Education Improvement Act of 2004 and related
21 state laws that place responsibility on state and local school
22 boards for providing specialized education and related services
23 to children three to twenty-two years of age who have autism
24 spectrum disorder.

25 C. The coverage required pursuant to Subsection A

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1 of this section shall not be subject to dollar limits,
2 deductibles or coinsurance provisions that are less favorable
3 to an insured than the dollar limits, deductibles or
4 coinsurance provisions that apply to physical illnesses that
5 are generally covered under the individual or group health
6 insurance policy, health care plan or certificate of health
7 insurance, except as otherwise provided in Subsection B of this
8 section.

9 D. An insurer shall not deny or refuse to issue
10 health insurance coverage for medically necessary services or
11 refuse to contract with, renew, reissue or otherwise terminate
12 or restrict health insurance coverage for an individual because
13 the individual is diagnosed as having autism spectrum disorder.

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

- 18 (1) the diagnosis;
19 (2) the proposed treatment by types;
20 (3) the frequency and duration of treatment;
21 (4) the anticipated outcomes stated as goals;
22 (5) the frequency with which the treatment
23 plan will be updated; and

24 (6) the signature of the treating physician.

25 F. This section shall not be construed as limiting

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1 benefits and coverage otherwise available to an insured under a
2 health insurance policy or plan.

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

9 H. As used in this section:

10 (1) "autism spectrum disorder" means a
11 condition that meets the diagnostic criteria for the pervasive
12 developmental disorders published in the *Diagnostic and*
13 *Statistical Manual of Mental Disorders*, [~~fourth~~] current
14 edition, [~~text revision, also known as DSM-IV-TR~~] published by
15 the American psychiatric association, including autistic
16 disorder; Asperger's disorder; pervasive development disorder
17 not otherwise specified; Rett's disorder; and childhood
18 disintegrative disorder;

19 (2) "habilitative or rehabilitative services"
20 means treatment programs that are necessary to develop,
21 maintain and restore to the maximum extent practicable the
22 functioning of an individual; and

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

25 SECTION 17. Section 59A-22-50 NMSA 1978 (being Laws 2010,
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1 Chapter 94, Section 1) is amended to read:

2 "59A-22-50. HEALTH INSURERS--DIRECT SERVICES.--

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

18 B. For individually underwritten health care
19 policies, plans or contracts, the superintendent shall
20 establish, after notice and informal hearing, the level of
21 reimbursement for direct services, as determined by the reports
22 filed with the insurance division, as a percent of premiums.
23 Additional informal hearings may be held at the
24 superintendent's discretion. In establishing the level of
25 reimbursement for direct services, the superintendent shall

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1 consider the costs associated with the individual marketing and
2 medical underwriting of these policies, plans or contracts at a
3 level not less than seventy-five percent of premiums. A health
4 insurer writing these policies, plans or contracts shall make
5 reimbursement for direct services at a level not less than that
6 level established by the superintendent pursuant to this
7 subsection over the three calendar years preceding the date
8 upon which that rate is established, but not earlier than
9 calendar year 2010. Nothing in this subsection shall be
10 construed to preclude a purchaser of one of these policies,
11 plans or contracts from negotiating an agreement with a health
12 insurer that requires a higher amount of premiums paid to be
13 used for reimbursement for direct services.

14 C. An insurer that fails to comply with the
15 reimbursement requirements pursuant to this section shall issue
16 a [~~dividend or credit against future premiums~~] rebate to all
17 policyholders or plan holders in [~~an amount sufficient to~~
18 ~~assure that the benefits paid in the preceding three calendar~~
19 ~~years plus the amount of the dividends or credits are equal to~~
20 ~~the required direct services reimbursement level pursuant to~~
21 ~~Subsection A of this section for group health coverage and~~
22 ~~blanket health coverage or the required direct services~~
23 ~~reimbursement level pursuant to Subsection B of this section~~
24 ~~for individually underwritten health policies, contracts or~~
25 ~~plans for the preceding three calendar years] accordance with~~

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1 rules that the superintendent has promulgated. If the insurer
2 fails to issue the [~~dividend or credit~~] rebate in accordance
3 with the requirements of this section, the superintendent shall
4 enforce these requirements and may pursue any other penalties
5 as provided by law, including general penalties pursuant to
6 Section 59A-1-18 NMSA 1978.

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

10 E. For the purposes of this section:

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

23 (2) "health insurer" means a person duly
24 authorized to transact the business of health insurance in the
25 state pursuant to the Insurance Code but does not include a

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1 person that only issues a limited-benefit policy intended to
2 supplement major medical coverage, including medicare
3 supplement, vision, dental, disease-specific, accident-only or
4 hospital indemnity-only insurance policies, or that only issues
5 policies for long-term care or disability income; and

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

15 SECTION 18. A new section of Chapter 59A, Article 22 NMSA
16 1978 is enacted to read:

17 "[NEW MATERIAL] CHILD DEFINED.--As used in Chapter 59A,
18 Article 22 NMSA 1978, "child" means an individual under twenty-
19 six years of age whom the principal insured covers or whom the
20 applicant for coverage applies to cover, regardless of the
21 individual's financial dependency, residency with a parent,
22 student status, employment and marital status."

23 SECTION 19. A new section of Chapter 59A, Article 22 NMSA
24 1978 is enacted to read:

25 "[NEW MATERIAL] ADJUSTED COMMUNITY RATING.--

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1 A. An individual health insurance policy, plan or
2 contract or certificate of insurance that is issued for
3 delivery in the state shall be offered without regard to the
4 health status of any individual. The only rating factors that
5 may be used to determine the initial year's premium charged a
6 group, subject to the maximum rate variation provided in this
7 section for all rating factors, are the covered individual's:

8 (1) age;

9 (2) geographic area. If the policy, plan,
10 contract or certificate is issued or delivered to an employer,
11 the geographic location of the place of employment shall be the
12 rating factor applied; and

13 (3) tobacco use.

14 B. A covered individual's rate shall not exceed the
15 rate of any other covered individual by more than:

16 (1) three hundred percent between any two
17 individuals on the basis of age, in accordance with age bands
18 the United States department of health and human services has
19 established by regulation;

20 (2) an amount that the superintendent shall
21 establish by rule, after review by the United States department
22 of health and human services, on the basis of geographic rating
23 area; and

24 (3) one hundred fifty percent between an
25 individual who uses tobacco and an individual who does not use

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1 tobacco.

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

4 SECTION 20. A new section of Chapter 59A, Article 22 NMSA
5 1978 is enacted to read:

6 "[NEW MATERIAL] GUARANTEED ISSUE--GUARANTEED
7 RENEWABILITY--MAXIMUM WAITING PERIOD--BAN ON PREEXISTING
8 CONDITION EXCLUSIONS.--

9 A. A health insurer shall issue coverage to any
10 individual who requests and offers to purchase the coverage
11 without permanent exclusion of preexisting conditions.

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

15 C. A health insurer may impose a waiting period not
16 to exceed ninety days before payment for any service related to
17 a preexisting condition.

18 D. A health insurer shall offer or make a referral
19 to a transition product to provide coverage during the waiting
20 period due to a preexisting condition.

21 E. A health insurer may restrict enrollment in
22 coverage described in Subsection A of this section to open or
23 special enrollment periods; provided that any special
24 enrollment period shall comply with the provisions of Section
25 22 of this 2013 act and rules the superintendent has

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1 promulgated.

2 F. For the purposes of this section:

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

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

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

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

23 A. Notwithstanding any other provision of law, a
24 group health plan, health insurance issuer offering group or
25 individual health insurance coverage, health maintenance

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1 organization, fraternal benefit society or nonprofit
2 organization shall not establish:

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

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

8 B. With respect to plan years beginning prior to
9 January 1, 2014, a group health plan, health insurance issuer
10 offering group or individual health insurance coverage, health
11 maintenance organization, fraternal benefit society or
12 nonprofit organization shall establish a restricted annual
13 limit on the dollar value of benefits for any participant or
14 beneficiary only with respect to the scope of benefits that are
15 essential health benefits, as the superintendent defines
16 "essential health benefits" by rule.

17 C. Subsection A of this section shall not be
18 construed to prevent a group health plan, health insurance
19 issuer offering group or individual health insurance coverage,
20 health maintenance organization, fraternal benefit society or
21 nonprofit organization from placing annual or lifetime per
22 beneficiary limits on specific covered benefits that are not
23 essential health benefits to the extent that these limits are
24 otherwise permitted under federal or state law.

25 D. The provisions of this section shall not apply

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

6 SECTION 22. A new section of Chapter 59A, Article 22 NMSA
7 1978 is enacted to read:

8 "[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY
9 REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--
10 OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

11 A. For health insurance policy, health plan or
12 certificate of health insurance years beginning on or after
13 September 23, 2010, if a child's coverage ended or did not
14 begin for the reasons described in Subsection E of this
15 section, a health insurer shall provide the child an
16 opportunity to enroll in a health plan or policy for which
17 coverage continues for at least sixty days and shall provide
18 written notice of the opportunity to enroll as described in
19 Subsection B of this section no later than the first day of the
20 plan or policy year.

21 B. A written notice of the opportunity to enroll
22 provided pursuant to this section shall include a statement
23 that children whose coverage ended, who were denied coverage or
24 who were not eligible for coverage because dependent coverage
25 of children was unavailable before the child reached twenty-six

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1 years of age are eligible to enroll in coverage. This notice
2 may be provided to a principal insured on behalf of the
3 principal insured's child.

4 C. For an individual who enrolls in an individual
5 health insurance policy, health plan or certificate of health
6 insurance, the coverage shall take effect not later than the
7 first day of the first plan or policy year.

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

20 E. The provisions of this section shall apply to a
21 child:

22 (1) whose coverage ended, or who was denied
23 coverage or was not eligible for coverage under an individual
24 or a group health insurance policy or health plan because,
25 under the terms of coverage, the availability of dependent

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1 coverage of a child ended before the child reached the age of
2 twenty-six; or

3 (2) who became eligible, or is required to
4 become eligible, for coverage on the first day of the first
5 policy, plan or certificate year, beginning on or after
6 September 23, 2010 by reason of the provisions of this
7 section."

8 SECTION 23. A new section of Chapter 59A, Article 22 NMSA
9 1978 is enacted to read:

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

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 shall not limit
15 or exclude coverage under an individual or group health benefit
16 plan for an individual under the age of nineteen by imposing a
17 preexisting condition exclusion on that individual.

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

23 C. During an open enrollment period, a health
24 insurer shall not deny or unreasonably delay the issuance of a
25 policy, plan or certificate, refuse to issue a policy, plan or

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1 certificate or issue a policy, plan or certificate with any
2 preexisting condition exclusion rider or endorsement to an
3 applicant or insured who is under the age of nineteen on the
4 basis of a preexisting condition.

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

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

16 SECTION 24. A new section of Chapter 59A, Article 22 NMSA
17 1978 is enacted to read:

18 "[NEW MATERIAL] EMERGENCY SERVICES.--

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 and that
22 provides or covers any benefits with respect to services in an
23 emergency department of a hospital shall cover emergency
24 services:

25 (1) without the need for any prior

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1 authorization determination; and

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

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

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

25 D. The provisions of this section shall not apply

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1 to:

2 (1) policies or plans intended to supplement
3 major medical group-type coverages such as medicare supplement,
4 long-term care, disability income, specified disease, accident-
5 only, hospital indemnity or other limited-benefit health
6 insurance policies or plans; or

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

10 E. As used in this section:

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

17 (a) placing the health of the individual
18 or, with respect to a pregnant woman, the health of the woman
19 or her unborn child, in serious jeopardy;

20 (b) serious impairment to bodily
21 functions; or

22 (c) serious dysfunction of any bodily
23 organ or part;

24 (2) "emergency services" means, with respect
25 to an emergency medical condition:

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1 (a) a medical screening examination that
2 is within the capability of the emergency department of a
3 hospital, including ancillary services routinely available to
4 the emergency department to evaluate the emergency medical
5 condition; and

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

13 (3) "stabilize" means:

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

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

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

23 "[NEW MATERIAL] OPTION FOR PEDIATRICIAN AS PRIMARY CARE
24 PHYSICIAN.--

25 A. An individual or group health insurance policy,

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1 health care plan or certificate of health insurance that is
2 delivered or issued for delivery in this state that requires or
3 provides for the designation of a participating primary care
4 provider shall allow a principal insured to designate for the
5 principal insured's dependent child who is a covered individual
6 an allopathic or osteopathic physician who specializes in
7 pediatrics as the principal insured child's primary care
8 provider if the provider participates in the network of the
9 policy, plan or issuer.

10 B. Nothing in Subsection A of this section shall be
11 construed to waive any exclusions of coverage under the terms
12 and conditions of the health insurance policy, health care plan
13 or certificate of health insurance with respect to coverage of
14 pediatric care.

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

22 SECTION 26. A new section of Chapter 59A, Article 22 NMSA
23 1978 is enacted to read:

24 "[NEW MATERIAL] OBSTETRICAL AND GYNECOLOGICAL CARE
25 OPTION.--

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

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

23 C. Nothing in Subsection A of this section shall be
24 construed to:

25 (1) waive any exclusions of coverage under the

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1 terms and conditions of the health insurance policy, health
2 care plan or certificate of health insurance with respect to
3 coverage of obstetrical or gynecological care; or

4 (2) preclude the health insurer from requiring
5 that the obstetrical or gynecological provider notify the
6 covered individual's primary care health care professional or
7 the policy, plan or issuer of treatment decisions.

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

15 SECTION 27. A new section of Chapter 59A, Article 22 NMSA
16 1978 is enacted to read:

17 "[NEW MATERIAL] PREVENTIVE ITEMS AND SERVICES--PROHIBITION
18 ON COST-SHARING.--

19 A. A health insurer providing coverage under an
20 individual health benefit policy or plan shall provide coverage
21 for items and services pursuant to Sections 59A-22-34.3,
22 59A-22-40, 59A-22-44 and 59A-22-47 NMSA 1978 and Sections 28
23 through 30 of this 2013 act and shall not impose any
24 cost-sharing requirements, such as a copayment, co-insurance or
25 deductible.

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1 B. A health insurer is not required to provide
2 coverage for any items or services specified in any
3 recommendation or guideline described in Subsection A of this
4 section after the recommendation or guideline is no longer
5 described by a source listed in that subsection.

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

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

15 E. The superintendent shall at least annually
16 revise the preventive services standards established pursuant
17 to Sections 59A-22-44 and 59A-22-47 NMSA 1978 and Sections 28
18 through 30 of this 2013 act to ensure that they are
19 respectively consistent with the current "A"-rated and "B"-
20 rated recommendations of the United States preventive services
21 task force, the federal centers for disease control and
22 prevention and the guidelines with respect to infants,
23 children, adolescents and women of evidence-based preventive
24 care and screenings by the federal health resources and
25 services administration. When changes are made to any of these

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1 guidelines or recommendations, the superintendent shall make
2 recommendations to the legislature for legislative changes to
3 conform these standards to current guidelines and
4 recommendations.

5 F. A health insurer may impose cost-sharing
6 requirements with respect to an office visit if a preventive
7 item or service provided pursuant to this section is billed
8 separately or is tracked as individual encounter data
9 separately from the office visit.

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

17 H. A health insurer may impose cost-sharing
18 requirements with respect to an office visit if a preventive
19 item or service provided pursuant to this section is not billed
20 separately or is not tracked as individual encounter data
21 separately from the office visit and the primary purpose of the
22 office visit is not the delivery of the preventive item or
23 service.

24 I. 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 28. A new section of Chapter 59A, Article 22 NMSA
6 1978 is enacted to read:

7 "[NEW MATERIAL] PREVENTIVE SERVICES BENEFITS--ASPIRIN
8 REGIMEN--HIGH BLOOD PRESSURE SCREENING--BREAST CANCER
9 SCREENING--LIPID DISORDERS SCREENING--COLORECTAL CANCER
10 SCREENING--DEPRESSION SCREENING--BEHAVIORAL DIETARY
11 COUNSELING--OBESITY COUNSELING AND SCREENING--OSTEOPOROSIS
12 SCREENING--FALLS PREVENTION--SKIN CANCER COUNSELING--HUMAN
13 IMMUNODEFICIENCY VIRUS SCREENING--HEPATITIS C SCREENING--
14 ALCOHOL MISUSE SCREENING AND COUNSELING.--

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

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

24 (2) an aspirin regimen for men between the
25 ages of forty-five and seventy-nine when the potential benefit

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1 due to a reduction in myocardial infarctions outweighs the
2 potential harm due to an increase in gastrointestinal
3 hemorrhage;

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

8 (4) screening for high blood pressure in
9 adults aged eighteen and older;

10 (5) genetic counseling and evaluation for
11 breast cancer BRCA-gene testing for women whose family
12 histories are associated with an increased risk for deleterious
13 mutations in BRCA1 or BRCA2 genes. Nothing in this paragraph
14 shall be construed as a waiver or exception to the Genetic
15 Information Privacy Act;

16 (6) screening of lipid disorders for:

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

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

21 (7) screening of individuals over eighteen
22 years of age for colorectal cancer using fecal occult blood
23 testing, sigmoidoscopy or colonoscopy;

24 (8) screening of individuals eighteen years of
25 age or older for depression;

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

3 (10) behavioral dietary counseling for adults
4 with hyperlipidemia and other known risk factors for
5 cardiovascular and diet-related chronic disease;

6 (11) screening and counseling for obesity for
7 individuals six years of age and older;

8 (12) screening for osteoporosis for:

9 (a) women who are sixty-five years of
10 age and older; and

11 (b) women who are under sixty-five years
12 of age who are at increased risk for osteoporotic fractures;

13 (13) exercise or physical therapy to prevent
14 falls in community-dwelling adults aged sixty-five years or
15 older who are at increased risk for falls;

16 (14) counseling of individuals at increased
17 risk for skin cancer by minimizing their exposure to
18 ultraviolet radiation;

19 (15) screening for human immunodeficiency
20 virus, also known as "HIV" for:

21 (a) individuals age fifteen to sixty-
22 five years of age; and

23 (b) individuals of any age who are at
24 increased risk of infection;

25 (16) screening for hepatitis C virus, also

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1 known as "HCV", infection in adults at high risk of infection,
2 including:

3 (a) individuals with any history of
4 intravenous drug use; or

5 (b) individuals who received a blood
6 transfusion before the year 1992; and

7 (17) screening and behavioral counseling
8 interventions for alcohol misuse for patients in primary care
9 settings.

10 B. The provisions of this section shall not apply
11 to health insurance policies or plans intended to supplement
12 major medical group-type coverages such as medicare supplement,
13 long-term care, disability income, specified disease, accident-
14 only, hospital indemnity or other limited-benefit health
15 insurance 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 over six months of age whose
2 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 (8) screening to detect amblyopia, strabismus
15 and defects in visual acuity in children less than five years
16 of age;

17 (9) counseling of individuals at increased
18 risk for skin cancer to minimize their exposure to ultraviolet
19 radiation; and

20 (10) interventions, including education or
21 brief counseling, to prevent initiation of tobacco use among
22 school-aged children and adolescents.

23 B. The provisions of this section shall not apply
24 to health insurance 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."

4 SECTION 30. A new section of Chapter 59A, Article 22 NMSA
5 1978 is enacted to read:

6 "[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--
7 REPRODUCTIVE HEALTH.--

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) screening for asymptomatic bacteriuria
15 with a urine culture for pregnant women;

16 (2) interventions during pregnancy and after
17 birth to promote and support breastfeeding;

18 (3) screening for cervical cancer in women who
19 have a cervix;

20 (4) screening for chlamydial infection for:

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

23 (b) older women who are at increased
24 risk of chlamydial infection;

25 (5) a daily supplement containing four hundred

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1 to eight hundred micrograms of folic acid for any woman
2 planning a pregnancy or capable of pregnancy;

3 (6) screening of all sexually active women who
4 are at increased risk for infection, including those who are
5 pregnant, for gonorrheal infection;

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

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

10 (a) all pregnant women; and

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

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

15 (a) all sexually active adolescents; and

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

18 (10) screening for hepatitis B virus infection
19 in pregnant women;

20 (11) screening for human immunodeficiency
21 virus for individuals twelve years of age and older who are at
22 risk of human immunodeficiency virus infection;

23 (12) screening for iron deficiency anemia in
24 asymptomatic pregnant women;

25 (13) screening for syphilis for:

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1 (a) any individual at increased risk for
2 syphilis infection; and

3 (b) any pregnant woman;

4 (14) screening of pregnant women for human
5 immunodeficiency virus, also known as "HIV", including those
6 who present at labor whose human immunodeficiency virus status
7 is unknown;

8 (15) screening of women of childbearing age
9 for intimate partner violence, including domestic violence, and
10 referral to or provision of intervention services to
11 individuals whose screening shows a positive result. Nothing
12 in this section shall be construed as a waiver or exception to
13 the Domestic Abuse Insurance Protection Act; and

14 (16) screening and behavioral counseling
15 interventions for pregnant women in primary care settings for
16 alcohol misuse.

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

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

25 "59A-23-6. [~~ALCOHOL DEPENDENCY~~] SUBSTANCE ABUSE TREATMENT

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1 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.~~ Such] substance abuse.

6 These benefits shall

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

10 ~~(2)]~~ provide [~~no less than thirty days]~~
11 necessary care and treatment in [~~an alcohol dependency]~~ a
12 substance abuse treatment center and [~~thirty]~~ outpatient visits
13 for [~~alcohol dependency]~~ substance abuse treatment [~~and~~

14 ~~(3) be offered for benefit periods of no more~~
15 ~~than one year and may be limited to a lifetime maximum of no~~
16 ~~less than two benefit periods. Such offer of benefits shall be~~
17 ~~subject to the rights of the group health insurance holder to~~
18 ~~reject the coverage or to select any alternative level of~~
19 ~~benefits if that right is offered by or negotiated with that~~
20 ~~insurer].~~

21 B. For purposes of this section, "[~~alcohol~~
22 ~~dependency]~~ substance abuse treatment center" means a facility
23 that provides a program [~~for the]~~ that offers behavioral health
24 services and substance abuse treatment [~~of alcohol dependency]~~
25 pursuant to a written treatment plan approved and monitored by

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1 a physician or meeting the quality standards of the behavioral
2 health services division of the human services department and
3 which facility also:

4 (1) is affiliated with a hospital under a
5 contractual agreement with an established system for patient
6 referral;

7 (2) is accredited as [~~such~~] a substance abuse
8 treatment facility by the joint commission [~~on accreditation of~~
9 ~~hospitals~~]; or

10 (3) meets at least the minimum standards
11 adopted by the behavioral health services division for the
12 provision of behavioral health services and the treatment of
13 [~~alcoholism~~] substance abuse in regional treatment centers.

14 C. This section applies to policies 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 policyholder, whichever is later; provided that this section
19 does not apply to blanket, short-term travel, accident-only,
20 limited or specified disease, individual conversion policies or
21 policies designed for issuance to persons eligible for coverage
22 under Title 18 of the Social Security Act, known as medicare,
23 or any other similar coverage under state or federal
24 governmental plans. With respect to any policy forms approved
25 by the office of superintendent of insurance [~~division of the~~

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1 ~~public regulation commission~~] prior to the effective date of
2 this section, an insurer is authorized to comply with this
3 section by the use of endorsements or riders, provided such
4 endorsements or riders are approved by the office of
5 superintendent of insurance [~~division~~] as being in compliance
6 with this section and applicable provisions of the Insurance
7 Code.

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

17 SECTION 32. Section 59A-23-7.2 NMSA 1978 (being Laws
18 1994, Chapter 64, Section 5, as amended) is amended to read:

19 "59A-23-7.2. COVERAGE OF CHILDREN.--

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

- 23 (1) was born out of wedlock;
24 (2) is not claimed as a dependent on the
25 parent's federal tax return; or

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

3 B. When a child has health coverage through an
4 insurer of a noncustodial parent, the insurer 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 and
18 the parent is eligible for family health coverage, the insurer
19 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 restrictions;

23 (2) if the parent is enrolled but fails to
24 make application to obtain coverage for the child, to enroll
25 the child under family coverage upon application of the child's

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1 other parent, the state agency administering the medicaid
2 program or the state agency administering 42 U.S.C. Sections
3 651 through 669, the child support enforcement program; and

4 (3) not to disenroll or eliminate coverage of
5 the child unless the insurer is provided satisfactory written
6 evidence that:

7 (a) the court or administrative order is
8 no longer in effect; or

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

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

19 E. An insurer shall provide coverage for children,
20 from birth through three years of age, for or under the family,
21 infant, toddler program administered by the department of
22 health, provided that eligibility criteria are met [~~for a~~
23 ~~maximum benefit of three thousand five hundred dollars (\$3,500)~~
24 ~~annually~~] for medically necessary early intervention services
25 provided as part of an individualized family service plan and

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1 delivered by certified and licensed personnel as defined in
2 7.30.8 NMAC who are working in early intervention programs
3 approved by the department of health. ~~[No payment under this~~
4 ~~subsection shall be applied against any maximum lifetime or~~
5 ~~annual limits specified in the policy, health benefits plan or~~
6 ~~contract.]"~~

7 SECTION 33. Section 59A-23-7.3 NMSA 1978 (being Laws
8 2003, Chapter 391, Section 3) is amended to read:

9 "59A-23-7.3. MAXIMUM AGE OF ~~[DEPENDENT]~~ CHILD.--Each
10 blanket or group health policy or plan or certificate of
11 insurance delivered, issued for delivery or renewed in New
12 Mexico on or after July 1, 2003 that provides coverage for an
13 insured's ~~[dependent]~~ child shall not terminate coverage of ~~[an~~
14 ~~unmarried dependent]~~ a child by reason of the ~~[dependent's]~~
15 child's age before the ~~[dependent's twenty-fifth]~~ child's
16 twenty-sixth birthday ~~[regardless of whether the dependent is~~
17 ~~enrolled in an educational institution]."~~

18 SECTION 34. Section 59A-23-7.9 NMSA 1978 (being Laws
19 2009, Chapter 74, Section 2) is amended to read:

20 "59A-23-7.9. COVERAGE FOR AUTISM SPECTRUM DISORDER
21 DIAGNOSIS AND TREATMENT.--

22 A. A blanket or group health insurance policy, plan
23 or contract that is delivered, issued for delivery or renewed
24 in this state shall provide coverage to an eligible individual
25 who is nineteen years of age or younger or an eligible

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1 individual who is twenty-two years of age or younger and is
2 enrolled in high school for:

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

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

8 B. Coverage required pursuant to Subsection A of
9 this section:

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

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

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

22 ~~(3)]~~ (2) shall not be denied on the basis that
23 the services are habilitative or rehabilitative in nature;

24 ~~[(4)]~~ (3) may be subject to other general
25 exclusions and limitations of the insurer's policy or plan,

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[bracketed material] = delete

1 including, but not limited to, coordination of benefits,
2 participating provider requirements, restrictions on services
3 provided by family or household members and utilization review
4 of health care services, including the review of medical
5 necessity, case management and other managed care provisions;
6 and

7 [~~(5)~~] (4) may be limited to exclude coverage
8 for services received under the federal Individuals with
9 Disabilities Education Improvement Act of 2004 and related
10 state laws that place responsibility on state and local school
11 boards for providing specialized education and related services
12 to children three to twenty-two years of age who have autism
13 spectrum disorder.

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

22 D. An insurer shall not deny or refuse to issue
23 health insurance coverage for medically necessary services or
24 refuse to contract with, renew, reissue or otherwise terminate
25 or restrict health insurance coverage for an individual because

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1 the individual is diagnosed as having autism spectrum disorder.

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

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

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

17 G. The provisions of this section shall not apply
18 to plans or policies 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 plans or policies.

23 H. As used in this section:

- 24 (1) "autism spectrum disorder" means a
25 condition that meets the diagnostic criteria for the pervasive

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

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

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

14 SECTION 35. A new section of Chapter 59A, Article 23 NMSA
15 1978 is enacted to read:

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

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

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

24 (2) except as provided in Subsection B of this
25 section, annual limits on the dollar value of benefits for any

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1 participant or beneficiary.

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

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

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

24 "[NEW MATERIAL] CHILD DEFINED.--For the purposes of
25 Chapter 59A, Article 23 NMSA 1978, "child" means an individual

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1 under twenty-six years of age whom the principal insured covers
2 or whom the applicant for coverage applies to cover, regardless
3 of the individual's financial dependency, residency with a
4 parent, student status, employment or marital status."

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

7 "[NEW MATERIAL] DIRECT SERVICES.--

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

18 B. An insurer that fails to comply with the
19 eighty-five percent reimbursement requirement in Subsection A
20 of this section shall issue a rebate to all policyholders in an
21 amount sufficient to assure that the benefits paid in the
22 preceding three calendar years plus the amount of the dividends
23 or credits equal eighty-five percent of the premiums collected
24 in the preceding three calendar years. If the insurer fails to
25 issue the dividend or credit in accordance with the

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1 requirements of this section, the superintendent shall enforce
2 the requirements and may pursue any other penalties as provided
3 by law, including general penalties pursuant to Section
4 59A-1-18 NMSA 1978.

5 C. After notice and hearing, the superintendent may
6 adopt and promulgate reasonable rules necessary and proper to
7 carry out the provisions of this section.

8 D. For the purposes of this section:

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

21 (2) "health insurer" means a person duly
22 authorized to transact the business of health insurance in the
23 state pursuant to the Insurance Code but does not include a
24 person that only issues a limited-benefit policy intended to
25 supplement major medical coverage, including medicare

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1 supplement, vision, dental, disease-specific, accident-only or
2 hospital indemnity-only insurance policies, or that only issues
3 policies for long-term care or disability income; and

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

13 SECTION 38. A new section of Chapter 59A, Article 23 NMSA
14 1978 is enacted to read:

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

16 A. A health insurer or insurer providing coverage
17 under a group or blanket health plan or policy shall not
18 rescind coverage under a group or blanket health policy or with
19 respect to an individual, including a group to which the
20 individual belongs or family coverage in which the individual
21 is included, after the individual is covered under the plan or
22 policy, unless a covered 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, as prohibited by the terms of the plan or
2 policy.

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

12 C. The provisions of this section apply regardless
13 of any applicable contestability period."

14 SECTION 39. A new section of Chapter 59A, Article 23 NMSA
15 1978 is enacted to read:

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

18 A. Except as provided pursuant to Subsection B of
19 this section, a health insurer that offers a health benefit
20 plan providing group coverage in the state shall issue coverage
21 to any employer that applies for such plan and agrees to make
22 the required premium payments and to satisfy the other
23 reasonable provisions of the coverage. An insurer:

24 (1) shall offer coverage to all of the
25 eligible employees of the employer and their children and

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1 dependents who apply for enrollment during the period in which
2 the employee first becomes eligible to enroll under the terms
3 of the plan; and

4 (2) shall not offer coverage to only certain
5 individuals or certain children or dependents of employees in
6 the group or to only part of the group.

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

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

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

17 (3) within the geographic service area for the
18 network plan where the insurer reasonably anticipates, and
19 demonstrates to the satisfaction of the superintendent, that it
20 will not have the capacity within its established geographic
21 service area to deliver service adequately to the members of
22 the groups because of its obligations to existing group
23 policyholders and enrollees.

24 C. A health insurer may restrict enrollment in
25 coverage described in Subsection A of this section to open or

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1 special enrollment periods; provided that any special
2 enrollment period shall comply with the provisions of Section
3 40 of this 2013 act and rules that the superintendent has
4 promulgated.

5 D. A health insurer may impose a waiting period not
6 to exceed ninety days before payment for any service related to
7 a preexisting condition. A health insurer shall offer or make
8 a referral to a transition product to provide coverage during
9 the waiting period due to a preexisting condition.

10 E. A health insurer shall renew any coverage at the
11 option of the employer, except as the superintendent has
12 provided by rule.

13 F. For the purposes of this section:

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

24 (2) "preexisting condition" means a physical
25 or mental condition for which medical advice, medication,

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1 diagnosis, care or treatment was recommended for or received by
2 an applicant for health insurance within six months before the
3 effective date of coverage, except that pregnancy is not
4 considered a preexisting condition for federally defined
5 individuals."

6 SECTION 40. A new section of Chapter 59A, Article 23 NMSA
7 1978 is enacted to read:

8 "[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY
9 REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--
10 OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

11 A. For health plan or policy years beginning on or
12 after September 23, 2010, if a child's coverage ended or did
13 not begin for the reasons described in Subsection E of this
14 section, a health insurer shall provide the child an
15 opportunity to enroll in a health plan or policy for which
16 coverage continues for at least sixty days and provide written
17 notice of the opportunity to enroll, as described in Subsection
18 B of this section, no later than the first day of the plan or
19 policy year.

20 B. A written notice of the opportunity to enroll
21 provided pursuant to this section shall include a statement
22 that children whose coverage ended, who were denied coverage or
23 who were not eligible for coverage because dependent coverage
24 of children was unavailable before the child reached twenty-six
25 years of age are eligible to enroll in coverage. This notice

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1 may be provided to a principal insured on behalf of the
2 principal insured's child. For a group plan or policy, the
3 notice may be included with other enrollment materials that the
4 health insurer distributes to employees, provided the statement
5 is prominent. If the notice is provided to an employee whose
6 child is entitled to an enrollment opportunity under Subsection
7 A of this section, the obligation to provide the notice of
8 enrollment opportunity under this subsection is satisfied for
9 both the individual or group health insurance policy, health
10 care plan or certificate of health insurance and the health
11 insurer.

12 C. For an individual who enrolls in a group health
13 insurance policy, health care plan or certificate of health
14 insurance pursuant to Subsection A of this section, the
15 coverage shall take effect not later than the first day of the
16 first policy or plan year.

17 D. A child enrolling pursuant to this section in a
18 group health insurance policy, health care plan or certificate
19 of health insurance shall be considered a "special enrollee"
20 pursuant to Section 59A-23E-8 NMSA 1978. The child and the
21 principal insured shall be offered all of the benefit packages
22 available to similarly situated individuals who were denied
23 coverage or whose coverage ended by reason of cessation of
24 dependent status. Any difference in benefits or cost-sharing
25 requirements constitutes a different benefit package. The

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1 child shall not be required to pay more for coverage than
2 similarly situated individuals who did not lose coverage by
3 reason of cessation of dependent status.

4 E. The provisions of this section shall apply to a
5 child:

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

12 (2) who became eligible, or is required to
13 become eligible, for coverage on the first day of the first
14 health plan or policy year, beginning on or after September 23,
15 2010, by reason of the provisions of this section."

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

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

20 A. A blanket or group health insurance policy, plan
21 or contract that is delivered, issued for delivery or renewed
22 in this state on behalf of an employer shall not discriminate
23 in favor of highly compensated individuals as to eligibility to
24 participate or as to the benefits offered. The benefits
25 provided for participants who are highly compensated

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1 individuals shall be provided for all other participants.

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

4 (1) seventy percent or more of all of that
5 employer's employees;

6 (2) eighty percent or more of all of that
7 employer's employees who are eligible to benefit under the
8 policy, plan or contract if seventy percent or more of all
9 employees are eligible to benefit; or

10 (3) any employees that qualify under a
11 classification that the employer has established and that the
12 secretary of the United States department of health and human
13 services has approved.

14 C. An employer may exclude the following types of
15 employees from an offering of health coverage under Subsections
16 A and B of this section:

17 (1) employees who have not completed three
18 years of service;

19 (2) employees who have not attained twenty-
20 five years of age;

21 (3) part-time or seasonal employees;

22 (4) employees not included in the policy, plan
23 or contract who are included in a unit of employees covered by
24 an agreement between employee representatives and one or more
25 employers that the secretary of the United States department of

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1 health and human services has found to be a collective
2 bargaining agreement, if accident and health benefits were the
3 subject of good-faith bargaining between these employee
4 representatives and the employer or employers; and

5 (5) employees who are nonresident aliens of
6 the United States and who receive no earned income, within the
7 meaning of Section 911(d)(2) of the federal Internal Revenue
8 Code of 1986, from the employer, that constitutes income from
9 sources within the United States, as defined in Section
10 861(a)(3) of the federal Internal Revenue Code of 1986.

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

13 (1) one of the five highest paid officers of
14 an employer;

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

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

21 SECTION 42. A new section of Chapter 59A, Article 23 NMSA
22 1978 is enacted to read:

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

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 not limit or exclude
3 coverage under a group health benefit plan for an individual
4 under the age of nineteen by imposing a preexisting condition
5 exclusion on that individual.

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

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

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

21 E. Each health insurer shall provide prior
22 prominent public notice on its web site and written notice to
23 each of its policyholders or plan holders annually at least
24 ninety days before any open enrollment period of the open
25 enrollment rights for individuals under the age of nineteen and

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1 shall provide information as to how an individual eligible for
2 this open enrollment right may apply for coverage with the
3 insurer during an open enrollment period."

4 SECTION 43. A new section of Chapter 59A, Article 23 NMSA
5 1978 is enacted to read:

6 "[NEW MATERIAL] EMERGENCY SERVICES.--

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

12 (1) without the need for any prior
13 authorization determination; and

14 (2) whether or not the health care provider
15 furnishing emergency services is a participating provider with
16 respect to emergency services.

17 B. If emergency services are provided to a covered
18 individual by a nonparticipating health care provider with or
19 without prior authorization, the services shall be provided
20 without imposing any requirement under the policy, plan or
21 certificate for prior authorization of services or any
22 limitation on coverage where the provider of services does not
23 have a contractual relationship with the insurer for the
24 provision of services that is more restrictive than the
25 requirements or limitations that apply to emergency department

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1 services received from providers who do have such a contractual
2 relationship with the health insurer.

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

12 D. The provisions of this section shall not apply
13 to:

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

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

22 E. As used in this section:

23 (1) "emergency medical condition" means a
24 medical condition manifesting itself by acute symptoms of
25 sufficient severity, including severe pain, such that a prudent

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1 layperson who possesses an average knowledge of health and
2 medicine could reasonably expect the absence of immediate
3 medical attention to result in one of the following conditions:

4 (a) placing the health of the individual
5 or, with respect to a pregnant woman, the health of the woman
6 or her unborn child, in serious jeopardy;

7 (b) serious impairment to bodily
8 functions; or

9 (c) serious dysfunction of any bodily
10 organ or part;

11 (2) "emergency services" means, with respect
12 to an emergency medical condition:

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

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

25 (3) "stabilize" means:

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

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

8 SECTION 44. A new section of Chapter 59A, Article 23 NMSA
9 1978 is enacted to read:

10 "[NEW MATERIAL] OPTION FOR PEDIATRICIAN AS PRIMARY CARE
11 PROVIDER.--

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

22 B. Nothing in Subsection A of this section shall be
23 construed to waive any exclusions of coverage under the terms
24 and conditions of the health insurance policy or health care
25 plan with respect to coverage of pediatric care.

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

8 SECTION 45. A new section of Chapter 59A, Article 23 NMSA
9 1978 is enacted to read:

10 "[NEW MATERIAL] OBSTETRICAL AND GYNECOLOGICAL CARE
11 OPTION.--

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

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1 pursuant to a treatment plan approved by the policy, plan or
2 issuer.

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

9 C. Nothing in Subsection A of this section shall be
10 construed to:

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

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

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

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1 SECTION 46. A new section of Chapter 59A, Article 23 NMSA
2 1978 is enacted to read:

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

5 A. A health insurer providing coverage under a
6 group or blanket health insurance policy, plan or certificate
7 of coverage shall provide coverage for all of the preventive
8 items and services pursuant to Sections 47 through 51 of this
9 2013 act, and shall not impose any cost-sharing requirements,
10 such as a copayment, coinsurance or deductible.

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

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

19 D. To the extent that a preventive care provision
20 in this section conflicts with any other preventive health care
21 law in New Mexico, the provision providing the greatest level
22 of coverage shall apply. The preventive care provisions in
23 this section are intended to supplement rather than supplant
24 existing preventive health care provisions in this state.

25 E. The superintendent shall at least annually

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1 revise the preventive services standards established pursuant
2 to Sections 47 through 51 of this 2013 act to ensure that they
3 are consistent with the recommendations of the United States
4 preventive services task force, the advisory committee on
5 immunization practices of the federal centers for disease
6 control and prevention and the guidelines with respect to
7 infants, children, adolescents and women of evidence-based
8 preventive care and screenings by the federal health resources
9 and services administration. When changes are made to any of
10 these guidelines or recommendations, the superintendent shall
11 make recommendations to the legislature for legislative changes
12 to conform these standards to current guidelines and
13 recommendations.

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

19 G. A health insurer shall not impose cost-sharing
20 requirements with respect to an office visit for an item or
21 service provided pursuant to this section if an item or service
22 is not billed separately or is not tracked as individual
23 encounter data separately from the office visit and the primary
24 purpose of the office visit is the delivery of the preventive
25 item or service.

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

8 I. 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 47. A new section of Chapter 59A, Article 23 NMSA
15 1978 is enacted to read:

16 "[NEW MATERIAL] COVERAGE FOR SMOKING AND TOBACCO CESSATION
17 TREATMENT.--

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

24 B. A group or blanket health insurance policy,
25 health care plan or certificate of health insurance that is

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1 delivered or issued for delivery in this state shall:

2 (1) offer tobacco cessation intervention
3 coverage for those who use tobacco products;

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

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

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

15 SECTION 48. A new section of Chapter 59A, Article 23 NMSA
16 1978 is enacted to read:

17 "[NEW MATERIAL] PREVENTIVE SERVICES BENEFITS--ASPIRIN
18 REGIMEN--HIGH BLOOD PRESSURE SCREENING--BREAST CANCER
19 SCREENING--LIPID DISORDERS SCREENING--COLORECTAL CANCER
20 SCREENING--DEPRESSION SCREENING--BEHAVIORAL DIETARY
21 COUNSELING--OBESITY COUNSELING AND SCREENING--OSTEOPOROSIS
22 SCREENING--FALLS PREVENTION--SKIN CANCER COUNSELING--HUMAN
23 IMMUNODEFICIENCY VIRUS SCREENING--HEPATITIS C
24 SCREENING--ALCOHOL MISUSE SCREENING AND COUNSELING.--

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 paragraph
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 individuals six years of age and older;
18 (12) screening for osteoporosis for:
19 (a) women who are sixty-five years of
20 age and older; and
21 (b) women who are under sixty-five years
22 of age who are at increased risk for osteoporotic fractures;
23 (13) exercise or physical therapy to prevent
24 falls in community-dwelling adults aged sixty-five years or
25 older who are at increased risk for falls;

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1 (14) counseling of individuals at increased
2 risk for skin cancer by minimizing their exposure to
3 ultraviolet radiation;

4 (15) screening for human immunodeficiency
5 virus, also known as "HIV" for:

6 (a) individuals age fifteen to sixty-
7 five years of age; and

8 (b) individuals of any age who are at
9 increased risk of infection;

10 (16) screening for hepatitis C virus, also
11 known as "HCV", infection in adults at high risk of infection,
12 including:

13 (a) individuals with any history of
14 intravenous drug use; or

15 (b) individuals who received a blood
16 transfusion before the year 1992; and

17 (17) screening and behavioral counseling
18 interventions for alcohol misuse for patients in primary care
19 settings.

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

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1 SECTION 49. A new section of Chapter 59A, Article 23 NMSA
2 1978 is enacted to read:

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

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

10 (1) oral fluoride supplementation at currently
11 recommended doses to children over six months of age whose
12 primary water sources are deficient in fluoride;

13 (2) prophylactic ocular topical medication
14 against gonococcal ophthalmia neonatorum for newborns;

15 (3) screening for hearing loss in newborns;

16 (4) screening for sickle cell disease for
17 newborns;

18 (5) screening for congenital hypothyroidism
19 for newborns;

20 (6) iron supplementation for asymptomatic
21 children six to twelve months of age who are at increased risk
22 for iron deficiency anemia;

23 (7) screening for phenylketonuria in newborns;

24 (8) screening to detect amblyopia, strabismus
25 and defects in visual acuity in children less than five years

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1 of age;

2 (9) counseling of individuals at increased
3 risk for skin cancer to minimize their exposure to ultraviolet
4 radiation; and

5 (10) interventions, including education or
6 brief counseling, to prevent initiation of tobacco use among
7 school-aged children and adolescents.

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 50. A new section of Chapter 59A, Article 23 NMSA
15 1978 is enacted to read:

16 "[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--
17 REPRODUCTIVE HEALTH.--

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

24 (1) screening for asymptomatic bacteriuria
25 with a urine culture for pregnant women;

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

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

3 (10) screening for hepatitis B virus infection
4 in pregnant women;

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

8 (12) screening for iron deficiency anemia in
9 asymptomatic pregnant women;

10 (13) screening for syphilis for:

11 (a) any individual at increased risk for
12 syphilis infection; and

13 (b) any pregnant woman;

14 (14) screening of pregnant women for human
15 immunodeficiency virus, also known as "HIV", including those
16 who present at labor whose human immunodeficiency virus status
17 is unknown;

18 (15) screening of women of childbearing age
19 for intimate partner violence, including domestic violence, and
20 referral to or provision of intervention services to
21 individuals whose screening shows a positive result. Nothing
22 in this section shall be construed as a waiver or exception to
23 the Domestic Abuse Insurance Protection Act; and

24 (16) screening and behavioral counseling
25 interventions for pregnant women in primary care settings for

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1 alcohol misuse.

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] CHILDHOOD IMMUNIZATION COVERAGE
11 REQUIRED.--

12 A. Each group or blanket health insurance policy,
13 plan and certificate of health insurance delivered or issued
14 for delivery in this state shall provide coverage for childhood
15 immunizations, as well as coverage for medically necessary
16 booster doses of all immunizing agents used in child
17 immunizations, in accordance with the current schedule of
18 immunizations recommended by the American academy of
19 pediatrics, the advisory committee on immunization practices of
20 the federal centers for disease control and prevention or the
21 United States preventive services task force "A"-rated and "B"-
22 rated recommendations, whichever provides greater coverage.

23 B. The provisions of this section shall not apply
24 to short-term travel, accident-only or limited or specified
25 disease plans or policies."

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1 SECTION 52. Section 59A-23B-3 NMSA 1978 (being Laws 1991,
2 Chapter 111, Section 3, as amended) is amended to read:

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

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

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

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

25 (a) a group that has been in existence

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1 for less than six months and has been without healthcare
2 coverage since the formation of the group;

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

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

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

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

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

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

24 (3) subject to a maximum limit on the cost of
25 healthcare services covered in any calendar year of not less

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1 than fifty thousand dollars (\$50,000) and, effective for
2 policies written or renewed on or after January 1, 2009, of not
3 less than one hundred thousand dollars (\$100,000), adjusted for
4 changes not to exceed the medical price index component of the
5 federal department of labor's consumer price index at intervals
6 and in a manner established by rule pursuant to the Minimum
7 Healthcare Protection Act, the policy or plan provides the
8 following minimum healthcare services to covered individuals:

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

15 (b) prenatal care, including a minimum
16 of one prenatal office visit per month during the first two
17 trimesters of pregnancy, two office visits per month during the
18 seventh and eighth months of pregnancy and one office visit per
19 week during the ninth month and until term; provided that
20 coverage for each office visit shall also include prenatal
21 counseling and education and necessary and appropriate
22 screening, including history, physical examination and the
23 laboratory and diagnostic procedures deemed appropriate by the
24 physician based upon recognized medical criteria for the risk
25 group of which the patient is a member;

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

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

15 (e) coverage for low-dose screening
16 mammograms for determining the presence of breast cancer;
17 provided that the mammogram coverage shall include one baseline
18 mammogram for persons age thirty-five through thirty-nine
19 years, one biennial mammogram for persons age forty through
20 forty-nine years and one annual mammogram for persons age fifty
21 years and over; and further provided that the mammogram
22 coverage shall only be subject to deductibles and co-insurance
23 requirements consistent with those imposed on other benefits
24 under the same policy or plan;

25 (f) coverage for cytologic screening, to

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1 include a Papanicolaou test and pelvic exam for asymptomatic as
2 well as symptomatic women;

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

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

17 (i) coverage for smoking cessation
18 treatment; and

19 (j) coverage for mastectomies and lymph
20 node dissections for the treatment of breast cancer.

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

23 (1) a panel of providers who have entered into
24 written agreements with the insurer, fraternal benefit society,
25 health maintenance organization or nonprofit healthcare plan to

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

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

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

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

23 D. Nothing contained in Subsection C of this
24 section shall prohibit an insurer, fraternal benefit society,
25 health maintenance organization or nonprofit healthcare plan

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1 from including in the policy or plan additional managed care
2 and cost control provisions that the superintendent determines
3 to have the potential for controlling costs in a manner that
4 does not cause discriminatory treatment of individuals,
5 families or groups covered by the policy or plan.

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

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

22 SECTION 53. Section 59A-23B-6 NMSA 1978 (being Laws 1991,
23 Chapter 111, Section 6, as amended) is amended to read:

24 "59A-23B-6. FORMS AND RATES--APPROVAL OF THE
25 SUPERINTENDENT--UNIFORM HEALTH COVERAGE DOCUMENTS--STANDARDIZED

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1 DEFINITIONS--ADJUSTED COMMUNITY RATING.--

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

7 B. No health insurance policy or plan may be issued
8 in the state unless the rates have first been filed with and
9 approved by the superintendent. This subsection shall not
10 apply to policies or plans subject to the Small Group Rate and
11 Renewability Act.

12 C. A health insurer, health maintenance
13 organization or nonprofit health care plan that offers an
14 individual policy, plan, evidence of coverage or certificate of
15 insurance issued for delivery in the state shall comply with
16 the uniform standards that the superintendent has established
17 by rule for the following documents issued by each policy,
18 plan, evidence of coverage or certificate issued in the state
19 relating to:

- 20 (1) a summary of benefits;
- 21 (2) an explanation of coverage;
- 22 (3) definitions of standard insurance terms
23 and medical terms;
- 24 (4) exceptions, reductions and limitations on
25 coverage;

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1 (5) cost-sharing provisions, including
2 deductible, coinsurance and copayment obligations;

3 (6) the renewability and continuation of
4 coverage provisions;

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

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

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

15 (b) ensures that the policy's, plan's,
16 evidence of coverage's or certificate's share of the total
17 allowed costs of benefits provided under the policy, plan,
18 evidence of coverage or certificate is not less than sixty
19 percent of those costs; and

20 (9) a contact number for the consumer to call
21 with additional questions and an internet web address where a
22 copy of the actual individual or group health policy, plan,
23 evidence of coverage or certificate can be reviewed and
24 obtained.

25 D. Prior to any enrollment restriction, an insurer,

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1 health maintenance organization or nonprofit health care plan
2 shall provide a summary of benefits and coverage explanation
3 required pursuant to Subsection A of this section to the
4 following persons:

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

6 (2) an enrollee or subscriber, prior to the
7 time of enrollment or re-enrollment, subscription or re-
8 subscription; and

9 (3) a policyholder, plan holder, evidence of
10 coverage holder, subscriber or certificate holder, at the time
11 of issuance of the policy, plan or evidence of coverage or the
12 delivery of the certificate.

13 ~~[G.]~~ E. In determining the initial year's premium
14 or rate charged for coverage under a policy or plan, the only
15 rating factors that may be used are age, ~~[gender pursuant to~~
16 ~~this subsection]~~ geographic area of the place of employment and
17 smoking practices, except that for individual policies the
18 rating factor of the individual's place of residence may be
19 used instead of the geographic area of the individual's place
20 of employment. ~~[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 ~~D.]~~ F. No person's rate shall exceed the rate of
8 any other person [~~with similar family composition~~] by more than
9 two hundred fifty percent of the lower rate, except that the
10 rates for children under the age of nineteen or children aged
11 nineteen to twenty-five who are full-time students may be as
12 much as three hundred percent lower than the [~~bottom~~] highest
13 age-based rates [~~in the two hundred fifty percent band. The~~
14 ~~rating factor restrictions shall not prohibit an insurer,~~
15 ~~society, organization or plan from offering rates that differ~~
16 ~~depending upon family composition].~~

17 G. 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 H. 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 ~~[E.]~~ I. The provisions of this section do not

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1 preclude an insurer, fraternal benefit society, health
2 maintenance organization or nonprofit health care plan from
3 using health status or occupational or industry classification
4 in establishing:

5 (1) rates for individual policies; or

6 (2) the amount an employer may be charged for
7 coverage under a group health plan.

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

10 ~~G.]~~ J. The superintendent shall adopt regulations
11 to implement the provisions of this section."

12 SECTION 54. Section 59A-23C-5.1 NMSA 1978 (being Laws
13 1994, Chapter 75, Section 33, as amended) is amended to read:

14 "59A-23C-5.1. ADJUSTED COMMUNITY RATING.--

15 A. A health benefit plan that is offered by a
16 carrier to a small employer shall be offered without regard to
17 the health status of any individual in the group, except as
18 provided in the Small Group Rate and Renewability Act. The
19 only rating factors that may be used to determine the initial
20 year's premium charged a group, subject to the maximum rate
21 variation provided in this section for all rating factors, are
22 the group members':

23 (1) ages;

24 ~~[(2) genders pursuant to Subsection B of this~~
25 ~~section;~~

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1 ~~(3)~~ (2) geographic areas of the place of
2 employment; or

3 ~~(4)~~ (3) smoking practices.

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

12 ~~(1) twenty percent for calendar year 2010;~~

13 ~~(2) fifteen percent for calendar year 2011;~~

14 ~~(3) ten percent for calendar year 2012; and~~

15 ~~(4) five percent for calendar year 2013.~~

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

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1 C. No person's rate shall exceed the rate of any
2 other person on the basis of geographic rating area by an
3 amount that the superintendent shall establish by rule, after
4 review by the United States department of health and human
5 services.

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

9 [~~D.~~] E. The provisions of this section do not
10 preclude a carrier from using health status or occupational or
11 industry classification in establishing the amount an employer
12 may be charged for coverage under a group health plan.

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

15 F. The superintendent shall adopt regulations to
16 implement the provisions of this section."

17 SECTION 55. Section 59A-23C-6 NMSA 1978 (being Laws 1991,
18 Chapter 153, Section 6) is amended to read:

19 "59A-23C-6. PROVISIONS ON RENEWABILITY OF COVERAGE.--

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

- 25 (1) nonpayment of required premiums;

underscored material = new
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1 (2) ~~[fraud or misrepresentation of the small~~
2 ~~employer, or with respect to coverage of an insured individual,~~
3 ~~fraud or misrepresentation by the insured individual or that~~
4 ~~individual's representative]~~ an act by a covered employee or
5 dependent that constitutes:

6 (a) fraud; or

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

9 (3) noncompliance with plan provisions;

10 (4) the number of individuals covered under
11 the plan is less than the number or percentage of eligible
12 individuals required by percentage requirements under the plan;
13 or

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

17 Eligibility classifications may not be changed if any
18 individual is eliminated, due to the change, who was insured
19 immediately prior to the change without first receiving the
20 approval of the superintendent.

21 B. A small employer carrier may cease to renew all
22 plans under a class of business. The carrier shall provide
23 notice to all affected health benefit plans and to the
24 superintendent in each state in which an affected insured
25 individual is known to reside at least ninety days prior to

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1 termination of coverage. A carrier [~~which~~] that exercises its
2 right to cease to renew all plans in a class of business shall
3 not:

4 (1) establish a new class of business for a
5 period of five years after the nonrenewal of the plans without
6 prior approval of the superintendent; or

7 (2) transfer or otherwise provide coverage to
8 any of the employers from the nonrenewed class of business
9 unless the insurer offers to transfer or provide coverage to
10 all affected employers and eligible employees and dependents
11 without regard to case characteristics, claim experience,
12 health status or duration of coverage.

13 C. A small employer carrier may not change
14 eligibility classifications upon renewal or replacement within
15 twelve months of its termination of its own coverage if the
16 change in classification eliminates from coverage any
17 individual who was insured previous to the change and would
18 have continued to be insured if the change in eligibility had
19 not occurred."

20 **SECTION 56.** Section 59A-23C-10 NMSA 1978 (being Laws
21 2010, Chapter 94, Section 2) is amended to read:

22 "59A-23C-10. HEALTH INSURERS--DIRECT SERVICES.--

23 A. A health insurer shall make reimbursement for
24 direct services at a level not less than eighty-five percent of
25 premiums across all health product lines, except individually

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1 underwritten health insurance policies, contracts or plans,
2 that are governed by the provisions of Chapter 59A, Article 22
3 NMSA 1978, the Health Maintenance Organization Law and the
4 Nonprofit Health Care Plan Law. Reimbursement shall be made
5 for direct services provided over the preceding three calendar
6 years, but not earlier than calendar year 2010, as determined
7 by reports filed with the insurance division of the commission.
8 Nothing in this subsection shall be construed to preclude a
9 purchaser from negotiating an agreement with a health insurer
10 that requires a higher amount of premiums paid to be used for
11 reimbursement for direct services for one or more products or
12 for one or more years.

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

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1 by the superintendent pursuant to this subsection over the
2 three calendar years preceding the date upon which that rate is
3 established, but not earlier than calendar year 2010. Nothing
4 in this subsection shall be construed to preclude a purchaser
5 of one of these policies, plans or contracts from negotiating
6 an agreement with a health insurer that requires a higher
7 amount of premiums paid to be used for reimbursement for direct
8 services.

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

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1 Section 59A-1-18 NMSA 1978.

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

5 E. For the purposes of this section:

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

18 (2) "health insurer" means a person duly
19 authorized to transact the business of health insurance in the
20 state pursuant to the Insurance Code but does not include a
21 person that only issues a limited-benefit policy intended to
22 supplement major medical coverage, including medicare
23 supplement, vision, dental, disease-specific, accident-only or
24 hospital indemnity-only insurance policies, or that only issues
25 policies for long-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 insurers
6 and interests less any premium tax paid pursuant to Section
7 59A-6-2 NMSA 1978 and fees associated with participating in a
8 health insurance exchange that serves as a clearinghouse for
9 insurance."

10 SECTION 57. Section 59A-23D-2 NMSA 1978 (being Laws 1995,
11 Chapter 93, Section 2, as amended) is amended to read:

12 "59A-23D-2. DEFINITIONS.--As used in the Medical Care
13 Savings Account Act:

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

- 16 (1) a national or state chartered bank,
17 savings and loan association, savings bank or credit union;
- 18 (2) a trust company authorized to act as a
19 fiduciary in this state;
- 20 (3) an insurance company or health maintenance
21 organization authorized to do business in this state pursuant
22 to the [~~New Mexico~~] Insurance Code; or
- 23 (4) a person approved by the federal secretary
24 of health and human services;

25 B. "deductible" means the total covered medical

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[bracketed material] = delete

1 expense an employee or [~~his~~] the employee's dependents must pay
2 prior to any payment by a qualified higher deductible health
3 plan for a calendar year;

4 C. "department" means the insurance division of the
5 public regulation commission;

6 D. "dependent" means:

7 (1) a spouse;

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

11 (a) a natural child;

12 (b) a legally adopted child;

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

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

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

23 [~~(3) an unmarried child described in~~
24 ~~Subparagraphs (a) through (e) of Paragraph (2) of this~~
25 ~~subsection who is between the ages of eighteen and twenty-five]~~

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1 or

2 [~~(4)~~] (3) a child over the age of [~~eighteen~~]
3 twenty-six who is incapable of self-sustaining employment by
4 reason of [~~mental retardation~~] cognitive or physical [~~handicap~~]
5 disability and who is chiefly dependent on the employee for
6 support and maintenance;

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

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

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

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

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

19 (3) is covered by a qualified higher
20 deductible health plan that is established and maintained by
21 the employer of the individual or of the spouse of the
22 individual;

23 F. "eligible medical expense" means an expense paid
24 by the employee for medical care described in Section 213(d) of
25 the Internal Revenue Code of 1986 that is deductible for

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1 federal income tax purposes to the extent that those amounts
2 are not compensated for by insurance or otherwise;

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

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

5 I. "medical care savings account" or "savings
6 account" means an account established by an employer in the
7 United States exclusively for the purpose of paying the
8 eligible medical expenses of the employee or dependent, but
9 only if the written governing instrument creating the trust
10 meets the following requirements:

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

13 (a) unless it is in cash; or

14 (b) to the extent the contribution, when
15 added to previous contributions to the trust for the calendar
16 year, exceeds seventy-five percent of the highest annual limit
17 deductible permitted pursuant to the Medical Care Savings
18 Account Act;

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

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

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

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

3 K. "qualified higher deductible health plan" means
4 a health coverage policy, certificate or contract that provides
5 for payments for covered health care benefits that exceed the
6 policy, certificate or contract deductible, that is purchased
7 by an employer for the benefit of an employee and that has the
8 following deductible provisions:

9 (1) self-only coverage with an annual
10 deductible of not less than one thousand five hundred dollars
11 (\$1,500) or more than two thousand two hundred fifty dollars
12 (\$2,250) and a maximum annual out-of-pocket expense requirement
13 of three thousand dollars (\$3,000), not including premiums;

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

19 (3) preventive care coverage may be provided
20 within the policies without the preventive care being subjected
21 to the qualified higher deductibles."

22 SECTION 58. Section 59A-23E-19 NMSA 1978 (being Laws
23 1998, Chapter 41, Section 23) is amended to read:

24 "59A-23E-19. INDIVIDUAL HEALTH INSURANCE COVERAGE--
25 GUARANTEED RENEWABILITY--EXCEPTIONS.--

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1 A. Except as otherwise provided in this section, a
2 health insurance issuer that provides individual health
3 insurance coverage to an individual shall renew or continue
4 that coverage in force at the option of the individual.

5 B. A health insurance issuer may refuse to renew or
6 discontinue health insurance coverage of an individual in the
7 individual market if:

8 (1) the individual has failed to pay premiums
9 or contributions in accordance with the terms of the health
10 insurance coverage or the issuer has not received timely
11 premium payments;

12 (2) the individual has ~~performed an act or~~
13 ~~practice~~ engaged in conduct that constitutes:

14 (a) fraud; or ~~has made~~

15 (b) an intentional misrepresentation of
16 a material fact ~~under~~ as prohibited by the terms of the
17 coverage;

18 (3) the issuer is ceasing to offer coverage in
19 the individual market in accordance with Subsection C of this
20 section;

21 (4) in the case of a health insurance issuer
22 that offers health insurance coverage in the market through a
23 network plan, the individual no longer lives, resides or works
24 in the service area of the issuer or the area for which the
25 issuer is authorized to do business, but only if the coverage

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~~[bracketed material] = delete~~

1 is terminated pursuant to this paragraph uniformly without
2 regard to any health status related factor of covered
3 individuals; and

4 (5) in the case of health insurance coverage
5 that is made available to the individual market only through
6 one or more bona fide associations, the membership of the
7 individual in the association on the basis of which the
8 coverage is provided ceases, but only if the coverage is
9 terminated pursuant to this paragraph uniformly without regard
10 to any health status related factor of covered individuals.

11 C. A health insurance issuer may discontinue
12 offering a particular type of group health insurance coverage
13 offered in the individual market only if:

14 (1) the issuer provides notice to each covered
15 individual provided coverage of this type in the market of the
16 discontinuation at least ninety days prior to the date of the
17 discontinuation;

18 (2) the issuer offers to each individual in
19 the individual market provided coverage of this type the option
20 to purchase any other individual health insurance coverage
21 currently being offered by the issuer for individuals in that
22 market; and

23 (3) in exercising the option to discontinue
24 coverage of this type and in offering the option of coverage
25 pursuant to Paragraph (2) of this subsection, the issuer acts

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1 uniformly without regard to any health status related factor of
2 enrolled individuals or individuals who may become eligible for
3 that coverage.

4 D. If a health insurance issuer elects to
5 discontinue offering all health insurance coverage, the
6 individual coverage may be discontinued only if:

7 (1) the issuer provides notice to the
8 superintendent and to each individual of the discontinuation at
9 least one hundred eighty days prior to the date of the
10 expiration of the coverage; and

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

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

20 F. At the time of coverage renewal pursuant to
21 Subsection A of this section, a health insurance issuer may
22 modify the coverage for a policy form offered to individuals in
23 the individual market if the modification is consistent with
24 law and effective on a uniform basis among all individuals with
25 that policy form.

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1 G. If health insurance coverage is made available
2 by a health insurance issuer in the individual market to an
3 individual only through one or more associations, a reference
4 to an "individual" is deemed to include a reference to that
5 association."

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

8 "59A-44-19. THE BENEFIT CONTRACT.--

9 A. Every society authorized to do business in this
10 state shall issue to each owner of a benefit contract a
11 certificate specifying the amount of benefits provided thereby.
12 The certificate, together with any riders or endorsements
13 attached thereto, the laws of the society, the application for
14 membership, the application for insurance and declaration of
15 insurability, if any, signed by the applicant, and all
16 amendments to each thereof, shall constitute the benefit
17 contract, as of the date of issuance, between the society and
18 the owner, and the certificate shall so state. A copy of the
19 application for insurance and declaration of insurability, if
20 any, shall be endorsed upon or attached to the certificate.
21 All statements on the application shall be representations and
22 not warranties. Any waiver of this provision shall be void.

23 B. Any changes, additions or amendments to the laws
24 of the society duly made or enacted subsequent to the issuance
25 of the certificate shall bind the owner and the beneficiaries

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[bracketed material] = delete

1 and shall govern and control the benefit contract in all
2 respects the same as though such changes, additions or
3 amendments had been made prior to and were in force at the time
4 of the application for insurance, except that no change,
5 addition or amendment shall destroy or diminish benefits
6 [~~which~~] that the society contracted to give the owner as of the
7 date of issuance.

8 C. Any person upon whose life a certificate is
9 issued prior to attaining the age of majority shall be bound by
10 the terms of the application and certificate and by all the
11 laws and rules of the society to the same extent as though the
12 age of majority had been attained at the time of application.

13 D. A society shall provide in its laws that if its
14 reserves as to all or any class of certificates become
15 impaired, its board of directors or corresponding body shall
16 require that there shall be paid by the owner to the society
17 the amount of the owner's equitable proportion of such
18 deficiency as ascertained by its board, and that if the payment
19 is not made, either:

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

23 (2) in lieu of or in combination with the
24 provisions of Paragraph (1) of this subsection, the owner may
25 accept a proportionate reduction in benefits under the

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1 certificate. The society may specify the manner of the
2 election and which alternative is to be presumed if no election
3 is made.

4 E. Copies of any of the documents mentioned in this
5 section, certified by the secretary or corresponding officer of
6 the society, shall be received in evidence of the terms and
7 conditions thereof.

8 F. No certificate shall be delivered or issued for
9 delivery in this state unless a copy of the form and rates and
10 rate increases applicable to accident and health insurance have
11 been filed with and approved by the superintendent in
12 accordance with Sections 59A-18-12, 59A-18-13 and 59A-18-14
13 NMSA 1978. Every life or accident and health insurance
14 certificate and every annuity certificate issued on or after
15 one year from [~~the effective date of this act~~] January 1, 1990
16 shall meet the standard contract provision requirements
17 consistent with Chapter 59A, Article 44 NMSA 1978, as specified
18 in Chapter 59A, Articles 20 and 22 NMSA 1978, except that a
19 society may provide for a grace period for payment of premiums
20 of one full month in its certificates. The certificate shall
21 also contain a provision stating the amount of premiums [~~which~~]
22 that are payable under the certificate and a provision reciting
23 or setting forth the substance of any sections of the society's
24 laws or rules in force at the time of issuance of the
25 certificate [~~which~~] that, if violated, will result in the

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1 termination or reduction of benefits payable under the
2 certificate. If the laws of the society provide for expulsion
3 or suspension of a member, the certificate shall also contain a
4 provision that any member so expelled or suspended, except for
5 nonpayment of a premium or within the contestable period for
6 engaging in conduct that constitutes fraud or an intentional
7 material misrepresentation [~~in the application for membership~~
8 ~~or insurance~~] of fact that is prohibited by the terms of
9 membership, shall have the privilege of maintaining the
10 certificate in force by continuing payment of the required
11 premium.

12 G. Certificates issued on the lives of persons
13 below the society's minimum age for adult membership may
14 provide for transfer of control of ownership to the insured at
15 an age specified in the certificate. A society may require
16 approval of an application for membership in order to effect
17 this transfer and may provide in all other respects for the
18 regulation, government and control of such certificates and all
19 rights, obligations and liabilities incident thereto and
20 connected therewith. Ownership rights prior to such transfer
21 shall be specified in the certificate.

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

24 SECTION 60. Section 59A-46-2 NMSA 1978 (being Laws 1993,
25 Chapter 266, Section 2, as amended) is amended to read:

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[bracketed material] = delete

1 "59A-46-2. DEFINITIONS.--As used in the Health
2 Maintenance Organization Law:

3 A. "basic health care services"

4 [~~(1)~~] means medically necessary services
5 consisting of preventive care, emergency care, inpatient and
6 outpatient hospital and physician care, mental health services,
7 services for alcohol or substance abuse, pediatric dental
8 services, pediatric vision services, diagnostic laboratory,
9 diagnostic and therapeutic radiological services and services
10 of pharmacists and pharmacist clinicians. [~~but~~

11 ~~(2) does not~~] An individual plan shall include
12 mental health services [or] and services for [alcohol or drug]
13 substance abuse [dental or vision services or long-term
14 rehabilitation treatment];

15 B. "capitated basis" means fixed per member per
16 month payment or percentage of premium payment wherein the
17 provider assumes the full risk for the cost of contracted
18 services without regard to the type, value or frequency of
19 services provided and includes the cost associated with
20 operating staff model facilities;

21 C. "carrier" means a health maintenance
22 organization, an insurer, a nonprofit health care plan or other
23 licensed entity responsible for the payment of benefits or
24 provision of services under a group contract;

25 D. "child" means an individual who is related to a

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1 principal enrollee or applicant for insurance or other coverage
2 pursuant to the Health Maintenance Organization Law by birth or
3 adoption;

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

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

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

13 ~~[G.]~~ H. "evidence of coverage" means a policy,
14 contract or certificate showing the essential features and
15 services of the health maintenance organization coverage that
16 is given to the subscriber by the health maintenance
17 organization or by the group contract holder;

18 ~~[H.]~~ I. "extension of benefits" means the
19 continuation of coverage under a particular benefit provided
20 under a contract or group contract following termination with
21 respect to an enrollee who is totally disabled on the date of
22 termination;

23 ~~[I.]~~ J. "grievance" means a written complaint
24 submitted in accordance with the health maintenance
25 organization's formal grievance procedure by or on behalf of

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~~[bracketed material]~~ = delete

1 the enrollee regarding any aspect of the health maintenance
2 organization relative to the enrollee;

3 ~~[J-]~~ K. "group contract" means a contract for
4 health care services that by its terms limits eligibility to
5 members of a specified group and may include coverage for
6 dependents;

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

9 ~~[L-]~~ M. "health care services" means any services
10 included in the furnishing to any individual of medical,
11 mental, dental, pharmaceutical or optometric care or
12 hospitalization or nursing home care or incident to the
13 furnishing of such care or hospitalization, as well as the
14 furnishing to any person of any and all other services for the
15 purpose of preventing, alleviating, curing or healing human
16 physical or mental illness or injury;

17 ~~[M-]~~ N. "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;

22 ~~[N-]~~ O. "health maintenance organization agent"
23 means a person who solicits, negotiates, effects, procures,
24 delivers, renews or continues a policy or contract for health
25 maintenance organization membership or who takes or transmits a

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1 membership fee or premium for such a policy or contract, other
2 than for [~~himself~~] that person, or a person who advertises or
3 otherwise [~~holds himself out~~] makes any representation to the
4 public as such;

5 [Ø-] P. "individual contract" means a contract for
6 health care services issued to and covering an individual, and
7 it may include dependents of the subscriber;

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

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

14 [R-] S. "net worth" means the excess of total
15 admitted assets over total liabilities, but the liabilities
16 shall not include fully subordinated debt;

17 [S-] T. "participating provider" means a provider
18 as defined in Subsection [U] W of this section who, under an
19 express contract with the health maintenance organization or
20 with its contractor or subcontractor, has agreed to provide
21 health care services to enrollees with an expectation of
22 receiving payment, other than copayment or deductible, directly
23 or indirectly from the health maintenance organization;

24 U. "pediatric care" means preventive and medical
25 services for an individual under nineteen years of age;

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1 ~~[F.]~~ V. "person" means an individual or other legal
2 entity;

3 ~~[U.]~~ W. "provider" means a physician, pharmacist,
4 pharmacist clinician, hospital or other person licensed or
5 otherwise authorized to furnish health care services;

6 ~~[V.]~~ X. "replacement coverage" means the benefits
7 provided by a succeeding carrier;

8 ~~[W.]~~ Y. "subscriber" means an individual whose
9 employment or other status, except family dependency, is the
10 basis for eligibility for enrollment in the health maintenance
11 organization or, in the case of an individual contract, the
12 person in whose name the contract is issued;

13 ~~[X.]~~ Z. "uncovered expenditures" means the costs to
14 the health maintenance organization for health care services
15 that are the obligation of the health maintenance organization,
16 for which an enrollee may also be liable in the event of the
17 health maintenance organization's insolvency and for which no
18 alternative arrangements have been made that are acceptable to
19 the superintendent;

20 ~~[Y.]~~ AA. "pharmacist" means a person licensed as a
21 pharmacist pursuant to the Pharmacy Act; and

22 ~~[Z.]~~ BB. "pharmacist clinician" means a pharmacist
23 who exercises prescriptive authority pursuant to the Pharmacist
24 Prescriptive Authority Act."

25 SECTION 61. Section 59A-46-38.1 NMSA 1978 (being Laws

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1 1994, Chapter 64, Section 9, as amended) is amended to read:

2 "59A-46-38.1. COVERAGE OF CHILDREN.--

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

- 6 (1) was born out of wedlock;
- 7 (2) is not claimed as a dependent on the
8 parent's federal tax return; or
- 9 (3) does not reside with the parent or in the
10 insurer's service area.

11 B. When a child has health coverage through ~~[an~~
12 ~~insurer]~~ a health maintenance organization of a noncustodial
13 parent, the ~~[insurer]~~ health maintenance organization shall:

- 14 (1) provide such information to the custodial
15 parent as may be necessary for the child to obtain benefits
16 through that coverage;
- 17 (2) permit the custodial parent or the
18 provider, with the custodial parent's approval, to submit
19 claims for covered services without the approval of the
20 noncustodial parent; and
- 21 (3) make payments on claims submitted in
22 accordance with Paragraph (2) of this subsection directly to
23 the custodial parent, the provider or the state medicaid
24 agency.

25 C. When a parent is required by a court or

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1 administrative order to provide health coverage for a child and
2 the parent is eligible for family health coverage, the
3 [~~insurer~~] health maintenance organization shall be required:

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

7 (2) if the parent is enrolled but fails to
8 make application to obtain coverage for the child, to enroll
9 the child under family coverage upon application of the child's
10 other parent, the state agency administering the medicaid
11 program or the state agency administering 42 U.S.C. Sections
12 651 through 669, the child support enforcement program; and

13 (3) not to disenroll or eliminate coverage of
14 the child unless the [~~insurer~~] health maintenance organization
15 is provided satisfactory written evidence that:

16 (a) the court or administrative order is
17 no longer in effect; or

18 (b) the child is or will be enrolled in
19 comparable health coverage through another [~~insurer~~] health
20 maintenance organization that will take effect not later than
21 the effective date of disenrollment.

22 D. [~~An insurer~~] A health maintenance organization
23 shall not impose requirements on a state agency that has been
24 assigned the rights of an individual eligible for medical
25 assistance under the medicaid program and covered for health

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1 benefits from the ~~[insurer]~~ health maintenance organization
2 that are different from requirements applicable to an agent or
3 assignee of any other individual so covered.

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

17 SECTION 62. Section 59A-46-38.2 NMSA 1978 (being Laws
18 1997, Chapter 250, Section 4) is amended to read:

19 "59A-46-38.2. CHILDHOOD IMMUNIZATION COVERAGE REQUIRED.--

20 A. Each individual and group health maintenance
21 contract delivered or issued for delivery in this state shall
22 provide coverage for childhood immunizations in accordance with
23 the current schedule of immunizations recommended by the
24 American academy of pediatrics, ~~[including coverage for all~~
25 ~~medically necessary booster doses of all immunizing agents used~~

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1 ~~in childhood immunizations]~~ the advisory committee on
2 immunization practices of the federal centers for disease
3 control and prevention or the United States preventive services
4 task force "A"-rated and "B"-rated recommendations, whichever
5 provides greater coverage.

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

9 ~~[B. Coverage for childhood immunizations and~~
10 ~~necessary booster doses may be subject to deductibles and~~
11 ~~coinsurance consistent with those imposed on other benefits~~
12 ~~under the same contract.]"~~

13 SECTION 63. Section 59A-46-38.3 NMSA 1978 (being Laws
14 2003, Chapter 391, Section 5, as amended) is amended to read:

15 "59A-46-38.3. MAXIMUM AGE OF ~~[DEPENDENT]~~ CHILD.--Each
16 individual or group health maintenance organization contract
17 delivered or issued for delivery or renewed in New Mexico that
18 provides coverage for an enrollee's ~~[dependents]~~ child shall
19 not terminate coverage of ~~[an unmarried dependent]~~ a child by
20 reason of the ~~[dependent's]~~ child's age before the ~~[dependent's~~
21 ~~twenty-fifth]~~ child's twenty-sixth birthday ~~[regardless of~~
22 ~~whether the dependent is enrolled in an educational~~
23 ~~institution]~~; provided that this requirement does not apply to
24 the medicaid managed care system."

25 SECTION 64. Section 59A-46-42 NMSA 1978 (being Laws 1992,
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1 Chapter 56, Section 1, as amended) is amended to read:

2 "59A-46-42. COVERAGE FOR CYTOLOGIC AND HUMAN
3 PAPILLOMAVIRUS SCREENING.--

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

19 B. Coverage for cytologic and human papillomavirus
20 screening may be subject to deductibles and coinsurance
21 consistent with those imposed on other benefits under the same
22 contract.

23 C. For the purposes of this section:

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

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1 women;

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

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

10 SECTION 65. Section 59A-46-41.1 NMSA 1978 (being Laws
11 1997, Chapter 249, Section 4) is amended to read:

12 "59A-46-41.1. MASTECTOMIES, BREAST RECONSTRUCTION AND
13 LYMPH NODE DISSECTION--MINIMUM HOSPITAL STAY COVERAGE
14 REQUIRED.--

15 A. Each individual and group health maintenance
16 contract delivered or issued for delivery in this state shall
17 provide coverage for not less than forty-eight hours of
18 inpatient care following a mastectomy and not less than
19 twenty-four hours of inpatient care following a lymph node
20 dissection for the treatment of breast cancer.

21 B. Nothing in this section shall be construed as
22 requiring the provision of inpatient coverage where the
23 attending physician and patient determine that a shorter period
24 of hospital stay is appropriate.

25 C. Coverage for minimum inpatient hospital stays

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1 for mastectomies and lymph node dissections for the treatment
2 of breast cancer may be subject to deductibles and co-insurance
3 consistent with those imposed on other benefits under the same
4 contract.

5 D. Each individual and group health maintenance
6 contract that is delivered or issued for delivery in the state
7 shall provide coverage for breast reconstruction in connection
8 with a mastectomy, including coverage for:

9 (1) all stages of reconstruction of the breast
10 on which the mastectomy was performed;

11 (2) surgery and reconstruction of the other
12 breast to produce a symmetrical appearance;

13 (3) prostheses; and

14 (4) treatment of any physical complications at
15 all stages of mastectomy, including lymphedemas, in a manner
16 determined in consultation with the attending physician and the
17 patient."

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
10 for 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
18 to 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
25 contract that is delivered, issued for delivery or renewed in

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1 this state shall provide coverage to an eligible individual who
2 is nineteen years of age or younger, or an eligible individual
3 who is twenty-two years of age or younger and is enrolled in
4 high 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
11 this 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
10 for 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
17 of this section shall not be subject to dollar limits,
18 deductibles or coinsurance provisions that are less favorable
19 to an insured than the dollar limits, deductibles or
20 coinsurance provisions that apply to physical illnesses that
21 are generally covered under the individual or group health
22 maintenance contract, except as otherwise provided in
23 Subsection B of this section.

24 D. [~~An insurer~~] A carrier shall not deny or refuse
25 to issue health insurance coverage for medically necessary

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1 services or refuse to contract with, renew, reissue or
2 otherwise terminate or restrict health insurance coverage for
3 an individual because the individual is diagnosed as having
4 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 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~~] current
5 edition, [~~text revision, also known as DSM-IV-TR~~] published by
6 the American psychiatric association, including autistic
7 disorder; Asperger's disorder; pervasive development disorder
8 not 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 68.** Section 59A-46-51 NMSA 1978 (being Laws 2010,
17 Chapter 94, Section 3) is amended to read:

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

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

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1 Maintenance Organization Law and the Nonprofit Health Care Plan
2 Law. Reimbursement shall be made for direct services provided
3 over the preceding three calendar years, but not earlier than
4 calendar year 2010, as determined by reports filed with the
5 insurance division of the commission. Nothing in this
6 subsection shall be construed to preclude a purchaser from
7 negotiating an agreement with a health maintenance organization
8 that requires a higher amount of premiums paid to be used for
9 reimbursement for direct services for one or more products or
10 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 by the reports
15 filed with the insurance division, as a percent of premiums.
16 Additional informal hearings may be held at the
17 superintendent's discretion. In establishing the level of
18 reimbursement for direct services, the superintendent shall
19 consider the costs associated with the individual marketing and
20 medical underwriting of these policies, plans or contracts at a
21 level not less than seventy-five percent of premiums. A health
22 insurer or health maintenance organization writing these
23 policies, plans or contracts shall make reimbursement for
24 direct services at a level not less than that level established
25 by the superintendent pursuant to this subsection over the

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

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

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1 Section 59A-1-18 NMSA 1978.

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

5 E. For the purposes of this section:

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

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

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1 hospital indemnity-only insurance policies, or that only issues
2 policies for long-term care or disability income; and

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

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

14 "[NEW MATERIAL] GUARANTEED ISSUE--GUARANTEED
15 RENEWABILITY--MAXIMUM WAITING PERIOD--BAN ON PREEXISTING
16 CONDITION EXCLUSIONS.--

17 A. A carrier shall issue coverage to any individual
18 who requests and offers to purchase the coverage without
19 permanent exclusion of preexisting conditions.

20 B. Except as provided in to Subsection C of this
21 section, a health maintenance organization that offers a health
22 benefit plan or contract providing group health insurance
23 coverage in the state shall issue any health benefit plan or
24 contract to any employer that applies for such plan and agrees
25 to make the required premium payments and satisfy the other

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1 reasonable provisions of the health plan or contract. A
2 carrier:

3 (1) shall offer coverage to all of the
4 eligible employees of the employer and the employees' children
5 and dependents who apply for enrollment during the period in
6 which the employee first becomes eligible to enroll under the
7 terms of the plan or contract; and

8 (2) shall not offer coverage to only certain
9 individuals or certain children or dependents of employees in
10 the group or to only part of the group.

11 C. A carrier that offers through a network plan or
12 contract shall not be required to offer coverage under that
13 plan or contract or accept applications for that plan or
14 contract pursuant to Subsection A of this section under the
15 following circumstances:

16 (1) to an employer, where the employer is not
17 physically located in the carrier's established geographic
18 service area for the network plan or contract;

19 (2) to an employee, when the employee does not
20 live, work or reside within the carrier's established
21 geographic service area for the network plan or contract; or

22 (3) within the geographic service area for the
23 network plan or contract where the carrier reasonably
24 anticipates, and demonstrates to the satisfaction of the
25 superintendent, that it will not have the capacity within its

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1 established geographic service area to deliver service
2 adequately to the members of the groups because of its
3 obligations to existing group plan holders and enrollees.

4 D. A carrier may restrict enrollment in coverage
5 described in Subsection B of this section to open or special
6 enrollment periods; provided that any special enrollment period
7 shall comply with the provisions of Section 73 of this 2013 act
8 and rules the superintendent has promulgated.

9 E. A carrier may impose a waiting period not to
10 exceed ninety days before payment for any service related to a
11 preexisting condition. A carrier shall offer or make a
12 referral to a transition product to provide coverage during the
13 waiting period due to a preexisting condition.

14 F. A carrier shall renew any health benefit plan or
15 contract at the option of the employer, except as the
16 superintendent has provided by rule.

17 G. For the purposes of this section:

18 (1) "coverage" means a health insurance
19 policy, health care plan, health maintenance organization
20 contract or certificate of insurance issued for delivery in the
21 state. "Coverage" does not mean a short-term, accident, fixed
22 indemnity or specified disease policy; disability income;
23 limited benefit insurance; credit insurance; workers'
24 compensation; or automobile or medical insurance under which
25 benefits are payable with or without regard to fault and that

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1 is required by law to be contained in any liability insurance
2 policy; and

3 (2) "preexisting condition" means a physical
4 or mental condition for which medical advice, medication,
5 diagnosis, care or treatment was recommended for or received by
6 an applicant for health insurance within six months before the
7 effective date of coverage, except that pregnancy is not
8 considered a preexisting condition for federally defined
9 individuals."

10 SECTION 70. A new section of the Health Maintenance
11 Organization Law is enacted to read:

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

13 A. Notwithstanding any other provision of law, a
14 health maintenance organization shall not establish:

15 (1) lifetime limits on the dollar value of
16 benefits for any enrollee; or

17 (2) except as provided in Subsection B of this
18 section, annual limits on the dollar value of benefits for any
19 enrollee.

20 B. With respect to contract years beginning prior
21 to January 1, 2014, a health maintenance organization shall
22 establish a restricted annual limit on the dollar value of
23 benefits for any enrollee only with respect to the scope of
24 benefits that are essential health benefits, as the
25 superintendent defines "essential health benefits" by rule.

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1 C. Subsection A of this section shall not be
2 construed to prevent a health maintenance organization from
3 placing annual or lifetime per enrollee limits on specific
4 covered benefits that are not essential health benefits to the
5 extent that these limits are otherwise permitted under federal
6 or state law.

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

13 **SECTION 71.** A new section of the Health Maintenance
14 Organization Law is enacted to read:

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

16 A. A health maintenance organization contract
17 offered shall not rescind coverage under a contract, plan or
18 policy with respect to an individual, including a group to
19 which the individual belongs or family coverage in which the
20 individual is included, after the individual is covered under
21 the contract, plan or policy, unless:

22 (1) the individual or a person seeking
23 coverage on behalf of the individual engages in conduct that
24 constitutes fraud; or

25 (2) the individual makes an intentional

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1 misrepresentation of material fact, as prohibited by the terms
2 of the contract or coverage.

3 B. For purposes of Paragraph (1) of Subsection A of
4 this section, a person seeking coverage on behalf of an
5 individual does not include an insurance producer or an
6 employee or authorized representative of the carrier.

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

17 D. The provisions of this section apply regardless
18 of any applicable contestability period."

19 SECTION 72. A new section of the Health Maintenance
20 Organization Law is enacted to read:

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

23 A. A group health maintenance organization contract
24 that is delivered, issued for delivery or renewed in this state
25 on behalf of an employer shall not discriminate in favor of

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1 highly compensated individuals as to eligibility to participate
2 or as to the benefits offered. The benefits provided for
3 participants who are highly compensated individuals shall be
4 provided for all other participants.

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

7 (1) seventy percent or more of all of that
8 employer's employees;

9 (2) eighty percent or more of all of that
10 employer's employees who are eligible to benefit under the
11 policy, plan or contract if seventy percent or more of all
12 employees are eligible to benefit; or

13 (3) any employees who qualify under a
14 classification that the employer has established and that the
15 secretary of the United States department of health and human
16 services has approved.

17 C. An employer may exclude the following types of
18 employees from an offering of health coverage under Subsections
19 A and B of this section:

20 (1) employees who have not completed three
21 years of service;

22 (2) employees who have not attained twenty-
23 five years of age;

24 (3) part-time or seasonal employees;

25 (4) employees not included in the plan who are

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1 included in a unit of employees covered by an agreement between
2 employee representatives and one or more employers that the
3 secretary of the United States department of health and human
4 services has found to be a collective bargaining agreement, if
5 accident and health benefits were the subject of good faith
6 bargaining between these employee representatives and the
7 employer or employers; and

8 (5) employees who are nonresident aliens of
9 the United States and who receive no earned income, within the
10 meaning of section 911(d)(2) of the federal Internal Revenue
11 Code of 1986, from the employer that constitutes income from
12 sources within the United States, as defined in Section
13 861(a)(3) of the federal Internal Revenue Code of 1986.

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

16 (1) one of the five highest paid officers of
17 an employer;

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

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

24 **SECTION 73.** A new section of the Health Maintenance
25 Organization Law is enacted to read:

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1 "[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY
2 REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--
3 OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

4 A. For individual or group health maintenance
5 organization contract years beginning on or after September 23,
6 2010, if a child's health maintenance organization coverage
7 ended or did not begin for the reasons described in Subsection
8 E of this section, a health maintenance organization shall
9 provide the child an opportunity to enroll in a health
10 maintenance organization contract for which coverage continues
11 for at least sixty days and provide written notice of the
12 opportunity to enroll as described in Subsection B of this
13 section no later than the first day of the contract 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 or
17 who were not eligible for coverage because dependent coverage
18 of children was unavailable before the child reached twenty-six
19 years of age are eligible to enroll in coverage. This notice
20 may be provided to a principal insured on behalf of the
21 principal insured's child. For a group health maintenance
22 organization contract, the notice may be included with other
23 enrollment materials that the carrier distributes to employees;
24 provided that the statement is prominent. If the notice is
25 provided to an employee whose child is entitled to an

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1 enrollment opportunity pursuant to Subsection A of this
2 section, the obligation to provide the notice of enrollment
3 opportunity pursuant to this subsection is satisfied for both
4 the individual or group health maintenance organization
5 contract.

6 C. For an individual who enrolls in an individual
7 or a group health maintenance organization contract pursuant to
8 Subsection A of this section, the coverage shall take effect
9 not later than the first day of the first contract year.

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

22 E. The provisions of this section shall apply to a
23 child:

24 (1) whose coverage ended, or who was denied
25 coverage or was not eligible for coverage under an individual

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1 or group health maintenance organization contract delivered,
2 issued for delivery or renewed in this state because, under the
3 terms of coverage, the availability of dependent coverage of a
4 child ended before the child reached the age of twenty-six; or

5 (2) who became eligible, or is required to
6 become eligible, for coverage on the first day of the first
7 contract year, beginning on or after September 23, 2010 by
8 reason of the provisions of this section."

9 SECTION 74. A new section of the Health Maintenance
10 Organization Law is enacted to read:

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

13 A. An individual or group health maintenance
14 organization contract delivered, issued for delivery or renewed
15 in this state shall not limit or exclude coverage under an
16 individual or group contract for an individual under the age of
17 nineteen by imposing a preexisting condition exclusion on that
18 individual.

19 B. When a carrier offers individual or group health
20 insurance coverage that only covers individuals under age
21 nineteen, that carrier shall offer the coverage continuously
22 throughout the year or during one or more open enrollment
23 periods as the superintendent prescribes by rule.

24 C. During an open enrollment period, a carrier
25 shall not deny or unreasonably delay the issuance of a policy,

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1 refuse to issue a policy or issue a policy with any preexisting
2 condition exclusion rider or endorsement to an applicant or
3 insured who is under the age of nineteen on the basis of a
4 preexisting condition.

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

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

16 SECTION 75. A new section of the Health Maintenance
17 Organization Law is enacted to read:

18 "[NEW MATERIAL] EMERGENCY SERVICES.--

19 A. An individual or group health maintenance
20 organization contract that is delivered, issued for delivery or
21 renewed in this state and that provides or covers any benefits
22 with respect to services in an emergency department of a
23 hospital shall cover emergency services:

24 (1) without the need for any prior
25 authorization determination; and

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

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

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

24 D. The provisions of this section shall not apply
25 to:

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

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

9 E. As used in this section:

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

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

19 (b) serious impairment to bodily
20 functions; or

21 (c) serious dysfunction of any bodily
22 organ or part;

23 (2) "emergency services" means, with respect
24 to an emergency medical condition:

25 (a) a medical screening examination that

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1 is within the capability of the emergency department of a
2 hospital, including ancillary services routinely available to
3 the emergency department to evaluate the emergency medical
4 condition; and

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

12 (3) "stabilize" means:

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

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

20 SECTION 76. A new section of the Health Maintenance
21 Organization Law is enacted to read:

22 "[NEW MATERIAL] OPTION FOR PEDIATRICIAN AS PRIMARY CARE
23 PHYSICIAN.--

24 A. An individual or group health maintenance
25 organization contract delivered, issued for delivery or renewed

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1 in this state that requires or provides for the designation of
2 a participating primary care provider shall allow a principal
3 insured to designate for the principal insured's dependent
4 child who is a covered individual an allopathic or osteopathic
5 physician who specializes in pediatrics as the principal
6 insured child's primary care provider if the provider
7 participates in the network of the carrier.

8 B. Nothing in Subsection A of this section shall be
9 construed to waive any exclusions of coverage under the terms
10 and conditions of the contract with respect to coverage of
11 pediatric care.

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

19 SECTION 77. A new section of the Health Maintenance
20 Organization Law is enacted to read:

21 "[NEW MATERIAL] ACCESS TO OBSTETRICAL AND GYNECOLOGICAL
22 CARE.--

23 A. An individual or group health maintenance
24 organization contract delivered, issued for delivery or renewed
25 in this state that provides coverage for obstetrical and

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

13 B. A health maintenance organization shall treat
14 the provision of obstetrical and gynecological care, and the
15 ordering of related obstetrical and gynecological items and
16 services by a participating health care professional who
17 specializes in obstetrics or gynecology, as the authorization
18 of the primary 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 contract with respect to coverage
23 of obstetrical or gynecological care; or

24 (2) preclude the carrier from requiring that
25 the obstetrical or gynecological provider notify the covered

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1 individual's primary care health care professional or the
2 carrier of treatment decisions.

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

10 SECTION 78. A new section of the Health Maintenance
11 Organization Law is enacted to read:

12 "[NEW MATERIAL] COST-SHARING FOR PREVENTIVE ITEMS AND
13 SERVICES.--

14 A. An individual or group health maintenance
15 organization contract delivered, issued for delivery or renewed
16 in this state shall provide coverage for all of the items and
17 services required under Sections 59A-46-38.2, 59A-46-42 and
18 59A-46-45 NMSA 1978 and Sections 79 through 81 of this 2013
19 act, and shall not impose any cost-sharing requirements, such
20 as a copayment, co-insurance or deductible.

21 B. A carrier is not required to provide coverage
22 for any items or services specified in any recommendation or
23 guideline described in Subsection A of this section after the
24 recommendation or guideline is no longer described by a source
25 listed in that subsection.

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1 C. Other provisions of state or federal law may
2 apply in connection with a carrier's ceasing to provide
3 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 care
6 law in New Mexico, the provision providing the greatest level
7 of coverage shall apply. The preventive care provisions in
8 this section are intended to supplement rather than supplant
9 existing preventive health care provisions in this state.

10 E. The superintendent shall at least annually
11 revise the preventive services standards established pursuant
12 to Sections 59A-46-38.2, 59A-46-42 and 59A-46-45 NMSA 1978 and
13 Sections 79 through 81 of this 2013 act to ensure that they are
14 consistent with the "A"-rated and "B"-rated recommendations of
15 the United States preventive services task force, the advisory
16 committee on immunization practices of the federal centers for
17 disease control and prevention and the guidelines with respect
18 to infants, children, adolescents and women of evidence-based
19 preventive care and screenings by the federal health resources
20 and services administration. When changes are made to any of
21 these guidelines or recommendations, the superintendent shall
22 make recommendations to the legislature for legislative changes
23 to conform these standards to current guidelines and
24 recommendations.

25 F. A health maintenance organization may impose

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

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

12 H. A health maintenance organization may impose
13 cost-sharing requirements with respect to an office visit if a
14 preventive item or service provided pursuant to this section is
15 not 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 item
18 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 79. A new section of the Health Maintenance

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1 Organization Law 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--FALLS PREVENTION--SKIN CANCER COUNSELING--HUMAN
8 IMMUNODEFICIENCY VIRUS SCREENING--HEPATITIS C
9 SCREENING--ALCOHOL MISUSE SCREENING AND COUNSELING.--

10 A. An individual or group health maintenance
11 organization contract that is delivered, issued for delivery or
12 renewed in this state shall provide the following benefits that
13 have, in effect, a rating of "A" or "B" in the current
14 recommendations of the United States preventive services task
15 force, for:

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

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

24 (3) an aspirin regimen for women between the
25 ages of fifty-five and seventy-nine when the potential benefit

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1 of a reduction in ischemic strokes outweighs the potential harm
2 due to an increase in gastrointestinal hemorrhage;

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

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

11 (6) screening of lipid disorders for:

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

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

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

19 (8) screening of individuals eighteen years of
20 age or older for depression;

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

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

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1 (11) screening and counseling for obesity for
2 individuals six years of age and older;

3 (12) screening for osteoporosis for:

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

6 (b) women who are under sixty-five years
7 of age who are at increased risk for osteoporotic fractures;

8 (13) exercise or physical therapy to prevent
9 falls in community-dwelling adults aged sixty-five years or
10 older who are at increased risk for falls;

11 (14) counseling of individuals at increased
12 risk for skin cancer by minimizing their exposure to
13 ultraviolet radiation;

14 (15) screening for human immunodeficiency
15 virus, also known as "HIV", for:

16 (a) individuals age fifteen to sixty-
17 five years of age; and

18 (b) individuals of any age who are at
19 increased risk of infection;

20 (16) screening for hepatitis C virus, also
21 known as "HCV", infection in adults at high risk of infection,
22 including:

23 (a) individuals with any history of
24 intravenous drug use; or

25 (b) individuals who received a blood

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1 transfusion before the year 1992; and

2 (17) screening and behavioral counseling
3 interventions for alcohol misuse for patients in primary care
4 settings.

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

11 SECTION 80. A new section of the Health Maintenance
12 Organization Law is enacted to read:

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

14 A. An individual or group health maintenance
15 organization contract that is delivered or issued for delivery
16 in this state shall provide the following benefits that have,
17 in effect, a rating of "A" or "B" in the current
18 recommendations of the United States preventive services task
19 force, for:

20 (1) oral fluoride supplementation at currently
21 recommended doses to children over six months of age whose
22 primary water sources are deficient in fluoride;

23 (2) prophylactic ocular topical medication
24 against gonococcal ophthalmia neonatorum for newborns;

25 (3) screening for hearing loss in newborns;

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- 1 (4) screening for sickle cell disease for
2 newborns;
- 3 (5) screening for congenital hypothyroidism
4 for newborns;
- 5 (6) iron supplementation for asymptomatic
6 children six to twelve months of age who are at increased risk
7 for iron deficiency anemia;
- 8 (7) screening for phenylketonuria in newborns;
- 9 (8) screening to detect amblyopia, strabismus
10 and defects in visual acuity in children over three and less
11 than five years of age;
- 12 (9) counseling of individuals at increased
13 risk for skin cancer to minimize their exposure to ultraviolet
14 radiation; and
- 15 (10) interventions, including education or
16 brief counseling, to prevent initiation of tobacco use among
17 school-aged children and adolescents.

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 81. A new section of the Health Maintenance
25 Organization Law 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 maintenance
4 organization contract that is delivered, issued for delivery or
5 renewed in this state shall provide the following benefits that
6 have, in effect, a rating of "A" or "B" in the current
7 recommendations of the United States preventive services task
8 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 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;

20 (13) screening for syphilis for:

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

23 (b) any pregnant woman;

24 (14) screening of pregnant women for human
25 immunodeficiency virus, also known as "HIV", including those

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1 who present at labor whose human immunodeficiency virus status
2 is unknown;

3 (15) screening of women of childbearing age
4 for intimate partner violence, including domestic violence, and
5 referral to or provision of intervention services to
6 individuals whose screening shows a positive result. Nothing
7 in this section shall be construed as a waiver or exception to
8 the Domestic Abuse Insurance Protection Act; and

9 (16) screening and behavioral counseling
10 interventions for pregnant women in primary care settings for
11 alcohol misuse.

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

18 SECTION 82. Section 59A-47-3 NMSA 1978 (being Laws 1984,
19 Chapter 127, Section 879.1, as amended) is amended to read:

20 "59A-47-3. DEFINITIONS.--As used in Chapter 59A, Article
21 47 NMSA 1978:

22 A. "health care" means the treatment of persons for
23 the prevention, cure or correction of any illness or physical
24 or mental condition, including optometric services;

25 B. "item of health care" includes any services or

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1 materials used in health care;

2 C. "health care expense payment" means a payment
3 for health care to a purveyor on behalf of a subscriber, or
4 such a payment to the subscriber;

5 D. "purveyor" means a person who furnishes any item
6 of health care and charges for that item;

7 E. "service benefit" means a payment that the
8 purveyor has agreed to accept as payment in full for health
9 care furnished the subscriber;

10 F. "indemnity benefit" means a payment that the
11 purveyor has not agreed to accept as payment in full for health
12 care furnished the subscriber;

13 G. "subscriber" means any individual who, because
14 of a contract with a health care plan entered into by or for
15 the individual, is entitled to have health care expense
16 payments made on the individual's behalf or to the individual
17 by the health care plan;

18 H. "underwriting manual" means the health care
19 plan's written criteria, approved by the superintendent, that
20 defines the terms and conditions under which subscribers may be
21 selected. The underwriting manual may be amended from time to
22 time, but amendment will not be effective until approved by the
23 superintendent. The superintendent shall notify the health
24 care plan filing the underwriting manual or the amendment
25 thereto of the superintendent's approval or disapproval thereof

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1 in writing within thirty days after filing or within sixty days
2 after filing if the superintendent shall so extend the time.

3 If the superintendent fails to act within such period, the
4 filing shall be deemed to be approved;

5 I. "acquisition expenses" includes all expenses
6 incurred in connection with the solicitation and enrollment of
7 subscribers;

8 J. "administration expenses" means all expenses of
9 the health care plan other than the cost of health care expense
10 payments and acquisition expenses;

11 K. "health care plan" means a nonprofit corporation
12 authorized by the superintendent to enter into contracts with
13 subscribers and to make health care expense payments;

14 L. "agent" means a person appointed by a health
15 care plan authorized to transact business in this state to act
16 as its representative in any given locality for soliciting
17 health care policies and other related duties as may be
18 authorized;

19 M. "solicitor" means a person employed by the
20 licensed agent of a health care plan for the purpose of
21 soliciting health care policies and other related duties in
22 connection with the handling of the business of the agent as
23 may be authorized and paid for the person's services either on
24 a commission basis or salary basis or part by commission and
25 part by salary;

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1 N. "chiropractor" means any person holding a
2 license provided for in the Chiropractic Physician Practice
3 Act;

4 O. "doctor of oriental medicine" means any person
5 licensed as a doctor of oriental medicine under the Acupuncture
6 and Oriental Medicine Practice Act;

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

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

12 R. "child" means an individual under twenty-six
13 years of age whom the principal insured covers or whom the
14 applicant for coverage applies to cover, regardless of the
15 individual's financial dependency, residency with a parent,
16 student status, employment or marital status."

17 SECTION 83. Section 59A-47-24 NMSA 1978 (being Laws
18 1984, Chapter 127, Section 879.22) is amended to read:

19 "59A-47-24. SUBSCRIBER CONTRACTS--REQUIREMENTS AND
20 PROVISIONS.--

21 A. Every health care expense payments contract
22 issued under ~~[this article]~~ the Nonprofit Health Care Plan
23 Law shall be in writing and shall comply with ~~[requirements~~
24 ~~and]~~ standards that the superintendent has established by
25 rule pursuant to United States department of health and human

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1 services regulations on uniform standards for the following
2 documents issued by each contract relating to:

3 (1) a summary of benefits;

4 (2) an explanation of coverage;

5 (3) definitions of standard insurance terms
6 and medical terms;

7 (4) exceptions, reductions and limitations
8 on coverage;

9 (5) cost-sharing provisions, including
10 deductible, co-insurance and copayment obligations;

11 (6) the renewability and continuation of
12 coverage provisions;

13 (7) a coverage facts disclosure that
14 includes examples that are based on nationally recognized
15 clinical practice guidelines to illustrate common benefits
16 scenarios, including pregnancy and serious or chronic medical
17 conditions and related cost-sharing;

18 (8) a statement of whether the contract:

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

22 (b) ensures that the coverage share of
23 the total allowed costs of benefits provided under the
24 contract is not less than sixty percent of those costs; and

25 (9) a contact number for the consumer to

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1 call with additional questions and an internet web address
2 where a copy of the actual individual or group health
3 coverage contract can be reviewed and obtained.

4 B. A health care expense payments contract shall
5 contain provisions in substance as follows:

6 [~~A.~~] (1) a provision that the policy, the
7 application of the policyholder (if it or a copy thereof is
8 attached to the policy) and the individual applications, if
9 any, submitted in connection with [~~such~~] the policy by the
10 employees or members constitutes the entire contract between
11 the parties, that no statement therein is a warranty in the
12 absence of fraud and that no such statement shall avoid the
13 obligation of the health care plan provided in the policy or
14 reduce benefits thereunder unless contained in a written
15 application for [~~such~~] the contract, attached to and made
16 part of the policy;

17 [~~B.~~] (2) if [~~such~~] the contract is a group
18 contract, a provision that the health care plan will furnish
19 to the subscriber, for delivery to each employee or member of
20 any covered group, an individual certificate, [~~or~~] an
21 identification card or other evidence of such coverage,
22 setting forth in summary form a statement of the essential
23 features of the contract of all persons included in the
24 coverage;

25 [~~C.~~] (3) if [~~such~~] the contract is a group

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1 contract, a provision that eligible new employees or members
2 or dependents, as the case may be, may be added from time to
3 time to the group originally covered, in accordance with the
4 terms of the contract;

5 [D.] (4) the amount payable to the health
6 care plan by the subscriber and the time at which and manner
7 in which [such] the amount is to be paid;

8 ~~[E. the nature of the benefits which will be
9 furnished and the period during which they will be furnished
10 and, if there are any benefits to be excepted, a detailed
11 statement of such exceptions;~~

12 F.] (5) any specific term or condition to
13 the effect that the contract may be canceled or otherwise
14 terminated by the health care plan, including the manner and
15 time of [such] the termination; provided that a contract may
16 not be canceled during the period for which the premium has
17 been paid unless written notice is delivered to the insured,
18 or mailed to [his] the insured's last address as shown by the
19 records of the health care plan, stating when, not less than
20 five days thereafter [such] the cancellation shall be
21 effective;

22 [G.] (6) that the contract includes the
23 endorsements thereon and attached papers, if any, and
24 constitutes the entire contract;

25 [H.] (7) that ~~[after two years no statement,~~

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1 ~~except a fraudulent statement, by the subscriber in the~~
2 ~~application for a contract shall void the contract or] once~~
3 ~~the subscriber is covered under the contract, only an act by~~
4 ~~a subscriber that constitutes fraud or an intentional~~
5 ~~misrepresentation of material fact that is prohibited by the~~
6 ~~terms of the contract shall rescind the contract;~~

7 (8) that no statement, except a fraudulent
8 statement by the subscriber in the application for a
9 contract, shall be used against the subscriber in any legal
10 action or proceedings relating to the contract unless [~~such~~]
11 the application or a true copy thereof is included in or
12 attached to [~~such~~] the contract; a statement that no change
13 in the contract shall be valid until approved by an executive
14 officer of the health care plan and unless [~~such~~] the
15 approval and countersignature be endorsed on or attached to
16 [~~such~~] the contract; and a statement that no agent has
17 authority to change the contract or waive any of its
18 provisions. No claim for loss incurred or disability, as
19 defined in the policy, shall be reduced or denied on the
20 ground that a disease or physical condition not excluded from
21 coverage by name or a specific description effective on the
22 date of loss had existed prior to the effective date of
23 coverage of [~~such~~] the policy;

24 [~~F.~~] (9) that if the subscriber defaults in
25 making any payment under the contract, the subsequent

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1 acceptance of an application for reinstatement and
2 accompanying payment or its failure to take any action with
3 respect thereto within thirty days following receipt of
4 [~~such~~] the application for reinstatement, by [~~such~~] the
5 health care plan or any duly authorized agent thereof,
6 reinstates the contract. The reinstated policy shall cover
7 only loss resulting from such accidental injury as may be
8 sustained after the date of reinstatement and loss due to
9 such sickness as may begin more than ten days after [~~such~~]
10 that date. In all other respects, the subscriber and the
11 health care plan shall have the same rights thereunder as
12 they had under the policy immediately before the due date of
13 the defaulted premium, subject to any provisions endorsed
14 thereon or attached thereto in connection with the
15 reinstatement. Any premium accepted in connection with a
16 reinstatement shall be applied to a period for which a
17 premium has not been previously paid, but not to any period
18 more than sixty days prior to the date of reinstatement.

19 (The last sentence of the above provision may be omitted from
20 any policy [~~which~~] that the insured has the right to continue
21 in force subject to its terms by the timely payment of
22 premiums:

23 [~~(1)~~] (a) until at least age fifty

24 [~~(50)~~]; or

25 [~~(2)~~] (b) in the case of a policy

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1 issued after age forty-four [~~(44)~~], for at least five [~~(5)~~]
2 years from the date of its issue); and

3 [~~(7)~~] (10) the period of grace [~~which~~] that
4 will be allowed the subscriber for making any payment due
5 under the contract, which period shall not be less than ten
6 [~~(10)~~] days.

7 C. Prior to any enrollment restriction, a health
8 care expense payments contract shall provide a summary of
9 benefits and coverage explanation required pursuant to
10 Subsection A of this section to the following persons:

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

13 (2) a subscriber, prior to the time of
14 enrollment or re-enrollment, subscription or re-subscription;
15 and

16 (3) a subscriber, at the time of issuance of
17 the health care expense payments contract."

18 **SECTION 84.** Section 59A-47-35 NMSA 1978 (being Laws
19 1984, Chapter 127, Section 879.34, as amended) is amended to
20 read:

21 "59A-47-35. [~~ALCOHOL DEPENDENCY~~] SUBSTANCE ABUSE
22 TREATMENT COVERAGE.--

23 A. Each health care plan that delivers or issues
24 for delivery in this state a group contract providing for
25 health care expense payments on a service benefit basis or an

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1 indemnity benefit basis or both shall offer and make
2 available benefits for the necessary care and treatment of
3 ~~[alcohol dependency. Such]~~ substance abuse. These benefits
4 shall

5 ~~[(1) be subject to annual deductibles and~~
6 ~~coinsurance consistent with those imposed on other benefits~~
7 ~~within the same contract;~~

8 ~~(2)]~~ provide ~~[no less than thirty days]~~
9 necessary care and treatment in ~~[an alcohol dependency]~~ a
10 substance abuse treatment center and ~~[thirty]~~ outpatient
11 visits for ~~[alcohol dependency]~~ substance abuse treatment
12 ~~[and~~

13 ~~(3) be offered for benefit periods of no~~
14 ~~more than one year and may be limited to a lifetime maximum~~
15 ~~of no less than two benefit periods.~~

16 ~~Such offer of benefits shall be subject to the rights of~~
17 ~~the group contract holder to reject the coverage or to select~~
18 ~~any alternative level of benefits if that right is offered by~~
19 ~~or negotiated with that health care plan].~~

20 B. For purposes of this section, "~~[alcohol~~
21 ~~dependency]~~ substance abuse treatment center" means a
22 facility that contracts with the health care plan and that
23 provides a program ~~[for the]~~ that offers behavioral health
24 services and substance abuse treatment ~~[of alcohol~~
25 ~~dependency]~~ pursuant to a written treatment plan approved and

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1 monitored by a physician or meeting the quality standards of
2 the behavioral health services division of the human services
3 department [~~of health and which~~]. The facility shall also:

4 (1) [~~is~~] be affiliated with a hospital under
5 a contractual agreement with an established system for
6 patient referral;

7 (2) [~~is~~] be accredited as [~~such~~] a substance
8 abuse facility by the joint commission [~~on accreditation of~~
9 ~~hospitals~~]; or

10 (3) [~~meets~~] meet at least the minimum
11 standards for the provision of behavioral health services and
12 substance abuse treatment adopted by the human services
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 office of

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1 superintendent of insurance [~~division~~] prior to the effective
2 date of this section, an insurer is authorized to comply with
3 this section by the use of endorsements or riders; provided
4 [~~such~~] that those endorsements or riders are approved by the
5 [~~insurance division~~] office as being in compliance with this
6 section and applicable provisions of the 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~~] substance abuse treatment coverage from
12 one health care plan or health insurer without requiring the
13 same level of [~~alcohol dependency~~] substance abuse treatment
14 coverage for all other health care plans or health insurance
15 policies that the organization makes available to its
16 members."

17 SECTION 85. Section 59A-47-37 NMSA 1978 (being Laws
18 1994, Chapter 64, Section 12, as amended) is amended to read:

19 "59A-47-37. COVERAGE OF CHILDREN.--

20 A. [~~An insurer~~] A health care plan shall not deny
21 enrollment of a child under the [~~health~~] plan of the child's
22 parent on the grounds that the child:

23 (1) was born out of wedlock;

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

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

3 B. When a child has health coverage through an
4 insurer of a noncustodial parent, the ~~[insurer]~~ health care
5 plan shall:

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

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

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

17 C. When a parent is required by a court or
18 administrative order to provide health coverage for a child,
19 and the parent is eligible for family health coverage, the
20 ~~[insurer]~~ health care plan shall be required:

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

25 (2) if the parent is enrolled but fails to

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

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

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

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

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

23 E. ~~[An insurer]~~ A health care plan shall provide
24 coverage for children, from birth through three years of age,
25 for or under the family, infant, toddler program administered

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

11 SECTION 86. Section 59A-47-40 NMSA 1978 (being Laws
12 2003, Chapter 391, Section 7, as amended) is amended to read:

13 "59A-47-40. MAXIMUM AGE OF ~~[DEPENDENT]~~ CHILD.--An
14 individual or group health care coverage, including any form
15 of self-insurance, offered, issued or renewed under the
16 Health Care Purchasing Act that offers coverage of an
17 insured's ~~[dependent]~~ child shall not terminate coverage of
18 ~~[an unmarried dependent]~~ a child by reason of the
19 ~~[dependent's]~~ child's age before the ~~[dependent's twenty-~~
20 ~~fifth]~~ child's twenty-sixth birthday ~~[regardless of whether~~
21 ~~the dependent is enrolled in an educational institution]."~~

22 SECTION 87. Section 59A-47-45 NMSA 1978 (being Laws
23 2009, Chapter 74, Section 4) is amended to read:

24 "59A-47-45. COVERAGE FOR AUTISM SPECTRUM DISORDER
25 DIAGNOSIS AND TREATMENT.--

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1 A. An individual or group health insurance
2 policy, health care plan or certificate of health insurance
3 that is delivered or issued for delivery in this state shall
4 provide coverage to an eligible individual who is nineteen
5 years of age or who is twenty-two years of age or younger and
6 is enrolled in high school, for:

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

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

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

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

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

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

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1 ~~(3)~~ (2) shall not be denied on the basis
2 that the services are habilitative or rehabilitative in
3 nature;

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

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

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

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1 Subsection B of this section.

2 D. ~~[An]~~ A health insurer shall not deny or refuse
3 to issue health insurance coverage for medically necessary
4 services or refuse to contract with, renew, reissue or
5 otherwise terminate or restrict health insurance coverage for
6 an individual because the individual is diagnosed as having
7 autism spectrum disorder.

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

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

21 F. This section shall not be construed as
22 limiting benefits and coverage otherwise available to an
23 insured under a health insurance plan.

24 G. 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 H. As used in this section:

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

15 (2) "habilitative or rehabilitative
16 services" means treatment programs that are necessary to
17 develop, maintain and restore to the maximum extent
18 practicable the functioning of an individual; and

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

21 **SECTION 88.** Section 59A-47-46 NMSA 1978 (being Laws
22 2010, Chapter 94, Section 4) is amended to read:

23 "59A-47-46. HEALTH [~~INSURERS~~] CARE PLANS--DIRECT
24 SERVICES.--

25 A. A health care plan shall make reimbursement

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

15 B. For individually underwritten health care
16 policies, plans or contracts, the superintendent shall
17 establish, after notice and informal hearing, the level of
18 reimbursement for direct services as determined as a percent
19 of premiums. Additional hearings may be held at the
20 superintendent's discretion. In establishing the level of
21 reimbursement for direct services, the superintendent shall
22 consider the costs associated with the individual marketing
23 and medical underwriting of these policies, plans or
24 contracts at a level not less than seventy-five percent of
25 premiums. A health insurer writing these policies, plans or

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1 contracts shall make reimbursement for direct services at a
2 level not less than that level established by the
3 superintendent pursuant to this subsection over the three
4 calendar years preceding the date upon which that rate is
5 established, but not earlier than calendar year 2010.

6 Nothing in this subsection shall be construed to preclude a
7 purchaser of one of these policies, plans or contracts from
8 negotiating an agreement with a health insurer that requires
9 a higher amount of premiums paid to be used for reimbursement
10 for direct services.

11 C. A health care plan that fails to comply with
12 the reimbursement requirements pursuant to this section shall
13 issue a [~~dividend or credit against future premiums~~] rebate
14 to all policyholders in [~~an amount sufficient to assure that~~
15 ~~the benefits paid in the preceding three calendar years plus~~
16 ~~the amount of the dividends or credits are equal to the~~
17 ~~required direct services reimbursement level pursuant to~~
18 ~~Subsection A of this section for group health coverage and~~
19 ~~blanket health coverage or the required direct services~~
20 ~~reimbursement level pursuant to Subsection B of this section~~
21 ~~for individually underwritten health policies, contracts or~~
22 ~~plans for the preceding three calendar years] accordance with
23 rules the superintendent has promulgated. If the health
24 insurer fails to issue the [~~dividend or credit~~] rebate in
25 accordance with the requirements of this section, the~~

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1 superintendent shall enforce these requirements and may
2 pursue any other penalties as provided by law, including
3 general penalties pursuant to Section 59A-1-18 NMSA 1978.

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

7 E. For the purposes of this section:

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

21 (2) "health care plan" means a nonprofit
22 corporation authorized by the superintendent to enter into
23 contracts with subscribers and to make health care expense
24 payments but does not include a person that only issues a
25 limited-benefit policy intended to supplement major medical

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1 coverage, including medicare supplement, vision, dental,
2 disease-specific, accident-only or hospital indemnity-only
3 insurance policies, or that only issues policies for long-
4 term care or disability income; and

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

14 SECTION 89. A new section of the Nonprofit Health Care
15 Plan Law is enacted to read:

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

17 A. Notwithstanding any other provision of law, a
18 group individual or group health care plan or certificate of
19 health insurance 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
23 this section, annual limits on the dollar value of benefits
24 for any enrollee.

25 B. With respect to plan years beginning prior to

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1 January 1, 2014, an individual or group health care plan
2 shall establish a restricted annual limit on the dollar value
3 of benefits for any enrollee only with respect to the scope
4 of 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 group health care plan from placing
8 annual or lifetime per enrollee limits on specific covered
9 benefits that are not essential health benefits to the extent
10 that these limits are otherwise permitted under federal or
11 state law.

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

18 **SECTION 90.** A new section of the Nonprofit Health Care
19 Plan Law is enacted to read:

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

22 A. A nonprofit health care plan providing
23 coverage under an individual health care plan or policy
24 shall not rescind coverage under a health care plan with
25 respect to an individual, including a group to which the

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1 individual belongs or family coverage in which the individual
2 is included, after the individual is covered under the plan,
3 unless:

4 (1) the individual engages in conduct that
5 constitutes fraud; or

6 (2) the individual makes an intentional
7 misrepresentation of material fact that is prohibited by the
8 terms of the plan or coverage.

9 B. For purposes of Paragraph (1) of Subsection A
10 of this section, a person seeking coverage on behalf of an
11 individual does not include an insurance producer or an
12 employee or authorized representative of the health care
13 plan.

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

23 D. The provisions of this section apply
24 regardless of any applicable contestability period."

25 SECTION 91. A new section of the Nonprofit Health Care

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1 Plan Law is enacted to read:

2 "[NEW MATERIAL] GUARANTEED ISSUE--GUARANTEED
3 RENEWABILITY--MAXIMUM WAITING PERIOD--BAN ON PREEXISTING
4 CONDITION EXCLUSIONS.--

5 A. A nonprofit health care plan shall issue
6 coverage to any individual who requests and offers to
7 purchase the coverage without permanent exclusion of
8 preexisting conditions.

9 B. Except as provided in Subsection C of this
10 section, a health care plan that offers a group health care
11 plan in the state shall issue any health care plan to any
12 employer that applies for such plan and agrees to make the
13 required premium payments and satisfy the other reasonable
14 provisions of the health care plan. A health care plan:

15 (1) shall offer coverage to all of the
16 eligible employees of the employer and the employees'
17 children and dependents who apply for enrollment during the
18 period in which the employee first becomes eligible to enroll
19 under the terms of the plan; and

20 (2) shall not offer coverage to only certain
21 individuals or certain children or dependents of employees in
22 the group or to only part of the group.

23 C. A health care plan that offers through a
24 network plan shall not be required to offer coverage under
25 that plan or accept applications for that plan pursuant to

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1 Subsection B of this section under the following
2 circumstances:

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

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

9 (3) within the geographic service area for
10 the network plan where the insurer reasonably anticipates,
11 and demonstrates to the satisfaction of the superintendent,
12 that it will not have the capacity within its established
13 geographic service area to deliver service adequately to the
14 members of the groups because of its obligations to existing
15 group plan holders and enrollees.

16 D. A health care plan may restrict enrollment in
17 coverage described in Subsection B of this section to open or
18 special enrollment periods; provided that any special
19 enrollment period shall comply with the provisions of Section
20 92 of this 2013 act and rules the superintendent has
21 promulgated.

22 E. A health care plan may impose a waiting period
23 not to exceed ninety days before payment for any service
24 related to a preexisting condition.

25 F. A health care plan shall offer or make a

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1 referral to a transition product to provide coverage during
2 the waiting period due to a preexisting condition.

3 G. A health insurer shall renew any health care
4 plan at the option of the employer, except as the
5 superintendent has provided by rule.

6 H. For the purposes of this section:

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

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

24 **SECTION 92.** A new section of the Nonprofit Health Care
25 Plan Law is enacted to read:

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1 "[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY
2 REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--
3 OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

4 A. For health care plan years beginning on or
5 after September 23, 2010, if a child's coverage ended or did
6 not begin for the reasons described in Subsection E of this
7 section, a health care plan shall provide the child an
8 opportunity to enroll in a health care plan or policy for
9 which coverage continues for at least sixty days and provide
10 written notice of the opportunity to enroll as described in
11 Subsection B of this section no later than the first day of
12 the plan or policy year.

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

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1 the notice of enrollment opportunity under this subsection is
2 satisfied for both the individual or group health insurance
3 policy, health care plan or certificate of health insurance
4 and the health care plan.

5 C. For a subscriber who enrolls in an individual
6 or a group health care plan pursuant to Subsection A of this
7 section, the coverage shall take effect not later than the
8 first day of the first plan or policy year.

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

20 E. The provisions of this section shall apply to
21 a child:

22 (1) whose coverage ended, or who was denied
23 coverage or was not eligible for coverage under an individual
24 or a group health insurance policy, health care plan or
25 certificate of health insurance because, under the terms of

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1 coverage, the availability of dependent coverage of a child
2 ended before the child reached the age of twenty-six; or

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

7 SECTION 93. A new section of the Nonprofit Health Care
8 Plan Law is enacted to read:

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

11 A. A group health care plan that is delivered,
12 issued for delivery or renewed in this state on behalf of an
13 employer shall not discriminate in favor of highly
14 compensated individuals as to eligibility to participate or
15 as to the benefits offered. Benefits provided for
16 participants who are highly compensated individuals shall be
17 provided for all other participants.

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

20 (1) seventy percent or more of all of that
21 employer's employees;

22 (2) eighty percent or more of all of that
23 employer's employees who are eligible to benefit under the
24 policy, plan or contract if seventy percent or more of all
25 employees are eligible to benefit; or

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1 (3) any employees who qualify under a
2 classification that the employer has established and that the
3 secretary of the United States department of health and human
4 services has approved.

5 C. An employer may exclude the following types of
6 employees from an offering of health coverage under
7 Subsections A and B of this section:

8 (1) employees who have not completed three
9 years of service;

10 (2) employees who have not attained twenty-
11 five years of age;

12 (3) part-time or seasonal employees;

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

21 (5) employees who are nonresident aliens of
22 the United States and who receive no earned income, within
23 the meaning of Section 911(d)(2) of the federal Internal
24 Revenue Code of 1986, from the employer which constitutes
25 income from sources within the United States, as defined in

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1 Section 861(a)(3) of the federal Internal Revenue Code of
2 1986.

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

5 (1) one of the five highest paid officers of
6 an employer;

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

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

13 SECTION 94. A new section of the Nonprofit Health Care
14 Plan Law is enacted to read:

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

17 A. An individual or group health care plan that
18 is delivered or issued for delivery in this state shall not
19 limit or exclude coverage under an individual or group health
20 benefit plan for an individual under the age of nineteen by
21 imposing a preexisting condition exclusion on that
22 individual.

23 B. When a health care plan offers individual or
24 group health insurance coverage that only covers individuals
25 under age nineteen, that plan shall offer the coverage

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1 continuously throughout the year or during one or more open
2 enrollment periods as the superintendent prescribes by rule.

3 C. During an open enrollment period, a health
4 care plan shall not deny or unreasonably delay the issuance
5 of a health care plan, refuse to issue a policy or issue a
6 policy with any preexisting condition exclusion rider or
7 endorsement to an applicant or insured who is under the age
8 of nineteen on the basis of a preexisting condition.

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

12 E. Each health care plan shall provide prior
13 prominent public notice on its web site and written notice to
14 each of its policyholders annually at least ninety days
15 before any open enrollment period of the open enrollment
16 rights for individuals under the age of nineteen and shall
17 provide information as to how an individual eligible for this
18 open enrollment right may apply for coverage with the plan
19 during an open enrollment period."

20 SECTION 95. A new section of the Nonprofit Health Care
21 Plan Law is enacted to read:

22 "[NEW MATERIAL] EMERGENCY SERVICES.--

23 A. An individual or group health care plan that
24 is delivered or issued for delivery in this state and that
25 provides or covers any benefits with respect to services in

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1 an emergency department of a hospital shall cover emergency
2 services:

3 (1) without the need for any prior
4 authorization determination; and

5 (2) whether or not the health care provider
6 furnishing emergency services is a participating provider
7 with respect to emergency services.

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

19 C. If emergency services are provided out of
20 network, the cost-sharing requirement, expressed as a
21 copayment amount or coinsurance rate, shall be the same
22 requirement that would apply if the emergency services were
23 provided in-network and without regard to any other term or
24 condition of such coverage, other than exclusion or
25 coordination of benefits, or an affiliation or waiting period

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1 other than the applicable cost-sharing otherwise permitted
2 pursuant to state or federal law.

3 D. The provisions of this section shall not apply
4 to:

5 (1) policies or plans intended to supplement
6 major medical group-type coverages such as medicare
7 supplement, long-term care, disability income, specified
8 disease, accident-only, hospital indemnity or other limited-
9 benefit health insurance policies or plans; or

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

13 E. As used in this section:

14 (1) "emergency medical condition" means a
15 medical condition manifesting itself by acute symptoms of
16 sufficient severity, including severe pain, such that a
17 prudent layperson who possesses an average knowledge of
18 health and medicine could reasonably expect the absence of
19 immediate medical attention to result in one of the following
20 conditions:

21 (a) placing the health of the
22 individual or, with respect to a pregnant woman, the health
23 of the woman or her unborn child, in serious jeopardy;

24 (b) serious impairment to bodily
25 functions; or

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1 (c) serious dysfunction of any bodily
2 organ or part;

3 (2) "emergency services" means, with respect
4 to an emergency medical condition:

5 (a) a medical screening examination
6 that is within the capability of the emergency department of
7 a hospital, including ancillary services routinely available
8 to the emergency department to evaluate the emergency medical
9 condition; and

10 (b) according to the capabilities of
11 the staff and facilities available at the hospital, further
12 medical examination and treatment required to stabilize the
13 patient's emergency medical condition or safe transfer of the
14 patient to another medical facility capable of providing the
15 medical examination or treatment required to stabilize the
16 patient's emergency medical condition; and

17 (3) "stabilize" means:

18 (a) to provide medical treatment of an
19 emergency medical condition as necessary to ensure, within
20 reasonable medical probability, that no material
21 deterioration of the condition is likely to result from or
22 occur during the transfer of the individual from a facility;
23 or

24 (b) with respect to a pregnant woman
25 who is having contractions, to deliver, including a

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1 placenta."

2 SECTION 96. A new section of the Nonprofit Health Care
3 Plan Law is enacted to read:

4 "[NEW MATERIAL] OPTION TO CHOOSE PEDIATRICIAN AS PRIMARY
5 CARE PHYSICIAN.--

6 A. An individual or group health care plan that
7 is delivered or issued for delivery in this state that
8 requires or provides for the designation of a participating
9 primary care provider shall allow a principal insured to
10 designate for the principal insured's dependent child who is
11 a covered individual an allopathic or osteopathic physician
12 who specializes in pediatrics as the principal insured
13 child's primary care provider if the provider participates in
14 the network of the plan or issuer.

15 B. Nothing in Subsection A of this section shall
16 be construed to waive any exclusions of coverage under the
17 terms and conditions of the health insurance policy or plan
18 with respect to coverage of pediatric care.

19 C. As used in this section, "primary care
20 provider" means a health care practitioner acting within the
21 scope of the health care practitioner's license who provides
22 the first level of basic or general health care for a covered
23 individual's health needs, including diagnostic and treatment
24 services, who initiates referrals to other health care
25 practitioners and who maintains the continuity of care when

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1 appropriate."

2 SECTION 97. A new section of the Nonprofit Health Care
3 Plan Law is enacted to read:

4 "[NEW MATERIAL] ACCESS TO OBSTETRICAL AND GYNECOLOGICAL
5 CARE.--

6 A. An individual or group health care plan that
7 is delivered or issued for delivery in this state that
8 provides coverage for obstetrical and gynecological care and
9 that requires that covered individuals designate a primary
10 care provider shall not require authorization or referral by
11 the plan or issuer or any person, including a primary care
12 provider, when a female covered individual seeks coverage for
13 obstetrical or gynecological care provided by a participating
14 health care professional who specializes in obstetrics or
15 gynecology. The obstetrical or gynecological health care
16 provider shall agree otherwise to adhere to the plan's or
17 issuer's policies and procedures, including procedures
18 regarding referrals, obtaining prior authorization and
19 providing services pursuant to a treatment plan approved by
20 the plan or issuer.

21 B. A health care plan shall treat the provision
22 of obstetrical and gynecological care, and the ordering of
23 related obstetrical and gynecological items and services by a
24 participating health care professional who specializes in
25 obstetrics or gynecology, as the authorization of the primary

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1 care provider.

2 C. Nothing in Subsection A of this section shall
3 be construed to:

4 (1) waive any exclusions of coverage under
5 the terms and conditions of the health care plan or health
6 insurance policy with respect to coverage of obstetrical or
7 gynecological care; or

8 (2) preclude the health care plan from
9 requiring that the obstetrical or gynecological provider
10 notify the covered individual's primary care health care
11 professional or the plan or issuer of treatment decisions.

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

20 SECTION 98. A new section of the Nonprofit Health Care
21 Plan Law is enacted to read:

22 "[NEW MATERIAL] COST-SHARING FOR PREVENTIVE ITEMS AND
23 SERVICES.--

24 A. A health care plan providing coverage under an
25 individual or group health plan shall provide coverage for

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1 all of the following items and services pursuant to Sections
2 99 through 103 of this 2013 act, and shall not impose any
3 cost-sharing requirements, such as a copayment, coinsurance
4 or deductible.

5 B. A health care plan is not required to provide
6 coverage for any items or services specified in any
7 recommendation or guideline described in Subsection A of this
8 section after the recommendation or guideline is no longer
9 described by a source listed in that subsection.

10 C. Other provisions of state or federal law may
11 apply in connection with a health care plan's ceasing to
12 provide coverage for any such items or services.

13 D. To the extent that a preventive care provision
14 in this section conflicts with any other preventive health
15 care law in New Mexico, the provision providing the greatest
16 level of coverage shall apply. The preventive care
17 provisions in this section are intended to supplement rather
18 than supplant existing preventive health care provisions in
19 this state.

20 E. The superintendent shall at least annually
21 revise the preventive services standards established pursuant
22 to Sections 99 through 103 of this 2013 act to ensure that
23 they are consistent with the recommendations of the United
24 States preventive services task force, the advisory committee
25 on immunization practices of the federal centers for disease

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1 control and prevention and the guidelines with respect to
2 infants, children, adolescents and women of evidence-based
3 preventive care and screenings by the federal health
4 resources and services administration. When changes are made
5 to any of these guidelines or recommendations, the
6 superintendent shall make recommendations to the legislature
7 for legislative changes to conform these standards to current
8 guidelines and recommendations.

9 F. A health care plan may impose cost-sharing
10 requirements with respect to an office visit if a preventive
11 item or service provided pursuant to this section is billed
12 separately or is tracked as individual encounter data
13 separately from the office visit.

14 G. A health care plan shall not impose
15 cost-sharing requirements with respect to an office visit for
16 an item or service provided pursuant to this section if an
17 item or service is not billed separately or is not tracked as
18 individual encounter data separately from the office visit
19 and the primary purpose of the office visit is the delivery
20 of the preventive item or service.

21 H. A health care plan may impose cost-sharing
22 requirements with respect to an office visit if a preventive
23 item or service provided pursuant to this section is not
24 billed separately or is not tracked as individual encounter
25 data separately from the office visit and the primary purpose

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1 of the office visit is not the delivery of the preventive
2 item or service.

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

9 SECTION 99. A new section of the Nonprofit Health Care
10 Plan Law is enacted to read:

11 "[NEW MATERIAL] COVERAGE FOR SMOKING AND TOBACCO
12 CESSATION TREATMENT.--

13 A. A health care plan or contract that is
14 delivered or issued for delivery in this state and that
15 offers maternity benefits shall offer coverage for smoking
16 cessation treatment and shall offer augmented counseling
17 tailored to pregnant women who smoke.

18 B. A health care plan shall:

19 (1) offer tobacco cessation intervention
20 coverage for those who use tobacco products;

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

24 (3) provide diagnostic, therapy and
25 counseling services and pharmacotherapy, including the

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1 coverage of prescription and nonprescription tobacco
2 cessation agents approved by the federal food and drug
3 administration for cessation of tobacco use by pregnant
4 women.

5 C. The provisions of this section shall not apply
6 to short-term travel, accident-only or limited or specified-
7 disease health care plans, policies, contracts or
8 certificates of insurance."

9 SECTION 100. A new section of the Nonprofit Health Care
10 Plan Law is enacted to read:

11 "[NEW MATERIAL] CHILDHOOD IMMUNIZATION COVERAGE
12 REQUIRED.--

13 A. A health care plan shall provide coverage for
14 childhood immunizations, as well as coverage for medically
15 necessary booster doses of all immunizing agents used in
16 child immunizations, in accordance with the current schedule
17 of immunizations recommended by the American academy of
18 pediatrics, the advisory committee on immunization practices
19 of the federal centers for disease control and prevention or
20 the United States preventive services task force "A"-rated
21 and "B"-rated recommendations, whichever provides greater
22 coverage.

23 B. The provisions of this section shall not apply
24 to short-term travel, accident-only or limited or specified
25 disease plans or policies."

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1 SECTION 101. A new section of the Nonprofit Health Care
2 Plan Law is enacted to read:

3 "[NEW MATERIAL] PREVENTIVE SERVICES BENEFITS--ASPIRIN
4 REGIMEN--HIGH BLOOD PRESSURE SCREENING--BREAST CANCER
5 SCREENING--LIPID DISORDERS SCREENING--COLORECTAL CANCER
6 SCREENING--DEPRESSION SCREENING--BEHAVIORAL DIETARY
7 COUNSELING--OBESITY COUNSELING AND SCREENING--OSTEOPOROSIS
8 SCREENING--FALLS PREVENTION--SKIN CANCER COUNSELING--HUMAN
9 IMMUNODEFICIENCY VIRUS SCREENING--HEPATITIS C SCREENING--
10 ALCOHOL MISUSE SCREENING AND COUNSELING.--

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

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

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

25 (3) an aspirin regimen for women between the

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1 ages of fifty-five and seventy-nine when the potential
2 benefit of a reduction in ischemic strokes outweighs the
3 potential harm due to an increase in gastrointestinal
4 hemorrhage;

5 (4) screening for high blood pressure in
6 adults aged eighteen and older;

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

13 (6) screening of lipid disorders for:

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

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

18 (7) screening of individuals over eighteen
19 years of age for colorectal cancer using fecal occult blood
20 testing, sigmoidoscopy or colonoscopy;

21 (8) screening of individuals eighteen years
22 of age or older for depression;

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

25 (10) behavioral dietary counseling for

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1 adults with hyperlipidemia and other known risk factors for
2 cardiovascular and diet-related chronic disease;

3 (11) screening and counseling for obesity
4 for individuals six years of age and older;

5 (12) screening for osteoporosis for:

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

8 (b) women who are under sixty-five
9 years of age who are at increased risk for osteoporotic
10 fractures;

11 (13) exercise or physical therapy to prevent
12 falls in community-dwelling adults aged sixty-five years or
13 older who are at increased risk for falls;

14 (14) counseling of individuals at increased
15 risk for skin cancer by minimizing their exposure to
16 ultraviolet radiation;

17 (15) screening for human immunodeficiency
18 virus, also known as "HIV", for:

19 (a) individuals age fifteen to sixty-
20 five years of age; and

21 (b) individuals of any age who are at
22 increased risk of infection;

23 (16) screening for hepatitis C virus, also
24 known as "HCV", infection in adults at high risk of
25 infection, including:

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1 (a) individuals with any history of
2 intravenous drug use; or

3 (b) individuals who received a blood
4 transfusion before the year 1992; and

5 (17) screening and behavioral counseling
6 interventions for alcohol misuse for patients in primary care
7 settings.

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 102. A new section of the Nonprofit Health Care
15 Plan Law is enacted to read:

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

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

22 (1) oral fluoride supplementation at
23 currently recommended doses to children over six months of
24 age whose primary water sources are deficient in fluoride;

25 (2) prophylactic ocular topical medication

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1 against gonococcal ophthalmia neonatorum for newborns;

2 (3) screening for hearing loss in newborns;

3 (4) screening for sickle cell disease for
4 newborns;

5 (5) screening for congenital hypothyroidism
6 for newborns;

7 (6) iron supplementation for asymptomatic
8 children six to twelve months of age who are at increased
9 risk for iron deficiency anemia;

10 (7) screening for phenylketonuria in
11 newborns;

12 (8) screening to detect amblyopia,
13 strabismus and defects in visual acuity in children over
14 three and less than five years of age;

15 (9) counseling of individuals at increased
16 risk for skin cancer to minimize their exposure to
17 ultraviolet radiation; and

18 (10) interventions, including education or
19 brief counseling, to prevent initiation of tobacco use among
20 school-aged children and adolescents.

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

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1 policies or plans."

2 SECTION 103. A new section of the Nonprofit Health Care
3 Plan Law is enacted to read:

4 "[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--
5 REPRODUCTIVE HEALTH.--

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

11 (1) screening for asymptomatic bacteriuria
12 with a urine culture for pregnant women;

13 (2) interventions during pregnancy and after
14 birth to promote and support breastfeeding;

15 (3) screening for cervical cancer in women
16 who have a cervix;

17 (4) screening for chlamydial infection for:

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

20 (b) older women who are at increased
21 risk of chlamydial infection;

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

25 (6) screening of all sexually active women

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1 who are at increased risk for infection, including those who
2 are pregnant, for gonorrheal infection;

3 (7) screening for iron deficiency anemia in
4 asymptomatic pregnant women;

5 (8) Rh (D) blood typing and antibody testing
6 for:

7 (a) all pregnant women; and

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

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

12 (a) all sexually active adolescents;

13 and

14 (b) individuals aged eighteen years
15 and older at increased risk for sexually transmitted
16 infections;

17 (10) screening for hepatitis B virus
18 infection in pregnant women;

19 (11) screening for human immunodeficiency
20 virus for individuals twelve years of age and older who are
21 at risk of human immunodeficiency virus infection;

22 (12) screening for iron deficiency anemia in
23 asymptomatic pregnant women;

24 (13) screening for syphilis for:

25 (a) any individual at increased risk

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1 for syphilis infection; and

2 (b) any pregnant woman;

3 (14) screening of pregnant women for human
4 immunodeficiency virus, also known as "HIV", including those
5 who present at labor whose human immunodeficiency virus
6 status is unknown;

7 (15) screening of women of childbearing age
8 for intimate partner violence, including domestic violence,
9 and referral to or provision of intervention services to
10 individuals whose screening shows a positive result. Nothing
11 in this section shall be construed as a waiver or exception
12 to the Domestic Abuse Insurance Protection Act; and

13 (16) screening and behavioral counseling
14 interventions for pregnant women in primary care settings for
15 alcohol misuse.

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 104. Section 59A-56-3 NMSA 1978 (being Laws
23 1994, Chapter 75, Section 3, as amended) is amended to read:

24 "59A-56-3. DEFINITIONS.--As used in the Health
25 Insurance Alliance Act:

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

3 B. "approved health plan" means any arrangement
4 for the provisions of health insurance offered through and
5 approved by the alliance;

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

8 D. "child" means [~~a dependent unmarried~~] an
9 individual who is less than [~~twenty-five~~] twenty-six years of
10 age;

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

13 (1) a group health plan;

14 (2) health insurance coverage;

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

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

20 (5) 10 USCA Chapter 55;

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

23 (7) the Medical Insurance Pool Act;

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

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

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

5 F. "department" means the insurance division of
6 the commission;

7 G. "director" means an individual who serves on
8 the board;

9 H. "earned premiums" means premiums paid or due
10 during a calendar year for coverage under an approved health
11 plan less any unearned premiums at the end of that calendar
12 year plus any unearned premiums from the end of the
13 immediately preceding calendar year;

14 I. "eligible expenses" means the allowable
15 charges for a health care service covered under an approved
16 health plan;

17 J. "eligible individual":

18 (1) means an individual who:

19 (a) as of the date of the individual's
20 application for coverage under an approved health plan, has
21 an aggregate of eighteen or more months of creditable
22 coverage, the most recent of which was under a group health
23 plan, governmental plan or church plan as those plans are
24 defined in Subsections P, N and D of Section 59A-23E-2 NMSA
25 1978, respectively, or health insurance offered in connection

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1 with any of those plans, but for the purposes of aggregating
2 creditable coverage, a period of creditable coverage shall
3 not be counted with respect to enrollment of an individual
4 for coverage under an approved health plan if, after that
5 period and before the enrollment date, there was a sixty-
6 three-day or longer period during all of which the individual
7 was not covered under any creditable coverage; or

8 (b) is entitled to continuation
9 coverage pursuant to Section 59A-56-20 or 59A-23E-19 NMSA
10 1978; and

11 (2) does not include an individual who:

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

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

17 (c) has health insurance coverage as
18 defined in Subsection R of Section 59A-23E-2 NMSA 1978;

19 (d) during the most recent coverage
20 within the coverage period described in Subparagraph (a) of
21 Paragraph (1) of this subsection was terminated from coverage
22 as a result of nonpayment of premium or fraud; or

23 (e) has been offered the option of
24 coverage under a COBRA continuation provision as that term is
25 defined in Subsection F of Section 59A-23E-2 NMSA 1978, or

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1 under a similar state program, except for continuation
2 coverage under Section 59A-56-20 NMSA 1978, and did not
3 exhaust the coverage available under the offered program;

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

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

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

19 N. "health care service" means a service or
20 product furnished an individual for the purpose of
21 preventing, alleviating, curing or healing human illness or
22 injury and includes services and products incidental to
23 furnishing the described services or products;

24 O. "health insurance" means "health" insurance as
25 defined in Section 59A-7-3 NMSA 1978; any hospital and

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1 medical expense-incurred policy; nonprofit health care plan
2 service contract; health maintenance organization subscriber
3 contract; short-term, accident, fixed indemnity, specified
4 disease policy or disability income insurance contracts and
5 limited health benefit or credit health insurance; coverage
6 for health care services under uninsured arrangements of
7 group or group-type contracts, including employer self-
8 insured, cost-plus or other benefits methodologies not
9 involving insurance or not subject to New Mexico premium
10 taxes; coverage for health care services under group-type
11 contracts that are not available to the general public and
12 can be obtained only because of connection with a particular
13 organization or group; coverage by medicare or other
14 governmental programs providing health care services; but
15 "health insurance" does not include insurance issued pursuant
16 to provisions of the Workers' Compensation Act or similar
17 law, automobile medical payment insurance or provisions by
18 which benefits are payable with or without regard to fault
19 and are required by law to be contained in any liability
20 insurance policy;

21 P. "health maintenance organization" means a
22 health maintenance organization as defined by Subsection M of
23 Section 59A-46-2 NMSA 1978;

24 Q. "incurred claims" means claims paid during a
25 calendar year plus claims incurred in the calendar year and

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1 paid prior to April 1 of the succeeding year, less claims
2 incurred previous to the current calendar year and paid prior
3 to April 1 of the current year;

4 R. "insured" means a small employer or its
5 employee and an individual covered by an approved health
6 plan, a former employee of a small employer who is covered by
7 an approved health plan through conversion or an individual
8 covered by an approved health plan that allows individual
9 enrollment;

10 S. "medicare" means coverage under both Parts A
11 and B of Title 18 of the federal Social Security Act;

12 T. "member" means a member of the alliance;

13 U. "nonprofit health care plan" means a health
14 care plan as defined in Subsection K of Section 59A-47-3 NMSA
15 1978;

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

19 W. "small employer" means a person that is a
20 resident of this state, that has employees at least fifty
21 percent of whom are residents of this state, that is actively
22 engaged in business and that, on at least fifty percent of
23 its working days during either of the two preceding calendar
24 years, employed no fewer than two and no more than fifty
25 eligible employees; provided that:

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1 (1) in determining the number of eligible
2 employees, the spouse or dependent of an employee may, at the
3 employer's discretion, be counted as a separate employee;

4 (2) companies that are affiliated companies
5 or that are eligible to file a combined tax return for
6 purposes of state income taxation shall be considered one
7 employer; and

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

14 X. "superintendent" means the superintendent of
15 insurance;

16 Y. "total premiums" means the total premiums for
17 business written in the state received during a calendar
18 year; and

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

22 SECTION 105. Section 59A-56-14 NMSA 1978 (being Laws
23 1994, Chapter 75, Section 14, as amended) is amended to read:

24 "59A-56-14. ELIGIBILITY--GUARANTEED ISSUE--PLAN
25 PROVISIONS.--

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

3 (1) at least fifty percent of its employees
4 not otherwise insured elect to be covered under the approved
5 health plan;

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

10 (3) the small employer does not offer other
11 general group health insurance coverage to its employees.

12 For the purposes of this paragraph, general group health
13 insurance coverage excludes coverage that:

14 (a) is offered by a state or federal
15 agency to a small employer's employee whose eligibility for
16 alternative coverage is based on the employee's income; or

17 (b) provides only a specific limited
18 form of health insurance such as accident or disability
19 income insurance coverage or a specific health care service
20 such as dental care.

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

25 C. An approved health plan shall provide in

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1 substance that attainment of the limiting age by an unmarried
2 dependent individual does not operate to terminate coverage
3 when the individual continues to be incapable of self-
4 sustaining employment by reason of developmental disability
5 or physical handicap and the individual is primarily
6 dependent for support and maintenance upon the employee.

7 Proof of incapacity and dependency shall be furnished to the
8 alliance and the member that offered the approved health plan
9 within one hundred twenty days of attainment of the limiting
10 age. The board may require subsequent proof annually after a
11 two-year period following attainment of the limiting age.

12 D. An approved health plan shall provide that the
13 health insurance benefits applicable for eligible dependents
14 are payable with respect to a newly born child of the family
15 member or the individual in whose name the contract is issued
16 from the moment of birth, including the necessary care and
17 treatment of medically diagnosed congenital defects and birth
18 abnormalities. If payment of a specific premium is required
19 to provide coverage for the child, the contract may require
20 that notification of the birth of a child and payment of the
21 required premium shall be furnished to the member within
22 thirty-one days after the date of birth in order to have the
23 coverage from birth. An approved health plan shall provide
24 that the health insurance benefits applicable for eligible
25 dependents are payable for an adopted child in accordance

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1 with the provisions of Section 59A-22-34.1 NMSA 1978.

2 E. ~~[Except as provided in Subsections G, H and I~~
3 ~~of this section]~~ An approved health plan offered to a small
4 employer shall not contain a preexisting condition exclusion
5 that relates to an individual under nineteen years of age.
6 An approved health plan may contain a preexisting condition
7 exclusion that relates to an individual over nineteen years
8 of age only if:

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

14 (2) the exclusion extends for a period of
15 not more than six months after the enrollment date; and

16 (3) the period of the exclusion is reduced
17 by the aggregate of the periods of creditable coverage
18 applicable to the participant or beneficiary as of the
19 enrollment date.

20 F. As used in this section, "preexisting
21 condition exclusion" means a limitation or exclusion of
22 benefits relating to a condition based on the fact that the
23 condition was present before the date of enrollment for
24 coverage for the benefits whether or not any medical advice,
25 diagnosis, care or treatment was recommended or received

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1 before that date, but genetic information is not included as
2 a preexisting condition for the purposes of limiting or
3 excluding benefits in the absence of a diagnosis of the
4 condition related to the genetic information.

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

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

10 [~~(2) that excludes a child who is adopted or~~
11 ~~placed for adoption before the child's eighteenth birthday~~
12 ~~and who, as of the last day of the thirty-day period~~
13 ~~beginning on and following the date of the adoption or~~
14 ~~placement for adoption, is covered under creditable coverage]~~
15 or

16 [~~(3)~~] (2) that relates to or includes
17 pregnancy as a preexisting condition.

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

23 I. The preexisting condition exclusions described
24 in Subsection E of this section shall be waived to the extent
25 to which similar exclusions have been satisfied under any

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1 prior health insurance coverage if the effective date of
2 coverage for health insurance through the alliance is made
3 not later than sixty-three days following the termination of
4 the prior coverage. In that case, coverage through the
5 alliance shall be effective from the date on which the prior
6 coverage was terminated. This subsection does not prohibit
7 preexisting conditions coverage in an approved health plan
8 that is more favorable to the covered individual than that
9 specified in this subsection.

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

13 K. An individual is not eligible for coverage by
14 the alliance under an approved health plan issued to a small
15 employer if the individual:

16 (1) is eligible for medicare; provided,
17 however, that if an individual has health insurance coverage
18 from an employer whose group includes twenty or more
19 individuals, an individual eligible for medicare who
20 continues to be employed may choose to be covered through an
21 approved health plan;

22 (2) has voluntarily terminated health
23 insurance issued through the alliance within the past twelve
24 months unless it was due to a change in employment; or

25 (3) is an inmate of a public institution.

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1 L. The alliance shall provide for an open
2 enrollment period of sixty days from the initial offering of
3 an approved health plan. Individuals enrolled during the
4 open enrollment period shall not be subject to the
5 preexisting conditions limitation.

6 M. If an insured covered by an approved health
7 plan switches to another approved health plan that provides
8 increased or additional benefits such as lower deductible or
9 copayment requirements, the member offering the approved
10 health plan with increased or additional benefits may require
11 the six-month period for preexisting conditions provided in
12 Subsection E of this section to be satisfied prior to receipt
13 of the additional benefits."

14 **SECTION 106.** A new section of the Health Insurance
15 Alliance Act is enacted to read:

16 "NEW MATERIAL ELIGIBILITY--GUARANTEED ISSUE--
17 GUARANTEED RENEWABILITY--MAXIMUM WAITING PERIOD--PLAN
18 PROVISIONS.--

19 A. A small employer who applies for an approved
20 health plan and agrees to make the required premium payments
21 and to satisfy the other reasonable provisions of the
22 approved health plan is eligible for an approved health plan.
23 The alliance shall:

24 (1) offer coverage to all of the eligible
25 employees of the employer and their children and dependents

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1 who apply for enrollment during the period in which the
2 employee first becomes eligible to enroll under the terms of
3 the plan; and

4 (2) not offer coverage only to certain
5 individuals or certain children or dependents of employees in
6 the group or only to part of the group.

7 B. An approved health plan that offers coverage
8 through a network plan shall not be required to offer
9 coverage under that plan or accept applications for that plan
10 pursuant to Subsection A of this section under the following
11 circumstances:

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

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

18 (3) within the geographic service area for
19 the network plan where the insurer reasonably anticipates,
20 and demonstrates to the satisfaction of the superintendent,
21 that it will not have the capacity within its established
22 geographic service area to deliver service adequately to the
23 members of the groups because of its obligations to existing
24 group policyholders and enrollees.

25 C. An approved health plan may restrict

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1 enrollment in coverage described in Subsection A of this
2 section to open or special enrollment periods; provided that
3 any special enrollment period shall comply with the
4 provisions of Section 107 of this 2013 act and rules that the
5 superintendent has promulgated.

6 D. An approved health plan may impose a waiting
7 period not to exceed ninety days before payment for any
8 service related to a preexisting condition. An approved
9 health plan shall offer or make a referral to a transition
10 product to provide coverage during the waiting period due to
11 a preexisting condition.

12 E. An approved health plan shall renew any health
13 benefit plan at the option of the employer, except as the
14 superintendent has provided by rule.

15 F. An approved health plan shall provide in
16 substance that attainment of the limiting age by an unmarried
17 dependent individual does not operate to terminate coverage
18 when the individual continues to be incapable of
19 self-sustaining employment by reason of developmental
20 disability or physical handicap and the individual is
21 primarily dependent for support and maintenance upon the
22 employee. Proof of incapacity and dependency shall be
23 furnished to the alliance and the member that offered the
24 approved health plan within one hundred twenty days of
25 attainment of the limiting age. The board may require

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1 subsequent proof annually after a two-year period following
2 attainment of the limiting age.

3 G. An approved health plan shall provide that the
4 health insurance benefits applicable for eligible dependents
5 are payable with respect to a newly born child of the family
6 member or the individual in whose name the contract is issued
7 from the moment of birth, including the necessary care and
8 treatment of medically diagnosed congenital defects and birth
9 abnormalities. If payment of a specific premium is required
10 to provide coverage for the child, the contract may require
11 that notification of the birth of a child and payment of the
12 required premium shall be furnished to the member within
13 thirty-one days after the date of birth in order to have the
14 coverage from birth. An approved health plan shall provide
15 that the health insurance benefits applicable for eligible
16 dependents are payable for an adopted child in accordance
17 with the provisions of Section 59A-22-34.1 NMSA 1978.

18 H. If an insured covered by an approved health
19 plan switches to another approved health plan that provides
20 increased or additional benefits such as lower deductible or
21 copayment requirements, the member offering the approved
22 health plan with increased or additional benefits may require
23 the ninety-day period for preexisting conditions provided in
24 Subsection D of this section to be satisfied prior to receipt
25 of the additional benefits.

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1 I. For the purposes of this section:

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

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

19 SECTION 107. A new section of the Health Insurance
20 Alliance Act is enacted to read:

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

24 A. For health plan or policy years beginning on
25 or after September 23, 2010, if a child's coverage ended or

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~~[bracketed material] = delete~~

1 did not begin for the reasons described in Subsection E of
2 this section, an approved health plan shall provide the child
3 an opportunity to enroll in the approved health plan for
4 which coverage continues for at least sixty days and provide
5 written notice of the opportunity to enroll, as described in
6 Subsection B of this section, no later than the first day of
7 the plan year.

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

23 C. For an individual who enrolls in an approved
24 health plan pursuant to Subsection A of this section, the
25 coverage shall take effect not later than the first day of

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1 the first plan year.

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

13 E. The provisions of this section shall apply to
14 a child:

15 (1) whose coverage ended, or who was denied
16 coverage or was not eligible for coverage under an approved
17 health plan, because under the terms of coverage the
18 availability of dependent coverage of a child ended before
19 the child reached the age of twenty-six; or

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

24 **SECTION 108.** Section 59A-57-2 NMSA 1978 (being Laws
25 1998, Chapter 107, Section 2) is amended to read:

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1 "59A-57-2. PURPOSE OF ACT.--The purpose of the Patient
2 Protection Act is to regulate aspects of health insurance by
3 specifying patient and provider rights and confirming and
4 clarifying the authority of the department to adopt
5 regulations to provide protections to persons enrolled in
6 ~~[managed]~~ health insurance policies or health care plans.
7 The insurance protections should ensure that ~~[managed]~~ health
8 insurance policies or health care plans treat patients fairly
9 and arrange for the delivery of good quality services."

10 SECTION 109. Section 59A-57-3 NMSA 1978 (being Laws
11 1998, Chapter 107, Section 3) is amended to read:

12 "59A-57-3. DEFINITIONS.--As used in the Patient
13 Protection Act:

14 A. "continuous quality improvement" means an
15 ongoing and systematic effort to measure, evaluate and
16 improve a ~~[managed]~~ health insurance policy's or health care
17 plan's process in order to improve continually the quality of
18 health care services provided to enrollees;

19 B. "covered person", "enrollee", "patient" or
20 "consumer" means an individual who is entitled to receive
21 health care benefits provided by a ~~[managed]~~ health insurance
22 policy or health care plan;

23 C. "department" means the insurance department;

24 D. "emergency care" means health care procedures,
25 treatments or services delivered to a covered person after

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1 the sudden onset of what reasonably appears to be a medical
2 condition that manifests itself by symptoms of sufficient
3 severity, including severe pain, that the absence of
4 immediate medical attention could be reasonably expected by a
5 reasonable layperson to result in jeopardy to a person's
6 health, serious impairment of bodily functions, serious
7 dysfunction of a bodily organ or part or disfigurement to a
8 person;

9 E. "health care facility" means an institution
10 providing health care services, including a hospital or other
11 licensed inpatient center; an ambulatory surgical or
12 treatment center; a skilled nursing center; a residential
13 treatment center; a home health agency; a diagnostic,
14 laboratory or imaging center; and a rehabilitation or other
15 therapeutic health setting;

16 F. "health care insurer" means a person that has
17 a valid certificate of authority in good standing under the
18 Insurance Code to act as an insurer, health maintenance
19 organization, nonprofit health care plan or prepaid dental
20 plan;

21 G. "health care professional" means a physician
22 or other health care practitioner, including a pharmacist,
23 who is licensed, certified or otherwise authorized by the
24 state to provide health care services consistent with state
25 law;

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underscored material = new
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1 H. "health care provider" or "provider" means a
2 person that is licensed or otherwise authorized by the state
3 to furnish health care services and includes health care
4 professionals and health care facilities;

5 I. "health care services" includes, to the extent
6 offered by the health insurance policy or health care plan,
7 physical health or community-based mental health or
8 developmental disability services, including services for
9 developmental delay;

10 J. "managed health care plan" [~~or "plan"~~] means a
11 health care insurer or a provider service network when
12 offering a benefit that either requires a covered person to
13 use, or creates incentives, including financial incentives,
14 for a covered person to use, health care providers managed,
15 owned, under contract with or employed by the health care
16 insurer or provider service network; [~~"Managed health care
17 plan" or "plan" does not include a health care insurer or
18 provider service network offering a traditional fee-for-
19 service indemnity benefit or a benefit that covers only
20 short-term travel, accident-only, limited benefit, student
21 health plan or specified disease policies]~~]

22 K. "health insurance policy" or "health care
23 plan" means a hospital, surgical and medical expense-incurred
24 policy, plan or contract offered by a health insurer,
25 nonprofit health service provider, health maintenance

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1 organization, managed care organization or provider service
2 organization; "health insurance policy" or "health care plan"
3 does not include a policy or plan intended to supplement
4 major medical group-type coverage, such as medicare, long-
5 term care, disability income, specified disease, accident-
6 only, hospital indemnity or any other limited-benefit health
7 insurance policy or health care plan;

8 [K.] L. "person" means an individual or other
9 legal entity;

10 [L.] M. "point-of-service plan" or "open plan"
11 means a [~~managed~~] health care plan that allows enrollees to
12 use health care providers other than providers under direct
13 contract with or employed by the health care plan, even if
14 the plan provides incentives, including financial incentives,
15 for covered persons to use the plan's designated
16 participating providers;

17 [M.] N. "provider service network" means two or
18 more health care providers affiliated for the purpose of
19 providing health care services to covered persons on a
20 capitated or similar prepaid flat-rate basis that hold a
21 certificate of authority pursuant to the Provider Service
22 Network Act;

23 [N.] O. "superintendent" means the superintendent
24 of insurance; and

25 [O.] P. "utilization review" means a system for

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1 reviewing the appropriate and efficient allocation of health
2 care services given or proposed to be given to a patient or
3 group of patients."

4 SECTION 110. Section 59A-57-4 NMSA 1978 (being Laws
5 1998, Chapter 107, Section 4) is amended to read:

6 "59A-57-4. PATIENT RIGHTS--DISCLOSURES--RIGHTS TO
7 BASIC AND COMPREHENSIVE HEALTH CARE SERVICES--GRIEVANCE
8 PROCEDURE-- UTILIZATION REVIEW PROGRAM--CONTINUOUS QUALITY
9 PROGRAM.--

10 A. Each covered person enrolled in a ~~[managed]~~
11 health insurance policy or health care plan has the right to
12 be treated fairly. A ~~[managed]~~ health insurance policy or
13 health care plan shall arrange for the delivery of good
14 quality and appropriate health care services to enrollees as
15 defined in the particular subscriber agreement. The
16 department shall adopt regulations to implement the
17 provisions of the Patient Protection Act and shall monitor
18 and oversee a ~~[managed]~~ health insurance policy or health
19 care plan to ensure that each covered person enrolled in a
20 health insurance policy or plan is treated fairly and in
21 accordance with the requirements of the Patient Protection
22 Act. In adopting regulations to implement the provisions of
23 Subparagraphs (a) and (b) of Paragraph (3) and Paragraphs (5)
24 and (6) of Subsection B of this section regarding health care
25 standards and specialists, utilization review programs and

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1 continuous quality improvement programs, the department shall
2 cooperate with and seek advice from the department of health.

3 B. The regulations adopted by the department to
4 protect patient rights shall provide at a minimum that:

5 (1) prior to or at the time of enrollment, a
6 ~~[managed]~~ health insurance policy or health care plan shall
7 provide a summary of benefits and exclusions, premium
8 information and a provider listing. Within a reasonable time
9 after enrollment and at subsequent periodic times as
10 appropriate, a ~~[managed]~~ health insurance policy or health
11 care plan shall provide written material that contains, in a
12 clear, conspicuous and readily understandable form, a full
13 and fair disclosure of the policy's or plan's benefits,
14 limitations, exclusions, conditions of eligibility, prior
15 authorization requirements, enrollee financial responsibility
16 for payments, grievance procedures, appeal rights and the
17 patients' rights generally available to all covered persons;

18 (2) a ~~[managed]~~ health insurance policy or
19 health care plan shall provide health care services that are
20 reasonably accessible and available in a timely manner to
21 each covered person;

22 (3) in providing reasonably accessible
23 health care services that are available in a timely manner, a
24 ~~[managed]~~ health insurance policy or health care plan shall
25 ensure that:

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1 (a) the policy or plan offers
2 sufficient numbers and types of qualified and adequately
3 staffed health care providers at reasonable hours of service
4 to provide health care services to the policy's or plan's
5 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
22 provider selection, provider education, the provision of
23 additional resources or other means, reasonably addresses the
24 cultural 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 111. 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
11 health care plan shall establish and adequately staff a
12 consumer assistance office. The purpose of the consumer
13 assistance office is to respond to consumer questions and
14 concerns and assist patients in exercising their rights and
15 protecting their interests as consumers of health care.

16 B. Each [~~managed~~] health insurance policy or
17 health care plan shall establish a consumer advisory board.
18 The 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]~~ that 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 112.** 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
19 RULES PROHIBITED--GRIEVANCE PROCEDURE FOR PROVIDERS.--

20 A. ~~[No managed]~~ A health insurance policy or
21 health 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
6 violate 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 113. 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 114. 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
10 a ~~[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
24 is 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 115.** 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 116.** 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 117. TEMPORARY PROVISION--RULEMAKING.--The
23 superintendent of insurance shall adopt and promulgate rules
24 pursuant to the provisions of this act.

25 SECTION 118. DELAYED REPEAL.--Effective January 1,

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1 2014, Sections 23, 42, 74, 94 and 105 of this act are
2 repealed.

3 SECTION 119. EFFECTIVE DATE.--

4 A. The effective date of the provisions of
5 Sections 1, 3 through 5, 7 through 18, 21 through 38, 40, 42
6 through 53, 55 through 68, 70, 71, 73 through 90, 92, 94
7 through 105 and 107 through 117 of this act is June 14, 2013.

8 B. The effective date of the provisions of
9 Sections 2, 6, 19, 20, 39, 41, 54, 69, 72, 91, 93 and 106 of
10 this act is January 1, 2014.