HOUSE HEALTH AND HUMAN SERVICES COMMITTEE SUBSTITUTE FOR
HOUSE BILL 285

54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019

Pursuant to House Rule 24-1, this document incorporates amendments that have been adopted prior to consideration of this measure by the House. It is a tool to show the amendments in context and is not to be used for the purpose of amendments.

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING THE SHORT-TERM HEALTH PLAN AND EXCEPTED BENEFIT ACT TO ESTABLISH GUIDELINES RELATING TO SHORT-TERM HEALTH AND EXCEPTED BENEFIT COVERAGE; ENACTING A NEW SECTION OF CHAPTER 59A, ARTICLE 16 NMSA 1978 TO BAN THE SALE AND ISSUANCE OF UNLICENSED AND UNAPPROVED HEALTH BENEFITS PLANS; AMENDING SECTIONS OF THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO ESTABLISH DIRECT-SERVICE RATIO APPLICABILITY FOR SHORT-TERM PLANS.

.213296.3

underscored material = new
[~~bracketed material~~] = delete
Amendments: new = →bold, blue, highlight←
delete = →~~bold, red, highlight, strikethrough~~←

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

SECTION 1. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] SHORT TITLE.--Sections 1 through 6 of this act may be cited as the "Short-Term Health Plan and Excepted Benefit Act"."

SECTION 2. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] DEFINITIONS.--As used in the Short-Term Health Plan and Excepted Benefit Act:

A. "bona fide association" means an association that has been in existence for not less than five years and that exists for purposes other than the business of insurance;

B. "excepted benefits" means benefits furnished pursuant to the following:

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

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

(3) liability insurance;

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other similar insurance coverage specified in regulations under which benefits for medical care are secondary or incidental to other benefits;

(9) the following benefits if offered separately:

(a) limited-scope dental or vision benefits;

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

(c) other similar excepted benefits specified in rule;

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

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

(b) hospital indemnity or other fixed indemnity insurance;

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

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

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

(12) other similar individual or group

insurance coverage or arrangement designated by the superintendent pursuant to rule under which benefits are secondary or incidental to health events, services or medical care;

C. "excepted benefits plan" means a health benefits plan that offers only HCEDC➜~~an~~➜HCEDC excepted HCEDC➜~~benefit~~➜HCEDC HCEDC➜benefits➜HCEDC;

D. "health benefits plan" means an individual or group policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services HCEDC➜~~, other than excepted benefits~~➜HCEDC;

E. "health insurance carrier" means an entity subject to the insurance laws of the state, including a health insurance company, a health maintenance organization, a hospital and health services corporation, a provider service network, a nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services, or that provides, offers or administers health benefits plans or managed health care plans in the state;

F. "health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise, and items, including items and

services paid for as medical care, pursuant to any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance carrier;

G. "major medical coverage" means a health benefits plan that provides benefits other than excepted benefits;

H. "permitted health insurance coverage" means a health benefits plan, excepted benefits plan, short-term plan and other categories or types of health insurance coverage designated by the superintendent; and

I. "short-term plan" means a nonrenewable health benefits plan covering a resident of the state, regardless of where the plan is delivered, that:

(1) has a maximum specified duration of not more than three months after the effective date of the plan; HCEDC→~~and~~←HCEDC

(2) is issued only to individuals who have not been enrolled in a health benefits plan that provides the same or similar nonrenewable coverage from any health insurance carrier within the three months preceding enrollment in the short-term plan HCEDC→~~."~~←HCEDC HCEDC→**; and**←HCEDC

HCEDC→**(3) is not an excepted benefit or combination of excepted benefits."**←HCEDC

SECTION 3. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] SHORT-TERM PLANS--EXCEPTED BENEFITS--STANDARDS FOR POLICY PROVISIONS.--

A. The superintendent shall adopt and promulgate

rules to establish specific standards:

(1) that set the manner, content and required disclosure for the sale of short-term plans and excepted benefits plans, including standards for full and fair disclosure; and

(2) for the sale of short-term plans and excepted benefits plans, which standards shall include standards relating to:

(a) terms of renewability or extension of coverage;

(b) initial and subsequent conditions of eligibility;

(c) nonduplication of coverage provisions;

(d) coverage of dependents;

(e) preexisting conditions;

(f) termination of insurance;

(g) probationary periods;

(h) limitations;

(i) exceptions;

(j) reductions and exclusions;

(k) elimination periods;

(l) requirements for replacement by the health insurance carrier;

(m) recurrent conditions;

(n) the definition of terms to describe the specific types of coverage sold pursuant to the Short-Term Health Plan and Excepted Benefit Act and specific standards and policy provisions required of these plans;

(o) benefit duration;

(p) scope of coverage;

(q) advertising and marketing;

(r) sales practices;

(s) mandatory disclosures;

(t) coverage suitability; and

(u) policy and certificate approval.

B. All advertisements, marketing materials and application and policy forms relating to short-term plans shall prominently display a notice that the coverage is unavailable to any potential insured who has been covered under a short-term plan in the previous twelve-month period."

SECTION 4. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] BENEFITS--MINIMUM STANDARDS.--

A. The superintendent shall adopt and promulgate rules to establish minimum standards for benefits provided by short-term plans and excepted benefits plans that are subject to the Short-Term Health Plan and Excepted Benefit Act.

B. Rules of the superintendent shall require short-term plans to cover state-mandated benefits in addition to each of the following categories of benefits:

(1) diagnostic;

(2) rehabilitative;

(3) maternity;

(4) neonatal;

(5) behavioral health services;

(6) emergency services;

(7) hospitalization;

(8) ambulatory services; and

(9) prescription drugs."

SECTION 5. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] RATES--MEDICAL LOSS RATIOS.--The superintendent shall adopt and promulgate rules to establish standards for rates, including medical loss ratios, of short-term plans and excepted benefits plans. Rules relating to rates shall be based on generally recognized and current actuarial standards."

SECTION 6. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] PROHIBITION--ASSOCIATION, TRUST OR MULTIPLE EMPLOYER WELFARE ARRANGEMENT PLANS.--No insurer shall issue, and no association, trust or multiple employer welfare arrangement shall offer, a short-term or excepted benefits plan to a resident of the state unless through a bona fide association."

SECTION 7. A new section of Chapter 59A, Article 16 NMSA 1978 is enacted to read:

"[NEW MATERIAL] HEALTH BENEFITS PLANS--PROHIBITION--UNLICENSED HEALTH BENEFITS PLANS--UNAPPROVED HEALTH BENEFITS PLANS.--

A. No person or entity shall sell or issue, or cause to be sold or issued, a health benefits plan that is unlicensed or unapproved for sale or delivery in the state.

B. No person or entity shall sell or issue, or cause to be sold or issued, health insurance coverage that is not permitted health insurance coverage.

C. As used in this section:

(1) "health benefits plan" means a policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services; and

(2) "health insurance carrier" means an entity subject to the insurance laws and regulations of this state, including a health insurance company, a health maintenance organization, a hospital and health services corporation, a provider service network, a nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services, or that provides, offers or administers health benefits plans or managed health care plans in this state."

SECTION 8. Section 59A-22-50 NMSA 1978 (being Laws 2010, Chapter 94, Section 1, as amended) is amended to read:

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

A. A health insurer shall make reimbursement for

direct services at a level not less than eighty-five percent of premiums across all health product lines, [~~except~~] including short-term plans and excluding individually underwritten health insurance policies, contracts or plans, that are governed by the provisions of Chapter 59A, Article 22 NMSA 1978, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law, and an excepted benefit policy intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or a plan that only issues policies for long-term care or disability income. Reimbursement shall be made for direct services provided over the preceding three calendar years, but not earlier than calendar year 2010, as determined by reports filed with the office of superintendent of insurance. Nothing in this subsection shall be construed to preclude a purchaser from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services for one or more products or for one or more years.

B. For individually underwritten health care policies, plans or contracts, the superintendent shall establish, after notice and informal hearing, the level of reimbursement for direct services, as determined by the reports filed with the office of superintendent of insurance, as a

percent of premiums. Additional informal hearings may be held at the superintendent's discretion. In establishing the level of reimbursement for direct services, the superintendent shall consider the costs associated with the individual marketing and medical underwriting of these policies, plans or contracts at a level not less than seventy-five percent of premiums. A health insurer writing these policies shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which that rate is established, but not earlier than calendar year 2010. Nothing in this subsection shall be construed to preclude a purchaser of one of these policies, plans or contracts from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services.

HCEDC→~~C. For excepted benefit policies, plans or contracts, the superintendent shall establish by rule the level of reimbursement for direct services, which level of reimbursement shall be determined by reports filed with the office of superintendent of insurance, as a percent of premiums. A health insurer writing these policies, plans or contracts shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which the rate is established. Nothing in this subsection shall be construed to preclude a purchaser of one of these policies, plans or~~

~~contracts from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement of direct services.~~HCEDC

[~~C.~~] HCEDC→~~D.~~ C.←HCEDC An insurer that fails to comply with the reimbursement requirements pursuant to this section shall issue a dividend or credit against future premiums to all policyholders in an amount sufficient to [~~assure~~] ensure that the benefits paid in the preceding three calendar years plus the amount of the dividends or credits are equal to the required direct services reimbursement level pursuant to Subsection A of this section for group health coverage and blanket health coverage or the required direct services reimbursement level pursuant to Subsection B of this section for individually underwritten health policies, contracts or plans for the preceding three calendar years. If the insurer fails to issue the dividend or credit in accordance with the requirements of this section, the superintendent shall enforce these requirements and may pursue any other penalties as provided by law, including general penalties pursuant to Section 59A-1-18 NMSA 1978.

[~~D.~~] HCEDC→~~E.~~ D.←HCEDC After notice and hearing, the superintendent may adopt and promulgate reasonable rules necessary and proper to carry out the provisions of this section.

[~~E.~~] HCEDC→~~F.~~ E.←HCEDC For the purposes of this section:

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

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

(3) "premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from third parties or other insurers and interests less any premium tax paid pursuant to Section

59A-6-2 NMSA 1978 and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance; and

(4) "short-term plan" means a nonrenewable health benefits plan covering a resident of the state, regardless of where the plan is delivered, that:

(a) has a maximum specified duration of not more than three months after the effective date of the plan; and

(b) is issued only to individuals who have not been enrolled in a health benefits plan that provides the same or similar nonrenewable coverage from any health insurance carrier within the three months preceding enrollment in the short-term plan."

SECTION 9. That version of Section 59A-22-50 NMSA 1978 (being Laws 2010, Chapter 94, Section 1, as amended) that is to become effective January 1, 2020 is amended to read:

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

A. A health insurer shall make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines, [~~except~~] including short-term plans and excluding individually underwritten health insurance policies, contracts or plans, that are governed by the provisions of Chapter 59A, Article 22 NMSA 1978, the Health Maintenance Organization Law and the Nonprofit Health Care Plan

Law, and an excepted benefit policy intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or a plan that only issues policies for long-term care or disability income. Reimbursement shall be made for direct services provided over the preceding three calendar years, but not earlier than calendar year 2010, as determined by reports filed with the office of superintendent of insurance. Nothing in this subsection shall be construed to preclude a purchaser from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services for one or more products or for one or more years.

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

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

HCEDC→~~C. For excepted benefit policies, plans or contracts, the superintendent shall establish by rule the level of reimbursement for direct services, which level of reimbursement shall be determined by reports filed with the office of superintendent of insurance, as a percent of premiums. A health insurer writing these policies, plans or contracts shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which the rate is established. Nothing in this subsection shall be construed to preclude a purchaser of one of these policies, plans or contracts from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement of direct services.~~←HCEDC

[~~C.~~] HCEDC→~~D.~~ C.←HCEDC An insurer that fails to comply with the reimbursement requirements pursuant to this section shall issue a dividend or credit against future premiums to all policyholders in an amount sufficient to [~~assure~~] ensure that

the benefits paid in the preceding three calendar years plus the amount of the dividends or credits are equal to the required direct services reimbursement level pursuant to Subsection A of this section for group health coverage and blanket health coverage or the required direct services reimbursement level pursuant to Subsection B of this section for individually underwritten health policies, contracts or plans for the preceding three calendar years. If the insurer fails to issue the dividend or credit in accordance with the requirements of this section, the superintendent shall enforce these requirements and may pursue any other penalties as provided by law, including general penalties pursuant to Section 59A-1-18 NMSA 1978.

[~~D.~~] HCEDC→~~E.~~ D.←HCEDC After notice and hearing, the superintendent may adopt and promulgate reasonable rules necessary and proper to carry out the provisions of this section.

[~~E.~~] HCEDC→~~F.~~ E.←HCEDC For the purposes of this section:

(1) "direct services" means services rendered to an individual by a health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of an assessment that covers services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act; provided, however, that "direct services" does not include care coordination, utilization review or management or any other

activity designed to manage utilization or services;

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

(3) "premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from third parties or other insurers and interests less any tax paid pursuant to the Insurance Premium Tax Act and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance; and

(4) "short-term plan" means a nonrenewable health benefits plan covering a resident of the state, regardless of where the plan is delivered, that:

(a) has a maximum specified duration of not more than three months after the effective date of the

plan; and

(b) is issued only to individuals who have not been enrolled in a health benefits plan that provides the same or similar nonrenewable coverage from any health insurance carrier within the three months preceding enrollment in the short-term plan."

SECTION 10. Section 59A-46-2 NMSA 1978 (being Laws 1993, Chapter 266, Section 2, as amended) is amended to read:

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

A. "basic health care services":

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

(2) does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment;

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

C. "carrier" means a health maintenance organization, an insurer, a nonprofit health care plan or other entity responsible for the payment of benefits or provision of

services under a group contract;

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

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

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

G. "direct services" means services rendered to an individual by a carrier or a health care practitioner, facility or other provider, which services include case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any proportion of an assessment that covers services rather than administration and for which a carrier does not receive a tax credit pursuant to the Medical Insurance Pool Act; provided that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

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

[~~H.~~] I. "evidence of coverage" means a policy,

contract or certificate showing the essential features and services of the health maintenance organization coverage that is given to the subscriber by the health maintenance organization or by the group contract holder;

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

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

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

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

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

[~~N.~~] O. "health maintenance organization" means [~~any~~] a person [~~who~~] that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles, including a carrier that issues:

(1) a short-term contract;

(2) an excepted benefit policy or contract intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies; or

(3) a policy for long-term care or disability income;

[~~O.~~] P. "health maintenance organization agent" means a person who solicits, negotiates, effects, procures, delivers, renews or continues a policy or contract for health maintenance organization membership or who takes or transmits a membership fee or premium for such a policy or contract, other than for that person, or a person who advertises or otherwise makes any representation to the public as such;

[~~P.~~] Q. "individual contract" means a contract for health care services issued to and covering an individual and it may include dependents of the subscriber;

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

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

[~~S.~~] T. "net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt;

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

[~~U.~~] V. "person" means an individual or other legal entity;

[~~V.~~] W. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act;

[~~W.~~] X. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act;

Y. "premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from third parties or other carriers and interests less any premium tax paid pursuant to Section 59A-6-2 NMSA 1978 and fees associated with participating in a

health insurance exchange that serves as a clearinghouse for insurance;

[~~X.~~] Z. "provider" means a physician, pharmacist, pharmacist clinician, hospital or other person licensed or otherwise authorized to furnish health care services;

[~~Y.~~] AA. "replacement coverage" means the benefits provided by a succeeding carrier;

BB. "short-term contract" means a nonrenewable health maintenance organization contract covering a resident of the state, regardless of where the contract is delivered, that:

(1) has a maximum specified duration of not more than three months after the effective date of the contract; and

(2) is issued only to individuals who have not been enrolled in a health maintenance organization contract that provides the same or similar nonrenewable coverage from any carrier within the three months preceding enrollment in the short-term contract;

[~~Z.~~] CC. "subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization or, in the case of an individual contract, the person in whose name the contract is issued; and

[~~AA.~~] DD. "uncovered expenditures" means the costs to the health maintenance organization for health care services

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

SECTION 11. Section 59A-46-51 NMSA 1978 (being Laws 2010, Chapter 94, Section 3, as amended) is amended to read:

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

A. A health maintenance organization shall make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines, [~~except~~] including short-term contracts and excluding individually underwritten health insurance policies, contracts or plans, that are governed by the provisions of Chapter 59A, Article 22 NMSA 1978, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law, and an excepted benefit health maintenance organization contract intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance contracts, or a carrier that only issues contracts for long-term care or disability income. Reimbursement shall be made for direct services provided over the preceding three calendar years, but not earlier than calendar year 2010, as determined by reports filed with the office of superintendent of insurance. Nothing in this subsection shall be construed to preclude a purchaser from negotiating an agreement with a health maintenance organization

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

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

HCEDC→~~C. For excepted benefit health maintenance organization contracts, the superintendent shall establish by rule the level of reimbursement for direct services, which level of reimbursement shall be determined by reports filed with the office of superintendent of insurance, as a percent of premiums. A carrier writing these contracts shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which the rate is established. Nothing in this subsection shall be construed to preclude a purchaser of one of these excepted benefit health maintenance organization contracts from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement of direct services.~~←HCEDC

[~~C.~~] HCEDC→~~D.~~ C.←HCEDC A health maintenance organization that fails to comply with the reimbursement requirements pursuant to this section shall issue a dividend or credit against future premiums to all policy or contract holders in an amount sufficient to [~~assure~~] ensure that the benefits paid in the preceding three calendar years plus the amount of the dividends or credits are equal to the required direct services reimbursement level pursuant to Subsection A of this section for group health coverage and blanket health coverage or the required direct services reimbursement level pursuant to Subsection B of this section for individually underwritten health policies, contracts or plans for the preceding three calendar years. If the insurer fails to issue the dividend or

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

[~~D.~~] HCEDC→~~E.~~ D.←HCEDC After notice and hearing, the superintendent may adopt and promulgate reasonable rules necessary and proper to carry out the provisions of this section.

[~~E. For the purposes of this section:~~

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

~~(2) "health maintenance organization" means any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for~~

~~copayments or deductibles, but does not include a person that only issues a limited-benefit policy or contract intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income; and~~

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

SECTION 12. That version of Section 59A-46-51 NMSA 1978 (being Laws 2010, Chapter 94, Section 3, as amended) that is to become effective January 1, 2020 is amended to read:

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

A. A health maintenance organization shall make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines, [~~except~~] including short-term contracts and excluding individually underwritten health insurance policies, contracts or plans, that are governed by the provisions of Chapter 59A, Article 22 NMSA 1978, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law, and an excepted benefit

health maintenance organization contract intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance contracts, or a carrier that only issues contracts for long-term care or disability income. Reimbursement shall be made for direct services provided over the preceding three calendar years, but not earlier than calendar year 2010, as determined by reports filed with the office of superintendent of insurance. Nothing in this subsection shall be construed to preclude a purchaser from negotiating an agreement with a health maintenance organization that requires a higher amount of premiums paid to be used for reimbursement for direct services for one or more products or for one or more years.

B. For individually underwritten health care policies, plans or contracts, the superintendent shall establish, after notice and informal hearing, the level of reimbursement for direct services, as determined by the reports filed with the office of superintendent of insurance, as a percent of premiums. Additional informal hearings may be held at the superintendent's discretion. In establishing the level of reimbursement for direct services, the superintendent shall consider the costs associated with the individual marketing and medical underwriting of these policies, plans or contracts at a level not less than seventy-five percent of premiums. A health

insurer or health maintenance organization writing these policies, plans or contracts shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which that rate is established, but not earlier than calendar year 2010. Nothing in this subsection shall be construed to preclude a purchaser of one of these policies, plans or contracts from negotiating an agreement with a health insurer or health maintenance organization that requires a higher amount of premiums paid to be used for reimbursement for direct services.

HCEDC→~~C. For excepted benefit health maintenance organization contracts, the superintendent shall establish by rule the level of reimbursement for direct services, which level of reimbursement shall be determined by reports filed with the office of superintendent of insurance, as a percent of premiums. A carrier writing these contracts shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which the rate is established. Nothing in this subsection shall be construed to preclude a purchaser of one of these excepted benefit health maintenance organization contracts from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement of direct services.~~←HCEDC

[~~C.~~] HCEDC→~~D.~~ C.←HCEDC A health maintenance organization that fails to comply with the reimbursement requirements

pursuant to this section shall issue a dividend or credit against future premiums to all policy or contract holders in an amount sufficient to [~~assure~~] ensure that the benefits paid in the preceding three calendar years plus the amount of the dividends or credits are equal to the required direct services reimbursement level pursuant to Subsection A of this section for group health coverage and blanket health coverage or the required direct services reimbursement level pursuant to Subsection B of this section for individually underwritten health policies, contracts or plans for the preceding three calendar years. If the insurer fails to issue the dividend or credit in accordance with the requirements of this section, the superintendent shall enforce these requirements and may pursue any other penalties as provided by law, including general penalties pursuant to Section 59A-1-18 NMSA 1978.

[~~D.~~] HCEDC→~~E.~~ D.←HCEDC After notice and hearing, the superintendent may adopt and promulgate reasonable rules necessary and proper to carry out the provisions of this section.

[~~E. For the purposes of this section:~~

~~(1) "direct services" means services rendered to an individual by a health maintenance organization or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to~~

~~providers and any portion of an assessment that covers services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act; provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;~~

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

~~(3) "premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from third parties or other insurers and interests less any tax paid pursuant to the Insurance Premium Tax Act and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance.~~]"

SECTION 13. Section 59A-47-3 NMSA 1978 (being Laws 1984, Chapter 127, Section 879.1, as amended) is amended to read:

"59A-47-3. DEFINITIONS.--As used in Chapter 59A, Article

47 NMSA 1978:

A. "acquisition expenses" includes all expenses incurred in connection with the solicitation and enrollment of subscribers;

B. "administration expenses" means all expenses of the health care plan other than the cost of health care expense payments and acquisition expenses;

C. "agent" means a person appointed by a health care plan authorized to transact business in this state to act as its representative in any given locality for soliciting health care policies and other related duties as may be authorized;

D. "chiropractor" means any person holding a license provided for in the Chiropractic Physician Practice Act;

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

F. "direct services" means services rendered to an individual by a health care plan, health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of an assessment that covers services rather

than administration and for which a health care plan or a health insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act; provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

G. "doctor of oriental medicine" means any person licensed as a doctor of oriental medicine under the Acupuncture and Oriental Medicine Practice Act;

[~~A.~~] H. "health care" means the treatment of persons for the prevention, cure or correction of any illness or physical or mental condition, including optometric services;

I. "health care expense payment" means a payment for health care to a purveyor on behalf of a subscriber, or such a payment to the subscriber;

J. "health care plan" means a nonprofit corporation authorized by the superintendent to enter into contracts with subscribers and to make health care expense payments, including a nonprofit corporation that issues:

(1) a short-term health care plan;

(2) an excepted benefit health care plan intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies; or

(3) a policy or plan for long-term care or disability income;

K. "indemnity benefit" means a payment that the purveyor has not agreed to accept as payment in full for health

care furnished the subscriber;

[~~B.~~] L. "item of health care" [~~includes any services or materials~~] means a service or material used in health care;

[~~C. "health care expense payment" means a payment for health care to a purveyor on behalf of a subscriber, or such a payment to the subscriber;~~]

M. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act;

N. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act;

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

P. "provider" means a physician or other individual licensed or otherwise authorized to furnish health care services in the state;

[~~D.~~] Q. "purveyor" means a person who furnishes any

item of health care and charges for that item;

[~~E.~~] R. "service benefit" means a payment that the purveyor has agreed to accept as payment in full for health care furnished the subscriber;

[~~F. "indemnity benefit" means a payment that the purveyor has not agreed to accept as payment in full for health care furnished the subscriber;~~]

S. "short-term health care plan" means a nonrenewable health care plan covering a resident of the state, regardless of where the plan is delivered, that:

(1) has a maximum specified duration of not more than three months after the effective date of the plan; and

(2) is issued only to individuals who have not been enrolled in a health care plan that provides the same or similar nonrenewable coverage from any nonprofit health care plan within the three months preceding enrollment in the short-term plan;

T. "solicitor" means a person employed by the licensed agent of a health care plan for the purpose of soliciting health care policies and other related duties in connection with the handling of the business of the agent as may be authorized and paid for the person's services either on a commission basis or salary basis or part by commission and part by salary;

[~~G.~~] U. "subscriber" means any individual who, because of a contract with a health care plan entered into by or for the individual, is entitled to have health care expense

payments made on the individual's behalf or to the individual by the health care plan; and

[~~H.~~] V. "underwriting manual" means the health care plan's written criteria, approved by the superintendent, that defines the terms and conditions under which subscribers may be selected. The underwriting manual may be amended from time to time, but amendment will not be effective until approved by the superintendent. The superintendent shall notify the health care plan filing the underwriting manual or the amendment thereto of the superintendent's approval or disapproval thereof in writing within thirty days after filing or within sixty days after filing if the superintendent shall so extend the time. If the superintendent fails to act within such period, the filing shall be deemed to be approved.

[~~I. "acquisition expenses" includes all expenses incurred in connection with the solicitation and enrollment of subscribers;~~

~~J. "administration expenses" means all expenses of the health care plan other than the cost of health care expense payments and acquisition expenses;~~

~~K. "health care plan" means a nonprofit corporation authorized by the superintendent to enter into contracts with subscribers and to make health care expense payments;~~

~~L. "agent" means a person appointed by a health care plan authorized to transact business in this state to act~~

~~as its representative in any given locality for soliciting health care policies and other related duties as may be authorized;~~

~~M. "solicitor" means a person employed by the licensed agent of a health care plan for the purpose of soliciting health care policies and other related duties in connection with the handling of the business of the agent as may be authorized and paid for the person's services either on a commission basis or salary basis or part by commission and part by salary;~~

~~N. "chiropractor" means any person holding a license provided for in the Chiropractic Physician Practice Act;~~

~~O. "doctor of oriental medicine" means any person licensed as a doctor of oriental medicine under the Acupuncture and Oriental Medicine Practice Act;~~

~~P. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act;~~

~~Q. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act;~~

~~R. "credentialing" means the process of obtaining and verifying information about a provider and evaluating that provider when that provider seeks to become a participating provider; and~~

~~S. "provider" means a physician or other individual licensed or otherwise authorized to furnish health care services in the state.~~]"

SECTION 14. That version of Section 59A-47-3 NMSA 1978 (being Laws 1984, Chapter 127, Section 879.1, as amended) that is to become effective January 1, 2020 is amended to read:

"59A-47-3. DEFINITIONS.--As used in Chapter 59A, Article 47 NMSA 1978:

A. "acquisition expenses" includes all expenses incurred in connection with the solicitation and enrollment of subscribers;

B. "administration expenses" means all expenses of the health care plan other than the cost of health care expense payments and acquisition expenses;

C. "agent" means a person appointed by a health care plan authorized to transact business in this state to act as its representative in any given locality for soliciting health care policies and other related duties as may be authorized;

D. "chiropractor" means any person holding a license provided for in the Chiropractic Physician Practice Act;

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

F. "direct services" means services rendered to an individual by a health care plan, health insurer or a health

care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of an assessment that covers services rather than administration and for which a health care plan or a health insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act; provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

G. "doctor of oriental medicine" means any person licensed as a doctor of oriental medicine under the Acupuncture and Oriental Medicine Practice Act;

[~~A.~~] H. "health care" means the treatment of persons for the prevention, cure or correction of any illness or physical or mental condition, including optometric services;

[~~B. "item of health care" includes any services or materials used in health care;~~

~~C.~~] I. "health care expense payment" means a payment for health care to a purveyor on behalf of a subscriber, or such a payment to the subscriber;

J. "health care plan" means an organization that demonstrates to the superintendent that it has been granted exemption from the federal income tax by the United States commissioner of internal revenue as an organization described in Section 501(c)(3) of the United States Internal Revenue Code of 1986, as that section may be amended or renumbered, and is authorized by the superintendent to enter into contracts with

subscribers and to make health care expense payments, including an organization that issues:

(1) a short-term health care plan;

(2) an excepted benefit health care plan intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies; or

(3) a policy or plan for long-term care or disability income;

K. "indemnity benefit" means a payment that the purveyor has not agreed to accept as payment in full for health care furnished the subscriber;

L. "item of health care" means a service or material used in health care;

M. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act;

N. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act;

O. "premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from third parties or other insurers and interests less any premium tax paid pursuant to Section

59A-6-2 NMSA 1978 and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance;

P. "provider" means a physician or other individual licensed or otherwise authorized to furnish health care services in the state;

~~D.~~] Q. "purveyor" means a person who furnishes any item of health care and charges for that item;

[~~E.~~] R. "service benefit" means a payment that the purveyor has agreed to accept as payment in full for health care furnished the subscriber;

[~~F. "indemnity benefit" means a payment that the purveyor has not agreed to accept as payment in full for health care furnished the subscriber;~~]

S. "short-term health care plan" means a nonrenewable health care plan covering a resident of the state, regardless of where the plan is delivered, that:

(1) has a maximum specified duration of not more than three months after the effective date of the plan; and

(2) is issued only to individuals who have not been enrolled in a health care plan that provides the same or similar nonrenewable coverage from any nonprofit health care plan within the three months preceding enrollment in the short-term plan;

T. "solicitor" means a person employed by the licensed agent of a health care plan for the purpose of soliciting health care policies and other related duties in

connection with the handling of the business of the agent as may be authorized and paid for the person's services either on a commission basis or salary basis or part by commission and part by salary;

[~~G.~~] U. "subscriber" means any individual who, because of a contract with a health care plan entered into by or for the individual, is entitled to have health care expense payments made on the individual's behalf or to the individual by the health care plan; and

[~~H.~~] V. "underwriting manual" means the health care plan's written criteria, approved by the superintendent, that defines the terms and conditions under which subscribers may be selected. The underwriting manual may be amended from time to time, but the amendment will not be effective until approved by the superintendent. The superintendent shall notify the health care plan filing the underwriting manual or the amendment thereto of the superintendent's approval or disapproval thereof in writing within thirty days after filing or within sixty days after filing if the superintendent shall so extend the time. If the superintendent fails to act within such period, the filing shall be deemed to be approved.

[~~I. "acquisition expenses" includes all expenses incurred in connection with the solicitation and enrollment of subscribers;~~

~~J. "administration expenses" means all expenses of~~

~~the health care plan other than the cost of health care expense payments and acquisition expenses;~~

~~K. "health care plan" means an organization that demonstrates to the superintendent that it has been granted exemption from the federal income tax by the United States commissioner of internal revenue as an organization described in Section 501(c)(3) of the United States Internal Revenue Code of 1986, as that section may be amended or renumbered, and is authorized by the superintendent to enter into contracts with subscribers and to make health care expense payments;~~

~~L. "agent" means a person appointed by a health care plan authorized to transact business in this state to act as its representative in any given locality for soliciting health care policies and other related duties as may be authorized;~~

~~M. "solicitor" means a person employed by the licensed agent of a health care plan for the purpose of soliciting health care policies and other related duties in connection with the handling of the business of the agent as may be authorized and paid for the person's services either on a commission basis or salary basis or part by commission and part by salary;~~

~~N. "chiropractor" means any person holding a license provided for in the Chiropractic Physician Practice Act;~~

~~O. "doctor of oriental medicine" means any person licensed as a doctor of oriental medicine under the Acupuncture and Oriental Medicine Practice Act;~~

~~P. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act;~~

~~Q. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act;~~

~~R. "credentialing" means the process of obtaining and verifying information about a provider and evaluating that provider when that provider seeks to become a participating provider; and~~

~~S. "provider" means a physician or other individual licensed or otherwise authorized to furnish health care services in the state.~~]"

SECTION 15. Section 59A-47-46 NMSA 1978 (being Laws 2010, Chapter 94, Section 4, as amended) is amended to read:

"59A-47-46. HEALTH INSURERS--DIRECT SERVICES.--

A. A health care plan shall make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines, [~~except~~] including short-term health care plans and excluding individually underwritten health care policies, contracts or plans, that are governed by the provisions of Chapter 59A, Article 22 NMSA 1978, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law, and an excepted benefit health care plan intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific,

accident-only or hospital indemnity-only insurance policies, or a health care plan that only issues policies for long-term care or disability income. Reimbursement shall be made for direct services provided over the preceding three calendar years, but not earlier than calendar year 2010, as determined by reports filed with the office of superintendent of insurance. Nothing in this subsection shall be construed to preclude a purchaser from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services for one or more products or for one or more years.

B. For individually underwritten health care policies, plans or contracts, the superintendent shall establish, after notice and informal hearing, the level of reimbursement for direct services as determined as a percent of premiums. Additional hearings may be held at the superintendent's discretion. In establishing the level of reimbursement for direct services, the superintendent shall consider the costs associated with the individual marketing and medical underwriting of these policies, plans or contracts at a level not less than seventy-five percent of premiums. A health insurer writing these policies, plans or contracts shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which that rate is established, but not earlier than calendar year 2010. Nothing in this subsection shall be construed to preclude a purchaser of one of these policies,

plans or contracts from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services.

HCEDC→~~C. For an excepted benefit health care plan, the superintendent shall establish by rule the level of reimbursement for direct services, which level of reimbursement shall be determined by reports filed with the office of superintendent of insurance, as a percent of premiums. A health care plan writing these excepted benefit health care plans shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which the rate is established. Nothing in this subsection shall be construed to preclude a purchaser of one of these excepted benefit health care plans from negotiating an agreement with a nonprofit health care plan that requires a higher amount of premiums paid to be used for reimbursement of direct services.~~←HCEDC

[~~C.~~] HCEDC→~~D.~~ C.←HCEDC A health care plan that fails to comply with the reimbursement requirements pursuant to this section shall issue a dividend or credit against future premiums to all policyholders in an amount sufficient to [~~assure~~] ensure that the benefits paid in the preceding three calendar years plus the amount of the dividends or credits are equal to the required direct services reimbursement level

pursuant to Subsection A of this section for group health coverage and blanket health coverage or the required direct services reimbursement level pursuant to Subsection B of this section for individually underwritten health policies, contracts or plans for the preceding three calendar years. If the insurer fails to issue the dividend or credit in accordance with the requirements of this section, the superintendent shall enforce these requirements and may pursue any other penalties as provided by law, including general penalties pursuant to Section 59A-1-18 NMSA 1978.

[~~D.~~] HCEDC→~~E.~~ D.←HCEDC After notice and hearing, the superintendent may adopt and promulgate reasonable rules necessary and proper to carry out the provisions of this section.

[~~E. For the purposes of this section:~~

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

~~(2) "health care plan" means a nonprofit~~

~~corporation authorized by the superintendent to enter into contracts with subscribers and to make health care expense payments, but does not include a person that only issues a limited-benefit policy intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income; and~~

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

SECTION 16. That version of Section 59A-47-46 NMSA 1978 (being Laws 2010, Chapter 94, Section 4, as amended) that is to become effective January 1, 2020 is amended to read:

"59A-47-46. HEALTH INSURERS--DIRECT SERVICES.--

A. A health care plan shall make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines, [~~except~~] including short-term health care plans and excluding individually

underwritten health care policies, contracts or plans, that are governed by the provisions of Chapter 59A, Article 22 NMSA 1978, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law, and an excepted benefit health care plan intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or a health care plan that only issues policies for long-term care or disability income. Reimbursement shall be made for direct services provided over the preceding three calendar years, but not earlier than calendar year 2010, as determined by reports filed with the office of superintendent of insurance. Nothing in this subsection shall be construed to preclude a purchaser from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services for one or more products or for one or more years.

B. For individually underwritten health care policies, plans or contracts, the superintendent shall establish, after notice and informal hearing, the level of reimbursement for direct services as determined as a percent of premiums. Additional hearings may be held at the superintendent's discretion. In establishing the level of reimbursement for direct services, the superintendent shall consider the costs associated with the individual marketing and medical underwriting of these policies, plans or contracts at a level not less than seventy-five percent of premiums. A health insurer writing these policies, plans or contracts shall make

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

HCEDC→~~C. For an excepted benefit health care plan, the superintendent shall establish by rule the level of reimbursement for direct services, which level of reimbursement shall be determined by reports filed with the office of superintendent of insurance, as a percent of premiums. A health care plan writing these excepted benefit health care plans shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which the rate is established. Nothing in this subsection shall be construed to preclude a purchaser of one of these excepted benefit health care plans from negotiating an agreement with a nonprofit health care plan that requires a higher amount of premiums paid to be used for reimbursement of direct services.~~←HCEDC

[~~C.~~] HCEDC→~~D.~~ C.←HCEDC A health care plan that fails to

comply with the reimbursement requirements pursuant to this section shall issue a dividend or credit against future premiums to all policyholders in an amount sufficient to [~~assure~~] ensure that the benefits paid in the preceding three calendar years plus the amount of the dividends or credits are equal to the required direct services reimbursement level pursuant to Subsection A of this section for group health coverage and blanket health coverage or the required direct services reimbursement level pursuant to Subsection B of this section for individually underwritten health policies, contracts or plans for the preceding three calendar years. If the insurer fails to issue the dividend or credit in accordance with the requirements of this section, the superintendent shall enforce these requirements and may pursue any other penalties as provided by law, including general penalties pursuant to Section 59A-1-18 NMSA 1978.

[~~D.~~] HCEDC→~~E.~~ D.←HCEDC After notice and hearing, the superintendent may adopt and promulgate reasonable rules necessary and proper to carry out the provisions of this section.

[~~E. For the purposes of this section:~~

~~(1) "direct services" means services rendered to an individual by a health care plan, health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of an assessment that covers services rather than administration and for which a health care plan or~~

~~a health insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act; provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;~~

~~(2) "health care plan" means a nonprofit corporation authorized by the superintendent to enter into contracts with subscribers and to make health care expense payments, but does not include a person that only issues a limited-benefit policy intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income; and~~

~~(3) "premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from third parties or other insurers and interests less any tax paid pursuant to the Insurance Premium Tax Act and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance.~~]"