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.

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:

"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:

"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 excepted benefits;

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;

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;
       (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; and
       (3) is not an excepted benefit or
   combination of excepted benefits."

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

   "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:

"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:

"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:

"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:

"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, 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.

C. 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 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. 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 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, including a person
that issues a short-term plan and a person that only issues
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;

(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, 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

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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.

C. 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 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. 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:

(l) "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, including a person
that issues a short-term plan and a person that only issues
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;

(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;

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

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;

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;

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;

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;

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

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;

O. "health maintenance organization" means a
person 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;
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;

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

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;

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;

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

U. "participating provider" means a provider as defined in Subsection Z of this section 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;

V. "person" means an individual or other legal 
entity;

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

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;

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

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;

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

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, 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.

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

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, 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.

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

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;

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;

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;

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

R. "service benefit" means a payment that the purveyor has 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;

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

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."

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;
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 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;

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

    R. "service benefit" means a payment that the purveyor has 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;

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

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."

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, 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.

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

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, 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.

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