AN ACT

RELATING TO HEALTH INSURANCE; MAKING CHANGES IN THE HEALTH INSURANCE PORTABILITY ACT TO FULFILL FEDERAL LAW REQUIREMENTS; AMENDING PROVISIONS OF THE INSURANCE CODE TO PROVIDE CONSISTENCY; DECLARING AN EMERGENCY.

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

Section 1. Section 59A-18-13.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 26, as amended by Laws 1997, Chapter 22, Section 1 and also by Laws 1997, Chapter 243, Section 18) is amended to read:

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

A. Every insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan that provides primary health insurance or health care coverage insuring or covering major medical expenses shall, in determining the initial year's premium charged for an individual, use only the rating factors of age, gender, geographic area of the place of employment and smoking practices, except that for individual policies the rating factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment.

B. In determining the initial and any subsequent year's rate, the difference in rates in any one age group

that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, society, organization or plan from offering rates that differ depending upon family composition.

C. The provisions of this section do not preclude an insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan from using health status or occupational or industry classification in establishing:

(1) rates for individual policies; or

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

D. As used in Subsection C of this section, "health status" does not include genetic information.

E. The superintendent shall adopt regulations to implement the provisions of this section."

Section 2. Section 59A-22-24 NMSA 1978 (being Laws

1984, Chapter 127, Section 445) is amended to read:

"59A-22-24. CANCELLATION.--There may be a provision as follows:

The insurance company may cancel this policy only pursuant to the provisions of Section 59A-23E-19 NMSA 1978."

Section 3. Section 59A-23B-6 NMSA 1978 (being Laws 1991, Chapter 111, Section 6, as amended by Laws 1997, Chapter 22, Section 2 and also by Laws 1997, Chapter 243, Section 21) is amended to read:

"59A-23B-6. FORMS AND RATES--APPROVAL OF THE SUPERINTENDENT--ADJUSTED COMMUNITY RATING.--

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

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

C. In determining the initial year's premium or rate charged for coverage under a policy or plan, the only rating factors that may be used are age, gender, geographic area of the place of employment and smoking practices,

except that for individual policies the rating factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rate in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, society, organization or plan from offering rates that differ depending upon family composition.

D. The provisions of this section do not preclude an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan from using health status or occupational or industry classification in establishing:

(1) rates for individual policies; or

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

E. As used in Subsection D of this section, "health status" does not include genetic information.

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

Section 4. Section 59A-23C-5.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 33, as amended by Laws 1997, Chapter 22, Section 3 and also by Laws 1997, Chapter 243, Section 24) is amended to read:

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

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

(1) ages;

(2) genders;

(3) geographic areas of the place of employment; or

(4) smoking practices.

B. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall

not exceed another person's rate in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit a carrier from offering rates that differ depending upon family composition.

C. The provisions of this section do not preclude a carrier from using health status or occupational or industry classification in establishing the amount an employer may be charged for coverage under a group health plan.

D. As used in Subsection C of this section, "health status" does not include genetic information.

E. The superintendent shall adopt regulations to implement the provisions of this section."

Section 5. Section 59A-23E-1 NMSA 1978 (being Laws 1997, Chapter 243, Section 1) is amended to read:

"59A-23E-1. SHORT TITLE.-- Chapter 59A, Article 23E NMSA 1978 may be cited as the "Health Insurance Portability Act"."

Section 6. Section 59A-23E-2 NMSA 1978 (being Laws

1997, Chapter 243, Section 2) is amended to read:

"59A-23E-2. DEFINITIONS.--As used in the Health Insurance Portability Act:

A. "affiliation period" means a period that must expire before health insurance coverage offered by a health maintenance organization becomes effective;

B. "beneficiary" means that term as defined in Section 3(8) of the federal Employee Retirement Income Security Act of 1974;

C. "bona fide association" means an association that:

(1) has been actively in existence for five or more years;

(2) has been formed and maintained in good faith for purposes other than obtaining insurance;

(3) does not condition membership in the association on any health status related factor relating to an individual, including an employee or a dependent of an employee;

(4) makes health insurance coverage offered through the association available to all members regardless of any health status related factor relating to the members or individuals eligible for coverage through a member; and

(5) does not offer health insurance coverage to an individual through the association except in

connection with a member of the association;

D. "church plan" means that term as defined pursuant to Section 3(33) of the federal Employee Retirement Income Security Act of 1974;

E. "COBRA" means the federal Consolidated Omnibus Budget Reconciliation Act of 1985;

F. "COBRA continuation provision" means:

(1) Section 4980 of the Internal Revenue Code of 1986, except for Subsection (f)(1) of that section as it relates to pediatric vaccines;

(2) Part 6 of Subtitle B of Title 1 of the federal Employee Retirement Income Security Act of 1974 except for Section 609 of that part; or

(3) Title 22 of the federal Health Insurance Portability and Accountability Act of 1996;

G. "creditable coverage" means, with respect to an individual, coverage of the individual pursuant to:

(1) a group health plan;

(2) health insurance coverage;

(3) Part A or Part B of Title 18 of the Social Security Act;

(4) Title 19 of the Social Security Act except coverage consisting solely of benefits pursuant to Section 1928 of that title;

(5) 10 USCA Chapter 55;

(6) a medical care program of the Indian health service or of an Indian nation, tribe or pueblo;

(7) the Comprehensive Health Insurance Pool Act;

(8) a health plan offered pursuant to 5 USCA Chapter 89;

(9) a public health plan as defined in federal regulations; or

(10) a health benefit plan offered pursuant to Section 5(e) of the federal Peace Corps Act;

H. "employee" means that term as defined in Section 3(6) of the federal Employee Retirement Income Security Act of 1974;

I. "employer" means:

(1) a person who is an employer as that term is defined in Section 3(5) of the federal Employee Retirement Income Security Act of 1974, and who employs two or more employees; and

(2) a partnership in relation to a partner pursuant to Section 59A-23E-17 NMSA 1978;

J. "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries;

K. "enrollment date" means, with respect to an

individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for enrollment;

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

(1) coverage only 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 limited benefits specified in regulations;

(10) the following benefits, offered as independent noncoordinated benefits:

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

(b) hospital indemnity or other fixed indemnity insurance; and

(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 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;

M. "federal governmental plan" means a governmental plan established or maintained for its employees by the United States government or an instrumentality of that government;

N. "governmental plan" means that term as defined in Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and includes a federal governmental

plan;

O. "group health insurance coverage" means health insurance coverage offered in connection with a group health plan;

P. "group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise;

Q. "group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer;

R. "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 issuer;

S. "health insurance issuer" means an insurance

company, insurance service or insurance organization, including a health maintenance organization, that is licensed to engage in the business of insurance in the state and that is subject to state law that regulates insurance within the meaning of Section 514(b)(2) of the federal Employee Retirement Income Security Act of 1974, but "health insurance issuer" does not include a group health plan;

T. "health maintenance organization" means:

(1) a federally qualified health maintenance organization;

(2) an organization recognized pursuant to state law as a health maintenance organization; or

(3) a similar organization regulated pursuant to state law for solvency in the same manner and to the same extent as a health maintenance organization defined in Paragraph (1) or (2) of this subsection;

U. "health status related factor" means any of the factors described in Section 2702(a)(1) of the federal Health Insurance Portability and Accountability Act of 1996;

V. "individual health insurance coverage" means health insurance coverage offered to an individual in the individual market, but "individual health insurance coverage" does not include short-term limited duration insurance;

W. "individual market" means the market for

health insurance coverage offered to individuals other than in connection with a group health plan;

X. "large employer" means, in connection with a group health plan and with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year;

Y. "large group market" means the health insurance market under which individuals obtain health insurance coverage on behalf of themselves and their dependents through a group health plan maintained by a large employer;

Z. "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(1) the first period in which the individual is eligible to enroll under the plan; or

(2) a special enrollment period pursuant to Sections 59A-23E-8 and 59A-23E-9 NMSA 1978;

AA. "medical care" means:

(1) services consisting of the diagnosis, cure, mitigation, treatment or prevention of human disease or provided for the purpose of affecting any structure or function of the human body; and

(2) transportation services primarily for and essential to provision of the services described in Paragraph (1) of this subsection;

BB. "network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care are provided through a defined set of providers under contract with the issuer;

CC. "nonfederal governmental plan" means a governmental plan that is not a federal governmental plan;

DD. "participant" means:

(1) that term as defined in Section 3(7) of the federal Employee Retirement Income Security Act of 1974;

(2) a partner in relationship to a partnership in connection with a group health plan maintained by the partnership; and

(3) a self-employed individual in connection with a group health plan maintained by the self-employed individual;

EE. "placed for adoption" means a child has been placed with a person who assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption of the child;

FF. "plan sponsor" means that term as defined in Section 3(16)(B) of the federal Employee Retirement Income Security Act of 1974;

GG. "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of the coverage for the benefits whether or not any medical advice, diagnosis, care or treatment was recommended before that date, but genetic information is not included as a preexisting condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the condition related to the genetic information;

HH. "small employer" means, in connection with a group health plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year;

II. "small group market" means the health insurance market under which individuals obtain health insurance coverage through a group health plan maintained by a small employer;

JJ. "state law" means laws, decisions, rules, regulations or state action having the effect of law; and

KK. "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is

eligible to be covered for benefits under the terms of the plan."

Section 7. Section 59A-23E-3 NMSA 1978 (being Laws 1997, Chapter 243, Section 3) is amended to read:

"59A-23E-3. GROUP HEALTH PLAN--GROUP HEALTH INSURANCE--LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD--CREDITING FOR PERIODS OF PREVIOUS COVERAGE.--Except as provided in Section 59A-23E-4 NMSA 1978, a group health plan and a health insurance issuer offering group health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

A. the exclusion relates to a condition, physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date;

B. the exclusion extends for a period of not more than six months, or eighteen months in the case of a late enrollee, after the enrollment date; and

C. the period of the exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date."

Section 8. Section 59A-23E-4 NMSA 1978 (being Laws 1997, Chapter 243, Section 4) is amended to read:

"59A-23E-4. GROUP HEALTH PLAN--GROUP HEALTH INSURANCE--PROHIBITION OF EXCLUSIONS IN CERTAIN CASES.--

A. A group health plan or a health insurer offering group health insurance shall not impose a preexisting condition exclusion:

(1) in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;

(2) that excludes a child who is adopted or placed for adoption before his eighteenth birthday and who, as of the last day of the thirty-day period beginning on and following the date of the adoption or placement for adoption, is covered under creditable coverage; or

(3) that relates to or includes pregnancy as a preexisting condition.

B. The provisions of Paragraphs (1) and (2) of Subsection A of this section do not apply to any individual after the end of the first continuous sixty-three-day period during which the individual was not covered under any creditable coverage."

Section 9. Section 59A-23E-5 NMSA 1978 (being Laws 1997, Chapter 243, Section 5) is amended to read:

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

A. A period of creditable coverage shall not be counted with respect to enrollment of an individual under a group health plan if, after the period and before the

enrollment date, there was a sixty-three-day continuous period during which the individual was not covered under any creditable coverage.

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

Section 10. Section 59A-23E-6 NMSA 1978 (being Laws 1997, Chapter 243, Section 6) is amended to read:

"59A-23E-6. GROUP HEALTH PLAN--GROUP HEALTH INSURANCE--METHOD OF CREDITING COVERAGE--ELECTION--NOTICE OF ELECTION.--

A. Except as provided in Subsection B of this section, for purposes of applying Subsection C of Section 59A-23E-3 NMSA 1978 a group health plan and a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period.

B. A group health plan or a health insurance issuer offering group health insurance coverage may elect to apply Subsection C of Section 59A-23E-3 NMSA 1978 based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided in Subsection A of this section. The election shall be made uniformly for all participants and beneficiaries. If the election is made, a group health plan or an issuer shall count a period of creditable coverage

with respect to any class or category of benefits if any level of benefits is covered within the class or category.

C. A group health plan making an election pursuant to Subsection B of this section, whether or not health insurance coverage is provided in connection with the plan, shall:

(1) prominently state in disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made the election; and

(2) include in the statements made a description of the effect of this election.

D. A health insurance issuer offering group health insurance coverage in the small or large group market making an election pursuant to Subsection B of this section shall:

(1) prominently state in disclosure statements concerning the coverage, and state to each employer at the time of the offer or sale of the coverage, that the issuer has made the election; and

(2) include in the statements made a description of the effect of this election."

Section 11. Section 59A-23E-7 NMSA 1978 (being Laws 1997, Chapter 243, Section 7) is amended to read:

"59A-23E-7. GROUP HEALTH PLAN--GROUP HEALTH INSURANCE--CERTIFICATION AND DISCLOSURE OF COVERAGE.--

A. Periods of creditable coverage with respect to an individual shall be established through the certification required by this section. A group health plan and a health

insurance issuer offering group health insurance coverage shall provide the certification described in Subsection B of this section:

(1) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, to the extent practicable, at a time consistent with notices required pursuant to any COBRA continuation provision;

(2) in the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(3) on the request on behalf of an individual made not later than twenty-four months after the date of cessation of the coverage described in Paragraph (1) or (2) of this subsection, whichever is later.

B. The required certification is a written certification of:

(1) the period of creditable coverage of the individual under the plan and the coverage, if any, under the COBRA continuation provision; and

(2) the waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

C. To the extent that medical care pursuant to a

group health plan is provided pursuant to group health insurance coverage, the plan satisfies the certification requirement of this section if the health insurance issuer offering the coverage provides for the certification pursuant to this section.

D. If a group health plan or health insurance issuer that has made an election pursuant to Subsection B of Section 59A-23E-6 NMSA 1978 enrolls an individual for coverage under the plan or insurance and the individual provides a certification pursuant to this section, the entity providing the individual that certification:

(1) shall upon request of the plan or issuer promptly disclose to the requester information on coverage of classes and categories of health benefits available under the entity's plan or coverage; and

(2) may charge the requesting plan or issuer the reasonable cost of disclosing the required information."

Section 12. Section 59A-23E-8 NMSA 1978 (being Laws 1997, Chapter 243, Section 8) is amended to read:

"59A-23E-8. GROUP HEALTH PLAN--GROUP HEALTH INSURANCE--SPECIAL ENROLLMENT PERIODS FOR INDIVIDUALS LOSING OTHER COVERAGE.--A group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall permit an employee

who is eligible but not enrolled for coverage under the terms of the plan, or a dependent of the employee if the dependent is eligible but not enrolled for coverage, to enroll for coverage under the terms of the plan if:

A. the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

B. the employee stated in writing at the time coverage was offered that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer required such a statement at the time and provided the employee with notice of that requirement and the consequences of the requirement at the time;

C. the employee's or dependent's coverage described in Subsection A of this section was:

(1) under a COBRA continuation provision and the coverage under that provision was exhausted; or

(2) not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment, or employer contributions toward the coverage

were terminated; and

D. under the terms of the plan, the employee requested enrollment not later than thirty days after the date of exhaustion of coverage described in Paragraph (1) of Subsection C of this section or termination of coverage or employer contribution described in Paragraph (2) of Subsection C of this section."

Section 13. Section 59A-23E-9 NMSA 1978 (being Laws 1997, Chapter 243, Section 9) is amended to read:

"59A-23E-9. GROUP HEALTH PLAN--SPECIAL ENROLLMENT PERIODS FOR DEPENDENT BENEFICIARIES.--

A. A group health plan shall provide for a dependent special enrollment period described in Subsection B of this section during which a person may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage, if:

(1) the plan makes coverage available to a dependent of an individual;

(2) the individual is a participant under the plan or has met any waiting period applicable to becoming a participant and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

(3) the person has become the dependent of the individual through marriage, birth, adoption or placement for adoption.

B. A dependent special enrollment period pursuant to this subsection shall be for a period of not less than thirty days and shall begin on the later of:

(1) the date dependent coverage is made available; or

(2) the date of the marriage, birth, adoption or placement for adoption described in Subsection A of this section.

C. If an individual seeks to enroll a person as a dependent during the first thirty days of a dependent special enrollment period, the coverage of the dependent becomes effective:

(1) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(2) in the case of birth, as of the date of the birth; or

(3) in the case of adoption or placement for adoption, the date of the adoption or placement."

Section 14. Section 59A-23E-10 NMSA 1978 (being Laws 1997, Chapter 243, Section 10) is amended to read:

"59A-23E-10. GROUP HEALTH PLAN--GROUP HEALTH

INSURANCE--USE OF AFFILIATION PERIOD BY HEALTH MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO PREEXISTING CONDITION EXCLUSION.--

A. A health maintenance organization that offers health insurance coverage in connection with a group health plan and does not impose any preexisting condition exclusion allowed pursuant to Section 59A-23E-3 NMSA 1978 with respect to any particular coverage option may impose an affiliation period for the coverage option if that period:

(1) is applied uniformly without regard to any health status related factors; and

(2) does not exceed two months, or three months in the case of a late enrollee.

B. During an affiliation period, a health maintenance organization is not required to provide health care services or benefits to a participant or beneficiary, and it shall not charge a premium to a participant or beneficiary for any coverage.

C. An affiliation period begins to run on the enrollment date and shall run concurrently with any waiting period under the plan.

D. A health maintenance organization described in Subsection A of this section may use alternative methods different from those described in that subsection to address adverse selection as approved by the superintendent."

Section 15. Section 59A-23E-11 NMSA 1978 (being Laws 1997, Chapter 243, Section 11) is amended to read:

"59A-23E-11. GROUP HEALTH PLAN--GROUP HEALTH INSURANCE--PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES IN ELIGIBILITY TO ENROLL.--

A. Except as provided in Subsection B of this section, a group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall not establish rules for eligibility or continued eligibility of any individual to enroll or continue to participate in a health plan based on any of the following health status related factors in relation to the individual or a dependent of the individual:

(1) health status;

(2) medical condition, including both physical and mental illnesses;

(3) claims experience;

(4) receipt of health care;

(5) medical history;

(6) genetic information;

(7) evidence of insurability, including conditions arising out of acts of domestic violence; or

(8) disability.

B. To the extent consistent with the provisions

of Section 59A-23E-3 NMSA 1978, the provisions of Subsection A of this section do not require a group health plan or group health insurance coverage to provide particular benefits other than those provided under the terms of the plan or coverage or to prevent the plan or coverage from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage."

Section 16. Section 59A-23E-12 NMSA 1978 (being Laws 1997, Chapter 243, Section 12) is amended to read:

"59A-23E-12. GROUP HEALTH PLAN--GROUP HEALTH INSURANCE--PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES IN PREMIUM CONTRIBUTIONS.--

A. Except as provided in Subsection B of this section, a group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall not require an individual as a condition to enroll or continue to participate in a health plan to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of the health status related factors specified in Subsection A of Section 59A-23E-11 NMSA 1978 in relation to the individual or a

person enrolled under the plan as a dependent of the individual.

B. The provisions of Subsection A of this section do not restrict the amount that an employer may be charged for coverage under a group health plan and do not prevent a group health plan or a health insurance issuer offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention."

Section 17. Section 59A-23E-13 NMSA 1978 (being Laws 1997, Chapter 243, Section 13) is amended to read:

"59A-23E-13. HEALTH INSURANCE ISSUERS--GUARANTEED AVAILABILITY OF COVERAGE FOR EMPLOYERS IN SMALL GROUP MARKET--EXCEPTIONS FOR NETWORK PLANS, INSUFFICIENT FINANCIAL CAPACITY AND BONA FIDE ASSOCIATIONS--EMPLOYER CONTRIBUTION RULES.--

A. Except as provided in Subsections B through G of this section, a health insurance issuer that offers health insurance coverage in the small group market shall:

(1) accept a small employer that applies for coverage;

(2) accept for enrollment under the offered coverage an eligible individual who applies for enrollment during the period in which the individual first becomes

eligible to enroll under the terms of the group health plan; and

(3) not place a restriction on an eligible individual being a participant or a beneficiary that is inconsistent with Sections 59A-23E-11 and 59A-23E-12 NMSA 1978.

B. A health insurance issuer that offers health insurance coverage in the small group market through a network plan may:

(1) limit the employers that may apply for the coverage to those with eligible individuals who live, work or reside in the service area for the network plan; and

(2) deny coverage to employers within the service area for the network plan if the issuer has demonstrated to the superintendent that it:

(a) will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

(b) is applying this exception uniformly to all employers without regard to the claims experience of those employers, their employees and their dependents or any health status related factor relating to those employees and dependents.

C. A health insurance issuer, upon denying

insurance coverage in any service area pursuant to the provisions of Subsection B of this section, shall not offer coverage in the small group market within the service area for a period of one hundred eighty days after the date coverage is denied.

D. A health insurance issuer may deny health insurance coverage in the small group market if the issuer has demonstrated to the superintendent that it:

(1) does not have the financial reserves necessary to underwrite additional coverage; and

(2) is applying this exception uniformly to all employers in the small group market in the state consistent with state law and without regard to the claims experience of those employers, their employees and their dependents or any health status related factor relating to those employees and dependents.

E. A health insurance issuer upon denying health insurance coverage in connection with group health plans pursuant to Subsection D of this section shall not offer coverage in connection with group health plans in the small group market in the state for a period of one hundred eighty days after the date coverage is denied or until the issuer has demonstrated to the superintendent that the issuer has sufficient financial reserves to underwrite the additional coverage, whichever is later. The superintendent may

provide for the application of this subsection on a service-area-specific basis.

F. The requirement of Subsection A of this section does not apply to health insurance coverage offered by a health insurance issuer if the coverage is made available in the small group market only through one or more bona fide associations.

G. Subsection A of this section does not preclude a health insurance issuer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health plan in the small group market.

H. As used in this section, "eligible individual" means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan in the small group market, an individual whose eligibility shall be determined:

(1) in accordance with the terms of the plan;

(2) as provided by the issuer under the rules of the issuer that are uniformly applicable in the state to small employers in the small group market; and

(3) in accordance with Insurance Code provisions governing the issuer and the small group market."

Section 18. Section 59A-23E-14 NMSA 1978 (being Laws

1997, Chapter 243, Section 14) is amended to read:

"59A-23E-14. HEALTH INSURANCE ISSUERS--GUARANTEED RENEWABILITY OF COVERAGE FOR EMPLOYERS IN THE SMALL OR LARGE GROUP MARKET--REQUIREMENT AND EXCEPTIONS TO REQUIREMENT.--

A. Except as provided in Subsections B through G of this section, a health insurance issuer that offers health insurance coverage in the small or large group market in connection with a group health plan shall renew or continue that coverage in force at the option of the plan sponsor of the plan.

B. A health insurance issuer may refuse to renew or may discontinue health insurance coverage offered pursuant to Subsection A of this section if:

(1) the plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

(2) the plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of the coverage;

(3) the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules permitted pursuant to Subsection G of Section 59A-23E-13 NMSA 1978;

(4) the issuer is ceasing to offer coverage in the market in accordance with Subsection C of this section;

(5) in the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with that plan who lives, resides or works in the service area of the issuer or the area for which the issuer is authorized to do business and, in the case of the small group market, the issuer would deny enrollment with respect to the network plan pursuant to Paragraph (1) of Subsection B of Section 59A-23E-13 NMSA 1978; or

(6) in the case of health insurance coverage that is made available only through one or more bona fide associations, the membership of any employer in the association ceases, but only if the coverage is terminated pursuant to this paragraph uniformly without regard to any health status related factor relating to a covered individual.

C. A health insurance issuer may discontinue offering a particular type of group health insurance coverage offered in the small or large group market only if:

(1) the issuer provides notice to each plan sponsor provided coverage of this type in the market and to the participants and beneficiaries covered under the

coverage of the discontinuation at least ninety days prior to the date of the discontinuation;

(2) the issuer offers to a plan sponsor provided coverage of this type in the market the option to purchase all, or in the case of the large group market, any, other health insurance coverage currently being offered by the issuer to a group health plan in that market; and

(3) in exercising the option to discontinue coverage of this type and in offering the option of coverage pursuant to Paragraph (2) of this subsection, the issuer acts uniformly without regard to the claims experience of those sponsors or any health status related factors relating to any participants or beneficiaries who may become eligible for that coverage.

D. If a health insurance issuer elects to discontinue offering all health insurance coverage in the small group market or the large group market, coverage may be discontinued only if:

(1) the issuer provides notice to the superintendent and to each plan sponsor and to participants and beneficiaries covered under the plan of the discontinuation at least one hundred eighty days prior to the date of discontinuation; and

(2) all health insurance issued or delivered for issuance in the state in the market is

discontinued and coverage is not renewed.

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

F. At the time of coverage renewal pursuant to Subsection A of this section, a health insurance issuer may modify the coverage for a product offered to a group health plan:

(1) in the large group market; or

(2) in the small group market if, for coverage available in that market other than through a bona fide association, the modification is effective on a uniform basis among group health plans with that product.

G. If health insurance coverage is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to that employer."

Section 19. Section 59A-23E-15 NMSA 1978 (being Laws 1997, Chapter 243, Section 15) is amended to read:

"59A-23E-15. DISCLOSURE OF INFORMATION BY HEALTH INSURANCE ISSUERS--OFFERING HEALTH INSURANCE COVERAGE TO

SMALL EMPLOYERS.--

A. A health insurance issuer when offering health insurance coverage to a small employer shall:

(1) make a reasonable disclosure to the small employer, as part of its solicitation and sales materials, of the availability of information described in Subsection B of this section; and

(2) upon request of the small employer provide the information described.

B. Except as provided in Subsection D of this section, a health insurance issuer shall provide information pursuant to Subsection A of this section concerning:

(1) the provisions of coverage concerning the issuer's right to change premium rates and the factors that may affect changes in premium rates;

(2) the provisions of coverage relating to renewability of coverage;

(3) the provisions of the coverage relating to preexisting condition exclusions; and

(4) the benefits and premiums available under all health insurance coverage for which the small employer is qualified.

C. Information furnished pursuant to this section shall be provided to small employers in a manner determined to be understandable by the average small employer and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

D. A health insurance issuer is not required by this section to disclose information that is proprietary and trade secret information."

Section 20. Section 59A-23E-16 NMSA 1978 (being Laws 1997, Chapter 243, Section 16) is amended to read:

"59A-23E-16. EXCLUSIONS, LIMITATIONS AND EXCEPTIONS FOR CERTAIN GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE.--

A. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply to any group health plan and health insurance coverage offered in connection with a group health plan if, on the first day of the plan year, the plan has fewer than two employees who are current employees.

B. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 shall not apply with respect to a group health plan that is a nonfederal governmental plan if the plan sponsor makes an election under the provisions of this subsection in conformity with regulations of the federal secretary of health and human services. The period of an election for exclusion made pursuant to this subsection is for a single specified plan year or, in the case of a plan provided pursuant to a collective bargaining agreement, for the term of the agreement. The plan for which an election is made shall provide under the terms of the election for:

(1) notice to enrollees on an annual basis and at the time of enrollment of the facts and consequences of the election; and

(2) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with Section 59A-23E-7 NMSA 1978.

C. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply

to a group health plan and group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in Paragraph (9) of Subsection L of Section 59A-23E-2 NMSA 1978 if the benefits are:

(1) provided under a separate policy, certificate or contract of insurance; or

(2) otherwise not an integral part of the plan.

D. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply to any group health plan and group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in Paragraph (10) of Subsection L of Section 59A-23E-2 NMSA 1978 if:

(1) the benefits are provided under a separate policy, certificate or contract of insurance;

(2) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(3) the benefits are paid with respect to an event without regard to whether benefits are provided with respect to that event under any group health plan maintained by the same plan sponsor.

E. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply to any group health plan and group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in Paragraph

(11) of Subsection L of Section 59A-23E-2 NMSA 1978 if the benefits are provided under a separate policy, certificate or contract of insurance."

Section 21. Section 59A-23E-17 NMSA 1978 (being Laws 1997, Chapter 243, Section 17) is amended to read:

"59A-23E-17. TREATMENT OF PARTNERS AND SELF-EMPLOYED INDIVIDUALS IN CONNECTION WITH GROUP HEALTH PLANS.--

A. Any plan, fund or program that would not be an employee welfare benefit plan, except for the provisions of this section, that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care to current or former partners in the partnership or to their dependents directly or through insurance, reimbursement or otherwise, shall be treated as an employee welfare benefit plan that is a group health plan.

B. As used in this section:

(1) "employer" includes a partnership in relation to a partner; and

(2) "participant" includes:

(a) in connection with a group health plan maintained by a partnership, an individual who is a partner in relationship to the partnership; and

(b) in connection with a group health plan maintained by a self-employed individual under which one or more employees are participants, the self-employed individual, if he or his beneficiaries are or may become eligible to receive a benefit under the plan."

Section 22. A new Section 59A-23E-18 NMSA 1978 is

enacted to read:

"59A-23E-18. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS OFFERED IN GROUP HEALTH PLANS OR GROUP HEALTH INSURANCE--DEFINITIONS.--

A. If a group health plan or group health insurance coverage offered in connection with the plan provides both medical and surgical benefits and mental health benefits:

(1) it may not impose an aggregate lifetime limit on mental health benefits if it does not impose an aggregate lifetime limit on substantially all medical and surgical benefits;

(2) it may not impose an annual limit on mental health benefits if it does not impose an annual limit on substantially all medical and surgical benefits;

(3) if it includes an aggregate lifetime limit on substantially all medical and surgical benefits, it shall either:

(a) apply the aggregate lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of the limit between medical and surgical benefits and mental health benefits; or

(b) not include an aggregate lifetime limit on mental health benefits that is less than the

aggregate lifetime limit imposed on medical and surgical benefits;

(4) if it includes an annual limit on substantially all medical and surgical benefits, it shall either:

(a) apply the annual limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of the limit between medical and surgical benefits and mental health benefits; or

(b) not include an annual limit on mental health benefits that is less than the annual limit imposed on medical and surgical benefits; and

(5) if it includes no or different aggregate lifetime limits or annual limits on different categories of medical and surgical benefits, it shall comply with rules established by the federal secretary of health and human services, which rules shall apply the provisions of Subparagraphs (a) or (b) of Paragraphs (3) or (4) of this subsection, respectively, by substituting for the aggregate lifetime limit or annual limit an average aggregate lifetime limit or average annual limit, respectively, that is computed by taking into account the weighted average of the aggregate lifetime limits or annual limits applicable to the categories.

B. Nothing in this section:

(1) requires a group health plan, or group health insurance coverage offered in connection with the plan, to provide any mental health benefits; or

(2) in the case of a group health plan, or group health insurance coverage offered in connection with the plan, that provides mental health benefits, affects the terms and conditions, including cost sharing, limits on numbers of visits or days of coverage and requirements relating to medical necessity, relating to the amount, duration or scope of mental health benefits under the plan or coverage except as provided specifically in Subsection A of this section.

C. The provisions of this section do not apply to a group health plan, or group health insurance coverage offered in connection with the plan, for a plan year of a small employer.

D. The provisions of this section do not apply to a group health plan, or group health insurance coverage offered in connection with the plan, if the application of the provisions results in an increase in cost under the plan of at least one percent.

E. If a group health plan offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied

separately for each option.

F. As used in this section:

(1) "aggregate lifetime limit" means a dollar limitation on the total amount that may be paid for benefits under a group health plan or group health insurance coverage for an individual or other coverage unit;

(2) "annual limit" means a dollar limitation on the total amount that may be paid for benefits in a twelve-month period under a group health plan or group health insurance coverage for an individual or other coverage unit;

(3) "medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of a group health plan or group health insurance coverage for an individual or other coverage unit, but does not include mental health benefits; and

(4) "mental health benefits" means benefits with respect to mental health services, as defined under the terms of a group health plan or group health insurance coverage for an individual or other coverage unit, but the term does not include benefits with respect to treatment of substance abuse or chemical dependency."

Section 23. A new Section 59A-23E-19 NMSA 1978 is enacted to read:

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

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

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

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

(2) the individual has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact under the terms of the coverage;

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

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

only if the coverage is terminated pursuant to this paragraph uniformly without regard to any health status related factor of covered individuals; and

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

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

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

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

(3) in exercising the option to discontinue coverage of this type and in offering the option of coverage

pursuant to Paragraph (2) of this subsection, the issuer acts uniformly without regard to any health status related factor of enrolled individuals or individuals who may become eligible for that coverage.

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

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

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

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

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

individuals with that policy form.

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

Section 24. A new Section 59A-23E-20 NMSA 1978 is enacted to read:

"59A-23E-20. CERTIFICATION OF COVERAGE BY ISSUERS IN THE INDIVIDUAL MARKET.--The provisions of Section 59A-23E-7 NMSA 1978 apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market."

Section 25. Section 59A-54-3 NMSA 1978 (being Laws 1987, Chapter 154, Section 3, as amended) is amended to read:

"59A-54-3. DEFINITIONS.--As used in the Comprehensive Health Insurance Pool Act:

A. "board" means the board of directors of the pool;

B. "creditable coverage" means, with respect to an individual, coverage of the individual pursuant to:

(1) a group health plan;

(2) health insurance coverage;

(3) Part A or Part B of Title 18 of the Social Security Act;

(4) Title 19 of the Social Security Act except coverage consisting solely of benefits pursuant to Section 1928 of that title;

(5) 10 USCA Chapter 55;

(6) a medical care program of the Indian health service or of an Indian nation, tribe or pueblo;

(7) the Comprehensive Health Insurance Pool Act;

(8) a health plan offered pursuant to 5 USCA Chapter 89;

(9) a public health plan as defined in federal regulations; or

(10) a health benefit plan offered pursuant to Section 5(e) of the federal Peace Corps Act;

C. "health care facility" means any entity providing health care services that is licensed by the department of health;

D. "health care services" means any services or products included in the furnishing to any individual of medical care or hospitalization, or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products

for the purpose of preventing, alleviating, curing or healing human illness or injury;

E. "health insurance" means any hospital and medical expense-incurred policy; nonprofit health care service plan contract; health maintenance organization subscriber contract; short-term, accident, fixed indemnity, specified disease policy or disability income contracts; limited benefit insurance; credit insurance; or as defined by Section 59A-7-3 NMSA 1978. "Health insurance" does not include insurance arising out of the Workers' Compensation Act or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is required by law to be contained in any liability insurance policy;

F. "health maintenance organization" means any person who provides, at a minimum, either directly or through contractual or other arrangements with others, basic health care services to enrollees on a fixed prepayment basis and who is responsible for the availability, accessibility and quality of the health care services provided or arranged, or as defined by Subsection M of Section 59A-46-2 NMSA 1978;

G. "health plan" means any arrangement by which persons, including dependents or spouses, covered or making application to be covered under the pool have access to

hospital and medical benefits or reimbursement, including group or individual insurance or subscriber contract; coverage through health maintenance organizations, preferred provider organizations or other alternate delivery systems; coverage under prepayment, group practice or individual practice plans; coverage under uninsured arrangements of group or group-type contracts, including employer self-insured, cost-plus or other benefits methodologies not involving insurance or not subject to New Mexico premium taxes; coverage under group-type contracts that are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by medicare or other governmental benefits. "Health plan" includes coverage through health insurance;

H. "insured" means an individual resident of this state who is eligible to receive benefits from any insurer or other health plan;

I. "insurer" means an insurance company authorized to transact health insurance business in this state, a nonprofit health care plan, a health maintenance organization and self-insurers not subject to federal preemption. "Insurer" does not include an insurance company that is licensed under the Prepaid Dental Plan Law or a company that is solely engaged in the sale of dental

insurance and is licensed not under that act, but under another provision of the Insurance Code;

J. "medicare" means coverage under Part A or Part B of Title 18 of the Social Security Act, as amended;

K. "pool" means the New Mexico comprehensive health insurance pool; and

L. "therapist" means a licensed physical, occupational, speech or respiratory therapist."

Section 26. Section 59A-54-12 NMSA 1978 (being Laws 1987, Chapter 154, Section 12, as amended) is amended to read:

"59A-54-12. ELIGIBILITY--POLICY PROVISIONS.--

A. Except as provided in Subsection B of this section, a person is eligible for a pool policy only if on the effective date of coverage or renewal of coverage the person is a New Mexico resident, and:

(1) is not eligible as an insured or covered dependent for any health plan that provides coverage for comprehensive major medical or comprehensive physician and hospital services;

(2) is only eligible for a health plan that is offered at a rate higher than that available from the pool;

(3) has been rejected for coverage for comprehensive major medical or comprehensive physician and hospital services;

(4) is only eligible for a health plan with a rider, waiver or restrictive provision for that particular

individual based on a specific condition;

(5) has as of the date the individual seeks coverage from the pool an aggregate of eighteen or more months of creditable coverage, the most recent of which was under a group health plan, governmental plan or church plan as defined in Subsections P, N and D, respectively, of Section 59A-23E-2 NMSA 1978, except, for the purposes of aggregating creditable coverage, a period of creditable coverage shall not be counted with respect to enrollment of an individual for coverage under the pool if, after that period and before the enrollment date, there was a sixty-three-day or longer period during all of which the individual was not covered under any creditable coverage; or

(6) is entitled to continuation coverage pursuant to Section 59A-23E-19 NMSA 1978.

B. Notwithstanding the provisions of Subsection A of this section:

(1) a person's eligibility for a policy issued under the Health Insurance Alliance Act shall not preclude a person from remaining on a pool policy; provided that a self-employed person who qualifies for an approved health plan under the Health Insurance Alliance Act by using a dependent as the second employee may choose a pool policy in lieu of the health plan under that act;

(2) a pool policyholder shall be eligible for renewal of pool coverage even though the policyholder became eligible for medicare or medicaid coverage while covered under a pool policy; and

(3) if a pool policyholder becomes eligible for any group health plan, the policyholder's pool coverage

shall not be involuntarily terminated until any pre-existing condition period imposed on the policyholder by the plan has been exhausted.

C. Coverage under a pool policy is in excess of and shall not duplicate coverage under any other form of health insurance.

D. A pool policy shall provide that coverage of a dependent unmarried person terminates when the person becomes nineteen years of age or, if the person is enrolled full time in an accredited educational institution, when he becomes twenty-five years of age. The policy shall also provide in substance that attainment of the limiting age does not operate to terminate coverage when the person is and continues to be:

(1) incapable of self-sustaining employment by reason of developmental disability or physical handicap; and

(2) primarily dependent for support and maintenance upon the person in whose name the contract is issued.

Proof of incapacity and dependency shall be furnished to the insurer within one hundred twenty days of attainment of the limiting age and subsequently as required by the insurer but not more frequently than annually after the two-year period following attainment of the limiting age.

E. A pool policy that provides coverage for a family member of the person in whose name the contract is issued shall, as to the coverage of the family member or the individual in whose name the contract was issued, provide that the health insurance benefits applicable for children

are payable with respect to a newly born child of the family member or the person in whose name the contract is issued from the moment of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium shall be furnished to the carrier within thirty-one days after the date of birth in order to have the coverage continued beyond the thirty-one day period.

F. Except for a person eligible as provided in Paragraph (5) of Subsection A of this section, a pool policy may contain provisions under which coverage is excluded during a six-month period following the effective date of coverage as to a given individual for preexisting conditions, as long as either of the following exists:

(1) the condition has manifested itself within a period of six months before the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnoses or treatment; or

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

G. The preexisting condition exclusions described in Subsection F of this section shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage that was involuntarily terminated, if the application for pool coverage is made not later than thirty-one days following the involuntary

termination. In that case, coverage in the pool shall be effective from the date on which the prior coverage was terminated. This subsection does not prohibit preexisting conditions coverage in a pool policy that is more favorable to the insured than that specified in this subsection.

H. An individual is not eligible for coverage by the pool if:

(1) he is, at the time of application, eligible for medicare or medicaid which would provide coverage for amounts in excess of limited policies such as dread disease, cancer policies or hospital indemnity policies;

(2) he has terminated coverage by the pool within the past twelve months;

(3) he is an inmate of a public institution or is eligible for public programs for which medical care is provided;

(4) he is eligible for coverage under a group health plan;

(5) he has health insurance coverage as defined in Subsection R of Section 59A-23E-2 NMSA 1978 ;

(6) the most recent coverages within the coverage period described in Paragraph (5) of Subsection A of this section were terminated as a result of nonpayment of premium or fraud; or

(7) he has been offered the option of continuation coverage under a federal COBRA continuation provision as defined in Subsection F of Section 59A-23E-2

NMSA 1978 or under a similar state program and he has elected the coverage and did not exhaust the continuation coverage under the provision or program.

I. Any person whose health insurance coverage from a qualified state health policy with similar coverage is terminated because of nonresidency in another state may apply for coverage under the pool. If the coverage is applied for within thirty-one days after that termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage."

Section 27. Section 59A-56-3 NMSA 1978 (being Laws 1994, Chapter 75, Section 3, as amended) is amended to read:

"59A-56-3. DEFINITIONS.--As used in the Health Insurance Alliance Act:

A. "alliance" means the New Mexico health insurance alliance;

B. "approved health plan" means any arrangement for the provisions of health insurance offered through and approved by the alliance;

C. "board" means the board of directors of the alliance;

D. "child" means a dependent unmarried individual who is less than nineteen years of age or an unmarried individual who is enrolled full time in an accredited educational institution until the individual becomes twenty-five years of age;

E. "creditable coverage" means, with respect to

an individual, coverage of the individual pursuant to:

(1) a group health plan;

(2) health insurance coverage;

(3) Part A or Part B of Title 18 of the Social Security Act;

(4) Title 19 of the Social Security Act except coverage consisting solely of benefits pursuant to Section 1928 of that title;

(5) 10 USCA Chapter 55;

(6) a medical care program of the Indian health service or of an Indian nation, tribe or pueblo;

(7) the Comprehensive Health Insurance Pool Act;

(8) a health plan offered pursuant to 5 USCA Chapter 89;

(9) a public health plan as defined in federal regulations; or

(10) a health benefit plan offered pursuant to Section 5(e) of the federal Peace Corps Act;

F. "department" means the department of insurance;

G. "director" means an individual who serves on the board;

H. "earned premiums" means premiums paid or due during a calendar year for coverage under an approved health plan less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year;

I. "eligible expenses" means the allowable charges for a health care service covered under an approved

health plan;

J. "eligible individual":

(1) means an individual who:

(a) as of the date of the individual's application for coverage under an approved health plan, has an aggregate of eighteen or more months of creditable coverage, the most recent of which was under a group health plan, governmental plan or church plan as those plans are defined in Subsections P, N and D of Section 59A-23E-2 NMSA 1978, respectively, or health insurance offered in connection with any of those plans, but for the purposes of aggregating creditable coverage, a period of creditable coverage shall not be counted with respect to enrollment of an individual for coverage under an approved health plan if, after that period and before the enrollment date, there was a sixty-three-day or longer period during all of which the individual was not covered under any creditable coverage; or

(b) is entitled to continuation coverage pursuant to Section 59A-56-20 or 59A-23E-19 NMSA 1978; and

(2) does not include an individual who:

(a) has or is eligible for coverage under a group health plan;

(b) is eligible for coverage under medicare or a state plan under Title 19 of the federal

Social Security Act or any successor program;

(c) has health insurance coverage as defined in Subsection R of Section 59A-23E-2 NMSA 1978;

(d) during the most recent coverage within the coverage period described in Subparagraph (a) of Paragraph (1) of this subsection was terminated from coverage as a result of nonpayment of premium or fraud; or

(e) has been offered the option of coverage under a COBRA continuation provision as that term is defined in Subsection F of Section 59A-23E-2 NMSA 1978, or under a similar state program, except for continuation coverage under Section 59A-56-20 NMSA 1978, and did not exhaust the coverage available under the offered program;

K. "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for that enrollment;

L. "gross earned premiums" means premiums paid or due during a calendar year for all health insurance written in the state less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year;

M. "group health plan" means an employee welfare benefit plan to the extent the plan provides hospital,

surgical or medical expenses benefits to employees or their dependents, as defined by the terms of the plan, directly through insurance, reimbursement or otherwise;

N. "health care service" means a service or product furnished an individual for the purpose of preventing, alleviating, curing or healing human illness or injury and includes services and products incidental to furnishing the described services or products;

O. "health insurance" means "health" insurance as defined in Section 59A-7-3 NMSA 1978; any hospital and medical expense-incurred policy; nonprofit health care plan service contract; health maintenance organization subscriber contract; short-term, accident, fixed indemnity, specified disease policy or disability income insurance contracts and limited health benefit or credit health insurance; coverage for health care services under uninsured arrangements of group or group-type contracts, including employer self-insured, cost-plus or other benefits methodologies not involving insurance or not subject to New Mexico premium taxes; coverage for health care services under group-type contracts that are not available to the general public and can be obtained only because of connection with a particular organization or group; coverage by medicare or other governmental programs providing health care services; but "health insurance" does not include insurance issued

pursuant to provisions of the Workers' Compensation Act or similar law, automobile medical payment insurance or provisions by which benefits are payable with or without regard to fault and are required by law to be contained in any liability insurance policy;

P. "health maintenance organization" means a health maintenance organization as defined by Subsection M of Section 59A-46-2 NMSA 1978;

Q. "incurred claims" means claims paid during a calendar year plus claims incurred in the calendar year and paid prior to April 1 of the succeeding year, less claims incurred previous to the current calendar year and paid prior to April 1 of the current year;

R. "insured" means a small employer or its employee and an individual covered by an approved health plan, a former employee of a small employer who is covered by an approved health plan through conversion or an individual covered by an approved health plan that allows individual enrollment;

S. "medicare" means coverage under both Parts A and B of Title 18 of the federal Social Security Act;

T. "member" means a member of the alliance;

U. "nonprofit health care plan" means a "health care plan" as defined in Subsection K of Section 59A-47-3 NMSA 1978;

V. "premiums" means the premiums received for coverage under an approved health plan during a calendar year;

W. "small employer" means a person that is a resident of this state, has employees at least fifty percent of whom are residents of this state, is actively engaged in business and that on at least fifty percent of its working days during either of the two preceding calendar years, employed no fewer than two and no more than fifty eligible employees; provided that:

(1) in determining the number of eligible employees, the spouse or dependent of an employee may, at the employer's discretion, be counted as a separate employee;

(2) companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state income taxation shall be considered one employer; and

(3) in the case of an employer that was not in existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year;

X. "superintendent" means the superintendent of

insurance;

Y. "total premiums" means the total premiums for business written in the state received during a calendar year; and

Z. "unearned premiums" means the portion of a premium previously paid for which the coverage period is in the future."

Section 28. Section 59A-56-20 NMSA 1978 (being Laws 1994, Chapter 75, Section 20, as amended) is amended to read:

"59A-56-20. RENEWABILITY.--

A. An approved health plan shall contain provisions under which the member offering the plan is obligated to renew the health insurance if premiums are paid until the day the plan is replaced by another plan or the small employer terminates coverage.

B. An approved health plan issued to an eligible individual shall contain provisions under which the member offering the plan is obligated to renew the health insurance except for:

(1) nonpayment of premium;

(2) fraud; or

(3) termination of the approved health plan, except that the individual has the right to transfer to another approved health plan.

C. If an approved health plan ceases to exist, the alliance shall provide an alternate approved health plan.

D. An approved health plan shall provide covered individuals the right to continue health insurance coverage through an approved health plan as individual health insurance provided by the same member upon the death of the employee or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the employee or by termination of employment by electing to do so within a period of time specified in the health insurance if the employee was covered under an approved health plan while employed for at least six consecutive months. The individual may be charged an additional administrative charge for the individual health insurance.

E. The right to continue health insurance coverage provided in this section terminates if the covered individual resides outside the United States for more than six consecutive months."

Section 29. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.