AN ACT

RELATING TO VACCINATION; REQUIRING RULES FOR THE IMMUNIZATION OF CHILDREN ATTENDING LICENSED CHILD CARE AND LICENSED EARLY CHILDHOOD CARE PROGRAMS AND PUBLIC, PRIVATE, HOME OR PAROCHIAL SCHOOLS TO BE BASED ON THE RECOMMENDATIONS OF THE DEPARTMENT OF HEALTH OR THE AMERICAN ACADEMY OF PEDIATRICS; REQUIRING THE DEPARTMENT OF HEALTH TO RECOMMEND IMMUNIZATIONS FOR ADULTS BASED ON GUIDANCE FROM THE AMERICAN ACADEMY OF FAMILY PHYSICIANS, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN COLLEGE OF PHYSICIANS OR THE DEPARTMENT OF HEALTH; REQUIRING VACCINES PURCHASED PURSUANT TO THE STATEWIDE VACCINE PURCHASING PROGRAM TO BE RECOMMENDED BY THE DEPARTMENT OF HEALTH; PROHIBITING CERTAIN HEALTH INSURANCE PLANS FROM IMPOSING COST-SHARING REQUIREMENTS ON IMMUNIZATIONS RECOMMENDED BY THE DEPARTMENT OF HEALTH; REPEALING AND REENACTING SECTIONS OF THE NMSA 1978.

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

SECTION 1. Section 24-5-1 NMSA 1978 (being Laws 1959, Chapter 329, Section 1, as amended) is amended to read:

"24-5-1. IMMUNIZATION REGULATIONS.--

A. The public health division of the department of health shall, after consultation with the public education department and the early childhood education and care department, promulgate rules governing the immunization against diseases deemed to be dangerous to the public health, to be required of children attending licensed child care and licensed early childhood care programs and public, private, home or parochial schools in the state. Rules promulgated pursuant to this subsection shall establish the immunizations required and the manner and frequency of their administration in accordance with recommendations from the department of

health or the American academy of pediatrics. The public health division shall supervise and secure the enforcement of the required immunization program.

B. The public health division of the department of health shall promulgate rules governing the immunization against diseases deemed to be dangerous to the public health, to be recommended for adults residing in the state. Rules promulgated pursuant to this subsection shall establish the immunizations recommended and the recommended manner and frequency of their administration in accordance with guidance from the American academy of family physicians, the American college of obstetricians and gynecologists, the American college of physicians or the department of health."

SECTION 2. Section 24-5-2 NMSA 1978 (being Laws 1959, Chapter 329, Section 2, as amended) is amended to read:

"24-5-2. UNLAWFUL TO ENROLL IN SCHOOL OR LICENSED CHILD CARE PROGRAMS UNIMMUNIZED--UNLAWFUL TO REFUSE TO PERMIT IMMUNIZATION.--It is unlawful for any child to enroll in school or a licensed child care or licensed early childhood care program unless the child has been immunized as required under the rules of the public health division of the department of health and can provide satisfactory evidence of such immunization; provided that, if the child produces satisfactory evidence of having begun the process of immunization, the child may enroll and attend school or the child care program as long as the immunization process is being accomplished in the prescribed manner. It is unlawful for any parent to refuse or neglect to have the parent's child immunized, as required by this section, unless the child is properly exempted."

SECTION 3. Section 24-5A-1 NMSA 1978 (being Laws 2015, Chapter 5, Section 1) is amended to read:

"24-5A-1. SHORT TITLE.--Chapter 24, Article 5A NMSA 1978 may be cited as the "Vaccine Purchasing Act"."

SECTION 4. Section 24-5A-2 NMSA 1978 (being Laws 2015, Chapter 5, Section 2) is amended to read:

"24-5A-2. DEFINITIONS.--As used in the Vaccine Purchasing Act:

A. "department" means the department of health;

B. "fund" means the vaccine purchasing fund;

C. "group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents under the federal Employee Retirement Income Security Act of 1974 directly or through insurance, reimbursement or other means;

D. "health insurance coverage" means benefits consisting of medical care provided directly or through insurance or reimbursement or other means under 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;

E. "health insurer" means any entity subject to regulation by the office of superintendent that:

(1) provides or is authorized to provide health insurance or health benefit plans;

(2) administers health insurance or health benefit coverage; or

(3) otherwise provides a plan of health insurance or health benefits;

F. "insured child" means a child under the age of nineteen who is eligible to receive health insurance coverage from a health insurer or medical care pursuant to a group health plan;

G. "office of superintendent" means the office of

superintendent of insurance;

H. "policy" means any contract of health insurance between a health insurer and the insured and all clauses, riders, endorsements and parts thereof;

I. "provider" means an individual or organization licensed, certified or otherwise authorized or permitted by law to provide vaccinations to insured children; and

J. "vaccines for children program" means the federally funded program that provides vaccines at no cost to eligible children pursuant to Section 1928 of the federal Social Security Act."

SECTION 5. Section 24-5A-3 NMSA 1978 (being Laws 2015, Chapter 5, Section 3) is amended to read:

"24-5A-3. STATEWIDE VACCINE PURCHASING PROGRAM.--

A. The department shall establish and administer a statewide vaccine purchasing program to:

(1) expand access to childhood immunizations recommended by the department pursuant to Section 24-5-1 NMSA 1978;

(2) maintain and improve immunization rates;

(3) facilitate the acquisition by providers of vaccines for childhood immunizations recommended by the department pursuant to Section 24-5-1 NMSA 1978; and

(4) leverage public and private funding and resources for the purchase, storage and distribution of vaccines for childhood immunizations recommended by the department pursuant to Section 24-5-1 NMSA 1978.

B. The department shall:

(1) purchase vaccines for all children in New Mexico, including children eligible for the vaccines for children program and insured children;

(2) invoice each health insurer and group

health plan to reimburse the department for the cost of vaccines provided directly or indirectly by the department to such health insurer's or group health plan's insured children;

(3) maintain a list of registered providers who receive vaccines for insured children that are purchased by the state and provide such list to each health insurer and group health plan with every invoice;

(4) report the failure of a health insurer to reimburse the department within thirty days of the date of the invoice to the office of superintendent;

(5) report the failure of a health insurer or group health plan to reimburse the department within thirty days of the date of the invoice to the state department of justice for collection; and

(6) credit all receipts collected from health insurers and group health plans pursuant to the Vaccine Purchasing Act to the fund.

C. No later than July 1, 2015 and July 1 of each year thereafter, the department shall estimate the amount to be expended annually by the department to purchase, store and distribute vaccines recommended by the department pursuant to Section 24-5-1 NMSA 1978 to all insured children in the state, including a reserve of ten percent of the amount estimated.

D. No later than September 1, 2015 and each quarter thereafter, the department shall invoice each health insurer and each group health plan for one-fourth of its proportionate share of the estimated amount and reserve pursuant to Subsection C of this section, calculated pursuant to Subsection B of Section 24-5A-6 NMSA 1978.

E. The department may update its estimated amount

to be expended annually and its reserve to take into account increases or decreases in the cost of vaccines or the costs of additional vaccines that the department determines should be included in the statewide vaccine purchasing program and adjust the amount invoiced to each health insurer and group health plan the following quarter."

SECTION 6. Section 24-5A-5 NMSA 1978 (being Laws 2015, Chapter 5, Section 5) is amended to read:

"24-5A-5. AUTHORIZED USES OF THE VACCINE PURCHASING FUND.--

A. The fund shall be used for the purchase, storage and distribution of vaccines, as recommended by the department pursuant to Section 24-5-1 NMSA 1978, for insured children who are not eligible for the vaccines for children program.

B. The department shall credit any balance remaining in the fund at the end of the fiscal year toward the department's purchase of vaccines the following year; provided that the department maintains a reserve of ten percent of the amount estimated to be expended in the following year.

C. The fund shall not be used:

(1) for the purchase, storage and distribution of vaccines for children who are eligible for the vaccines for children program;

(2) for administrative expenses associated with the statewide vaccine purchasing program; or

(3) to pass through a federally negotiated discount pursuant to 42 U.S.C. 1396s."

SECTION 7. Section 59A-18-16.2 NMSA 1978 (being Laws 2011, Chapter 144, Section 12, as amended) is amended to read:

"59A-18-16.2. HEALTH INSURANCE OR HEALTH PLAN FORM AND RATE FILINGS--SUPERINTENDENT--RULEMAKING--COMPLIANCE WITH FEDERAL LAW.--

A. A small group health plan and a health insurance issuer or multiple employer welfare arrangement offering a small group or individual health insurance plan that provides benefits other than excepted benefits shall:

(1) provide the essential health benefits defined by the superintendent under Subsection B of this section;

(2) limit cost sharing for such coverage in accordance with Subsection D of this section; and

(3) provide coverage without cost sharing for preventive benefits in accordance with Subsection E of this section.

B. The superintendent shall define by rule the essential health benefits package to include at least the following general categories and the items and services covered within the categories:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

(5) mental health and substance use disorder services, including behavioral health treatment;

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

(9) preventive and wellness services and chronic disease management; and

(10) pediatric services, including oral and

vision care.

C. In defining the essential health benefits pursuant to Subsection B of this section, the superintendent shall:

(1) ensure that such essential health benefits reflect an appropriate balance among the categories described in that subsection, so that benefits are not unduly weighted toward any category;

(2) not make coverage decisions, determine reimbursement rates, establish incentive programs or design benefits in ways that discriminate against individuals because of their age, disability or expected length of life;

(3) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities and other groups;

(4) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency or quality of life;

(5) provide that if a plan is offered through the New Mexico health insurance exchange, another health insurance plan offered through the New Mexico health insurance exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the standalone plan that are otherwise required; and

(6) periodically update the essential health benefits under Subsection B of this section to address any gaps in access to coverage or changes in the evidence base identified by the superintendent.

D. A group health plan and a health insurance

issuer offering a group or individual health insurance plan shall not establish a restricted lifetime or annual limit on the dollar value of benefits for any participant or beneficiary with respect to benefits that are essential health benefits, as determined by the superintendent. The provisions of this subsection shall not be construed to prevent a group health plan or health insurance plan from placing annual or lifetime per-beneficiary limits on specific covered benefits that are not essential health benefits, to the extent that these limits are otherwise permitted under federal or state law.

E. The superintendent shall adopt and promulgate rules specifying the maximum cost-sharing amounts for which an insured may be held liable for payment of covered benefits under any health insurance plan that provides benefits other than excepted benefits, including deductibles, coinsurance, copayments or similar charge, and any other expenditure required of an insured individual with respect to essential health benefits covered under the plan, but not including premiums, balance billing amounts for non-network providers or spending for non-covered services.

F. Any rules that the office of superintendent of insurance intends to adopt and promulgate pursuant to this section shall be adopted no later than the first day of February of the year prior to the first plan year for which the rules would be effective.

G. A group health plan and a health insurance issuer offering a group or individual health insurance plan that provides benefits other than excepted benefits shall provide coverage for and shall not impose any cost-sharing requirements for:

(1) items or services that have in effect a

rating of "A" or "B" in the current recommendations of the United States preventive services task force;

(2) immunizations that have in effect a recommendation from the department of health, with respect to the insured for which immunization is considered;

(3) with respect to infants, children and adolescents, preventive care and screenings provided for in the comprehensive guidelines supported by the health resources and services administration of the United States department of health and human services; and

(4) with respect to women, additional preventive care and screenings to those described in Paragraph (1) of this subsection, as provided for in comprehensive guidelines supported by the health resources and services administration of the United States department of health and human services.

H. The provisions of Subsection G of this section shall not be construed to prohibit a health insurance plan or health insurance issuer from providing coverage for services in addition to those recommended by the United States preventive services task force or to deny coverage for services that are not described in this section. The superintendent shall establish by rule a minimum interval between the date on which a recommendation described in Paragraphs (1) and (2) of Subsection G of this section or a guideline under Paragraph (3) of Subsection G of this section is issued and the plan year with respect to which the requirement described in Subsection G of this section is effective with respect to the service described in such recommendation or guideline; provided that the interval shall not be less than one year from the date the federal recommendation or guideline is published.

I. If a health insurance plan is offered as a qualified health plan through the New Mexico health insurance exchange, the insurer offering the qualified health plan shall also offer that plan through the health insurance exchange as a plan that restricts enrollment to individuals who, as of the beginning of a plan year, have not attained the age of twenty-one years.

J. The superintendent shall adopt rules:

(1) to define terms used regarding forms, rates, reviews and blocks of business that an insurer or health care plan submits in filing matters;

(2) to govern any additional filing requirements the superintendent deems appropriate;

(3) to provide notice of hearings and the grounds on which the hearings have been requested;

(4) to meet criteria for review in accordance with federal law; and

(5) that the superintendent deems appropriate to carry out the provisions of Chapter 59A, Article 18 NMSA 1978.

K. Except as provided by state or federal rule or law, nothing in this section shall be construed to prohibit a health insurance carrier from appropriately using reasonable health care cost management techniques.

L. As used in this section, "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 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."

SECTION 8. Section 24-5-1 NMSA 1978 (being Laws 1959,

Chapter 329, Section 1, as amended by Section 1 of this act) is repealed and a new Section 24-5-1 NMSA 1978 is enacted to read:

"24-5-1. IMMUNIZATION REGULATIONS.--The public health division of the department of health shall, after consultation with the public education department, promulgate rules governing the immunization against diseases deemed to be dangerous to the public health, to be required of children attending public, private, home or parochial schools in the state. The immunizations required and the manner and frequency of their administration shall conform to recommendations of the advisory committee on immunization practices of the United States department of health and human services and the American academy of pediatrics. The public health division shall supervise and secure the enforcement of the required immunization program."

SECTION 9. Section 24-5-2 NMSA 1978 (being Laws 1959, Chapter 329, Section 2, as amended by Section 2 of this act) is repealed and a new Section 24-5-2 NMSA 1978 is enacted to read:

"24-5-2. UNLAWFUL TO ENROLL IN SCHOOL UNIMMUNIZED--UNLAWFUL TO REFUSE TO PERMIT IMMUNIZATION.--It is unlawful for any student to enroll in school unless the student has been immunized as required under the rules of the public health division of the department of health and can provide satisfactory evidence of such immunization; provided that, if the student produces satisfactory evidence of having begun the process of immunization, the student may enroll and attend school as long as the immunization process is being accomplished in the prescribed manner. It is unlawful for any parent to refuse or neglect to have the parent's child immunized, as required by this section, unless the child is

properly exempted."

SECTION 10. Section 24-5A-2 NMSA 1978 (being Laws 2015, Chapter 5, Section 2, as amended by Section 4 of this act) is repealed and a new Section 24-5A-2 NMSA 1978 is enacted to read:

"24-5A-2. DEFINITIONS.--As used in the Vaccine Purchasing Act:

A. "advisory committee on immunization practices" means the group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States, established under Section 222 of the federal Public Health Service Act;

B. "department" means the department of health;

C. "fund" means the vaccine purchasing fund;

D. "group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents under the federal Employee Retirement Income Security Act of 1974 directly or through insurance, reimbursement or other means;

E. "health insurance coverage" means benefits consisting of medical care provided directly or through insurance or reimbursement or other means under 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;

F. "health insurer" means any entity subject to regulation by the office of superintendent that:

(1) provides or is authorized to provide health insurance or health benefit plans;

(2) administers health insurance or health benefit coverage; or

(3) otherwise provides a plan of health

insurance or health benefits;

G. "insured child" means a child under the age of nineteen who is eligible to receive health insurance coverage from a health insurer or medical care pursuant to a group health plan;

H. "office of superintendent" means the office of superintendent of insurance;

I. "policy" means any contract of health insurance between a health insurer and the insured and all clauses, riders, endorsements and parts thereof;

J. "provider" means an individual or organization licensed, certified or otherwise authorized or permitted by law to provide vaccinations to insured children; and

K. "vaccines for children program" means the federally funded program that provides vaccines at no cost to eligible children pursuant to Section 1928 of the federal Social Security Act."

SECTION 11. Section 24-5A-3 NMSA 1978 (being Laws 2015, Chapter 5, Section 3, as amended by Section 5 of this act) is repealed and a new Section 24-5A-3 NMSA 1978 is enacted to read:

"24-5A-3. STATEWIDE VACCINE PURCHASING PROGRAM.--

A. The department shall establish and administer a statewide vaccine purchasing program to:

(1) expand access to childhood immunizations recommended by the advisory committee on immunization practices;

(2) maintain and improve immunization rates;

(3) facilitate the acquisition by providers of vaccines for childhood immunizations recommended by the advisory committee on immunization practices; and

(4) leverage public and private funding and

resources for the purchase, storage and distribution of vaccines for childhood immunizations recommended by the advisory committee on immunization practices.

B. The department shall:

(1) purchase vaccines for all children in New Mexico, including children eligible for the vaccines for children program and insured children;

(2) invoice each health insurer and group health plan to reimburse the department for the cost of vaccines provided directly or indirectly by the department to such health insurer's or group health plan's insured children;

(3) maintain a list of registered providers who receive vaccines for insured children that are purchased by the state and provide such list to each health insurer and group health plan with every invoice;

(4) report the failure of a health insurer to reimburse the department within thirty days of the date of the invoice to the office of superintendent;

(5) report the failure of a health insurer or group health plan to reimburse the department within thirty days of the date of the invoice to the state department of justice for collection; and

(6) credit all receipts collected from health insurers and group health plans pursuant to the Vaccine Purchasing Act to the fund.

C. No later than July 1, 2015 and July 1 of each year thereafter, the department shall estimate the amount to be expended annually by the department to purchase, store and distribute vaccines recommended by the advisory committee on immunization practices to all insured children in the state, including a reserve of ten percent of the amount estimated.

D. No later than September 1, 2015 and each quarter thereafter, the department shall invoice each health insurer and each group health plan for one-fourth of its proportionate share of the estimated amount and reserve pursuant to Subsection C of this section, calculated pursuant to Subsection B of Section 24-5A-6 NMSA 1978.

E. The department may update its estimated amount to be expended annually and its reserve to take into account increases or decreases in the cost of vaccines or the costs of additional vaccines that the department determines should be included in the statewide vaccine purchasing program and adjust the amount invoiced to each health insurer and group health plan the following quarter."

SECTION 12. Section 24-5A-5 NMSA 1978 (being Laws 2015, Chapter 5, Section 5, as amended by Section 6 of this act) is repealed and a new Section 24-5A-5 NMSA 1978 is enacted to read:

"24-5A-5. AUTHORIZED USES OF THE VACCINE PURCHASING FUND.--

A. The fund shall be used for the purchase, storage and distribution of vaccines, as recommended by the advisory committee on immunization practices, for insured children who are not eligible for the vaccines for children program.

B. The department shall credit any balance remaining in the fund at the end of the fiscal year toward the department's purchase of vaccines the following year; provided that the department maintains a reserve of ten percent of the amount estimated to be expended in the following year.

C. The fund shall not be used:

(1) for the purchase, storage and

distribution of vaccines for children who are eligible for the vaccines for children program;

(2) for administrative expenses associated with the statewide vaccine purchasing program; or

(3) to pass through a federally negotiated discount pursuant to 42 U.S.C. 1396s."

SECTION 13. Section 59A-18-16.2 NMSA 1978 (being Laws 2011, Chapter 144, Section 12, as amended by Section 7 of this act) is repealed and a new Section 59A-18-16.2 NMSA 1978 is enacted to read:

"59A-18-16.2. HEALTH INSURANCE OR HEALTH PLAN FORM AND RATE FILINGS--SUPERINTENDENT--RULEMAKING--COMPLIANCE WITH FEDERAL LAW.--

A. A small group health plan and a health insurance issuer or multiple employer welfare arrangement offering a small group or individual health insurance plan that provides benefits other than excepted benefits shall:

(1) provide the essential health benefits defined by the superintendent under Subsection B of this section;

(2) limit cost sharing for such coverage in accordance with Subsection D of this section; and

(3) provide coverage without cost sharing for preventive benefits in accordance with Subsection E of this section.

B. The superintendent shall define by rule the essential health benefits package to include at least the following general categories and the items and services covered within the categories:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

(5) mental health and substance use disorder services, including behavioral health treatment;

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

(9) preventive and wellness services and chronic disease management; and

(10) pediatric services, including oral and vision care.

C. In defining the essential health benefits pursuant to Subsection B of this section, the superintendent shall:

(1) ensure that such essential health benefits reflect an appropriate balance among the categories described in that subsection, so that benefits are not unduly weighted toward any category;

(2) not make coverage decisions, determine reimbursement rates, establish incentive programs or design benefits in ways that discriminate against individuals because of their age, disability or expected length of life;

(3) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities and other groups;

(4) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency or quality of life;

(5) provide that if a plan is offered through the New Mexico health insurance exchange, another

health insurance plan offered through the New Mexico health insurance exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the standalone plan that are otherwise required; and

(6) periodically update the essential health benefits under Subsection B of this section to address any gaps in access to coverage or changes in the evidence base identified by the superintendent.

D. A group health plan and a health insurance issuer offering a group or individual health insurance plan shall not establish a restricted lifetime or annual limit on the dollar value of benefits for any participant or beneficiary with respect to benefits that are essential health benefits, as determined by the superintendent. The provisions of this subsection shall not be construed to prevent a group health plan or health insurance plan from placing annual or lifetime per-beneficiary limits on specific covered benefits that are not essential health benefits, to the extent that these limits are otherwise permitted under federal or state law.

E. The superintendent shall adopt and promulgate rules specifying the maximum cost-sharing amounts for which an insured may be held liable for payment of covered benefits under any health insurance plan that provides benefits other than excepted benefits, including deductibles, coinsurance, copayments or similar charge, and any other expenditure required of an insured individual with respect to essential health benefits covered under the plan, but not including premiums, balance billing amounts for non-network providers or spending for non-covered services.

F. Any rules that the office of superintendent of

insurance intends to adopt and promulgate pursuant to this section shall be adopted no later than the first day of February of the year prior to the first plan year for which the rules would be effective.

G. A group health plan and a health insurance issuer offering a group or individual health insurance plan that provides benefits other than excepted benefits shall provide coverage for and shall not impose any cost-sharing requirements for:

(1) items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States preventive services task force;

(2) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the federal centers for disease control and prevention, with respect to the insured for which immunization is considered;

(3) with respect to infants, children and adolescents, preventive care and screenings provided for in the comprehensive guidelines supported by the health resources and services administration of the United States department of health and human services; and

(4) with respect to women, additional preventive care and screenings to those described in Paragraph (1) of this subsection, as provided for in comprehensive guidelines supported by the health resources and services administration of the United States department of health and human services.

H. The provisions of Subsection G of this section shall not be construed to prohibit a health insurance plan or health insurance issuer from providing coverage for services in addition to those recommended by the United States

preventive services task force or to deny coverage for services that are not described in this section. The superintendent shall establish by rule a minimum interval between the date on which a recommendation described in Paragraphs (1) and (2) of Subsection G of this section or a guideline under Paragraph (3) of Subsection G of this section is issued and the plan year with respect to which the requirement described in Subsection G of this section is effective with respect to the service described in such recommendation or guideline; provided that the interval shall not be less than one year from the date the federal recommendation or guideline is published.

I. If a health insurance plan is offered as a qualified health plan through the New Mexico health insurance exchange, the insurer offering the qualified health plan shall also offer that plan through the health insurance exchange as a plan that restricts enrollment to individuals who, as of the beginning of a plan year, have not attained the age of twenty-one years.

J. The superintendent shall adopt rules:

(1) to define terms used regarding forms, rates, reviews and blocks of business that an insurer or health care plan submits in filing matters;

(2) to govern any additional filing requirements the superintendent deems appropriate;

(3) to provide notice of hearings and the grounds on which the hearings have been requested;

(4) to meet criteria for review in accordance with federal law; and

(5) that the superintendent deems appropriate to carry out the provisions of Chapter 59A, Article 18 NMSA 1978.

K. Except as provided by state or federal rule or law, nothing in this section shall be construed to prohibit a health insurance carrier from appropriately using reasonable health care cost management techniques.

L. As used in this section, "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 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."

SECTION 14. DELAYED EFFECTIVE DATE.--The provisions of Sections 8 through 13 of this act are effective July 1, 2026.