

HOUSE BUSINESS AND INDUSTRY COMMITTEE SUBSTITUTE FOR  
HOUSE BILL 12

49TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2010

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING NEW SECTIONS OF CHAPTER  
59A, ARTICLE 22 NMSA 1978 AND THE SMALL GROUP RATE AND  
RENEWABILITY ACT TO SET MINIMUM REIMBURSEMENT LEVELS FOR DIRECT  
SERVICES; ENACTING A NEW SECTION OF THE HEALTH MAINTENANCE  
ORGANIZATION LAW TO SET MINIMUM REIMBURSEMENT LEVELS FOR DIRECT  
SERVICES; ENACTING A NEW SECTION OF THE NONPROFIT HEALTH CARE  
PLAN LAW TO SET MINIMUM REIMBURSEMENT LEVELS FOR DIRECT  
SERVICES.

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

Section 1. A new section of Chapter 59A, Article 22 NMSA  
1978 is enacted to read:

"NEW MATERIAL HEALTH INSURERS--DIRECT SERVICES.--

A. A health insurer shall make reimbursement for  
direct services at a level not less than eighty-five percent of  
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underscored material = new  
[bracketed material] = delete

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

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

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

10 C. An insurer that fails to comply with the  
11 reimbursement requirements pursuant to this section shall issue  
12 a dividend or credit against future premiums to all  
13 policyholders in an amount sufficient to assure that the  
14 benefits paid in the preceding three calendar years plus the  
15 amount of the dividends or credits are equal to the required  
16 direct services reimbursement level pursuant to Subsection A of  
17 this section for group health coverage and blanket health  
18 coverage or the required direct services reimbursement level  
19 pursuant to Subsection B of this section for individually  
20 underwritten health policies, contracts or plans for the  
21 preceding three calendar years. If the insurer fails to issue  
22 the dividend or credit in accordance with the requirements of  
23 this section, the superintendent shall enforce these  
24 requirements and may pursue any other penalties as provided by  
25 law, including general penalties pursuant to Section 59A-1-18

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1 NMSA 1978.

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

5 E. For the purposes of this section:

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

18 (2) "health insurer" means a person duly  
19 authorized to transact the business of health insurance in the  
20 state pursuant to the Insurance Code but does not include a  
21 person that only issues a limited-benefit policy intended to  
22 supplement major medical coverage, including medicare  
23 supplement, vision, dental, disease-specific, accident-only or  
24 hospital indemnity-only insurance policies, or that only issues  
25 policies for long-term care or disability income; and

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

10 Section 2. A new section of the Small Group Rate and  
11 Renewability Act is enacted to read:

12 "[NEW MATERIAL] HEALTH INSURERS--DIRECT SERVICES.--

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

23 B. An insurer that fails to comply with the  
24 eighty-five percent reimbursement requirement in Subsection A  
25 of this section shall issue a dividend or credit against future

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1 premiums to all policyholders in an amount sufficient to assure  
2 that the benefits paid in the preceding three calendar years  
3 plus the amount of the dividends or credits equal eighty-five  
4 percent of the premiums collected in the preceding three  
5 calendar years. If the insurer fails to issue the dividend or  
6 credit in accordance with the requirements of this section, the  
7 superintendent shall enforce the requirements and may pursue  
8 any other penalties as provided by law, including general  
9 penalties pursuant to Section 59A-1-18 NMSA 1978.

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

13 D. For the purposes of this section:

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

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

9                   (3) "premium" means all income received from  
 10 individuals and private and public payers or sources for the  
 11 procurement of health coverage, including capitated payments,  
 12 self-funded administrative fees, self-funded claim  
 13 reimbursements, recoveries from third parties or other insurers  
 14 and interests less any premium tax paid pursuant to Section  
 15 59A-6-2 NMSA 1978 and fees associated with participating in a  
 16 health insurance exchange that serves as a clearinghouse for  
 17 insurance."

18                   Section 3. A new section of the Health Maintenance  
 19 Organization Law is enacted to read:

20                   "NEW MATERIAL] HEALTH MAINTENANCE ORGANIZATIONS--DIRECT  
 21 SERVICES.--

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

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

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

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

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

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1 Section 59A-1-18 NMSA 1978.

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

5 E. For the purposes of this section:

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

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

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

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

12 Section 4. A new section of the Nonprofit Health Care  
13 Plan Law is enacted to read:

14 "[NEW MATERIAL] HEALTH INSURERS--DIRECT SERVICES.--

15 A. A health care plan shall make reimbursement for  
16 direct services at a level not less than eighty-five percent of  
17 premiums across all health product lines, except individually  
18 underwritten health care policies, contracts or plans, that are  
19 governed by the provisions of Chapter 59A, Article 22 NMSA  
20 1978, the Health Maintenance Organization Law and the Nonprofit  
21 Health Care Plan Law. Reimbursement shall be made for direct  
22 services provided over the preceding three calendar years, but  
23 not earlier than calendar year 2010, as determined by reports  
24 filed with the insurance division of the commission. Nothing  
25 in this subsection shall be construed to preclude a purchaser

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1 from negotiating an agreement with a health insurer that  
2 requires a higher amount of premiums paid to be used for  
3 reimbursement for direct services for one or more products or  
4 for one or more years.

5 B. For individually underwritten health care  
6 policies, plans or contracts, the superintendent shall  
7 establish, after notice and informal hearing, the level of  
8 reimbursement for direct services as determined as a percent of  
9 premiums. Additional hearings may be held at the  
10 superintendent's discretion. In establishing the level of  
11 reimbursement for direct services, the superintendent shall  
12 consider the costs associated with the individual marketing and  
13 medical underwriting of these policies, plans or contracts at a  
14 level not less than seventy-five percent of premiums. A health  
15 insurer writing these policies, plans or contracts shall make  
16 reimbursement for direct services at a level not less than that  
17 level established by the superintendent pursuant to this  
18 subsection over the three calendar years preceding the date  
19 upon which that rate is established, but not earlier than  
20 calendar year 2010. Nothing in this subsection shall be  
21 construed to preclude a purchaser of one of these policies,  
22 plans or contracts from negotiating an agreement with a health  
23 insurer that requires a higher amount of premiums paid to be  
24 used for reimbursement for direct services.

25 C. A health care plan that fails to comply with the

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

17 D. After notice and hearing, the superintendent may  
18 adopt and promulgate reasonable rules necessary and proper to  
19 carry out the provisions of this section.

20 E. For the purposes of this section:

21 (1) "direct services" means services rendered  
22 to an individual by a health care plan, health insurer or a  
23 health care practitioner, facility or other provider, including  
24 case management, disease management, health education and  
25 promotion, preventive services, quality incentive payments to

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1 providers and any portion of an assessment that covers services  
2 rather than administration and for which a health care plan or  
3 a health insurer does not receive a tax credit pursuant to the  
4 Medical Insurance Pool Act or the Health Insurance Alliance  
5 Act; provided, however, that "direct services" does not include  
6 care coordination, utilization review or management or any  
7 other activity designed to manage utilization or services;

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

17 (3) "premium" means all income received from  
18 individuals and private and public payers or sources for the  
19 procurement of health coverage, including capitated payments,  
20 self-funded administrative fees, self-funded claim  
21 reimbursements, recoveries from third parties or other insurers  
22 and interests less any premium tax paid pursuant to Section  
23 59A-6-2 NMSA 1978 and fees associated with participating in a  
24 health insurance exchange that serves as a clearinghouse for  
25 insurance."

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