SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
SENATE BILL 608

50TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2011

AN ACT

RELATING TO THE PUBLIC PEACE, HEALTH, SAFETY AND WELFARE; AMENDING, REPEALING AND ENACTING SECTIONS OF THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO PROHIBIT LIFETIME OR ANNUAL LIMITS; PROHIBITING RESCISSIONS OF COVERAGE; PROVIDING FOR THE EXPULSION OR SUSPENSION OF FRATERNAL BENEFIT SOCIETY MEMBERSHIP IN CASES OF INTENTIONAL MISREPRESENTATION; PROVIDING FOR RESCISSION OR BREACH OF NONPROFIT HEALTH CARE PLAN SUBSCRIBER CONTRACTS IN CASES OF INTENTIONALLY MISLEADING MISREPRESENTATION; PROVIDING FOR COVERAGE FOR PREVENTIVE ITEMS AND SERVICE FOR OFFICE VISITS IN CONJUNCTION WITH PREVENTIVE ITEMS AND SERVICES; MANDATING COVERAGE FOR INDIVIDUALS UNDER THE AGE OF TWENTY-SIX WHO SEEK COVERAGE UNDER THEIR PARENTS' COVERAGE; PROHIBITING PREEXISTING CONDITION EXCLUSIONS FOR INDIVIDUALS UNDER NINETEEN; PROVIDING FOR SPECIAL ENROLLMENT

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FOR INDIVIDUALS WHOSE COVERAGE ENDED BY REASONS OF CESSATION OF DEPENDENT STATUS; PROVIDING FOR APPLICABILITY OF HEALTH INSURANCE MANDATE CHANGES TO "GRANDFATHERED" HEALTH PLAN COVERAGE BEGINNING BEFORE MARCH 23, 2010 AND CONTINUING IN EFFECT; AMENDING A SECTION OF THE MEDICAL CARE SAVINGS ACCOUNT ACT TO PROVIDE FOR DEPENDENT COVERAGE UNTIL THE AGE OF TWENTY-SIX; ESTABLISHING HEALTH COVERAGE REQUIREMENTS RELATED TO THE PROVISION OF EMERGENCY SERVICES; REQUIRING THAT COVERED CHILDREN HAVE ACCESS TO PEDIATRIC CARE; REQUIRING THAT FEMALE COVERED INDIVIDUALS HAVE ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE; ENACTING NEW SECTIONS OF THE NEW MEXICO INSURANCE CODE TO DEFINE "CHILD" AND "DEPENDENT".

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

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

"[NEW MATERIAL] "CHILD"--"DEPENDENT".--

A. "Child" means an individual who is related to a principal insured or applicant for insurance or other coverage pursuant to the Insurance Code by birth or adoption.

B. "Dependent" means the spouse of a principal insured or a child who is under the age of twenty-six."

SECTION 2. A new section of Chapter 59A, Article 1 NMSA 1978 is enacted to read:

"[NEW MATERIAL] "GRANDFATHERED HEALTH PLAN" OR

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"GRANDFATHERED HEALTH POLICY COVERAGE".--

A. "Grandfathered health plan" or "grandfathered health policy coverage" means individual or group coverage provided by a health insurer, health maintenance organization or nonprofit health plan that was in effect on March 23, 2010 and that remains in effect through the original term of coverage or through renewal of the original term.

B. A dependent of an individual enrolled in a grandfathered health plan may enroll in a grandfathered health plan or policy if the terms of the plan in effect as of March 23, 2010 permitted the dependent to enroll.

C. A group health plan that provides coverage on March 23, 2010 may provide for the enrolling of new employees and their dependents in that grandfathered health plan.

D. Coverage provided by a health insurer, health maintenance organization or nonprofit health plan pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010 constitutes a "grandfathered health plan" until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage that amends the coverage solely to conform to any requirement of the Insurance Code shall not be treated as a termination of the collective bargaining

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agreement."

SECTION 3. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PROHIBITION ON LIFETIME OR ANNUAL LIMITS.--

A. Notwithstanding any other provision of law, a group health plan, health insurance issuer offering group or individual health insurance coverage, health maintenance organization, fraternal benefit society or nonprofit organization shall not establish:

(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

(2) except as provided in Subsection B of this section, annual limits on the dollar value of benefits for any participant or beneficiary.

B. With respect to plan years beginning prior to January 1, 2014, a group health plan, health insurance issuer offering group or individual health insurance coverage, fraternal benefit society or nonprofit organization shall establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary only with respect to the scope of benefits that are essential health benefits.

C. Subsection A of this section shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health

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benefits to the extent that these limits are otherwise permitted under federal or state law."

SECTION 4. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PROHIBITION ON LIFETIME OR ANNUAL LIMITS.--

A. Notwithstanding any other provision of law, a group health plan, health insurance issuer offering group or individual health insurance coverage, health maintenance organization, fraternal benefit society or nonprofit organization shall not establish:

(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

(2) except as provided in Subsection B of this section, annual limits on the dollar value of benefits for any participant or beneficiary.

B. With respect to plan years beginning prior to January 1, 2014, a group health plan, health insurance issuer offering group or individual health insurance coverage, fraternal benefit society or nonprofit organization may establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary only with respect to the scope of benefits that are essential health benefits.

C. Subsection A of this section shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits

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on specific covered benefits that are not essential health benefits to the extent that these limits are otherwise permitted under federal or state law."

SECTION 5. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] PROHIBITION ON LIFETIME OR ANNUAL LIMITS.--

A. Notwithstanding any other provision of law, a group health plan, health insurance issuer offering group or individual health insurance coverage, health maintenance organization, fraternal benefit society or nonprofit organization shall not establish:

(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

(2) except as provided in Subsection B of this section, annual limits on the dollar value of benefits for any participant or beneficiary.

B. With respect to plan years beginning prior to January 1, 2014, a group health plan, health insurance issuer offering group or individual health insurance coverage, fraternal benefit society or nonprofit organization may establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary only with respect to the scope of benefits that are essential health benefits.

C. Subsection A of this section shall not be construed to prevent a group health plan or health insurance

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coverage 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."

SECTION 6. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] PROHIBITION ON LIFETIME OR ANNUAL LIMITS.--

A. Notwithstanding any other provision of law, a group health plan, health insurance issuer offering group or individual health insurance coverage, health maintenance organization, fraternal benefit society or nonprofit organization shall not establish:

(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

(2) except as provided in Subsection B of this section, annual limits on the dollar value of benefits for any participant or beneficiary.

B. With respect to plan years beginning prior to January 1, 2014, a group health plan, health insurance issuer offering group or individual health insurance coverage, fraternal benefit society or nonprofit organization may establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary only with respect to the scope of benefits that are essential health benefits.

C. Subsection A of this section shall not be

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construed to prevent a group health plan or health insurance coverage 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."

SECTION 7. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PROHIBITION ON RESCISSIONS OF COVERAGE.--

A. A health insurer or insurer providing coverage under an individual health benefit plan or policy or a grandfathered health plan or policy coverage shall not rescind coverage under a health benefit plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(1) the individual or a person seeking coverage on behalf of the individual performs an act, practice or omission that constitutes fraud; or

(2) the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

B. For purposes of Paragraph (1) of Subsection A of this section, a person seeking coverage on behalf of an individual does not include an insurance producer or an employee or authorized representative of the health insurer.

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C. A health insurer shall provide at least thirty days' advance written notice to each plan enrollee, or for individual health insurance coverage, to each primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with Subsection A of this section regardless, in the case of group health insurance coverage, of whether the rescission applies to the entire group or only to an individual within the group.

D. The provisions of this section apply regardless of any applicable contestability period."

SECTION 8. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PROHIBITION ON RESCISSIONS OF COVERAGE.--

A. A health insurer or insurer providing coverage under an individual health benefit plan or policy or grandfathered health plan or policy coverage shall not rescind coverage under a health benefit plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(1) the individual or a person seeking coverage on behalf of the individual performs an act, practice or omission that constitutes fraud; or

(2) the individual makes an intentional

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misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

B. For purposes of Paragraph (1) of Subsection A of this section, a person seeking coverage on behalf of an individual does not include an insurance producer or an employee or authorized representative of the health insurer.

C. A health insurer shall provide at least thirty days' advance written notice to each plan enrollee, or for individual health insurance coverage, to each primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with Subsection A of this section regardless, in the case of group health insurance coverage, of whether the rescission applies to the entire group or only to an individual within the group.

D. The provisions of this section apply regardless of any applicable contestability period."

SECTION 9. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] PROHIBITION ON RESCISSIONS OF COVERAGE.--

A. A health maintenance organization providing coverage under an individual health benefit plan or policy or grandfathered health plan or policy coverage shall not rescind coverage under a health benefit plan with respect to an individual, including a group to which the individual belongs

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or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(1) the individual or a person seeking coverage on behalf of the individual performs an act, practice or omission that constitutes fraud; or

(2) the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

B. For purposes of Paragraph (1) of Subsection A of this section, a person seeking coverage on behalf of an individual does not include an insurance producer or an employee or authorized representative of the health insurer.

C. A health insurer shall provide at least thirty days' advance written notice to each plan enrollee, or for individual health insurance coverage, to each primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with Subsection A of this section regardless, in the case of group health insurance coverage, of whether the rescission applies to the entire group or only to an individual within the group.

D. The provisions of this section apply regardless of any applicable contestability period."

SECTION 10. A new section of the Nonprofit Health Care Plan Law is enacted to read:

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"[NEW MATERIAL] PROHIBITION ON RESCISSIONS OF COVERAGE.--

A. A nonprofit health care plan providing coverage under an individual health benefit plan or policy or grandfathered health plan or policy coverage shall not rescind coverage under a health benefit plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(1) the individual or a person seeking coverage on behalf of the individual performs an act, practice or omission that constitutes fraud; or

(2) the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

B. For purposes of Paragraph (1) of Subsection A of this section, a person seeking coverage on behalf of an individual does not include an insurance producer or an employee or authorized representative of the health insurer.

C. A nonprofit health care plan shall provide at least thirty days' advance written notice to each plan enrollee, or for individual health plan coverage, to each primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with Subsection A of this section regardless, in the case of group health plan coverage, of

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whether the rescission applies to the entire group or only to an individual within the group.

D. The provisions of this section apply regardless of any applicable contestability period."

SECTION 11. Section 59A-23A-8 NMSA 1978 (being Laws 1993, Chapter 126, Section 12) is amended to read:

"59A-23A-8. INCONTESTABILITY PERIOD.--

A. For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of intentional misrepresentation that is material to the acceptance for coverage.

B. For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of intentional misrepresentation that is both material to the acceptance for coverage and [~~which~~] that pertains to the condition for which benefits are sought.

[~~C. After a policy or certificate has been in force for two years, it is not contestable upon the grounds of misrepresentation alone. Such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the~~

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~~insured's health.~~

~~D.~~] C. No long-term care insurance policy or certificate may be field issued based on medical or health status. For purposes of this subsection, "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.

[~~E.~~] D. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded."

SECTION 12. Section 59A-23D-2 NMSA 1978 (being Laws 1995, Chapter 93, Section 2, as amended) is amended to read:

"59A-23D-2. DEFINITIONS.--As used in the Medical Care Savings Account Act:

A. "account administrator" means any of the following that administers medical care savings accounts:

(1) a national or state chartered bank, savings and loan association, savings bank or credit union;

(2) a trust company authorized to act as a fiduciary in this state;

(3) an insurance company or health maintenance organization authorized to do business in this state pursuant to the New Mexico Insurance Code; or

(4) a person approved by the federal secretary

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of health and human services;

B. "deductible" means the total covered medical expense an employee or [~~his~~] the employee's dependents must pay prior to any payment by a qualified higher deductible health plan for a calendar year;

C. "department" means the insurance division of the public regulation commission;

D. "dependent" means:

(1) a spouse;

(2) an unmarried or unemancipated child of the employee who is a minor and who is:

(a) a natural child;

(b) a legally adopted child;

(c) a stepchild living in the same household who is primarily dependent on the employee for maintenance and support;

(d) a child for whom the employee is the legal guardian and who is primarily dependent on the employee for maintenance and support, as long as evidence of the guardianship is evidenced in a court order or decree; or

(e) a foster child living in the same household, if the child is not otherwise provided with health care or health insurance coverage;

(3) [~~an unmarried~~] a child described in Subparagraphs (a) through (e) of Paragraph (2) of this

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subsection who is between the ages of eighteen and [~~twenty-five~~] twenty-six; or

(4) a child over the age of eighteen who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who is chiefly dependent on the employee for support and maintenance;

E. "eligible individual" means an individual who with respect to any month:

(1) is covered under a qualified higher deductible health plan as of the first day of that month;

(2) is not, while covered under a qualified higher deductible health plan, covered under [~~any~~] a health plan that:

(a) is not a qualified higher deductible health plan; and

(b) provides coverage for [~~any~~] a benefit that is covered under the qualified higher deductible health plan; and

(3) is covered by a qualified higher deductible health plan that is established and maintained by the employer of the individual or of the spouse of the individual;

F. "eligible medical expense" means an expense paid by the employee for medical care described in Section 213(d) of the Internal Revenue Code of 1986 that is deductible for

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federal income tax purposes to the extent that those amounts are not compensated for by insurance or otherwise;

G. "employee" includes a self-employed individual;

H. "employer" includes a self-employed individual;

I. "medical care savings account" or "savings account" means an account established by an employer in the United States exclusively for the purpose of paying the eligible medical expenses of the employee or dependent, but only if the written governing instrument creating the trust meets the following requirements:

(1) except in the case of a rollover contribution, no contribution will be accepted:

(a) unless it is in cash; or

(b) to the extent the contribution, when added to previous contributions to the trust for the calendar year, exceeds seventy-five percent of the highest annual limit deductible permitted pursuant to the Medical Care Savings Account Act;

(2) no part of the trust assets will be invested in life insurance contracts;

(3) the assets of the trust will not be commingled with other property except in a common trust fund or common investment fund; and

(4) the interest of an individual in the balance in [~~his~~] the individual's account is nonforfeitable;

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J. "program" means the medical care savings account program established by an employer for [~~his~~] employees; and

K. "qualified higher deductible health plan" means a health coverage policy, certificate or contract that provides for payments for covered health care benefits that exceed the policy, certificate or contract deductible, that is purchased by an employer for the benefit of an employee and that has the following deductible provisions:

(1) self-only coverage with an annual deductible of not less than one thousand five hundred dollars ($1,500) or more than two thousand two hundred fifty dollars ($2,250) and a maximum annual out-of-pocket expense requirement of three thousand dollars ($3,000), not including premiums;

(2) family coverage with an annual deductible of not less than three thousand dollars ($3,000) or more than four thousand five hundred dollars ($4,500) and a maximum annual out-of-pocket expense requirement of five thousand five hundred dollars ($5,500), not including premiums; and

(3) preventive care coverage may be provided within the policies without the preventive care being subjected to the qualified higher deductibles."

SECTION 13. Section 59A-44-19 NMSA 1978 (being Laws 1989, Chapter 388, Section 19) is amended to read:

"59A-44-19. THE BENEFIT CONTRACT.--

A. Every society authorized to do business in this

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state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

B. Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate shall bind the owner and the beneficiaries and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits [~~which~~] that the society contracted to give the owner as of the date of issuance.

C. Any person upon whose life a certificate is issued prior to attaining the age of majority shall be bound by

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the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

D. A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body shall require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made either:

(1) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or

(2) in lieu of or in combination with the provisions of Paragraph (1) of this subsection, the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

E. Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

F. No certificate shall be delivered or issued for delivery in this state unless a copy of the form and rates and

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rate increases applicable to accident and health insurance have been filed with and approved by the superintendent in accordance with Sections 59A-18-12, 59A-18-13 and 59A-18-14 NMSA 1978. Every life or accident and health insurance certificate and every annuity certificate issued on or after one year from [~~the effective date of this act~~] January 1, 1990 shall meet the standard contract provision requirements consistent with Chapter 59A, Article 44 NMSA 1978, as specified in Chapter 59A, Articles 20 and 22 NMSA 1978, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums [~~which~~] that are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate [~~which~~] that, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for intentional material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

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G. Certificates issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

H. A society may specify the terms and conditions on which certificates may be assigned."

SECTION 14. Section 59A-47-24 NMSA 1978 (being Laws 1984, Chapter 127, Section 879.22) is amended to read:

"59A-47-24. SUBSCRIBER CONTRACTS--REQUIREMENTS AND PROVISIONS.--Every health care expense payments contract issued under [~~this article~~] the Nonprofit Health Care Plan Law shall be in writing and comply with requirements and contain provisions in substance as follows:

A. a provision that the policy, the application of the policyholder (if it or a copy thereof is attached to the policy) and the individual applications, if any, submitted in connection with [~~such~~] the policy by the employees or members constitutes the entire contract between the parties, that no statement therein is a warranty in the absence of fraud and

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that no such statement shall avoid the obligation of the health care plan provided in the policy or reduce benefits thereunder unless contained in a written application for [~~such~~] the contract, attached to and made part of the policy;

B. if [~~such~~] the contract is a group contract, a provision that the health care plan will furnish to the subscriber, for delivery to each employee or member of any covered group, an individual certificate, [~~or~~] an identification card or other evidence of such coverage, setting forth in summary form a statement of the essential features of the contract of all persons included in the coverage;

C. if [~~such~~] the contract is a group contract, a provision that eligible new employees or members or dependents, as the case may be, may be added from time to time to the group originally covered, in accordance with the terms of the contract;

D. the amount payable to the health care plan by the subscriber and the time at which and manner in which [~~such~~] the amount is to be paid;

E. the nature of the benefits [~~which~~] that will be furnished and the period during which they will be furnished and, if there are any benefits to be excepted, a detailed statement of [~~such~~] the exceptions;

F. any specific term or condition to the effect that the contract may be canceled or otherwise terminated by the

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health care plan, including the manner and time of [~~such~~] the termination; provided that a contract may not be canceled during the period for which the premium has been paid unless written notice is delivered to the insured, or mailed to [~~his~~] the insured's last address as shown by the records of the health care plan, stating when, not less than five days thereafter [~~such~~] the cancellation shall be effective;

G. that the contract includes the endorsements thereon and attached papers, if any, and constitutes the entire contract;

H. that [~~after two years~~] no statement, except [~~a~~] an intentionally misleading or fraudulent statement, by the subscriber in the application for a contract shall void the contract or be used against the subscriber in any legal action or proceedings relating to the contract unless [~~such~~] the application or a true copy thereof is included in or attached to [~~such~~] the contract; a statement that no change in the contract shall be valid until approved by an executive officer of the health care plan and unless [~~such~~] the approval and countersignature be endorsed on or attached to [~~such~~] the contract; and a statement that no agent has authority to change the contract or waive any of its provisions. No claim for loss incurred or disability (as defined in the policy) shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific

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description effective on the date of loss had existed prior to the effective date of coverage of [~~such~~] the policy;

I. that if the subscriber defaults in making any payment under the contract, the subsequent acceptance of an application for reinstatement and accompanying payment or its failure to take any action with respect thereto within thirty days following receipt of [~~such~~] the application for reinstatement, by [~~such~~] the health care plan or any duly authorized agent thereof, reinstates the contract. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after [~~such~~] that date. In all other respects, the subscriber and the health care plan shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed thereon or attached thereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which a premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement. (The last sentence of the above provision may be omitted from any policy [~~which~~] that the insured has the right to continue in force subject to its terms by the timely payment of premiums:

(1) until at least age fifty [~~(50)~~]; or

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(2) in the case of a policy issued after age forty-four [~~(44)~~], for at least five [~~(5)~~] years from the date of its issue); and

J. the period of grace [~~which~~] that will be allowed the subscriber for making any payment due under the contract, which period shall not be less than ten [~~(10)~~] days."

SECTION 15. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] COVERAGE FOR PREVENTIVE ITEMS AND SERVICES.--

A. A health insurer providing coverage under an individual or group health benefit plan, except for grandfathered health plan coverage, shall provide coverage for all of the following items and services and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

(1) except as otherwise provided in Subsections B through E of this section, evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States preventive services task force as of September 23, 2010 with respect to the individual involved;

(2) immunizations for routine use in children, adolescents and adults that have in effect a recommendation

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from the advisory committee on immunization practices of the federal centers for disease control and prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the advisory committee on immunization practices is considered in effect after it has been adopted by the director of the centers for disease control and prevention, and a recommendation is considered to be for routine use if it is listed on the immunization schedules of the centers for disease control and prevention;

(3) with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the federal health resources and services administration; and

(4) with respect to women, to the extent not described in Paragraph (1) of this subsection, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration.

B. A health insurer is not required to provide coverage for any items or services specified in any recommendation or guideline described in Subsection A of this section after the recommendation or guideline is no longer described by a source listed in that subsection.

C. Other provisions of state or federal law may apply in connection with a health insurer's ceasing to provide

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coverage for any such items or services.

D. For purposes of Subsection A of this section and for purposes of any other provision of law, the current United States preventive services task force recommendations regarding breast cancer screening, mammography and prevention shall be used.

E. To the extent that a preventive care provision in this section conflicts with any other preventive health care law in New Mexico, the provision providing the greatest level of coverage shall apply. The preventive care provisions in this section are intended to supplement rather than supplant existing preventive health care provisions in this state.

F. A health insurer shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States preventive services task force, the advisory committee on immunization practices of the federal centers for disease control and prevention and the guidelines with respect to infants, children, adolescents and women of evidence-based preventive care and screenings by the federal health resources and services administration in effect at the time."

SECTION 16. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] COVERAGE FOR PREVENTIVE ITEMS AND SERVICE.--

A. A health insurer providing coverage under an individual or group health benefit plan, except for grandfathered plan coverage, shall provide coverage for all of the following items and services and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

(1) except as otherwise provided in Subsections B through E of this section, evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States preventive services task force as of September 23, 2010 with respect to the individual involved;

(2) immunizations for routine use in children, adolescents and adults 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 individual involved. For purposes of this paragraph, a recommendation from the advisory committee on immunization practices is considered in effect after it has been adopted by the director of the centers for disease control and prevention, and a recommendation is considered to be for routine use if it is listed on the immunization schedules of the centers for disease control and prevention;

(3) with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the federal health resources and services administration; and

(4) with respect to women, to the extent not described in Paragraph (1) of this subsection, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration.

B. A health insurer is not required to provide coverage for any items or services specified in any recommendation or guideline described in Subsection A of this section after the recommendation or guideline is no longer described by a source listed in that subsection.

C. Other provisions of state or federal law may apply in connection with a health insurer's ceasing to provide coverage for any such items or services.

D. For purposes of Subsection A of this section and for purposes of any other provision of law, the current United States preventive services task force recommendations regarding breast cancer screening, mammography and prevention shall be used.

E. To the extent that a preventive care provision in this section conflicts with any other preventive health care law in New Mexico, the provision providing the greatest level

of coverage shall apply. The preventive care provisions in this section are intended to supplement rather than supplant existing preventive health care provisions in this state.

F. A health insurer shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States preventive services task force, the advisory committee on immunization practices of the federal centers for disease control and prevention and the guidelines with respect to infants, children, adolescents and women of evidence-based preventive care and screenings by the health resources and services administration in effect at the time."

SECTION 17. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] COVERAGE FOR PREVENTIVE ITEMS AND SERVICE.--

A. A health maintenance organization providing coverage under an individual or group health benefit plan, except for grandfathered health plan coverage, shall provide coverage for all of the following items and services and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

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(1) except as otherwise provided in Subsections B through E of this section, evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States preventive services task force as of September 23, 2010 with respect to the individual involved;

(2) immunizations for routine use in children, adolescents and adults 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 individual involved. For purposes of this paragraph, a recommendation from the advisory committee on immunization practices is considered in effect after it has been adopted by the director of the centers for disease control and prevention, and a recommendation is considered to be for routine use if it is listed on the immunization schedules of the centers for disease control and prevention;

(3) with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the federal health resources and services administration; and

(4) with respect to women, to the extent not described in Paragraph (1) of this subsection, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and

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services administration.

B. A health maintenance organization is not required to provide coverage for any items or services specified in any recommendation or guideline described in Subsection A of this section after the recommendation or guideline is no longer described by a source listed in that subsection.

C. Other provisions of state or federal law may apply in connection with a health maintenance organization's ceasing to provide coverage for any such items or services.

D. For purposes of Subsection A of this section and for purposes of any other provision of law, the current United States preventive services task force recommendations regarding breast cancer screening, mammography and prevention shall be used.

E. To the extent that a preventive care provision in this section conflicts with any other preventive health care law in New Mexico, the provision providing the greatest level of coverage shall apply. The preventive care provisions in this section are intended to supplement rather than supplant existing preventive health care provisions in this state.

F. A health maintenance organization shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States

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preventive services task force, the advisory committee on immunization practices of the federal centers for disease control and prevention and the guidelines with respect to infants, children, adolescents and women of evidence-based preventive care and screenings by the health resources and services administration in effect at the time."

SECTION 18. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] COVERAGE FOR PREVENTIVE ITEMS AND SERVICE.--

A. A nonprofit health care plan providing coverage under an individual or group health benefit plan, except for grandfathered health plan coverage, shall provide coverage for all of the following items and services and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

(1) except as otherwise provided in Subsections B through E of this section, evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States preventive services task force as of September 23, 2010 with respect to the individual involved;

(2) immunizations for routine use in children, adolescents and adults that have in effect a recommendation

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[bracketed material] = delete

from the advisory committee on immunization practices of the federal centers for disease control and prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the advisory committee on immunization practices is considered in effect after it has been adopted by the director of the centers for disease control and prevention, and a recommendation is considered to be for routine use if it is listed on the immunization schedules of the centers for disease control and prevention;

(3) with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the federal health resources and services administration; and

(4) with respect to women, to the extent not described in Paragraph (1) of this subsection, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration.

B. A nonprofit health care plan is not required to provide coverage for any items or services specified in any recommendation or guideline described in Subsection A of this section after the recommendation or guideline is no longer described by a source listed in that subsection.

C. Other provisions of state or federal law may apply in connection with a nonprofit health care plan ceasing to

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provide coverage for any such items or services.

D. For purposes of Subsection A of this section and for purposes of any other provision of law, the current United States preventive services task force recommendations regarding breast cancer screening, mammography and prevention shall be used.

E. To the extent a preventive care provision in this section conflicts with any other preventive health care law in the state, the provision providing the greatest level of coverage shall apply. The preventive care provisions in this section are intended to supplement rather than supplant existing preventive health care provisions in this state.

F. A nonprofit health care plan shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States preventive services task force, the advisory committee on immunization practices of the federal centers for disease control and prevention and the guidelines with respect to infants, children, adolescents and women of evidence-based preventive care and screenings by the health resources and services administration in effect at the time."

SECTION 19. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] COVERAGE FOR OFFICE VISITS IN CONJUNCTION WITH PREVENTIVE ITEMS AND SERVICES.--

A. An insurer may impose cost-sharing requirements with respect to an office visit if an item or service is billed separately or is tracked as individual encounter data separately from the office visit.

B. An insurer shall not impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

C. An insurer may impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service."

SECTION 20. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] COVERAGE FOR OFFICE VISITS IN CONJUNCTION WITH PREVENTIVE ITEMS AND SERVICES.--

A. An insurer may impose cost-sharing requirements with respect to an office visit if an item or service is billed separately or is tracked as individual encounter data

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separately from the office visit.

B. An insurer shall not impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

C. An insurer may impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service."

SECTION 21. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] COVERAGE FOR OFFICE VISITS IN CONJUNCTION WITH PREVENTIVE ITEMS AND SERVICES.--

A. A health maintenance organization may impose cost-sharing requirements with respect to an office visit if an item or service is billed separately or is tracked as individual encounter data separately from the office visit.

B. A health maintenance organization shall not impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and

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the primary purpose of the office visit is the delivery of the item or service.

C. A health maintenance organization may impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service."

SECTION 22. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] COVERAGE FOR OFFICE VISITS IN CONJUNCTION WITH PREVENTIVE ITEMS AND SERVICES.--

A. A nonprofit health care plan may impose cost-sharing requirements with respect to an office visit if an item or service is billed separately or is tracked as individual encounter data separately from the office visit.

B. A nonprofit health care plan shall not impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

C. A nonprofit health care plan may impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as

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individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service."

SECTION 23. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] DEPENDENT COVERAGE FOR CHILDREN UNDER THE AGE OF TWENTY-SIX.--

A. For plan or policy years beginning on or after September 23, 2010, a health insurer that makes available dependent coverage of children shall make that coverage available to a child until the age of twenty-six.

B. A health insurer shall not define "dependent" for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and a principal insured.

C. A health insurer shall not deny or restrict coverage for a child under twenty-six based on the child's:

(1) financial independence from or dependency on the plan participant or primary subscriber or any other person;

(2) residency with the plan participant or primary subscriber or with any other person;

(3) marital status;

(4) student status;

(5) employment status; or

(6) any combination of the factors listed in

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Paragraphs (1) through (5) of this subsection.

D. Except in regard to a grandfathered health plan, a health insurer shall not deny or restrict coverage of a child based on the child's eligibility for other coverage."

SECTION 24. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

A. For plan or policy years beginning on or after September 23, 2010, if a child's coverage ended or did not begin for the reasons described in Subsection E of this section, a health insurer shall provide the child an opportunity to enroll that continues for at least sixty days and written notice of the opportunity to enroll as described in Subsection B of this section no later than the first day of the plan or policy year.

B. A written notice of opportunity to enroll provided pursuant to this section shall include a statement that children whose coverage ended, or who were denied coverage or were not eligible for coverage because of dependent coverage of children was unavailable before the child reached twenty-six years of age are eligible to enroll in the coverage. This notice may be provided to a principal insured on behalf of the principal insured's child. For group coverage, the notice may

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be included with other enrollment materials that the health insurer distributes to employees, provided the statement is prominent. If the notice is provided to an employee whose child is entitled to an enrollment opportunity under Subsection A of this section, the obligation to provide the notice of enrollment opportunity under this subsection is satisfied for both the individual or group health insurance policy, health care plan or certificate of health insurance and the health insurer.

C. For an individual who enrolls in an individual or a group health insurance policy, health care plan or certificate of health insurance pursuant to Subsection A of this section, the coverage shall take effect not later than the first day of the first plan or policy year.

D. A child enrolling pursuant to this section in a group health insurance policy, health care plan or certificate of health insurance shall be considered a "special enrollee" pursuant to Section 59A-23E-8 NMSA 1978. The child and the principal insured shall be offered all of the benefit packages available to similarly situated individuals who did not lose coverage by reasons of cessation of dependent status. Any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent

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status.

E. The provisions of this section shall apply to a child:

(1) whose coverage ended, or who was denied coverage or was not eligible for coverage under an individual or a group health insurance policy, health care plan or certificate of health insurance because, under the terms of coverage, the availability of dependent coverage of a child ended before the child reached the age of twenty-six; or

(2) who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan or policy year, beginning on or after September 23, 2010 by reason of the provisions of this section."

SECTION 25. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] GRANDFATHERED HEALTH PLANS--ADULT CHILD DEPENDENT ELIGIBLE FOR EMPLOYER-SPONSORED HEALTH BENEFIT PLAN--EXCLUSION FROM DEPENDENT COVERAGE ELIGIBILITY PERMITTED.--

A. For plan years beginning before January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered health plan and makes available dependent coverage of children may exclude an adult child under twenty-six years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in Section 5000A(f)(2) of the federal

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Internal Revenue Code of 1986, other than the group health plan of a parent.

B. For plan years beginning on or after January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered health plan shall comply with the requirements of Sections 23 and 24 of this 2011 act."

SECTION 26. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] DEPENDENT COVERAGE FOR CHILDREN UNDER THE AGE OF TWENTY-SIX.--

A. For plan or policy years beginning on or after September 23, 2010, a health insurer that makes available dependent coverage of children shall make that coverage available to a child until the age of twenty-six.

B. A health insurer shall not define "dependent" for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and a principal insured.

C. A health insurer shall not deny or restrict coverage for a child under twenty-six based on the child's:

(1) financial independence from or dependency on the plan participant or primary subscriber or any other person;

(2) residency with the plan participant or primary subscriber or with any other person;

(3) marital status;

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(4) student status;

(5) employment status; or

(6) any combination of the factors listed in Paragraphs (1) through (5) of this subsection.

D. Except in regard to a grandfathered health plan, a health insurer shall not deny or restrict coverage of a child based on the child's eligibility for other coverage."

SECTION 27. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

A. For plan or policy years beginning on or after September 23, 2010, if a child's coverage ended or did not begin for the reasons described in Subsection E of this section, a health insurer shall provide the child an opportunity to enroll that continues for at least sixty days and written notice of the opportunity to enroll as described in Subsection B of this section no later than the first day of the plan or policy year.

B. A written notice of opportunity to enroll provided pursuant to this section shall include a statement that children whose coverage ended, or who were denied coverage or were not eligible for coverage, because dependent coverage of children was unavailable before the child reached twenty-six

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are eligible to enroll in the coverage. This notice may be provided to a principal insured on behalf of the principal insured's child. For group coverage, the notice may be included with other enrollment materials that the health insurer distributes to employees, provided the statement is prominent. If the notice is provided to an employee whose child is entitled to an enrollment opportunity under Subsection A of this section, the obligation to provide the notice of enrollment opportunity under this subsection is satisfied for both the group or blanket health insurance policy, health care plan or certificate of health insurance and the health insurer.

C. For an individual who enrolls in a group or blanket health insurance policy, health care plan or certificate of health insurance pursuant to Subsection A of this section, the coverage shall take effect not later than the first day of the first plan or policy year.

D. A child enrolling pursuant to this section in a group or blanket health insurance policy, health care plan or certificate of health insurance shall be considered a "special enrollee" pursuant to Section 59A-23E-8 NMSA 1978. The child and the principal insured shall be offered all of the benefit packages available to similarly situated individuals who did not lose coverage by reasons of cessation of dependent status. Any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child shall not

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be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

E. The provisions of this section shall apply to a child:

(1) whose coverage ended, or who was denied coverage or was not eligible for coverage under a group or blanket health insurance policy, health care plan or certificate of health insurance, because, under the terms of coverage, the availability of dependent coverage of a child ended before the child reached the age of twenty-six; or

(2) who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan or policy year, beginning on or after September 23, 2010 by reason of the provisions of this section."

SECTION 28. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] GRANDFATHERED HEALTH PLANS--ADULT CHILD DEPENDENT ELIGIBLE FOR EMPLOYER-SPONSORED HEALTH BENEFIT PLAN--EXCLUSION FROM DEPENDENT COVERAGE ELIGIBILITY PERMITTED.--

A. For plan years beginning before January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered health plan and makes available dependent coverage of children may exclude an adult child under twenty-six from coverage only if the adult child is eligible to

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enroll in an eligible employer-sponsored health benefit plan, as defined in Section 5000A(f)(2) of the federal Internal Revenue Code of 1986, other than the group health plan of a parent.

B. For plan years beginning on or after January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered health plan shall comply with the requirements of Sections 26 and 27 of this 2011 act."

SECTION 29. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] DEPENDENT COVERAGE FOR CHILDREN UNDER THE AGE OF TWENTY-SIX.--

A. For plan or policy years beginning on or after September 23, 2010, a health maintenance organization that makes available dependent coverage of children shall make that coverage available to a child until the age of twenty-six.

B. A health maintenance organization shall not define "dependent" for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and a principal insured.

C. A health maintenance organization shall not deny or restrict coverage for a child under twenty-six based on the child's:

(1) financial independence from or dependency on the plan participant or primary subscriber or any other person;

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(2) residency with the plan participant or primary subscriber or with any other person;

(3) marital status;

(4) student status;

(5) employment status; or

(6) any combination of the factors listed in Paragraphs (1) through (5) of this subsection.

D. Except in regard to a grandfathered health plan, a health maintenance organization shall not deny or restrict coverage of a child based on the child's eligibility for other coverage."

SECTION 30. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

A. For plan or policy years beginning on or after September 23, 2010, if a child's coverage ended or did not begin for the reasons described in Subsection E of this section, a health maintenance organization shall provide the child an opportunity to enroll that continues for at least sixty days and written notice of the opportunity to enroll as described in Subsection B of this section no later than the first day of the plan or policy year.

B. A written notice of opportunity to enroll provided

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[bracketed material] = delete

pursuant to this section shall include a statement that children whose coverage ended, or who were denied coverage or were not eligible for coverage, because dependent coverage of children was unavailable before the child reached twenty-six years of age are eligible to enroll in the coverage. This notice may be provided to a principal insured on behalf of the principal insured's child. For group coverage, the notice may be included with other enrollment materials that the health insurer distributes to employees, provided the statement is prominent. If the notice is provided to an employee whose child is entitled to an enrollment opportunity under Subsection A of this section, the obligation to provide the notice of enrollment opportunity under this subsection is satisfied for both the individual or group health maintenance organization policy, health care plan or contract and the health maintenance organization.

C. For an individual who enrolls in an individual or group health maintenance organization policy, health care plan or contract pursuant to Subsection A of this section, the coverage shall take effect not later than the first day of the first plan or policy year.

D. A child enrolling pursuant to this section in a group health maintenance organization policy, health care plan or contract shall be considered a "special enrollee" pursuant to Section 59A-23E-8 NMSA 1978. The child and the principal

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[~~bracketed material~~] = delete

insured shall be offered all of the benefit packages available to similarly situated individuals who did not lose coverage by reasons of cessation of dependent status. Any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

E. The provisions of this section shall apply to a child:

(1) whose coverage ended, or who was denied coverage or was not eligible for coverage under an individual or a group health maintenance organization policy, health care plan or contract because, under the terms of coverage, the availability of dependent coverage of a child ended before the child reached the age of twenty-six; or

(2) who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan or policy year, beginning on or after September 23, 2010 by reason of the provisions of this section."

SECTION 31. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] GRANDFATHERED HEALTH PLANS--ADULT CHILD DEPENDENT ELIGIBLE FOR EMPLOYER-SPONSORED HEALTH BENEFIT PLAN--EXCLUSION FROM DEPENDENT COVERAGE ELIGIBILITY PERMITTED.--

A. For plan years beginning before January 1, 2014, a

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[bracketed material] = delete

group health maintenance organization policy, health care plan or contract providing group health coverage that is a grandfathered health maintenance organization policy, health care plan or contract and makes available dependent coverage of children may exclude an adult child under twenty-six from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in Section 5000A(f)(2) of the federal Internal Revenue Code of 1986, other than the group health plan of a parent.

B. For plan years beginning on or after January 1, 2014, a group health maintenance organization policy, health care plan or contract providing group health coverage that is a grandfathered health plan shall comply with the requirements of Sections 29 and 30 of this 2011 act."

SECTION 32. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] DEPENDENT COVERAGE FOR CHILDREN UNDER THE AGE OF TWENTY-SIX.--

A. For plan or policy years beginning on or after September 23, 2010, a nonprofit health care plan that makes available dependent coverage of children shall make that coverage available to a child until the age of twenty-six.

B. A nonprofit health care plan shall not define "dependent" for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a

underscored material = new
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child and a principal insured.

C. A nonprofit health care plan shall not deny or restrict coverage for a child under twenty-six based on the child's:

(1) financial independence from or dependency on the plan participant or primary subscriber or any other person;

(2) residency with the plan participant or primary subscriber or with any other person;

(3) marital status;

(4) student status;

(5) employment status; or

(6) any combination of the factors listed in Paragraphs (1) through (5) of this subsection.

D. Except in regard to a grandfathered health plan, a nonprofit health care plan shall not deny or restrict coverage of a child based on the child's eligibility for other coverage."

SECTION 33. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

A. For plan or policy years beginning on or after September 23, 2010, if a child's coverage ended or did not begin for the reasons described in Subsection E of this

underscored material = new
[bracketed material] = delete

section, a nonprofit health care plan shall provide the child an opportunity to enroll that continues for at least sixty days and written notice of the opportunity to enroll as described in Subsection B of this section no later than the first day of the plan or policy year.

B. A written notice of opportunity to enroll provided pursuant to this section shall include a statement that children whose coverage ended, or who were denied coverage or were not eligible for coverage, because the availability of dependent coverage of children before the child reached twenty-six are eligible to enroll in the coverage. This notice may be provided to a principal insured on behalf of the principal insured's child. For group coverage, the notice may be included with other enrollment materials that the health insurer distributes to employees, provided the statement is prominent. If the notice is provided to an employee whose child is entitled to an enrollment opportunity under Subsection A of this section, the obligation to provide the notice of enrollment opportunity under this subsection is satisfied for both the individual or group nonprofit health care plan or contract and the health maintenance organization.

C. For an individual who enrolls in an individual or group nonprofit health care plan or contract pursuant to Subsection A of this section, the coverage shall take effect not later than the first day of the first plan or policy year.

underscored material = new
[~~bracketed material~~] = delete

D. A child enrolling pursuant to this section in a group nonprofit health care plan or contract shall be considered a "special enrollee" pursuant to Section 59A-23E-8 NMSA 1978. The child and the principal insured shall be offered all of the benefit packages available to similarly situated individuals who did not lose coverage by reasons of cessation of dependent status. Any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

E. The provisions of this section shall apply to a child:

(1) whose coverage ended, or who was denied coverage or was not eligible for coverage under an individual or a group nonprofit health care plan or contract because, under the terms of coverage, the availability of dependent coverage of a child ended before the child reached the age of twenty-six; or

(2) who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan or policy year, beginning on or after September 23, 2010 by reason of the provisions of this section."

SECTION 34. A new section of the Nonprofit Health Care Plan Law is enacted to read:

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"[NEW MATERIAL] GRANDFATHERED HEALTH PLANS--ADULT CHILD DEPENDENT ELIGIBLE FOR EMPLOYER-SPONSORED HEALTH BENEFIT PLAN--EXCLUSION FROM DEPENDENT COVERAGE ELIGIBILITY PERMITTED.--

A. For plan years beginning before January 1, 2014, a group nonprofit health care plan or contract providing group health coverage that is a grandfathered nonprofit health care plan or contract and makes available dependent coverage of children may exclude an adult child under twenty-six from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in Section 5000A(f)(2) of the federal Internal Revenue Code of 1986, other than the group health plan of a parent.

B. For plan years beginning on or after January 1, 2014, a group nonprofit health care plan or contract providing group health coverage that is a grandfathered health plan shall comply with the requirements of Sections 32 and 33 of this 2011 act."

SECTION 35. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS FOR INDIVIDUALS UNDER THE AGE OF NINETEEN.--

A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered or issued for delivery in this state shall not limit or exclude coverage under an individual or group health benefit

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plan for an individual under the age of nineteen by imposing a preexisting condition exclusion on that individual.

B. When a health insurer offers individual or group health insurance coverage that only covers individuals under age nineteen, that insurer shall offer the coverage continuously throughout the year or during one or more open enrollment periods as the superintendent prescribes by rule.

C. During an open enrollment period, a health insurer shall not deny or unreasonably delay the issuance of a policy or refuse to issue a policy or issue a policy with any preexisting condition exclusion rider or endorsement to an applicant or insured who is under the age of nineteen on the basis of a preexisting condition.

D. Coverage shall be effective for those applying during an open enrollment period on the same basis as any applicant qualifying for coverage on an underwritten basis.

E. Each health insurer shall provide prior prominent public notice on its web site and written notice to each of its policyholders annually at least ninety days before any open enrollment period of the open enrollment rights for individuals under the age of nineteen and shall provide information as to how an individual eligible for this open enrollment right may apply for coverage with the insurer during an open enrollment period."

SECTION 36. A new section of Chapter 59A, Article 23 NMSA

1978 is enacted to read:

"[NEW MATERIAL] PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS FOR INDIVIDUALS UNDER THE AGE OF NINETEEN.--

A. A blanket or group health insurance policy or contract that is delivered or issued for delivery in this state shall not limit or exclude coverage under an individual or group health benefit plan for an individual under the age of nineteen by imposing a preexisting condition exclusion on that individual.

B. When a health insurer offers individual or group health insurance coverage that only covers individuals under age nineteen, that insurer shall offer the coverage continuously throughout the year or during one or more open enrollment periods as the superintendent prescribes by rule.

C. During an open enrollment period, a health insurer shall not deny or unreasonably delay the issuance of a policy or refuse to issue a policy or issue a policy with any preexisting condition exclusion rider or endorsement to an applicant or insured who is under the age of nineteen on the basis of a preexisting condition.

D. Coverage shall be effective for those applying during an open enrollment period on the same basis as any applicant qualifying for coverage on an underwritten basis.

E. Each health insurer shall provide prior prominent public notice on its web site and written notice to each of its

policyholders annually at least ninety days before any open enrollment period of the open enrollment rights for individuals under the age of nineteen and shall provide information as to how an individual eligible for this open enrollment right may apply for coverage with the insurer during an open enrollment period."

SECTION 37. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS FOR INDIVIDUALS UNDER THE AGE OF NINETEEN.--

A. An individual or group health maintenance organization contract that is delivered or issued for delivery in this state shall not limit or exclude coverage under an individual or group health maintenance organization plan for an individual under the age of nineteen by imposing a preexisting condition exclusion on that individual.

B. When a health maintenance organization offers individual or group health coverage that only covers individuals under age nineteen, that health maintenance organization shall offer the coverage continuously throughout the year or during one or more open enrollment periods as the superintendent prescribes by rule.

C. During an open enrollment period, a health maintenance organization shall not deny or unreasonably delay the issuance of a policy or refuse to issue a policy or issue a

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policy with any preexisting condition exclusion rider or endorsement to an applicant or enrollee who is under the age of nineteen on the basis of a preexisting condition.

D. Coverage shall be effective for those applying during an open enrollment period on the same basis as any applicant qualifying for coverage on an underwritten basis.

E. Each health maintenance organization shall provide prior prominent public notice on its web site and written notice to each of its enrollees annually at least ninety days before any open enrollment period of the open enrollment rights for individuals under the age of nineteen and shall provide information as to how an individual eligible for this open enrollment right may apply for coverage with the health maintenance organization during an open enrollment period."

SECTION 38. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS FOR INDIVIDUALS UNDER THE AGE OF NINETEEN.--

A. An individual or group health insurance policy, health care plan or certificate of health insurance delivered or issued for delivery in the state shall not limit or exclude coverage under an individual or group nonprofit health care plan for an individual under the age of nineteen by imposing a preexisting condition exclusion on that individual.

B. When a nonprofit health care plan offers

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individual or group health coverage that only covers individuals under age nineteen, that nonprofit health care plan shall offer the coverage continuously throughout the year or during one or more open enrollment periods as the superintendent prescribes by rule.

C. During an open enrollment period, a nonprofit health care plan shall not deny or unreasonably delay the issuance of a plan or refuse to issue a plan or issue a plan with any preexisting condition exclusion rider or endorsement to an applicant or covered individual who is under the age of nineteen on the basis of a preexisting condition.

D. Coverage shall be effective for those applying during an open enrollment period on the same basis as any applicant qualifying for coverage on an underwritten basis.

E. Each nonprofit health care plan shall provide prior prominent public notice on its web site and written notice to each of its subscribers annually at least ninety days before any open enrollment period of the open enrollment rights for individuals under the age of nineteen and shall provide information as to how an individual eligible for this open enrollment right may apply for coverage with the nonprofit health care plan during an open enrollment period."

SECTION 39. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] EMERGENCY SERVICES.--

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A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered or issued for delivery in this state and that provides or covers any benefits with respect to services in an emergency department of a hospital shall cover emergency services:

(1) without the need for any prior authorization determination; and

(2) whether or not the health care provider furnishing emergency services is a participating provider with respect to emergency services.

B. If emergency services are provided to a covered individual by a nonparticipating health care provider with or without prior authorization, the services shall be provided without imposing any requirement under the policy, plan or certificate for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the insurer for the provision of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the health insurer.

C. If emergency services are provided out of network, the cost-sharing requirement, expressed as a copayment amount or coinsurance rate, shall be the same requirement that would

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apply if the emergency services were provided in-network and without regard to any other term or condition of such coverage, other than exclusion or coordination of benefits, or an affiliation or waiting period other than the applicable cost-sharing otherwise permitted pursuant to state or federal law.

D. As used in this section:

(1) "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

(a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part;

(2) "emergency services" means, with respect to an emergency medical condition:

(a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to

the emergency department to evaluate the emergency medical condition; and

(b) according to the capabilities of the staff and facilities available at the hospital, further medical examination and treatment required to stabilize the patient's emergency medical condition or safe transfer of the patient to another medical facility capable of providing the medical examination or treatment required to stabilize the patient's emergency medical condition; and

(3) "stabilize" means:

(a) to provide medical treatment of a condition as necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or

(b) with respect to a pregnant woman who is having contractions, to deliver, including a placenta."

SECTION 40. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] EMERGENCY SERVICES.--

A. A blanket or group health insurance policy or contract that is delivered or issued for delivery in this state and that provides or covers any benefits with respect to services in an emergency department of a hospital shall cover emergency services:

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(1) without the need for any prior authorization determination; and

(2) whether or not the health care provider furnishing emergency services is a participating provider with respect to emergency services.

B. If emergency services are provided to a covered individual by a nonparticipating health care provider with or without prior authorization, the services shall be provided without imposing any requirement under the policy or contract for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the health insurer for the provision of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the health insurer.

C. If emergency services are provided out of network, the cost-sharing requirement, expressed as a copayment amount or coinsurance rate, shall be the same requirement that would apply if the emergency services were provided in-network and without regard to any other term or condition of such coverage, other than exclusion or coordination of benefits, or an affiliation or waiting period other than the applicable cost-sharing otherwise permitted pursuant to state or federal law.

D. As used in this section:

(1) "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

(a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part;

(2) "emergency services" means, with respect to an emergency medical condition:

(a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(b) according to the capabilities of the staff and facilities available at the hospital, further medical examination and treatment required to stabilize the patient's emergency medical condition or safe transfer of the patient to

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another medical facility capable of providing the medical examination or treatment required to stabilize the patient's emergency medical condition; and

(3) "stabilize" means:

(a) to provide medical treatment of a condition as necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or

(b) with respect to a pregnant woman who is having contractions, to deliver, including a placenta."

SECTION 41. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] EMERGENCY SERVICES.--

A. An individual or group health maintenance organization contract delivered or issued for delivery in this state that provides or covers any benefits with respect to services in an emergency department of a hospital shall cover emergency services:

(1) without the need for any prior authorization determination; and

(2) whether or not the health care provider furnishing emergency services is a participating provider with respect to emergency services.

B. If emergency services are provided to a covered

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individual by a nonparticipating health care provider with or without prior authorization, the services shall be provided without imposing any requirement under the contract for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the health maintenance organization for the provision of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the health maintenance organization.

C. If emergency services are provided out of network, the cost-sharing requirement, expressed as a copayment amount or coinsurance rate, shall be the same requirement that would apply if the emergency services were provided in-network and without regard to any other term or condition of such coverage, other than exclusion or coordination of benefits, or an affiliation or waiting period other than the applicable cost-sharing otherwise permitted pursuant to state or federal law.

D. As used in this section:

(1) "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate

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medical attention to result in one of the following conditions:

(a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part;

(2) "emergency services" means, with respect to an emergency medical condition:

(a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(b) according to the capabilities of the staff and facilities available at the hospital, further medical examination and treatment required to stabilize the patient's emergency medical condition or safe transfer of the patient to another medical facility capable of providing the medical examination or treatment required to stabilize the patient's emergency medical condition; and

(3) "stabilize" means:

(a) to provide medical treatment of a condition as necessary to ensure, within reasonable medical

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probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or

(b) with respect to a pregnant woman who is having contractions, to deliver, including a placenta."

SECTION 42. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] EMERGENCY SERVICES.--

A. An individual or group subscriber contract delivered or issued for delivery in the state by a nonprofit health care plan that provides or covers any benefits with respect to services in an emergency department of a hospital shall cover emergency services:

(1) without the need for any prior authorization determination; and

(2) whether or not the health care provider furnishing emergency services is a participating provider with respect to emergency services.

B. If emergency services are provided to a covered individual by a nonparticipating health care provider with or without prior authorization, the services shall be provided without imposing any requirement under the contract for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the nonprofit health care plan for the

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provision of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the nonprofit health care plan.

C. If emergency services are provided out of network, the cost-sharing requirement, expressed as a copayment amount or coinsurance rate, shall be the same requirement that would apply if the emergency services were provided in-network and without regard to any other term or condition of such coverage, other than exclusion or coordination of benefits, or an affiliation or waiting period other than the applicable cost-sharing otherwise permitted pursuant to state or federal law.

D. As used in this section:

(1) "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

(a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) serious impairment to bodily functions; or

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(c) serious dysfunction of any bodily organ or part;

(2) "emergency services" means, with respect to an emergency medical condition:

(a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(b) according to the capabilities of the staff and facilities available at the hospital, further medical examination and treatment required to stabilize the patient's emergency medical condition or safe transfer of the patient to another medical facility capable of providing the medical examination or treatment required to stabilize the patient's emergency medical condition; and

(3) "stabilize" means:

(a) to provide medical treatment of a condition as necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or

(b) with respect to a pregnant woman who is having contractions, to deliver, including a placenta."

SECTION 43. A new section in Chapter 59A, Article 22 NMSA

1978 is enacted to read:

"[NEW MATERIAL] ACCESS TO PEDIATRIC CARE.--

A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered or issued for delivery in this state that requires or provides for the designation of a participating primary care provider shall allow a principal insured to designate for the principal insured's dependent child who is a covered individual an allopathic or osteopathic physician who specializes in pediatrics as the principal insured child's primary care provider if the provider participates in the network of the plan or issuer.

B. Nothing in Subsection A of this section shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

C. As used in this section, "primary care provider" means a health care practitioner acting within the scope of the health care practitioner's license who provides the first level of basic or general health care for a covered individual's health needs, including diagnostic and treatment services, who initiates referrals to other health care practitioners and who maintains the continuity of care when appropriate."

SECTION 44. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

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"[NEW MATERIAL] ACCESS TO PEDIATRIC CARE.--

A. A blanket or group health insurance policy or contract that is delivered or issued for delivery in this state that requires or provides for the designation of a participating primary care provider shall allow a principal insured to designate for the principal insured's dependent child who is a covered individual an allopathic or osteopathic physician who specializes in pediatrics as the principal insured child's primary care provider if the provider participates in the network of the plan or issuer.

B. Nothing in Subsection A of this section shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

C. As used in this section, "primary care provider" means a health care practitioner acting within the scope of the health care practitioner's license who provides the first level of basic or general health care for a covered individual's health needs, including diagnostic and treatment services, who initiates referrals to other health care practitioners and who maintains the continuity of care when appropriate."

SECTION 45. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] ACCESS TO PEDIATRIC CARE.--

A. An individual or group health maintenance

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organization contract that is delivered or issued for delivery in this state that requires or provides for the designation of a participating primary care provider shall allow a principal insured to designate for the principal insured's dependent child who is a covered individual an allopathic or osteopathic physician who specializes in pediatrics as the principal insured child's primary care provider if the provider participates in the network of the health maintenance organization contract or plan.

B. Nothing in Subsection A of this section shall be construed to waive any exclusions of coverage under the terms and conditions of the health maintenance organization plan or coverage with respect to coverage of pediatric care.

C. As used in this section, "primary care provider" means a health care practitioner acting within the scope of the health care practitioner's license who provides the first level of basic or general health care for a covered individual's health needs, including diagnostic and treatment services, who initiates referrals to other health care practitioners and who maintains the continuity of care when appropriate."

SECTION 46. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] ACCESS TO PEDIATRIC CARE.--

A. An individual or group subscriber contract delivered or issued for delivery in the state by a nonprofit

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health care plan that requires or provides for the designation of a participating primary care provider shall allow a principal insured to designate for the principal insured's dependent child who is a covered individual an allopathic or osteopathic physician who specializes in pediatrics as the principal insured child's primary care provider if the provider participates in the network of the nonprofit health care contract or plan.

B. Nothing in Subsection A of this section shall be construed to waive any exclusions of coverage under the terms and conditions of the nonprofit health care contract or plan with respect to coverage of pediatric care.

C. As used in this section, "primary care provider" means a health care practitioner acting within the scope of the health care practitioner's license who provides the first level of basic or general health care for a covered individual's health needs, including diagnostic and treatment services, who initiates referrals to other health care practitioners and who maintains the continuity of care when appropriate."

SECTION 47. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.--

A. An individual or group health insurance policy, health care plan or certificate of health insurance that is

delivered or issued for delivery in this state that provides coverage for obstetrical and gynecological care and that requires that covered individuals designate a primary care provider shall not require authorization or referral by the plan or issuer or any person, including a primary care provider, when a female covered individual seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The obstetrical or gynecological health care provider shall agree otherwise to adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan approved by the plan or issuer.

B. A health insurer shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services by a participating health care professional who specializes in obstetrics or gynecology, as the authorization of the primary care provider.

C. Nothing in Subsection A of this section shall be construed to:

(1) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care;

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or

(2) preclude the health insurer from requiring that the obstetrical or gynecological provider notify the covered individual's primary care health care professional or the plan or issuer of treatment decisions.

D. As used in this section, "primary care provider" means a health care practitioner acting within the scope of the health care practitioner's license who provides the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, who initiates referrals to other health care practitioners and who maintains the continuity of care when appropriate."

SECTION 48. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.--

A. A blanket or group health insurance policy or contract that is delivered or issued for delivery in this state that provides coverage for obstetrical and gynecological care and that requires that covered individuals designate a primary care provider shall not require authorization or referral by the plan or issuer or any person, including a primary care provider, when a female covered individual seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or

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gynecology. The obstetrical or gynecological health care provider shall agree otherwise to adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan approved by the plan or issuer.

B. A health insurer shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services by a participating health care professional who specializes in obstetrics or gynecology, as the authorization of the primary care provider.

C. Nothing in Subsection A of this section shall be construed to:

(1) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the health insurer from requiring that the obstetrical or gynecological provider notify the covered individual's primary care health care professional or the plan or issuer of treatment decisions.

D. As used in this section, "primary care provider" means a health care practitioner acting within the scope of the health care practitioner's license who provides the first level

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of basic or general health care for a person's health needs, including diagnostic and treatment services, who initiates referrals to other health care practitioners and who maintains the continuity of care when appropriate."

SECTION 49. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.--

A. An individual or group health maintenance organization contract delivered or issued for delivery in this state that provides coverage for obstetrical and gynecological care and that requires that covered individuals designate a primary care provider shall not require authorization or referral by the plan or issuer or any person, including a primary care provider, when a female covered individual seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The obstetrical or gynecological health care provider shall agree otherwise to adhere to the health maintenance organization's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan approved by the health maintenance organization.

B. A health maintenance organization shall treat the provision of obstetrical and gynecological care, and the

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ordering of related obstetrical and gynecological items and services by a participating health care professional who specializes in obstetrics or gynecology, as the authorization of the primary care provider.

C. Nothing in Subsection A of this section shall be construed to:

(1) waive any exclusions of coverage under the terms and conditions of the health maintenance organization coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the health maintenance organization from requiring that the obstetrical or gynecological provider notify the covered individual's primary care health care professional or the plan or issuer of treatment decisions.

D. As used in this section, "primary care provider" means a health care practitioner acting within the scope of the health care practitioner's license who provides the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, who initiates referrals to other health care practitioners and who maintains the continuity of care when appropriate."

SECTION 50. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.--

underscored material = new
[~~bracketed material~~] = delete

A. An individual or group subscriber contract delivered or issued for delivery in the state by a nonprofit health care plan that provides coverage for obstetrical and gynecological care and that requires that covered individuals designate a primary care provider shall not require authorization or referral by the plan or issuer or any person, including a primary care provider, when a female covered individual seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The obstetrical or gynecological health care provider shall agree otherwise to adhere to the nonprofit health care plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan approved by the nonprofit health care plan.

B. A nonprofit health care plan shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services by a participating health care professional who specializes in obstetrics or gynecology, as the authorization of the primary care provider.

C. Nothing in Subsection A of this section shall be construed to:

(1) waive any exclusions of coverage under the terms and conditions of the nonprofit health care plan coverage

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with respect to coverage of obstetrical or gynecological care; or

(2) preclude the nonprofit health care plan from requiring that the obstetrical or gynecological provider notify the covered individual's primary care health care professional or the plan or issuer of treatment decisions.

D. As used in this section, "primary care provider" means a health care practitioner acting within the scope of the health care practitioner's license who provides the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, who initiates referrals to other health care practitioners and who maintains the continuity of care when appropriate."

SECTION 51. 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 [~~twenty-five~~] twenty-six 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 federal Social Security Act;

(4) Title 19 of the federal 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 Medical 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 insurance division of the commission;

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

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(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

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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

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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, that has employees at least fifty percent of whom are residents of this state, that 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;

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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 52. REPEAL.--

A. Section 59A-22-30.1 NMSA 1978 (being Laws 2005, Chapter 41, Section 1) is repealed.

B. Section 59A-23-7.3 NMSA 1978 (being Laws 2003, Chapter 391, Section 3) is repealed.

C. Section 59A-46-38.3 NMSA 1978 (being Laws 2003, Chapter 391, Section 5, as amended) is repealed.

D. Section 59A-47-40 NMSA 1978 (being Laws 2003, Chapter 391, Section 7, as amended) is repealed.