

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

13  
14 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

15 SECTION 1. A new section of Chapter 59A, Article 1 NMSA  
16 1978 is enacted to read:

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

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

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

23 SECTION 2. A new section of Chapter 59A, Article 1 NMSA  
24 1978 is enacted to read:

25 "[NEW MATERIAL] "GRANDFATHERED HEALTH PLAN" OR

1 "GRANDFATHERED HEALTH POLICY COVERAGE".--

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

8 B. A dependent of an individual enrolled in a  
9 grandfathered health plan may enroll in a grandfathered health  
10 plan or policy if the terms of the plan in effect as of March  
11 23, 2010 permitted the dependent to enroll.

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

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

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1 agreement."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 coverage from placing annual or lifetime per beneficiary limits  
2 on specific covered benefits that are not essential health  
3 benefits to the extent that these limits are otherwise  
4 permitted under federal or state law."

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

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

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

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

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

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

25 C. Subsection A of this section shall not be

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1 construed to prevent a group health plan or health insurance  
2 coverage from placing annual or lifetime per beneficiary limits  
3 on specific covered benefits that are not essential health  
4 benefits to the extent that these limits are otherwise  
5 permitted under federal or state law."

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

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

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

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

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

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

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

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

12           **SECTION 8.** A new section of Chapter 59A, Article 23 NMSA  
13 1978 is enacted to read:

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

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

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

25                   (2) the individual makes an intentional

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[bracketed material] = delete

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

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

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

7 "59A-23A-8. INCONTESTABILITY PERIOD.--

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

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

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

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1 ~~insured's health.~~

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

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

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

14           "59A-23D-2. DEFINITIONS.--As used in the Medical Care  
15 Savings Account Act:

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

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

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

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

25                   (4) a person approved by the federal secretary

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1 of health and human services;

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

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

8 D. "dependent" means:

9 (1) a spouse;

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

12 (a) a natural child;

13 (b) a legally adopted child;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (a) unless it is in cash; or

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

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

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

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

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

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

9 (1) self-only coverage with an annual  
10 deductible of not less than one thousand five hundred dollars  
11 (\$1,500) or more than two thousand two hundred fifty dollars  
12 (\$2,250) and a maximum annual out-of-pocket expense requirement  
13 of three thousand dollars (\$3,000), not including premiums;

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

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

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

24 "59A-44-19. THE BENEFIT CONTRACT.--

25 A. Every society authorized to do business in this

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

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

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

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

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

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

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

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

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

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

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

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

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

15           "59A-47-24. SUBSCRIBER CONTRACTS--REQUIREMENTS AND  
16 PROVISIONS.--Every health care expense payments contract issued  
17 under ~~[this article]~~ the Nonprofit Health Care Plan Law shall  
18 be in writing and comply with requirements and contain  
19 provisions in substance as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7                   **SECTION 15.** A new section of Chapter 59A, Article 22 NMSA  
8 1978 is enacted to read:

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

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

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

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

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

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

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

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

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

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1 coverage for any such items or services.

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

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

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

24 SECTION 16. A new section of Chapter 59A, Article 23 NMSA  
25 1978 is enacted to read:

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

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

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

15                   (2) immunizations for routine use in children,  
16 adolescents and adults that have in effect a recommendation  
17 from the advisory committee on immunization practices of the  
18 federal centers for disease control and prevention with respect  
19 to the individual involved. For purposes of this paragraph, a  
20 recommendation from the advisory committee on immunization  
21 practices is considered in effect after it has been adopted by  
22 the director of the centers for disease control and prevention,  
23 and a recommendation is considered to be for routine use if it  
24 is listed on the immunization schedules of the centers for  
25 disease control and prevention;

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

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

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

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

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

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

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

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

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

17 "NEW MATERIAL COVERAGE FOR PREVENTIVE ITEMS AND  
18 SERVICE.--

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

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

7                   (2) immunizations for routine use in children,  
8 adolescents and adults that have in effect a recommendation  
9 from the advisory committee on immunization practices of the  
10 federal centers for disease control and prevention with respect  
11 to the individual involved. For purposes of this paragraph, a  
12 recommendation from the advisory committee on immunization  
13 practices is considered in effect after it has been adopted by  
14 the director of the centers for disease control and prevention,  
15 and a recommendation is considered to be for routine use if it  
16 is listed on the immunization schedules of the centers for  
17 disease control and prevention;

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

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

1 services administration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 provide coverage for any such items or services.

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

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

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

24 SECTION 19. A new section of Chapter 59A, Article 22 NMSA  
25 1978 is enacted to read:

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

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

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

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

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

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

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

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1 separately from the office visit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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underscored material = new  
[bracketed material] = delete

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

4 SECTION 23. A new section of Chapter 59A, Article 22 NMSA  
5 1978 is enacted to read:

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

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

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

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

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

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

22 (3) marital status;

23 (4) student status;

24 (5) employment status; or

25 (6) any combination of the factors listed in

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

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

5 SECTION 24. A new section of Chapter 59A, Article 22 NMSA  
6 1978 is enacted to read:

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

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

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

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

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

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

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1 status.

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

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

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

14 SECTION 25. A new section of Chapter 59A, Article 22 NMSA  
15 1978 is enacted to read:

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

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

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

3 B. For plan years beginning on or after January 1,  
4 2014, a group health plan providing group health insurance  
5 coverage that is a grandfathered health plan shall comply with  
6 the requirements of Sections 23 and 24 of this 2011 act."

7 SECTION 26. A new section of Chapter 59A, Article 23 NMSA  
8 1978 is enacted to read:

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

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

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

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

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

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

25 (3) marital status;

- 1 (4) student status;  
 2 (5) employment status; or  
 3 (6) any combination of the factors listed in  
 4 Paragraphs (1) through (5) of this subsection.

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

8 SECTION 27. A new section of Chapter 59A, Article 23 NMSA  
 9 1978 is enacted to read:

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

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

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

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

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

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

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

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

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

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

16 SECTION 28. A new section of Chapter 59A, Article 23 NMSA  
 17 1978 is enacted to read:

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

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

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

5 B. For plan years beginning on or after January 1,  
6 2014, a group health plan providing group health insurance  
7 coverage that is a grandfathered health plan shall comply with  
8 the requirements of Sections 26 and 27 of this 2011 act."

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

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

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

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

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

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

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1                   (2) residency with the plan participant or  
2 primary subscriber or with any other person;  
3                   (3) marital status;  
4                   (4) student status;  
5                   (5) employment status; or  
6                   (6) any combination of the factors listed in  
7 Paragraphs (1) through (5) of this subsection.

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

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

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

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

25                   B. A written notice of opportunity to enroll provided

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

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

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

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

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

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

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

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

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

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

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1 group health maintenance organization policy, health care plan  
2 or contract providing group health coverage that is a  
3 grandfathered health maintenance organization policy, health  
4 care plan or contract and makes available dependent coverage of  
5 children may exclude an adult child under twenty-six from  
6 coverage only if the adult child is eligible to enroll in an  
7 eligible employer-sponsored health benefit plan, as defined in  
8 Section 5000A(f)(2) of the federal Internal Revenue Code of  
9 1986, other than the group health plan of a parent.

10 B. For plan years beginning on or after January 1,  
11 2014, a group health maintenance organization policy, health  
12 care plan or contract providing group health coverage that is a  
13 grandfathered health plan shall comply with the requirements of  
14 Sections 29 and 30 of this 2011 act."

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

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

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

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

1 child and a principal insured.

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

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

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

9 (3) marital status;

10 (4) student status;

11 (5) employment status; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4           A. For plan years beginning before January 1, 2014, a  
5           group nonprofit health care plan or contract providing group  
6           health coverage that is a grandfathered nonprofit health care  
7           plan or contract and makes available dependent coverage of  
8           children may exclude an adult child under twenty-six from  
9           coverage only if the adult child is eligible to enroll in an  
10          eligible employer-sponsored health benefit plan, as defined in  
11          Section 5000A(f)(2) of the federal Internal Revenue Code of  
12          1986, other than the group health plan of a parent.

13          B. For plan years beginning on or after January 1,  
14          2014, a group nonprofit health care plan or contract providing  
15          group health coverage that is a grandfathered health plan shall  
16          comply with the requirements of Sections 32 and 33 of this 2011  
17          act."

18          SECTION 35. A new section of Chapter 59A, Article 22 NMSA  
19          1978 is enacted to read:

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

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

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

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

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

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

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

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

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1 1978 is enacted to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 B. When a nonprofit health care plan offers

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

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

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

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

23 SECTION 39. A new section of Chapter 59A, Article 22 NMSA  
 24 1978 is enacted to read:

25 "[NEW MATERIAL] EMERGENCY SERVICES.--

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

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

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

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

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

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

7 D. As used in this section:

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

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

17 (b) serious impairment to bodily functions;  
18 or

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

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

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

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1 the emergency department to evaluate the emergency medical  
2 condition; and

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

10 (3) "stabilize" means:

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

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

18 SECTION 40. A new section of Chapter 59A, Article 23 NMSA  
19 1978 is enacted to read:

20 "[NEW MATERIAL] EMERGENCY SERVICES.--

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

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

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

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

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

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1 D. As used in this section:

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

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

11 (b) serious impairment to bodily functions;  
12 or

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

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

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

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

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

4 (3) "stabilize" means:

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

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

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

14 "[NEW MATERIAL] EMERGENCY SERVICES.--

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

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

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

25 B. If emergency services are provided to a covered

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

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

20 D. As used in this section:

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

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1 medical attention to result in one of the following conditions:

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

5 (b) serious impairment to bodily functions;

6 or

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

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

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

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

23 (3) "stabilize" means:

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

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

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

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

8 "[NEW MATERIAL] EMERGENCY SERVICES.--

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

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

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

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

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

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

14 D. As used in this section:

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

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

24 (b) serious impairment to bodily functions;

25 or

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

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

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

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

17 (3) "stabilize" means:

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

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

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

1 1978 is enacted to read:

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

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

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

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

24 **SECTION 44.** A new section of Chapter 59A, Article 23 NMSA  
25 1978 is enacted to read:

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

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

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

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

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

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

25           A. An individual or group health maintenance

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

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

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

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

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

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

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

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

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

20 SECTION 47. A new section of Chapter 59A, Article 22 NMSA  
21 1978 is enacted to read:

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

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

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

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

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

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

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1 or

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

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

13 SECTION 48. A new section of Chapter 59A, Article 23 NMSA  
14 1978 is enacted to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 with respect to coverage of obstetrical or gynecological care;  
2 or

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

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

14 SECTION 51. Section 59A-56-3 NMSA 1978 (being Laws 1994,  
15 Chapter 75, Section 3, as amended) is amended to read:

16 "59A-56-3. DEFINITIONS.--As used in the Health Insurance  
17 Alliance Act:

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

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

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

25 D. "child" means a dependent unmarried individual who

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1 is less than [~~twenty-five~~] twenty-six years of age;

2 E. "creditable coverage" means, with respect to an  
3 individual, coverage of the individual pursuant to:

4 (1) a group health plan;  
5 (2) health insurance coverage;  
6 (3) Part A or Part B of Title 18 of the federal  
7 Social Security Act;

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

11 (5) 10 USCA Chapter 55;  
12 (6) a medical care program of the Indian health  
13 service or of an Indian nation, tribe or pueblo;

14 (7) the Medical Insurance Pool Act;  
15 (8) a health plan offered pursuant to 5 USCA  
16 Chapter 89;

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

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

21 F. "department" means the insurance division of the  
22 commission;

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

25 H. "earned premiums" means premiums paid or due

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

1 during a calendar year for coverage under an approved health  
2 plan less any unearned premiums at the end of that calendar  
3 year plus any unearned premiums from the end of the immediately  
4 preceding calendar year;

5 I. "eligible expenses" means the allowable charges  
6 for a health care service covered under an approved health  
7 plan;

8 J. "eligible individual":

9 (1) means an individual who:

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

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

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- 1                   (2) does not include an individual who:
- 2                   (a) has or is eligible for coverage under a
- 3 group health plan;
- 4                   (b) is eligible for coverage under medicare
- 5 or a state plan under Title 19 of the federal Social Security
- 6 Act or any successor program;
- 7                   (c) has health insurance coverage as defined
- 8 in Subsection R of Section 59A-23E-2 NMSA 1978;
- 9                   (d) during the most recent coverage within
- 10 the coverage period described in Subparagraph (a) of Paragraph
- 11 (1) of this subsection was terminated from coverage as a result
- 12 of nonpayment of premium or fraud; or
- 13                   (e) has been offered the option of coverage
- 14 under a COBRA continuation provision as that term is defined in
- 15 Subsection F of Section 59A-23E-2 NMSA 1978, or under a similar
- 16 state program, except for continuation coverage under Section
- 17 59A-56-20 NMSA 1978, and did not exhaust the coverage available
- 18 under the offered program;
- 19                   K. "enrollment date" means, with respect to an
- 20 individual covered under a group health plan or health
- 21 insurance coverage, the date of enrollment of the individual in
- 22 the plan or coverage or, if earlier, the first day of the
- 23 waiting period for that enrollment;
- 24                   L. "gross earned premiums" means premiums paid or due
- 25 during a calendar year for all health insurance written in the

1 state less any unearned premiums at the end of that calendar  
2 year plus any unearned premiums from the end of the immediately  
3 preceding calendar year;

4 M. "group health plan" means an employee welfare  
5 benefit plan to the extent the plan provides hospital, surgical  
6 or medical expenses benefits to employees or their dependents,  
7 as defined by the terms of the plan, directly through  
8 insurance, reimbursement or otherwise;

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

14 O. "health insurance" means "health" insurance as  
15 defined in Section 59A-7-3 NMSA 1978; any hospital and medical  
16 expense-incurred policy; nonprofit health care plan service  
17 contract; health maintenance organization subscriber contract;  
18 short-term, accident, fixed indemnity, specified disease policy  
19 or disability income insurance contracts and limited health  
20 benefit or credit health insurance; coverage for health care  
21 services under uninsured arrangements of group or group-type  
22 contracts, including employer self-insured, cost-plus or other  
23 benefits methodologies not involving insurance or not subject  
24 to New Mexico premium taxes; coverage for health care services  
25 under group-type contracts that are not available to the

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1 general public and can be obtained only because of connection  
2 with a particular organization or group; coverage by medicare  
3 or other governmental programs providing health care services;  
4 but "health insurance" does not include insurance issued  
5 pursuant to provisions of the Workers' Compensation Act or  
6 similar law, automobile medical payment insurance or provisions  
7 by which benefits are payable with or without regard to fault  
8 and are required by law to be contained in any liability  
9 insurance policy;

10 P. "health maintenance organization" means a health  
11 maintenance organization as defined by Subsection M of Section  
12 59A-46-2 NMSA 1978;

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

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

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

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

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

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

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

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

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

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

24 X. "superintendent" means the superintendent of  
25 insurance;

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