

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE SUBSTITUTE FOR
HOUSE BILL 285

54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING THE SHORT-TERM HEALTH PLAN AND EXCEPTED BENEFIT ACT TO ESTABLISH GUIDELINES RELATING TO SHORT-TERM HEALTH AND EXCEPTED BENEFIT COVERAGE; ENACTING A NEW SECTION OF CHAPTER 59A, ARTICLE 16 NMSA 1978 TO BAN THE SALE AND ISSUANCE OF UNLICENSED AND UNAPPROVED HEALTH BENEFITS PLANS; AMENDING SECTIONS OF THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO ESTABLISH DIRECT-SERVICE RATIO APPLICABILITY FOR SHORT-TERM PLANS.

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

SECTION 1. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] SHORT TITLE.--Sections 1 through 6 of this act may be cited as the "Short-Term Health Plan and Excepted

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underscoring material = new
[bracketed material] = delete

1 Benefit Act".

2 SECTION 2. A new section of the New Mexico Insurance Code
3 is enacted to read:

4 "[NEW MATERIAL] DEFINITIONS.--As used in the Short-Term
5 Health Plan and Excepted Benefit Act:

6 A. "bona fide association" means an association
7 that has been in existence for not less than five years and
8 that exists for purposes other than the business of insurance;

9 B. "excepted benefits" means benefits furnished
10 pursuant to the following:

11 (1) coverage-only for accident or disability
12 income insurance;

13 (2) coverage issued as a supplement to
14 liability insurance;

15 (3) liability insurance;

16 (4) workers' compensation or similar
17 insurance;

18 (5) automobile medical payment insurance;

19 (6) credit-only insurance;

20 (7) coverage for on-site medical clinics;

21 (8) other similar insurance coverage specified
22 in regulations under which benefits for medical care are
23 secondary or incidental to other benefits;

24 (9) the following benefits if offered
25 separately:

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1 (a) limited-scope dental or vision
2 benefits;

3 (b) benefits for long-term care, nursing
4 home care, home health care, community-based care or any
5 combination of those benefits; and

6 (c) other similar excepted benefits
7 specified in rule;

8 (10) the following benefits, offered as
9 independent, non-coordinated benefits:

10 (a) coverage-only for a specified
11 disease or illness; or

12 (b) hospital indemnity or other fixed
13 indemnity insurance;

14 (11) the following benefits if offered as a
15 separate insurance policy:

16 (a) medicare supplemental health
17 insurance as defined pursuant to Section 1882(g)(1) of the
18 federal Social Security Act; and

19 (b) coverage supplemental to the
20 coverage provided pursuant to Chapter 55 of Title 10 USCA and
21 similar supplemental coverage provided to coverage pursuant to
22 a group health plan; and

23 (12) other similar individual or group
24 insurance coverage or arrangement designated by the
25 superintendent pursuant to rule under which benefits are

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1 secondary or incidental to health events, services or medical
2 care;

3 C. "excepted benefits plan" means a health benefits
4 plan that offers only an excepted benefit;

5 D. "health benefits plan" means an individual or
6 group policy or agreement entered into, offered or issued by a
7 health insurance carrier to provide, deliver, arrange for, pay
8 for or reimburse any of the costs of health care services,
9 other than excepted benefits;

10 E. "health insurance carrier" means an entity
11 subject to the insurance laws of the state, including a health
12 insurance company, a health maintenance organization, a
13 hospital and health services corporation, a provider service
14 network, a nonprofit health care plan or any other entity that
15 contracts or offers to contract, or enters into agreements to
16 provide, deliver, arrange for, pay for or reimburse any costs
17 of health care services, or that provides, offers or
18 administers health benefits plans or managed health care plans
19 in the state;

20 F. "health insurance coverage" means benefits
21 consisting of medical care provided directly, through insurance
22 or reimbursement, or otherwise, and items, including items and
23 services paid for as medical care, pursuant to any hospital or
24 medical service policy or certificate, hospital or medical
25 service plan contract or health maintenance organization

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1 contract offered by a health insurance carrier;

2 G. "major medical coverage" means a health benefits
3 plan that provides benefits other than excepted benefits;

4 H. "permitted health insurance coverage" means a
5 health benefits plan, excepted benefits plan, short-term plan
6 and other categories or types of health insurance coverage
7 designated by the superintendent; and

8 I. "short-term plan" means a nonrenewable health
9 benefits plan covering a resident of the state, regardless of
10 where the plan is delivered, that:

11 (1) has a maximum specified duration of not
12 more than three months after the effective date of the plan;
13 and

14 (2) is issued only to individuals who have not
15 been enrolled in a health benefits plan that provides the same
16 or similar nonrenewable coverage from any health insurance
17 carrier within the three months preceding enrollment in the
18 short-term plan."

19 **SECTION 3.** A new section of the New Mexico Insurance Code
20 is enacted to read:

21 "[NEW MATERIAL] SHORT-TERM PLANS--EXCEPTED BENEFITS--
22 STANDARDS FOR POLICY PROVISIONS.--

23 A. The superintendent shall adopt and promulgate
24 rules to establish specific standards:

25 (1) that set the manner, content and required

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1 disclosure for the sale of short-term plans and excepted
2 benefits plans, including standards for full and fair
3 disclosure; and

4 (2) for the sale of short-term plans and
5 excepted benefits plans, which standards shall include
6 standards relating to:

7 (a) terms of renewability or extension
8 of coverage;

9 (b) initial and subsequent conditions of
10 eligibility;

11 (c) nonduplication of coverage
12 provisions;

13 (d) coverage of dependents;

14 (e) preexisting conditions;

15 (f) termination of insurance;

16 (g) probationary periods;

17 (h) limitations;

18 (i) exceptions;

19 (j) reductions and exclusions;

20 (k) elimination periods;

21 (l) requirements for replacement by the
22 health insurance carrier;

23 (m) recurrent conditions;

24 (n) the definition of terms to describe
25 the specific types of coverage sold pursuant to the Short-Term

1 Health Plan and Excepted Benefit Act and specific standards and
2 policy provisions required of these plans;

3 (o) benefit duration;

4 (p) scope of coverage;

5 (q) advertising and marketing;

6 (r) sales practices;

7 (s) mandatory disclosures;

8 (t) coverage suitability; and

9 (u) policy and certificate approval.

10 B. All advertisements, marketing materials and
11 application and policy forms relating to short-term plans shall
12 prominently display a notice that the coverage is unavailable
13 to any potential insured who has been covered under a short-
14 term plan in the previous twelve-month period."

15 SECTION 4. A new section of the New Mexico Insurance Code
16 is enacted to read:

17 "[NEW MATERIAL] BENEFITS--MINIMUM STANDARDS.--

18 A. The superintendent shall adopt and promulgate
19 rules to establish minimum standards for benefits provided by
20 short-term plans and excepted benefits plans that are subject
21 to the Short-Term Health Plan and Excepted Benefit Act.

22 B. Rules of the superintendent shall require
23 short-term plans to cover state-mandated benefits in addition
24 to each of the following categories of benefits:

25 (1) diagnostic;

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- 1 (2) rehabilitative;
- 2 (3) maternity;
- 3 (4) neonatal;
- 4 (5) behavioral health services;
- 5 (6) emergency services;
- 6 (7) hospitalization;
- 7 (8) ambulatory services; and
- 8 (9) prescription drugs."

9 SECTION 5. A new section of the New Mexico Insurance Code
10 is enacted to read:

11 "[NEW MATERIAL] RATES--MEDICAL LOSS RATIOS.--The
12 superintendent shall adopt and promulgate rules to establish
13 standards for rates, including medical loss ratios, of
14 short-term plans and excepted benefits plans. Rules relating
15 to rates shall be based on generally recognized and current
16 actuarial standards."

17 SECTION 6. A new section of the New Mexico Insurance Code
18 is enacted to read:

19 "[NEW MATERIAL] PROHIBITION--ASSOCIATION, TRUST OR
20 MULTIPLE EMPLOYER WELFARE ARRANGEMENT PLANS.--No insurer shall
21 issue, and no association, trust or multiple employer welfare
22 arrangement shall offer, a short-term or excepted benefits plan
23 to a resident of the state unless through a bona fide
24 association."

25 SECTION 7. A new section of Chapter 59A, Article 16 NMSA

1 1978 is enacted to read:

2 "[NEW MATERIAL] HEALTH BENEFITS PLANS--PROHIBITION--
3 UNLICENSED HEALTH BENEFITS PLANS--UNAPPROVED HEALTH BENEFITS
4 PLANS.--

5 A. No person or entity shall sell or issue, or
6 cause to be sold or issued, a health benefits plan that is
7 unlicensed or unapproved for sale or delivery in the state.

8 B. No person or entity shall sell or issue, or
9 cause to be sold or issued, health insurance coverage that is
10 not permitted health insurance coverage.

11 C. As used in this section:

12 (1) "health benefits plan" means a policy or
13 agreement entered into, offered or issued by a health insurance
14 carrier to provide, deliver, arrange for, pay for or reimburse
15 any of the costs of health care services; and

16 (2) "health insurance carrier" means an entity
17 subject to the insurance laws and regulations of this state,
18 including a health insurance company, a health maintenance
19 organization, a hospital and health services corporation, a
20 provider service network, a nonprofit health care plan or any
21 other entity that contracts or offers to contract, or enters
22 into agreements to provide, deliver, arrange for, pay for or
23 reimburse any costs of health care services, or that provides,
24 offers or administers health benefits plans or managed health
25 care plans in this state."

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1 SECTION 8. Section 59A-22-50 NMSA 1978 (being Laws 2010,
2 Chapter 94, Section 1, as amended) is amended to read:

3 "59A-22-50. HEALTH INSURERS--DIRECT SERVICES.--

4 A. A health insurer shall make reimbursement for
5 direct services at a level not less than eighty-five percent of
6 premiums across all health product lines, [~~except~~] including
7 short-term plans and excluding individually underwritten health
8 insurance policies, contracts or plans, that are governed by
9 the provisions of Chapter 59A, Article 22 NMSA 1978, the Health
10 Maintenance Organization Law and the Nonprofit Health Care Plan
11 Law, and an excepted benefit policy intended to supplement
12 major medical coverage, including medicare supplement, vision,
13 dental, disease-specific, accident-only or hospital
14 indemnity-only insurance policies, or a plan that only issues
15 policies for long-term care or disability income.

16 Reimbursement shall be made for direct services provided over
17 the preceding three calendar years, but not earlier than
18 calendar year 2010, as determined by reports filed with the
19 office of superintendent of insurance. Nothing in this
20 subsection shall be construed to preclude a purchaser from
21 negotiating an agreement with a health insurer that requires a
22 higher amount of premiums paid to be used for reimbursement for
23 direct services for one or more products or for one or more
24 years.

25 B. For individually underwritten health care

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

21 C. For excepted benefit policies, plans or
22 contracts, the superintendent shall establish by rule the level
23 of reimbursement for direct services, which level of
24 reimbursement shall be determined by reports filed with the
25 office of superintendent of insurance, as a percent of

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

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

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1 provided by law, including general penalties pursuant to
2 Section 59A-1-18 NMSA 1978.

3 ~~[D.]~~ E. After notice and hearing, the
4 superintendent may adopt and promulgate reasonable rules
5 necessary and proper to carry out the provisions of this
6 section.

7 ~~[E.]~~ F. For the purposes of this section:

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

20 (2) "health insurer" means a person duly
21 authorized to transact the business of health insurance in the
22 state pursuant to the Insurance Code, ~~[but does not include]~~
23 including a person that issues a short-term plan and a person
24 that only issues [a limited benefit] an excepted benefit policy
25 intended to supplement major medical coverage, including

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1 medicare supplement, vision, dental, disease-specific,
2 accident-only or hospital indemnity-only insurance policies, or
3 that only issues policies for long-term care or disability
4 income; ~~and~~

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

14 (4) "short-term plan" means a nonrenewable
15 health benefits plan covering a resident of the state,
16 regardless of where the plan is delivered, that:

17 (a) has a maximum specified duration of
18 not more than three months after the effective date of the
19 plan; and

20 (b) is issued only to individuals who
21 have not been enrolled in a health benefits plan that provides
22 the same or similar nonrenewable coverage from any health
23 insurance carrier within the three months preceding enrollment
24 in the short-term plan."

25 SECTION 9. That version of Section 59A-22-50 NMSA 1978

1 (being Laws 2010, Chapter 94, Section 1, as amended) that is to
2 become effective January 1, 2020 is amended to read:

3 "59A-22-50. HEALTH INSURERS--DIRECT SERVICES.--

4 A. A health insurer shall make reimbursement for
5 direct services at a level not less than eighty-five percent of
6 premiums across all health product lines, [~~except~~] including
7 short-term plans and excluding individually underwritten health
8 insurance policies, contracts or plans, that are governed by
9 the provisions of Chapter 59A, Article 22 NMSA 1978, the Health
10 Maintenance Organization Law and the Nonprofit Health Care Plan
11 Law, and an excepted benefit policy intended to supplement
12 major medical coverage, including medicare supplement, vision,
13 dental, disease-specific, accident-only or hospital indemnity-
14 only insurance policies, or a plan that only issues policies
15 for long-term care or disability income. Reimbursement shall
16 be made for direct services provided over the preceding three
17 calendar years, but not earlier than calendar year 2010, as
18 determined by reports filed with the office of superintendent
19 of insurance. Nothing in this subsection shall be construed to
20 preclude a purchaser from negotiating an agreement with a
21 health insurer that requires a higher amount of premiums paid
22 to be used for reimbursement for direct services for one or
23 more products or for one or more years.

24 B. For individually underwritten health care
25 policies, plans or contracts, the superintendent shall

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

20 C. For excepted benefit policies, plans or
21 contracts, the superintendent shall establish by rule the level
22 of reimbursement for direct services, which level of
23 reimbursement shall be determined by reports filed with the
24 office of superintendent of insurance, as a percent of
25 premiums. A health insurer writing these policies, plans or

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

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

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1 Section 59A-1-18 NMSA 1978.

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

6 ~~[E-]~~ F. For the purposes of this section:

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

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

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underscored material = new
[bracketed material] = delete

1 that only issues policies for long-term care or disability
2 income; ~~and~~

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

12 (4) "short-term plan" means a nonrenewable
13 health benefits plan covering a resident of the state,
14 regardless of where the plan is delivered, that:

15 (a) has a maximum specified duration of
16 not more than three months after the effective date of the
17 plan; and

18 (b) is issued only to individuals who
19 have not been enrolled in a health benefits plan that provides
20 the same or similar nonrenewable coverage from any health
21 insurance carrier within the three months preceding enrollment
22 in the short-term plan."

23 SECTION 10. Section 59A-46-2 NMSA 1978 (being Laws 1993,
24 Chapter 266, Section 2, as amended) is amended to read:

25 "59A-46-2. DEFINITIONS.--As used in the Health

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1 Maintenance Organization Law:

2 A. "basic health care services":

3 (1) means medically necessary services
4 consisting of preventive care, emergency care, inpatient and
5 outpatient hospital and physician care, diagnostic laboratory,
6 diagnostic and therapeutic radiological services and services
7 of pharmacists and pharmacist clinicians; but

8 (2) does not include mental health services or
9 services for alcohol or drug abuse, dental or vision services
10 or long-term rehabilitation treatment;

11 B. "capitated basis" means fixed per member per
12 month payment or percentage of premium payment wherein the
13 provider assumes the full risk for the cost of contracted
14 services without regard to the type, value or frequency of
15 services provided and includes the cost associated with
16 operating staff model facilities;

17 C. "carrier" means a health maintenance
18 organization, an insurer, a nonprofit health care plan or other
19 entity responsible for the payment of benefits or provision of
20 services under a group contract;

21 D. "copayment" means an amount an enrollee must pay
22 in order to receive a specific service that is not fully
23 prepaid;

24 E. "credentialing" means the process of obtaining
25 and verifying information about a provider and evaluating that

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1 provider when that provider seeks to become a participating
2 provider;

3 F. "deductible" means the amount an enrollee is
4 responsible to pay out-of-pocket before the health maintenance
5 organization begins to pay the costs associated with treatment;

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

17 [~~G.~~] H. "enrollee" means an individual who is
18 covered by a health maintenance organization;

19 [~~H.~~] I. "evidence of coverage" means a policy,
20 contract or certificate showing the essential features and
21 services of the health maintenance organization coverage that
22 is given to the subscriber by the health maintenance
23 organization or by the group contract holder;

24 [~~I.~~] J. "extension of benefits" means the
25 continuation of coverage under a particular benefit provided

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1 under a contract or group contract following termination with
2 respect to an enrollee who is totally disabled on the date of
3 termination;

4 ~~[J.]~~ K. "grievance" means a written complaint
5 submitted in accordance with the health maintenance
6 organization's formal grievance procedure by or on behalf of
7 the enrollee regarding any aspect of the health maintenance
8 organization relative to the enrollee;

9 ~~[K.]~~ L. "group contract" means a contract for
10 health care services that by its terms limits eligibility to
11 members of a specified group and may include coverage for
12 dependents;

13 ~~[L.]~~ M. "group contract holder" means the person to
14 whom a group contract has been issued;

15 ~~[M.]~~ N. "health care services" means any services
16 included in the furnishing to any individual of medical,
17 mental, dental, pharmaceutical or optometric care or
18 hospitalization or nursing home care or incident to the
19 furnishing of such care or hospitalization, as well as the
20 furnishing to any person of any and all other services for the
21 purpose of preventing, alleviating, curing or healing human
22 physical or mental illness or injury;

23 ~~[N.]~~ O. "health maintenance organization" means
24 ~~[any]~~ a person ~~[who]~~ that undertakes to provide or arrange for
25 the delivery of basic health care services to enrollees on a

1 prepaid basis, except for enrollee responsibility for
 2 copayments or deductibles, including a carrier that issues:
 3 (1) a short-term contract;
 4 (2) an excepted benefit policy or contract
 5 intended to supplement major medical coverage, including
 6 medicare supplement, vision, dental, disease-specific,
 7 accident-only or hospital indemnity-only insurance policies; or
 8 (3) a policy for long-term care or disability
 9 income;

10 ~~[P.]~~ P. "health maintenance organization agent"
 11 means a person who solicits, negotiates, effects, procures,
 12 delivers, renews or continues a policy or contract for health
 13 maintenance organization membership or who takes or transmits a
 14 membership fee or premium for such a policy or contract, other
 15 than for that person, or a person who advertises or otherwise
 16 makes any representation to the public as such;

17 ~~[P.]~~ Q. "individual contract" means a contract for
 18 health care services issued to and covering an individual and
 19 it may include dependents of the subscriber;

20 ~~[Q.]~~ R. "insolvent" or "insolvency" means that the
 21 organization has been declared insolvent and placed under an
 22 order of liquidation by a court of competent jurisdiction;

23 ~~[R.]~~ S. "managed hospital payment basis" means
 24 agreements in which the financial risk is related primarily to
 25 the degree of utilization rather than to the cost of services;

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1 ~~[S.]~~ T. "net worth" means the excess of total
2 admitted assets over total liabilities, but the liabilities
3 shall not include fully subordinated debt;

4 ~~[F.]~~ U. "participating provider" means a provider
5 as defined in Subsection ~~[X]~~ Z of this section ~~[who]~~ that,
6 under an express contract with the health maintenance
7 organization or with its contractor or subcontractor, has
8 agreed to provide health care services to enrollees with an
9 expectation of receiving payment, other than copayment or
10 deductible, directly or indirectly from the health maintenance
11 organization;

12 ~~[U.]~~ V. "person" means an individual or other legal
13 entity;

14 ~~[V.]~~ W. "pharmacist" means a person licensed as a
15 pharmacist pursuant to the Pharmacy Act;

16 ~~[W.]~~ X. "pharmacist clinician" means a pharmacist
17 who exercises prescriptive authority pursuant to the Pharmacist
18 Prescriptive Authority Act;

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

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1 health insurance exchange that serves as a clearinghouse for
 2 insurance;

3 [~~X.~~] Z. "provider" means a physician, pharmacist,
 4 pharmacist clinician, hospital or other person licensed or
 5 otherwise authorized to furnish health care services;

6 [~~Y.~~] AA. "replacement coverage" means the benefits
 7 provided by a succeeding carrier;

8 BB. "short-term contract" means a nonrenewable
 9 health maintenance organization contract covering a resident of
 10 the state, regardless of where the contract is delivered, that:

11 (1) has a maximum specified duration of not
 12 more than three months after the effective date of the
 13 contract; and

14 (2) is issued only to individuals who have not
 15 been enrolled in a health maintenance organization contract
 16 that provides the same or similar nonrenewable coverage from
 17 any carrier within the three months preceding enrollment in the
 18 short-term contract;

19 [~~Z.~~] CC. "subscriber" means an individual whose
 20 employment or other status, except family dependency, is the
 21 basis for eligibility for enrollment in the health maintenance
 22 organization or, in the case of an individual contract, the
 23 person in whose name the contract is issued; and

24 [~~AA.~~] DD. "uncovered expenditures" means the costs
 25 to the health maintenance organization for health care services

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1 that are the obligation of the health maintenance organization,
2 for which an enrollee may also be liable in the event of the
3 health maintenance organization's insolvency and for which no
4 alternative arrangements have been made that are acceptable to
5 the superintendent."

6 SECTION 11. Section 59A-46-51 NMSA 1978 (being Laws 2010,
7 Chapter 94, Section 3, as amended) is amended to read:

8 "59A-46-51. HEALTH MAINTENANCE ORGANIZATIONS--DIRECT
9 SERVICES.--

10 A. A health maintenance organization shall make
11 reimbursement for direct services at a level not less than
12 eighty-five percent of premiums across all health product
13 lines, ~~[except]~~ including short-term contracts and excluding
14 individually underwritten health insurance policies, contracts
15 or plans, that are governed by the provisions of Chapter 59A,
16 Article 22 NMSA 1978, the Health Maintenance Organization Law
17 and the Nonprofit Health Care Plan Law, and an excepted benefit
18 health maintenance organization contract intended to supplement
19 major medical coverage, including medicare supplement, vision,
20 dental, disease-specific, accident-only or hospital indemnity-
21 only insurance contracts, or a carrier that only issues
22 contracts for long-term care or disability income.

23 Reimbursement shall be made for direct services provided over
24 the preceding three calendar years, but not earlier than
25 calendar year 2010, as determined by reports filed with the

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1 office of superintendent of insurance. Nothing in this
2 subsection shall be construed to preclude a purchaser from
3 negotiating an agreement with a health maintenance organization
4 that requires a higher amount of premiums paid to be used for
5 reimbursement for direct services for one or more products or
6 for one or more years.

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

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1 an agreement with a health insurer or health maintenance
2 organization that requires a higher amount of premiums paid to
3 be used for reimbursement for direct services.

4 C. For excepted benefit health maintenance
5 organization contracts, the superintendent shall establish by
6 rule the level of reimbursement for direct services, which
7 level of reimbursement shall be determined by reports filed
8 with the office of superintendent of insurance, as a percent of
9 premiums. A carrier writing these contracts shall make
10 reimbursement for direct services at a level not less than that
11 level established by the superintendent pursuant to this
12 subsection over the three calendar years preceding the date
13 upon which the rate is established. Nothing in this subsection
14 shall be construed to preclude a purchaser of one of these
15 excepted benefit health maintenance organization contracts from
16 negotiating an agreement with a health insurer that requires a
17 higher amount of premiums paid to be used for reimbursement of
18 direct services.

19 [~~G.~~] D. A health maintenance organization that
20 fails to comply with the reimbursement requirements pursuant to
21 this section shall issue a dividend or credit against future
22 premiums to all policy or contract holders in an amount
23 sufficient to [~~assure~~] ensure that the benefits paid in the
24 preceding three calendar years plus the amount of the dividends
25 or credits are equal to the required direct services

1 reimbursement level pursuant to Subsection A of this section
 2 for group health coverage and blanket health coverage or the
 3 required direct services reimbursement level pursuant to
 4 Subsection B of this section for individually underwritten
 5 health policies, contracts or plans for the preceding three
 6 calendar years. If the insurer fails to issue the dividend or
 7 credit in accordance with the requirements of this section, the
 8 superintendent shall enforce these requirements and may pursue
 9 any other penalties as provided by law, including general
 10 penalties pursuant to Section 59A-1-18 NMSA 1978.

11 ~~[D.]~~ E. After notice and hearing, the
 12 superintendent may adopt and promulgate reasonable rules
 13 necessary and proper to carry out the provisions of this
 14 section.

15 ~~[E. For the purposes of this section:~~

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

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1 ~~utilization review or management or any other activity designed~~
2 ~~to manage utilization or services;~~

3 ~~(2) "health maintenance organization" means~~
4 ~~any person who undertakes to provide or arrange for the~~
5 ~~delivery of basic health care services to enrollees on a~~
6 ~~prepaid basis, except for enrollee responsibility for~~
7 ~~copayments or deductibles, but does not include a person that~~
8 ~~only issues a limited-benefit policy or contract intended to~~
9 ~~supplement major medical coverage, including medicare~~
10 ~~supplement, vision, dental, disease-specific, accident-only or~~
11 ~~hospital indemnity-only insurance policies, or that only issues~~
12 ~~policies for long-term care or disability income; and~~

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

22 SECTION 12. That version of Section 59A-46-51 NMSA 1978
23 (being Laws 2010, Chapter 94, Section 3, as amended) that is to
24 become effective January 1, 2020 is amended to read:

25 "59A-46-51. HEALTH MAINTENANCE ORGANIZATIONS--DIRECT

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1 SERVICES.--

2 A. A health maintenance organization shall make
3 reimbursement for direct services at a level not less than
4 eighty-five percent of premiums across all health product
5 lines, [~~except~~] including short-term contracts and excluding
6 individually underwritten health insurance policies, contracts
7 or plans, that are governed by the provisions of Chapter 59A,
8 Article 22 NMSA 1978, the Health Maintenance Organization Law
9 and the Nonprofit Health Care Plan Law, and an excepted benefit
10 health maintenance organization contract intended to supplement
11 major medical coverage, including medicare supplement, vision,
12 dental, disease-specific, accident-only or hospital indemnity-
13 only insurance contracts, or a carrier that only issues
14 contracts for long-term care or disability income.

15 Reimbursement shall be made for direct services provided over
16 the preceding three calendar years, but not earlier than
17 calendar year 2010, as determined by reports filed with the
18 office of superintendent of insurance. Nothing in this
19 subsection shall be construed to preclude a purchaser from
20 negotiating an agreement with a health maintenance organization
21 that requires a higher amount of premiums paid to be used for
22 reimbursement for direct services for one or more products or
23 for one or more years.

24 B. For individually underwritten health care
25 policies, plans or contracts, the superintendent shall

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

21 C. For excepted benefit health maintenance
22 organization contracts, the superintendent shall establish by
23 rule the level of reimbursement for direct services, which
24 level of reimbursement shall be determined by reports filed
25 with the office of superintendent of insurance, as a percent of

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

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

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1 any other penalties as provided by law, including general
2 penalties pursuant to Section 59A-1-18 NMSA 1978.

3 ~~[D.]~~ E. After notice and hearing, the
4 superintendent may adopt and promulgate reasonable rules
5 necessary and proper to carry out the provisions of this
6 section.

7 ~~[E. For the purposes of this section:~~

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

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

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1 supplement, vision, dental, disease-specific, accident-only or
 2 hospital indemnity-only insurance policies, or that only issues
 3 policies for long-term care or disability income; and

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

13 SECTION 13. Section 59A-47-3 NMSA 1978 (being Laws 1984,
 14 Chapter 127, Section 879.1, as amended) is amended to read:

15 "59A-47-3. DEFINITIONS.--As used in Chapter 59A, Article
 16 47 NMSA 1978:

17 A. "acquisition expenses" includes all expenses
 18 incurred in connection with the solicitation and enrollment of
 19 subscribers;

20 B. "administration expenses" means all expenses of
 21 the health care plan other than the cost of health care expense
 22 payments and acquisition expenses;

23 C. "agent" means a person appointed by a health
 24 care plan authorized to transact business in this state to act
 25 as its representative in any given locality for soliciting

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1 health care policies and other related duties as may be
2 authorized;

3 D. "chiropractor" means any person holding a
4 license provided for in the Chiropractic Physician Practice
5 Act;

6 E. "credentialing" means the process of obtaining
7 and verifying information about a provider and evaluating that
8 provider when that provider seeks to become a participating
9 provider;

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

22 G. "doctor of oriental medicine" means any person
23 licensed as a doctor of oriental medicine under the Acupuncture
24 and Oriental Medicine Practice Act;

25 [A.] H. "health care" means the treatment of

1 persons for the prevention, cure or correction of any illness
 2 or physical or mental condition, including optometric services;

3 I. "health care expense payment" means a payment
 4 for health care to a purveyor on behalf of a subscriber, or
 5 such a payment to the subscriber;

6 J. "health care plan" means a nonprofit corporation
 7 authorized by the superintendent to enter into contracts with
 8 subscribers and to make health care expense payments, including
 9 a nonprofit corporation that issues:

10 (1) a short-term health care plan;

11 (2) an excepted benefit health care plan
 12 intended to supplement major medical coverage, including
 13 medicare supplement, vision, dental, disease-specific,
 14 accident-only or hospital indemnity-only insurance policies; or

15 (3) a policy or plan for long-term care or
 16 disability income;

17 K. "indemnity benefit" means a payment that the
 18 purveyor has not agreed to accept as payment in full for health
 19 care furnished the subscriber;

20 ~~[B.]~~ L. "item of health care" [includes any
 21 ~~services or materials] means a service or material used in
 22 health care;~~

23 ~~[C. "health care expense payment" means a payment~~
 24 ~~for health care to a purveyor on behalf of a subscriber, or~~
 25 ~~such a payment to the subscriber;]~~

1 M. "pharmacist" means a person licensed as a
2 pharmacist pursuant to the Pharmacy Act;

3 N. "pharmacist clinician" means a pharmacist who
4 exercises prescriptive authority pursuant to the Pharmacist
5 Prescriptive Authority Act;

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

15 P. "provider" means a physician or other individual
16 licensed or otherwise authorized to furnish health care
17 services in the state;

18 [~~D.~~] Q. "purveyor" means a person who furnishes any
19 item of health care and charges for that item;

20 [~~E.~~] R. "service benefit" means a payment that the
21 purveyor has agreed to accept as payment in full for health
22 care furnished the subscriber;

23 [~~F.~~ "indemnity benefit" means a payment that the
24 purveyor has not agreed to accept as payment in full for health
25 care furnished the subscriber;]

1 S. "short-term health care plan" means a
 2 nonrenewable health care plan covering a resident of the state,
 3 regardless of where the plan is delivered, that:

4 (1) has a maximum specified duration of not
 5 more than three months after the effective date of the plan;

6 and

7 (2) is issued only to individuals who have not
 8 been enrolled in a health care plan that provides the same or
 9 similar nonrenewable coverage from any nonprofit health care
 10 plan within the three months preceding enrollment in the
 11 short-term plan;

12 T. "solicitor" means a person employed by the
 13 licensed agent of a health care plan for the purpose of
 14 soliciting health care policies and other related duties in
 15 connection with the handling of the business of the agent as
 16 may be authorized and paid for the person's services either on
 17 a commission basis or salary basis or part by commission and
 18 part by salary;

19 ~~[G.]~~ U. "subscriber" means any individual who,
 20 because of a contract with a health care plan entered into by
 21 or for the individual, is entitled to have health care expense
 22 payments made on the individual's behalf or to the individual
 23 by the health care plan; and

24 ~~[H.]~~ V. "underwriting manual" means the health care
 25 plan's written criteria, approved by the superintendent, that

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1 defines the terms and conditions under which subscribers may be
2 selected. The underwriting manual may be amended from time to
3 time, but amendment will not be effective until approved by the
4 superintendent. The superintendent shall notify the health
5 care plan filing the underwriting manual or the amendment
6 thereto of the superintendent's approval or disapproval thereof
7 in writing within thirty days after filing or within sixty days
8 after filing if the superintendent shall so extend the time.
9 If the superintendent fails to act within such period, the
10 filing shall be deemed to be approved.

11 ~~I. "acquisition expenses" includes all expenses~~
12 ~~incurred in connection with the solicitation and enrollment of~~
13 ~~subscribers;~~

14 ~~J. "administration expenses" means all expenses of~~
15 ~~the health care plan other than the cost of health care expense~~
16 ~~payments and acquisition expenses;~~

17 ~~K. "health care plan" means a nonprofit corporation~~
18 ~~authorized by the superintendent to enter into contracts with~~
19 ~~subscribers and to make health care expense payments;~~

20 ~~L. "agent" means a person appointed by a health~~
21 ~~care plan authorized to transact business in this state to act~~
22 ~~as its representative in any given locality for soliciting~~
23 ~~health care policies and other related duties as may be~~
24 ~~authorized;~~

25 ~~M. "solicitor" means a person employed by the~~

1 ~~licensed agent of a health care plan for the purpose of~~
 2 ~~soliciting health care policies and other related duties in~~
 3 ~~connection with the handling of the business of the agent as~~
 4 ~~may be authorized and paid for the person's services either on~~
 5 ~~a commission basis or salary basis or part by commission and~~
 6 ~~part by salary;~~

7 N. ~~"chiropractor" means any person holding a~~
 8 ~~license provided for in the Chiropractic Physician Practice~~
 9 ~~Act;~~

10 O. ~~"doctor of oriental medicine" means any person~~
 11 ~~licensed as a doctor of oriental medicine under the Acupuncture~~
 12 ~~and Oriental Medicine Practice Act;~~

13 P. ~~"pharmacist" means a person licensed as a~~
 14 ~~pharmacist pursuant to the Pharmacy Act;~~

15 Q. ~~"pharmacist clinician" means a pharmacist who~~
 16 ~~exercises prescriptive authority pursuant to the Pharmacist~~
 17 ~~Prescriptive Authority Act;~~

18 R. ~~"credentialing" means the process of obtaining~~
 19 ~~and verifying information about a provider and evaluating that~~
 20 ~~provider when that provider seeks to become a participating~~
 21 ~~provider; and~~

22 S. ~~"provider" means a physician or other individual~~
 23 ~~licensed or otherwise authorized to furnish health care~~
 24 ~~services in the state.]"~~

25 SECTION 14. That version of Section 59A-47-3 NMSA 1978

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1 (being Laws 1984, Chapter 127, Section 879.1, as amended) that
2 is to become effective January 1, 2020 is amended to read:

3 "59A-47-3. DEFINITIONS.--As used in Chapter 59A, Article
4 47 NMSA 1978:

5 A. "acquisition expenses" includes all expenses
6 incurred in connection with the solicitation and enrollment of
7 subscribers;

8 B. "administration expenses" means all expenses of
9 the health care plan other than the cost of health care expense
10 payments and acquisition expenses;

11 C. "agent" means a person appointed by a health
12 care plan authorized to transact business in this state to act
13 as its representative in any given locality for soliciting
14 health care policies and other related duties as may be
15 authorized;

16 D. "chiropractor" means any person holding a
17 license provided for in the Chiropractic Physician Practice
18 Act;

19 E. "credentialing" means the process of obtaining
20 and verifying information about a provider and evaluating that
21 provider when that provider seeks to become a participating
22 provider;

23 F. "direct services" means services rendered to an
24 individual by a health care plan, health insurer or a health
25 care practitioner, facility or other provider, including case

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

10 G. "doctor of oriental medicine" means any person
 11 licensed as a doctor of oriental medicine under the Acupuncture
 12 and Oriental Medicine Practice Act;

13 ~~[A.]~~ H. "health care" means the treatment of
 14 persons for the prevention, cure or correction of any illness
 15 or physical or mental condition, including optometric services;

16 ~~[B. "item of health care" includes any services or~~
 17 ~~materials used in health care;~~

18 ~~G.]~~ I. "health care expense payment" means a
 19 payment for health care to a purveyor on behalf of a
 20 subscriber, or such a payment to the subscriber;

21 J. "health care plan" means an organization that
 22 demonstrates to the superintendent that it has been granted
 23 exemption from the federal income tax by the United States
 24 commissioner of internal revenue as an organization described
 25 in Section 501(c)(3) of the United States Internal Revenue Code

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1 of 1986, as that section may be amended or renumbered, and is
2 authorized by the superintendent to enter into contracts with
3 subscribers and to make health care expense payments, including
4 an organization that issues:

5 (1) a short-term health care plan;

6 (2) an excepted benefit health care plan
7 intended to supplement major medical coverage, including
8 medicare supplement, vision, dental, disease-specific,
9 accident-only or hospital indemnity-only insurance policies; or

10 (3) a policy or plan for long-term care or
11 disability income;

12 K. "indemnity benefit" means a payment that the
13 purveyor has not agreed to accept as payment in full for health
14 care furnished the subscriber;

15 L. "item of health care" means a service or
16 material used in health care;

17 M. "pharmacist" means a person licensed as a
18 pharmacist pursuant to the Pharmacy Act;

19 N. "pharmacist clinician" means a pharmacist who
20 exercises prescriptive authority pursuant to the Pharmacist
21 Prescriptive Authority Act;

22 O. "premium" means all income received from
23 individuals and private and public payers or sources for the
24 procurement of health coverage, including capitated payments,
25 self-funded administrative fees, self-funded claim

1 reimbursements, recoveries from third parties or other insurers
 2 and interests less any premium tax paid pursuant to Section
 3 59A-6-2 NMSA 1978 and fees associated with participating in a
 4 health insurance exchange that serves as a clearinghouse for
 5 insurance;

6 P. "provider" means a physician or other individual
 7 licensed or otherwise authorized to furnish health care
 8 services in the state;

9 ~~D.]~~ Q. "purveyor" means a person who furnishes any
 10 item of health care and charges for that item;

11 ~~[E.]~~ R. "service benefit" means a payment that the
 12 purveyor has agreed to accept as payment in full for health
 13 care furnished the subscriber;

14 ~~[F. "indemnity benefit" means a payment that the~~
 15 ~~purveyor has not agreed to accept as payment in full for health~~
 16 ~~care furnished the subscriber;]~~

17 S. "short-term health care plan" means a
 18 nonrenewable health care plan covering a resident of the state,
 19 regardless of where the plan is delivered, that:

20 (1) has a maximum specified duration of not
 21 more than three months after the effective date of the plan;
 22 and

23 (2) is issued only to individuals who have not
 24 been enrolled in a health care plan that provides the same or
 25 similar nonrenewable coverage from any nonprofit health care

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1 plan within the three months preceding enrollment in the
2 short-term plan;

3 T. "solicitor" means a person employed by the
4 licensed agent of a health care plan for the purpose of
5 soliciting health care policies and other related duties in
6 connection with the handling of the business of the agent as
7 may be authorized and paid for the person's services either on
8 a commission basis or salary basis or part by commission and
9 part by salary;

10 [~~G-~~] U. "subscriber" means any individual who,
11 because of a contract with a health care plan entered into by
12 or for the individual, is entitled to have health care expense
13 payments made on the individual's behalf or to the individual
14 by the health care plan; and

15 [~~H-~~] V. "underwriting manual" means the health care
16 plan's written criteria, approved by the superintendent, that
17 defines the terms and conditions under which subscribers may be
18 selected. The underwriting manual may be amended from time to
19 time, but the amendment will not be effective until approved by
20 the superintendent. The superintendent shall notify the health
21 care plan filing the underwriting manual or the amendment
22 thereto of the superintendent's approval or disapproval thereof
23 in writing within thirty days after filing or within sixty days
24 after filing if the superintendent shall so extend the time.
25 If the superintendent fails to act within such period, the

1 filing shall be deemed to be approved.

2 ~~I. "acquisition expenses" includes all expenses~~
3 ~~incurred in connection with the solicitation and enrollment of~~
4 ~~subscribers;~~

5 ~~J. "administration expenses" means all expenses of~~
6 ~~the health care plan other than the cost of health care expense~~
7 ~~payments and acquisition expenses;~~

8 ~~K. "health care plan" means an organization that~~
9 ~~demonstrates to the superintendent that it has been granted~~
10 ~~exemption from the federal income tax by the United States~~
11 ~~commissioner of internal revenue as an organization described~~
12 ~~in Section 501(c)(3) of the United States Internal Revenue Code~~
13 ~~of 1986, as that section may be amended or renumbered, and is~~
14 ~~authorized by the superintendent to enter into contracts with~~
15 ~~subscribers and to make health care expense payments;~~

16 ~~L. "agent" means a person appointed by a health~~
17 ~~care plan authorized to transact business in this state to act~~
18 ~~as its representative in any given locality for soliciting~~
19 ~~health care policies and other related duties as may be~~
20 ~~authorized;~~

21 ~~M. "solicitor" means a person employed by the~~
22 ~~licensed agent of a health care plan for the purpose of~~
23 ~~soliciting health care policies and other related duties in~~
24 ~~connection with the handling of the business of the agent as~~
25 ~~may be authorized and paid for the person's services either on~~

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1 ~~a commission basis or salary basis or part by commission and~~
2 ~~part by salary;~~

3 N. ~~"chiropractor" means any person holding a~~
4 ~~license provided for in the Chiropractic Physician Practice~~
5 ~~Act;~~

6 O. ~~"doctor of oriental medicine" means any person~~
7 ~~licensed as a doctor of oriental medicine under the Acupuncture~~
8 ~~and Oriental Medicine Practice Act;~~

9 P. ~~"pharmacist" means a person licensed as a~~
10 ~~pharmacist pursuant to the Pharmacy Act;~~

11 Q. ~~"pharmacist clinician" means a pharmacist who~~
12 ~~exercises prescriptive authority pursuant to the Pharmacist~~
13 ~~Prescriptive Authority Act;~~

14 R. ~~"credentialing" means the process of obtaining~~
15 ~~and verifying information about a provider and evaluating that~~
16 ~~provider when that provider seeks to become a participating~~
17 ~~provider; and~~

18 S. ~~"provider" means a physician or other individual~~
19 ~~licensed or otherwise authorized to furnish health care~~
20 ~~services in the state.]"~~

21 SECTION 15. Section 59A-47-46 NMSA 1978 (being Laws 2010,
22 Chapter 94, Section 4, as amended) is amended to read:

23 "59A-47-46. HEALTH INSURERS--DIRECT SERVICES.--

24 A. A health care plan shall make reimbursement for
25 direct services at a level not less than eighty-five percent of

1 premiums across all health product lines, [~~except~~] including
2 short-term health care plans and excluding individually
3 underwritten health care policies, contracts or plans, that are
4 governed by the provisions of Chapter 59A, Article 22 NMSA
5 1978, the Health Maintenance Organization Law and the Nonprofit
6 Health Care Plan Law, and an excepted benefit health care plan
7 intended to supplement major medical coverage, including
8 medicare supplement, vision, dental, disease-specific,
9 accident-only or hospital indemnity-only insurance policies, or
10 a health care plan that only issues policies for long-term care
11 or disability income. Reimbursement shall be made for direct
12 services provided over the preceding three calendar years, but
13 not earlier than calendar year 2010, as determined by reports
14 filed with the office of superintendent of insurance. Nothing
15 in this subsection shall be construed to preclude a purchaser
16 from negotiating an agreement with a health insurer that
17 requires a higher amount of premiums paid to be used for
18 reimbursement for direct services for one or more products or
19 for one or more years.

20 B. For individually underwritten health care
21 policies, plans or contracts, the superintendent shall
22 establish, after notice and informal hearing, the level of
23 reimbursement for direct services as determined as a percent of
24 premiums. Additional hearings may be held at the
25 superintendent's discretion. In establishing the level of

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1 reimbursement for direct services, the superintendent shall
2 consider the costs associated with the individual marketing and
3 medical underwriting of these policies, plans or contracts at a
4 level not less than seventy-five percent of premiums. A health
5 insurer writing these policies, plans or contracts shall make
6 reimbursement for direct services at a level not less than that
7 level established by the superintendent pursuant to this
8 subsection over the three calendar years preceding the date
9 upon which that rate is established, but not earlier than
10 calendar year 2010. Nothing in this subsection shall be
11 construed to preclude a purchaser of one of these policies,
12 plans or contracts from negotiating an agreement with a health
13 insurer that requires a higher amount of premiums paid to be
14 used for reimbursement for direct services.

15 C. For an excepted benefit health care plan, the
16 superintendent shall establish by rule the level of
17 reimbursement for direct services, which level of reimbursement
18 shall be determined by reports filed with the office of
19 superintendent of insurance, as a percent of premiums. A
20 health care plan writing these excepted benefit health care
21 plans shall make reimbursement for direct services at a level
22 not less than that level established by the superintendent
23 pursuant to this subsection over the three calendar years
24 preceding the date upon which the rate is established. Nothing
25 in this subsection shall be construed to preclude a purchaser

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1 of one of these excepted benefit health care plans from
2 negotiating an agreement with a nonprofit health care plan that
3 requires a higher amount of premiums paid to be used for
4 reimbursement of direct services.

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

22 ~~[D.]~~ E. After notice and hearing, the
23 superintendent may adopt and promulgate reasonable rules
24 necessary and proper to carry out the provisions of this
25 section.

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1 ~~[E. For the purposes of this section:~~

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

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

23 ~~(3) "premium" means all income received from~~
24 ~~individuals and private and public payers or sources for the~~
25 ~~procurement of health coverage, including capitated payments,~~

underscoring material = new
[bracketed material] = delete

1 ~~self-funded administrative fees, self-funded claim~~
 2 ~~reimbursements, recoveries from third parties or other insurers~~
 3 ~~and interests less any premium tax paid pursuant to Section~~
 4 ~~59A-6-2 NMSA 1978 and fees associated with participating in a~~
 5 ~~health insurance exchange that serves as a clearinghouse for~~
 6 ~~insurance.]"~~

7 SECTION 16. That version of Section 59A-47-46 NMSA 1978
 8 (being Laws 2010, Chapter 94, Section 4, as amended) that is to
 9 become effective January 1, 2020 is amended to read:

10 "59A-47-46. HEALTH INSURERS--DIRECT SERVICES.--

11 A. A health care plan shall make reimbursement for
 12 direct services at a level not less than eighty-five percent of
 13 premiums across all health product lines, ~~[except]~~ including
 14 short-term health care plans and excluding individually
 15 underwritten health care policies, contracts or plans, that are
 16 governed by the provisions of Chapter 59A, Article 22 NMSA
 17 1978, the Health Maintenance Organization Law and the Nonprofit
 18 Health Care Plan Law, and an excepted benefit health care plan
 19 intended to supplement major medical coverage, including
 20 medicare supplement, vision, dental, disease-specific,
 21 accident-only or hospital indemnity-only insurance policies, or
 22 a health care plan that only issues policies for long-term care
 23 or disability income. Reimbursement shall be made for direct
 24 services provided over the preceding three calendar years, but
 25 not earlier than calendar year 2010, as determined by reports

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1 filed with the office of superintendent of insurance. Nothing
2 in this subsection shall be construed to preclude a purchaser
3 from negotiating an agreement with a health insurer that
4 requires a higher amount of premiums paid to be used for
5 reimbursement for direct services for one or more products or
6 for one or more years.

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

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1 used for reimbursement for direct services.

2 C. For an excepted benefit health care plan, the
3 superintendent shall establish by rule the level of
4 reimbursement for direct services, which level of reimbursement
5 shall be determined by reports filed with the office of
6 superintendent of insurance, as a percent of premiums. A
7 health care plan writing these excepted benefit health care
8 plans shall make reimbursement for direct services at a level
9 not less than that level established by the superintendent
10 pursuant to this subsection over the three calendar years
11 preceding the date upon which the rate is established. Nothing
12 in this subsection shall be construed to preclude a purchaser
13 of one of these excepted benefit health care plans from
14 negotiating an agreement with a nonprofit health care plan that
15 requires a higher amount of premiums paid to be used for
16 reimbursement of direct services.

17 [~~G.~~] D. A health care plan that fails to comply
18 with the reimbursement requirements pursuant to this section
19 shall issue a dividend or credit against future premiums to all
20 policyholders in an amount sufficient to [~~assure~~] ensure that
21 the benefits paid in the preceding three calendar years plus
22 the amount of the dividends or credits are equal to the
23 required direct services reimbursement level pursuant to
24 Subsection A of this section for group health coverage and
25 blanket health coverage or the required direct services

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1 reimbursement level pursuant to Subsection B of this section
2 for individually underwritten health policies, contracts or
3 plans for the preceding three calendar years. If the insurer
4 fails to issue the dividend or credit in accordance with the
5 requirements of this section, the superintendent shall enforce
6 these requirements and may pursue any other penalties as
7 provided by law, including general penalties pursuant to
8 Section 59A-1-18 NMSA 1978.

9 ~~[D.]~~ E. After notice and hearing, the
10 superintendent may adopt and promulgate reasonable rules
11 necessary and proper to carry out the provisions of this
12 section.

13 ~~[E. For the purposes of this section:~~

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

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

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