

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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:

"SHORT TITLE.--Sections 1 through 6 of this act may be cited as the "Short-Term Health Plan and Excepted Benefit Act"."

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

"DEFINITIONS.--As used in the Short-Term Health Plan and Excepted Benefit Act:

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

1 B. "excepted benefits" means benefits furnished
2 pursuant to the following:

3 (1) coverage-only for accident or disability
4 income insurance;

5 (2) coverage issued as a supplement to
6 liability insurance;

7 (3) liability insurance;

8 (4) workers' compensation or similar
9 insurance;

10 (5) automobile medical payment insurance;

11 (6) credit-only insurance;

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

13 (8) other similar insurance coverage
14 specified in regulations under which benefits for medical
15 care are secondary or incidental to other benefits;

16 (9) the following benefits if offered
17 separately:

18 (a) limited-scope dental or vision
19 benefits;

20 (b) benefits for long-term care,
21 nursing home care, home health care, community-based care or
22 any combination of those benefits; and

23 (c) other similar excepted benefits
24 specified in rule;

25 (10) the following benefits, offered as

1 independent, non-coordinated benefits:

2 (a) coverage-only for a specified
3 disease or illness; or

4 (b) hospital indemnity or other fixed
5 indemnity insurance;

6 (11) the following benefits if offered as a
7 separate insurance policy:

8 (a) medicare supplemental health
9 insurance as defined pursuant to Section 1882(g)(1) of the
10 federal Social Security Act; and

11 (b) coverage supplemental to the
12 coverage provided pursuant to Chapter 55 of Title 10 USCA and
13 similar supplemental coverage provided to coverage pursuant
14 to a group health plan; and

15 (12) other similar individual or group
16 insurance coverage or arrangement designated by the
17 superintendent pursuant to rule under which benefits are
18 secondary or incidental to health events, services or medical
19 care;

20 C. "excepted benefits plan" means a health
21 benefits plan that offers only excepted benefits;

22 D. "health benefits plan" means an individual or
23 group policy or agreement entered into, offered or issued by
24 a health insurance carrier to provide, deliver, arrange for,
25 pay for or reimburse any of the costs of health care

1 services;

2 E. "health insurance carrier" means an entity
3 subject to the insurance laws of the state, including a
4 health insurance company, a health maintenance organization,
5 a hospital and health services corporation, a provider
6 service network, a nonprofit health care plan or any other
7 entity that contracts or offers to contract, or enters into
8 agreements to provide, deliver, arrange for, pay for or
9 reimburse any costs of health care services, or that
10 provides, offers or administers health benefits plans or
11 managed health care plans in the state;

12 F. "health insurance coverage" means benefits
13 consisting of medical care provided directly, through
14 insurance or reimbursement, or otherwise, and items,
15 including items and services paid for as medical care,
16 pursuant to any hospital or medical service policy or
17 certificate, hospital or medical service plan contract or
18 health maintenance organization contract offered by a health
19 insurance carrier;

20 G. "major medical coverage" means a health
21 benefits plan that provides benefits other than excepted
22 benefits;

23 H. "permitted health insurance coverage" means a
24 health benefits plan, excepted benefits plan, short-term plan
25 and other categories or types of health insurance coverage

1 designated by the superintendent; and

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

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

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

12 (3) is not an excepted benefit or
13 combination of excepted benefits."

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

16 "SHORT-TERM PLANS--EXCEPTED BENEFITS--STANDARDS FOR
17 POLICY PROVISIONS.--

18 A. The superintendent shall adopt and promulgate
19 rules to establish specific standards:

20 (1) that set the manner, content and
21 required disclosure for the sale of short-term plans and
22 excepted benefits plans, including standards for full and
23 fair disclosure; and

24 (2) for the sale of short-term plans and
25 excepted benefits plans, which standards shall include

- 1 standards relating to:
- 2 (a) terms of renewability or extension
- 3 of coverage;
- 4 (b) initial and subsequent conditions
- 5 of eligibility;
- 6 (c) nonduplication of coverage
- 7 provisions;
- 8 (d) coverage of dependents;
- 9 (e) preexisting conditions;
- 10 (f) termination of insurance;
- 11 (g) probationary periods;
- 12 (h) limitations;
- 13 (i) exceptions;
- 14 (j) reductions and exclusions;
- 15 (k) elimination periods;
- 16 (l) requirements for replacement by the
- 17 health insurance carrier;
- 18 (m) recurrent conditions;
- 19 (n) the definition of terms to describe
- 20 the specific types of coverage sold pursuant to the
- 21 Short-Term Health Plan and Excepted Benefit Act and specific
- 22 standards and policy provisions required of these plans;
- 23 (o) benefit duration;
- 24 (p) scope of coverage;
- 25 (q) advertising and marketing;

- 1 (r) sales practices;
- 2 (s) mandatory disclosures;
- 3 (t) coverage suitability; and
- 4 (u) policy and certificate approval.

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

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

12 "BENEFITS--MINIMUM STANDARDS.--

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

17 B. Rules of the superintendent shall require
18 short-term plans to cover state-mandated benefits in addition
19 to each of the following categories of benefits:

- 20 (1) diagnostic;
- 21 (2) rehabilitative;
- 22 (3) maternity;
- 23 (4) neonatal;
- 24 (5) behavioral health services;
- 25 (6) emergency services;

- 1 (7) hospitalization;
- 2 (8) ambulatory services; and
- 3 (9) prescription drugs."

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

6 "RATES--MEDICAL LOSS RATIOS.--The superintendent shall
7 adopt and promulgate rules to establish standards for rates,
8 including medical loss ratios, of short-term plans and
9 excepted benefits plans. Rules relating to rates shall be
10 based on generally recognized and current actuarial
11 standards."

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

14 "PROHIBITION--ASSOCIATION, TRUST OR MULTIPLE EMPLOYER
15 WELFARE ARRANGEMENT PLANS.--No insurer shall issue, and no
16 association, trust or multiple employer welfare arrangement
17 shall offer, a short-term or excepted benefits plan to a
18 resident of the state unless through a bona fide
19 association."

20 SECTION 7. A new section of Chapter 59A, Article 16
21 NMSA 1978 is enacted to read:

22 "HEALTH BENEFITS PLANS--PROHIBITION--UNLICENSED HEALTH
23 BENEFITS PLANS--UNAPPROVED HEALTH BENEFITS PLANS.--

24 A. No person or entity shall sell or issue, or
25 cause to be sold or issued, a health benefits plan that is

1 unlicensed or unapproved for sale or delivery in the state.

2 B. No person or entity shall sell or issue, or
3 cause to be sold or issued, health insurance coverage that is
4 not permitted health insurance coverage.

5 C. As used in this section:

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

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

20 **SECTION 8.** Section 59A-22-50 NMSA 1978 (being Laws
21 2010, Chapter 94, Section 1, as amended) is amended to read:

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

23 A. A health insurer shall make reimbursement for
24 direct services at a level not less than eighty-five percent
25 of premiums across all health product lines, including short-

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

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

1 the level of reimbursement for direct services, the
2 superintendent shall consider the costs associated with the
3 individual marketing and medical underwriting of these
4 policies, plans or contracts at a level not less than
5 seventy-five percent of premiums. A health insurer writing
6 these policies shall make reimbursement for direct services
7 at a level not less than that level established by the
8 superintendent pursuant to this subsection over the three
9 calendar years preceding the date upon which that rate is
10 established, but not earlier than calendar year 2010.

11 Nothing in this subsection shall be construed to preclude a
12 purchaser of one of these policies, plans or contracts from
13 negotiating an agreement with a health insurer that requires
14 a higher amount of premiums paid to be used for reimbursement
15 for direct services.

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

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

8 D. After notice and hearing, the superintendent
9 may adopt and promulgate reasonable rules necessary and
10 proper to carry out the provisions of this section.

11 E. For the purposes of this section:

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

24 (2) "health insurer" means a person duly
25 authorized to transact the business of health insurance in

1 the state pursuant to the Insurance Code, including a person
2 that issues a short-term plan and a person that only issues
3 an excepted benefit policy intended to supplement major
4 medical coverage, including medicare supplement, vision,
5 dental, disease-specific, accident-only or hospital
6 indemnity-only insurance policies, or that only issues
7 policies for long-term care or disability income;

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

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

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

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

1 health insurance carrier within the three months preceding
2 enrollment in the short-term plan."

3 SECTION 9. That version of Section 59A-22-50 NMSA 1978
4 (being Laws 2010, Chapter 94, Section 1, as amended) that is
5 to become effective January 1, 2020 is amended to read:

6 "59A-22-50. HEALTH INSURERS--DIRECT SERVICES.--

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

1 for direct services for one or more products or for one or
2 more years.

3 B. For individually underwritten health care
4 policies, plans or contracts, the superintendent shall
5 establish, after notice and informal hearing, the level of
6 reimbursement for direct services, as determined by the
7 reports filed with the office of superintendent of insurance,
8 as a percent of premiums. Additional informal hearings may
9 be held at the superintendent's discretion. In establishing
10 the level of reimbursement for direct services, the
11 superintendent shall consider the costs associated with the
12 individual marketing and medical underwriting of these
13 policies, plans or contracts at a level not less than
14 seventy-five percent of premiums. A health insurer writing
15 these policies shall make reimbursement for direct services
16 at a level not less than that level established by the
17 superintendent pursuant to this subsection over the three
18 calendar years preceding the date upon which that rate is
19 established, but not earlier than calendar year 2010.

20 Nothing in this subsection shall be construed to preclude a
21 purchaser of one of these policies, plans or contracts from
22 negotiating an agreement with a health insurer that requires
23 a higher amount of premiums paid to be used for reimbursement
24 for direct services.

25 C. An insurer that fails to comply with the

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

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

20 E. For the purposes of this section:

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

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

8 (2) "health insurer" means a person duly
9 authorized to transact the business of health insurance in
10 the state pursuant to the Insurance Code, including a person
11 that issues a short-term plan and a person that only issues
12 an excepted benefit policy intended to supplement major
13 medical coverage, including medicare supplement, vision,
14 dental, disease-specific, accident-only or hospital
15 indemnity-only insurance policies, or that only issues
16 policies for long-term care or disability income;

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

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

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

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

12 SECTION 10. Section 59A-46-2 NMSA 1978 (being Laws
13 1993, Chapter 266, Section 2, as amended) is amended to read:

14 "59A-46-2. DEFINITIONS.--As used in the Health
15 Maintenance Organization Law:

16 A. "basic health care services":

17 (1) means medically necessary services
18 consisting of preventive care, emergency care, inpatient and
19 outpatient hospital and physician care, diagnostic
20 laboratory, diagnostic and therapeutic radiological services
21 and services of pharmacists and pharmacist clinicians; but

22 (2) does not include mental health services
23 or services for alcohol or drug abuse, dental or vision
24 services or long-term rehabilitation treatment;

25 B. "capitated basis" means fixed per member per

1 month payment or percentage of premium payment wherein the
2 provider assumes the full risk for the cost of contracted
3 services without regard to the type, value or frequency of
4 services provided and includes the cost associated with
5 operating staff model facilities;

6 C. "carrier" means a health maintenance
7 organization, an insurer, a nonprofit health care plan or
8 other entity responsible for the payment of benefits or
9 provision of services under a group contract;

10 D. "copayment" means an amount an enrollee must
11 pay in order to receive a specific service that is not fully
12 prepaid;

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

17 F. "deductible" means the amount an enrollee is
18 responsible to pay out-of-pocket before the health
19 maintenance organization begins to pay the costs associated
20 with treatment;

21 G. "direct services" means services rendered to an
22 individual by a carrier or a health care practitioner,
23 facility or other provider, which services include case
24 management, disease management, health education and
25 promotion, preventive services, quality incentive payments to

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

8 H. "enrollee" means an individual who is covered
9 by a health maintenance organization;

10 I. "evidence of coverage" means a policy, contract
11 or certificate showing the essential features and services of
12 the health maintenance organization coverage that is given to
13 the subscriber by the health maintenance organization or by
14 the group contract holder;

15 J. "extension of benefits" means the continuation
16 of coverage under a particular benefit provided under a
17 contract or group contract following termination with respect
18 to an enrollee who is totally disabled on the date of
19 termination;

20 K. "grievance" means a written complaint submitted
21 in accordance with the health maintenance organization's
22 formal grievance procedure by or on behalf of the enrollee
23 regarding any aspect of the health maintenance organization
24 relative to the enrollee;

25 L. "group contract" means a contract for health

1 care services that by its terms limits eligibility to members
2 of a specified group and may include coverage for dependents;

3 M. "group contract holder" means the person to
4 whom a group contract has been issued;

5 N. "health care services" means any services
6 included in the furnishing to any individual of medical,
7 mental, dental, pharmaceutical or optometric care or
8 hospitalization or nursing home care or incident to the
9 furnishing of such care or hospitalization, as well as the
10 furnishing to any person of any and all other services for
11 the purpose of preventing, alleviating, curing or healing
12 human physical or mental illness or injury;

13 O. "health maintenance organization" means a
14 person that undertakes to provide or arrange for the delivery
15 of basic health care services to enrollees on a prepaid
16 basis, except for enrollee responsibility for copayments or
17 deductibles, including a carrier that issues:

18 (1) a short-term contract;

19 (2) an excepted benefit policy or contract
20 intended to supplement major medical coverage, including
21 medicare supplement, vision, dental, disease-specific,
22 accident-only or hospital indemnity-only insurance policies;
23 or

24 (3) a policy for long-term care or
25 disability income;

1 P. "health maintenance organization agent" means a
2 person who solicits, negotiates, effects, procures, delivers,
3 renews or continues a policy or contract for health
4 maintenance organization membership or who takes or transmits
5 a membership fee or premium for such a policy or contract,
6 other than for that person, or a person who advertises or
7 otherwise makes any representation to the public as such;

8 Q. "individual contract" means a contract for
9 health care services issued to and covering an individual and
10 it may include dependents of the subscriber;

11 R. "insolvent" or "insolvency" means that the
12 organization has been declared insolvent and placed under an
13 order of liquidation by a court of competent jurisdiction;

14 S. "managed hospital payment basis" means
15 agreements in which the financial risk is related primarily
16 to the degree of utilization rather than to the cost of
17 services;

18 T. "net worth" means the excess of total admitted
19 assets over total liabilities, but the liabilities shall not
20 include fully subordinated debt;

21 U. "participating provider" means a provider as
22 defined in Subsection Z of this section that, under an
23 express contract with the health maintenance organization or
24 with its contractor or subcontractor, has agreed to provide
25 health care services to enrollees with an expectation of

1 receiving payment, other than copayment or deductible,
2 directly or indirectly from the health maintenance
3 organization;

4 V. "person" means an individual or other legal
5 entity;

6 W. "pharmacist" means a person licensed as a
7 pharmacist pursuant to the Pharmacy Act;

8 X. "pharmacist clinician" means a pharmacist who
9 exercises prescriptive authority pursuant to the Pharmacist
10 Prescriptive Authority Act;

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

20 Z. "provider" means a physician, pharmacist,
21 pharmacist clinician, hospital or other person licensed or
22 otherwise authorized to furnish health care services;

23 AA. "replacement coverage" means the benefits
24 provided by a succeeding carrier;

25 BB. "short-term contract" means a nonrenewable

1 health maintenance organization contract covering a resident
2 of the state, regardless of where the contract is delivered,
3 that:

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

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

12 CC. "subscriber" means an individual whose
13 employment or other status, except family dependency, is the
14 basis for eligibility for enrollment in the health
15 maintenance organization or, in the case of an individual
16 contract, the person in whose name the contract is issued;
17 and

18 DD. "uncovered expenditures" means the costs to
19 the health maintenance organization for health care services
20 that are the obligation of the health maintenance
21 organization, for which an enrollee may also be liable in the
22 event of the health maintenance organization's insolvency and
23 for which no alternative arrangements have been made that are
24 acceptable to the superintendent."

25 SECTION 11. Section 59A-46-51 NMSA 1978 (being Laws

1 2010, Chapter 94, Section 3, as amended) is amended to read:

2 "59A-46-51. HEALTH MAINTENANCE ORGANIZATIONS--DIRECT
3 SERVICES.--

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

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

25 C. A health maintenance organization that fails to

HHHC/HB 285/a
Page 26

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

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

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

24 "59A-46-51. HEALTH MAINTENANCE ORGANIZATIONS--DIRECT
25 SERVICES.--

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

23 B. For individually underwritten health care
24 policies, plans or contracts, the superintendent shall
25 establish, after notice and informal hearing, the level of

1 reimbursement for direct services, as determined by the
2 reports filed with the office of superintendent of insurance,
3 as a percent of premiums. Additional informal hearings may
4 be held at the superintendent's discretion. In establishing
5 the level of reimbursement for direct services, the
6 superintendent shall consider the costs associated with the
7 individual marketing and medical underwriting of these
8 policies, plans or contracts at a level not less than
9 seventy-five percent of premiums. A health insurer or health
10 maintenance organization writing these policies, plans or
11 contracts shall make reimbursement for direct services at a
12 level not less than that level established by the
13 superintendent pursuant to this subsection over the three
14 calendar years preceding the date upon which that rate is
15 established, but not earlier than calendar year 2010.

16 Nothing in this subsection shall be construed to preclude a
17 purchaser of one of these policies, plans or contracts from
18 negotiating an agreement with a health insurer or health
19 maintenance organization that requires a higher amount of
20 premiums paid to be used for reimbursement for direct
21 services.

22 C. A health maintenance organization that fails to
23 comply with the reimbursement requirements pursuant to this
24 section shall issue a dividend or credit against future
25 premiums to all policy or contract holders in an amount

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

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

18 **SECTION 13.** Section 59A-47-3 NMSA 1978 (being Laws
19 1984, Chapter 127, Section 879.1, as amended) is amended to
20 read:

21 "59A-47-3. DEFINITIONS.--As used in Chapter 59A,
22 Article 47 NMSA 1978:

23 A. "acquisition expenses" includes all expenses
24 incurred in connection with the solicitation and enrollment
25 of subscribers;

1 B. "administration expenses" means all expenses of
2 the health care plan other than the cost of health care
3 expense payments and acquisition expenses;

4 C. "agent" means a person appointed by a health
5 care plan authorized to transact business in this state to
6 act as its representative in any given locality for
7 soliciting health care policies and other related duties as
8 may be authorized;

9 D. "chiropractor" means any person holding a
10 license provided for in the Chiropractic Physician Practice
11 Act;

12 E. "credentialing" means the process of obtaining
13 and verifying information about a provider and evaluating
14 that provider when that provider seeks to become a
15 participating provider;

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

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

3 G. "doctor of oriental medicine" means any person
4 licensed as a doctor of oriental medicine under the
5 Acupuncture and Oriental Medicine Practice Act;

6 H. "health care" means the treatment of persons
7 for the prevention, cure or correction of any illness or
8 physical or mental condition, including optometric services;

9 I. "health care expense payment" means a payment
10 for health care to a purveyor on behalf of a subscriber, or
11 such a payment to the subscriber;

12 J. "health care plan" means a nonprofit
13 corporation authorized by the superintendent to enter into
14 contracts with subscribers and to make health care expense
15 payments, including a nonprofit corporation that issues:

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

17 (2) an excepted benefit health care plan
18 intended to supplement major medical coverage, including
19 medicare supplement, vision, dental, disease-specific,
20 accident-only or hospital indemnity-only insurance policies;
21 or

22 (3) a policy or plan for long-term care or
23 disability income;

24 K. "indemnity benefit" means a payment that the
25 purveyor has not agreed to accept as payment in full for

1 health care furnished the subscriber;

2 L. "item of health care" means a service or
3 material used in health care;

4 M. "pharmacist" means a person licensed as a
5 pharmacist pursuant to the Pharmacy Act;

6 N. "pharmacist clinician" means a pharmacist who
7 exercises prescriptive authority pursuant to the Pharmacist
8 Prescriptive Authority Act;

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

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

21 Q. "purveyor" means a person who furnishes any
22 item of health care and charges for that item;

23 R. "service benefit" means a payment that the
24 purveyor has 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
3 state, 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
8 not been enrolled in a health care plan that provides the
9 same or similar nonrenewable coverage from any nonprofit
10 health care plan within the three months preceding enrollment
11 in the 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
17 on a commission basis or salary basis or part by commission
18 and part by salary;

19 U. "subscriber" means any individual who, because
20 of a contract with a health care plan entered into by or for
21 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 V. "underwriting manual" means the health care
25 plan's written criteria, approved by the superintendent, that

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

12 SECTION 14. That version of Section 59A-47-3 NMSA 1978
13 (being Laws 1984, Chapter 127, Section 879.1, as amended)
14 that is to become effective January 1, 2020 is amended to
15 read:

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

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

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

24 C. "agent" means a person appointed by a health
25 care plan authorized to transact business in this state to

1 act as its representative in any given locality for
2 soliciting health care policies and other related duties as
3 may be authorized;

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

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

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

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

1 H. "health care" means the treatment of persons
2 for the prevention, cure or correction of any illness or
3 physical or mental condition, including optometric services;

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

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

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

17 (2) an excepted benefit health care plan
18 intended to supplement major medical coverage, including
19 medicare supplement, vision, dental, disease-specific,
20 accident-only or hospital indemnity-only insurance policies;
21 or

22 (3) a policy or plan for long-term care or
23 disability income;

24 K. "indemnity benefit" means a payment that the
25 purveyor has not agreed to accept as payment in full for

1 health care furnished the subscriber;

2 L. "item of health care" means a service or
3 material used in health care;

4 M. "pharmacist" means a person licensed as a
5 pharmacist pursuant to the Pharmacy Act;

6 N. "pharmacist clinician" means a pharmacist who
7 exercises prescriptive authority pursuant to the Pharmacist
8 Prescriptive Authority Act;

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

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

21 Q. "purveyor" means a person who furnishes any
22 item of health care and charges for that item;

23 R. "service benefit" means a payment that the
24 purveyor has 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
3 state, 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
8 not been enrolled in a health care plan that provides the
9 same or similar nonrenewable coverage from any nonprofit
10 health care plan within the three months preceding enrollment
11 in the 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
17 on a commission basis or salary basis or part by commission
18 and part by salary;

19 U. "subscriber" means any individual who, because
20 of a contract with a health care plan entered into by or for
21 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 V. "underwriting manual" means the health care
25 plan's written criteria, approved by the superintendent, that

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

12 SECTION 15. Section 59A-47-46 NMSA 1978 (being Laws
13 2010, Chapter 94, Section 4, as amended) is amended to read:

14 "59A-47-46. HEALTH INSURERS--DIRECT SERVICES.--

15 A. A health care plan shall make reimbursement for
16 direct services at a level not less than eighty-five percent
17 of premiums across all health product lines, including short-
18 term health care plans and excluding individually
19 underwritten health care policies, contracts or plans, that
20 are governed by the provisions of Chapter 59A, Article 22
21 NMSA 1978, the Health Maintenance Organization Law and the
22 Nonprofit Health Care Plan Law, and an excepted benefit
23 health care plan intended to supplement major medical
24 coverage, including medicare supplement, vision, dental,
25 disease-specific, accident-only or hospital indemnity-only

1 insurance policies, or a health care plan that only issues
2 policies for long-term care or disability income.
3 Reimbursement shall be made for direct services provided over
4 the preceding three calendar years, but not earlier than
5 calendar year 2010, as determined by reports filed with the
6 office of superintendent of insurance. Nothing in this
7 subsection shall be construed to preclude a purchaser from
8 negotiating an agreement with a health insurer that requires
9 a higher amount of premiums paid to be used for reimbursement
10 for direct services for one or more products or for one or
11 more years.

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

1 calendar years preceding the date upon which that rate is
2 established, but not earlier than calendar year 2010.

3 Nothing in this subsection shall be construed to preclude a
4 purchaser of one of these policies, plans or contracts from
5 negotiating an agreement with a health insurer that requires
6 a higher amount of premiums paid to be used for reimbursement
7 for direct services.

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

25 D. After notice and hearing, the superintendent

1 may adopt and promulgate reasonable rules necessary and
2 proper to carry out the provisions of this section."

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

6 "59A-47-46. HEALTH INSURERS--DIRECT SERVICES.--

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

20 Reimbursement shall be made for direct services provided over
21 the preceding three calendar years, but not earlier than
22 calendar year 2010, as determined by reports filed with the
23 office of superintendent of insurance. Nothing in this
24 subsection shall be construed to preclude a purchaser from
25 negotiating an agreement with a health insurer that requires

1 a higher amount of premiums paid to be used for reimbursement
2 for direct services for one or more products or for one or
3 more years.

4 B. For individually underwritten health care
5 policies, plans or contracts, the superintendent shall
6 establish, after notice and informal hearing, the level of
7 reimbursement for direct services as determined as a percent
8 of premiums. Additional hearings may be held at the
9 superintendent's discretion. In establishing the level of
10 reimbursement for direct services, the superintendent shall
11 consider the costs associated with the individual marketing
12 and medical underwriting of these policies, plans or
13 contracts at a level not less than seventy-five percent of
14 premiums. A health insurer writing these policies, plans or
15 contracts shall make reimbursement for direct services at a
16 level not less than that level established by the
17 superintendent pursuant to this subsection over the three
18 calendar years preceding the date upon which that rate is
19 established, but not earlier than calendar year 2010.

20 Nothing in this subsection shall be construed to preclude a
21 purchaser of one of these policies, plans or contracts from
22 negotiating an agreement with a health insurer that requires
23 a higher amount of premiums paid to be used for reimbursement
24 for direct services.

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

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

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