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SENATE BILL

51ST LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2013

INTRODUCED BY

DISCUSSION DRAFT

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH COVERAGE; AMENDING AND ENACTING SECTIONS OF
THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE
ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO
PROHIBIT LIFETIME OR ANNUAL LIMITS; PROVIDING FOR GUARANTEED
ISSUE; BANNING PREEEXISTING CONDITION EXCLUSIONS AND EXCESSIVE
WAITING PERIODS; PROHIBITING RESCISSIONS OF COVERAGE EXCEPT IN
CASES OF FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL
FACT; MANDATING COVERAGE FOR INDIVIDUALS UNDER THE AGE OF
TWENTY-SIX WHO SEEK COVERAGE UNDER THEIR PARENTS' COVERAGE;
REQUIRING THAT INSURERS MAKE REBATES TO CONSUMERS WHEN
ADMINISTRATIVE LOSSES EXCEED THE STATUTORY MAXIMUM; PROHIBITING
LIFETIME OR ANNUAL LIMITS; PROVIDING FOR SMOKING AND TOBACCO
CESSATION COVERAGE; ALIGNING COVERAGE FOR IMMUNIZATIONS,
COLORECTAL CANCER SCREENINGS AND CYTOLOGIC AND HUMAN
PAPILLOMAVIRUS SCREENINGS WITH FEDERAL GUIDELINES; PROVIDING

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1 FOR ALCOHOL DEPENDENCY AND MISUSE COVERAGE; PROHIBITING
2 PREEXISTING CONDITION EXCLUSIONS FOR INDIVIDUALS UNDER THE AGE
3 OF NINETEEN; PROHIBITING EMPLOYER-SPONSORED PLANS FROM
4 DISCRIMINATING IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS;
5 PROVIDING FOR APPLICABILITY TO "GRANDFATHERED" HEALTH PLAN
6 COVERAGE; REQUIRING EMERGENCY SERVICES COVERAGE; PROVIDING FOR
7 EXTENDED HEALTH COVERAGE FOR DISABLED CHILDREN; PROVIDING FOR
8 OBSTETRICAL AND GYNECOLOGICAL PRIMARY CARE AND PEDIATRIC
9 PRIMARY CARE; REQUIRING COVERAGE OF CERTAIN PREVENTIVE ITEMS
10 AND SERVICES WITHOUT COST-SHARING; PROVIDING FOR RULEMAKING;
11 AMENDING SECTIONS OF THE HEALTH CARE PURCHASING ACT AND THE
12 MEDICAL CARE SAVINGS ACCOUNT ACT TO PROVIDE FOR DEPENDENT
13 COVERAGE UNTIL THE AGE OF TWENTY-SIX; AMENDING A SECTION OF THE
14 SMALL GROUP RATE AND RENEWABILITY ACT TO PROVIDE FOR
15 RENEWABILITY OF COVERAGE, TO LIMIT ADJUSTED COMMUNITY RATING
16 AND ADMINISTRATIVE LOSS RATIOS AND TO BAN PREEXISTING
17 CONDITIONS EXCLUSIONS; PROVIDING FOR THE EXPULSION OR
18 SUSPENSION OF FRATERNAL BENEFIT SOCIETY MEMBERSHIP FOR FRAUD OR
19 INTENTIONAL MISREPRESENTATION OF MATERIAL FACT; PROVIDING FOR
20 RESCISSION OR BREACH OF NONPROFIT HEALTH CARE PLAN SUBSCRIBER
21 CONTRACTS IN CASES OF FRAUD OR INTENTIONALLY MISLEADING
22 REPRESENTATIONS OF MATERIAL FACT; AMENDING THE HEALTH INSURANCE
23 PORTABILITY ACT TO PROVIDE FOR RENEWABILITY OF COVERAGE;
24 AMENDING A SECTION OF THE HEALTH INSURANCE ALLIANCE ACT TO
25 REQUIRE GUARANTEED ISSUE AND RENEWABILITY AND SPECIAL

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1 ENROLLMENT; AMENDING SECTIONS OF THE PATIENT PROTECTION ACT TO
2 EXTEND ITS PROVISIONS TO ALL HEALTH INSURANCE AND HEALTH CARE
3 PLANS IN THE STATE; PROVIDING FOR INTERNAL GRIEVANCE
4 PROCEDURES; PROVIDING FOR FORMAL HEARINGS ON VIOLATIONS OF THE
5 PATIENT PROTECTION ACT.

6
7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

8 SECTION 1. Section 13-7-8 NMSA 1978 (being Laws 2003,
9 Chapter 391, Section 2) is amended to read:

10 "13-7-8. MAXIMUM AGE OF ~~[DEPENDENT]~~ CHILD.--Any group
11 health care coverage, including any form of self-insurance,
12 offered, issued or renewed under the Health Care Purchasing Act
13 on or after July 1, 2003 that offers coverage of an insured's
14 ~~[dependent]~~ child shall not terminate coverage of ~~[an unmarried~~
15 ~~dependent]~~ a child by reason of the ~~[dependent's]~~ child's age
16 before the ~~[dependent's twenty-fifth]~~ child's twenty-sixth
17 birthday ~~[regardless of whether the dependent is enrolled in an~~
18 ~~educational institution]."~~

19 SECTION 2. Section 59A-18-13.1 NMSA 1978 (being Laws
20 1994, Chapter 75, Section 26, as amended) is amended to read:

21 "59A-18-13.1. ADJUSTED COMMUNITY RATING.--

22 A. Every insurer, fraternal benefit society, health
23 maintenance organization or nonprofit health care plan that
24 provides primary health insurance or health care coverage
25 insuring or covering major medical expenses shall, in

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1 determining the initial year's premium charged for an
2 individual, use only the rating factors of age, [~~gender~~
3 ~~pursuant to Subsection B of this section~~] geographic area of
4 the place of employment and smoking practices, except that for
5 individual policies the rating factor of the individual's place
6 of residence may be used instead of the geographic area of the
7 individual's place of employment.

8 B. In determining the initial and any subsequent
9 year's rate, [~~the difference in rates in any one age group that~~
10 ~~may be charged on the basis of a person's gender shall not~~
11 ~~exceed another person's rates in the age group by more than the~~
12 ~~following percentage of the lower rate for policies issued or~~
13 ~~delivered in the respective year; provided, however, that~~
14 ~~gender shall not be used as a rating factor for policies issued~~
15 ~~or delivered on or after January 1, 2014:~~

- 16 (1) ~~twenty percent for calendar year 2010;~~
17 (2) ~~fifteen percent for calendar year 2011;~~
18 (3) ~~ten percent for calendar year 2012; and~~
19 (4) ~~five percent for calendar year 2013.~~

20 ~~G.~~] no person's rate shall exceed the rate of any
21 other person [~~with similar family composition~~] on the basis of
22 age by more than two hundred fifty percent of the lower rate,
23 except that the rates for children under the age of nineteen or
24 children aged nineteen to twenty-five who are full-time
25 students may be as much as three hundred percent lower than the

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1 [bottom] highest age-based rates [~~in the two hundred fifty~~
2 ~~percent band. The rating factor restrictions shall not~~
3 ~~prohibit an insurer, fraternal benefit society, health~~
4 ~~maintenance organization or nonprofit health care plan from~~
5 ~~offering rates that differ depending upon family composition].~~

6 C. No person's rate shall exceed the rate of any
7 other person on the basis of geographic rating area by an
8 amount that the superintendent shall establish by rule, after
9 review by the United States department of health and human
10 services.

11 D. The rate difference between any one person who
12 smokes and any person who does not use tobacco shall not differ
13 by more than one hundred fifty percent.

14 [~~D.~~] E. The provisions of this section do not
15 preclude an insurer, fraternal benefit society, health
16 maintenance organization or nonprofit health care plan from
17 using health status or occupational or industry classification
18 in establishing:

- 19 (1) rates for individual policies; or
20 (2) the amount an employer may be charged for
21 coverage under the group health plan.

22 [~~E. As used in Subsection D of this section,~~
23 ~~"health status" does not include genetic information.]~~

24 F. The superintendent shall adopt regulations to
25 implement the provisions of this section."

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1 SECTION 3. A new section of Chapter 59A, Article 18 NMSA
2 1978 is enacted to read:

3 "[NEW MATERIAL] UNIFORM HEALTH COVERAGE DOCUMENTS--
4 STANDARDIZED DEFINITIONS.--

5 A. A health maintenance organization that offers an
6 individual or group health care policy, plan, evidence of
7 coverage or certificate of insurance in the state shall comply
8 with the standards established by the superintendent by rule
9 for the following documents issued by each policy, plan,
10 evidence of coverage or certificate issued in the state
11 relating to:

- 12 (1) a summary of benefits;
- 13 (2) an explanation of coverage;
- 14 (3) definitions of standard insurance terms
15 and medical terms;
- 16 (4) exceptions, reductions and limitations on
17 coverage;
- 18 (5) cost-sharing provisions, including
19 deductible, coinsurance and copayment obligations;
- 20 (6) the renewability and continuation of
21 coverage provisions;
- 22 (7) a coverage facts disclosure that includes
23 examples that are based on nationally recognized clinical
24 practice guidelines to illustrate common benefits scenarios,
25 including pregnancy and serious or chronic medical conditions

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1 and related cost-sharing;

2 (8) a statement that the policy, plan,
3 evidence of coverage or certificate:

4 (a) provides minimum essential coverage,
5 as defined under Section 5000A(f) of the federal Internal
6 Revenue Code of 1986; and

7 (b) ensures that the policy's, plan's,
8 evidence's or certificate's share of the total allowed costs of
9 benefits provided under the policy, plan, evidence of coverage
10 or certificate is not less than sixty percent of those costs;
11 and

12 (9) a contact number for the consumer to call
13 with additional questions and an internet web address where a
14 copy of the actual health care policy, plan, evidence or
15 certificate can be reviewed and obtained.

16 B. Prior to any enrollment restriction, an insurer,
17 health maintenance organization or nonprofit health care plan
18 shall provide a summary of benefits and coverage explanation
19 required pursuant to Subsection A of this section to the
20 following persons:

21 (1) an applicant, at the time of application;
22 (2) an enrollee or subscriber, prior to the
23 time of enrollment or re-enrollment, subscription or re-
24 subscription; and

25 (3) a policyholder, plan holder, evidence of

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1 coverage holder, enrollee, subscriber or certificate holder, at
2 the time of issuance of the policy, plan or evidence of
3 coverage or the delivery of the certificate."

4 SECTION 4. Section 59A-22-2 NMSA 1978 (being Laws 1984,
5 Chapter 127, Section 423) is amended to read:

6 "59A-22-2. FORM AND CONTENT OF POLICY.--

7 A. No policy of individual health insurance shall
8 be delivered or issued for delivery in this state unless the
9 policy sets forth:

- 10 (1) a summary of benefits;
- 11 (2) an explanation of coverage;
- 12 (3) definitions of standard insurance terms
13 and medical terms;
- 14 (4) exceptions, reductions of indemnity and
15 limitations on coverage;
- 16 (5) cost-sharing provisions, including
17 deductible, coinsurance and copayment obligation provisions;
- 18 (6) renewability and continuation of coverage
19 provisions;
- 20 (7) a coverage facts disclosure that includes
21 examples that are based on nationally recognized clinical
22 practice guidelines to illustrate common benefits scenarios,
23 including pregnancy and serious or chronic medical conditions
24 and related cost-sharing;
- 25 (8) a statement of whether the policy:

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1 (a) provides minimum essential coverage,
2 as defined under Section 5000A(f) of the federal Internal
3 Revenue Code of 1986; and

4 (b) ensures that the plan or policy's
5 share of the total allowed costs of benefits provided under the
6 policy is not less than sixty percent of those costs; and

7 (9) a contact number for the consumer to call
8 with additional questions and an internet web address where a
9 copy of the actual individual health coverage policy can be
10 reviewed and obtained.

11 B. Prior to any enrollment restriction, an insurer
12 shall provide a summary of benefits and coverage explanation
13 required pursuant to Subsection A of this section to the
14 following persons:

15 (1) an applicant, at the time of application;

16 (2) an enrollee or subscriber, prior to the
17 time of enrollment or re-enrollment, subscription or re-
18 subscription; and

19 (3) a policyholder at the time of issuance of
20 the policy.

21 C. No policy or contract of individual health
22 insurance shall be delivered or issued for delivery in this
23 state unless:

24 ~~[A.]~~ (1) the entire money and other
25 considerations therefor are expressed therein; ~~and~~

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1 B.] (2) the time at which insurance takes
2 effect and terminates is expressed therein; ~~and~~

3 C.] (3) it purports to insure only one person,
4 except as provided in Chapter 59A, Article 23 ~~[of the Insurance~~
5 ~~Code]~~ NMSA 1978, and except that a policy or contract may be
6 issued upon application of the head of a family, who shall be
7 deemed the policyholder, covering members of any one family,
8 including husband, wife, ~~[dependent]~~ children ~~[or any children]~~
9 under the age of ~~[nineteen (19)]~~ twenty-six and ~~[other]~~ any
10 dependents living with the family; ~~and~~

11 D.] (4) every printed portion of the text
12 matter and of any endorsements or attached papers shall be
13 printed in uniform type of which the face shall be not less
14 than ten ~~[(10)]~~ point; provided that the "text" shall include
15 all printed matter except the name and address of the insurer,
16 name and title of the policy, captions, subcaptions and form
17 numbers; ~~[but]~~ and provided further that, notwithstanding any
18 provision of this law, the superintendent shall not disapprove
19 any such policy on the ground that every printed portion of its
20 text matter or of any endorsement or attached paper is not
21 printed in uniform type if it shall be shown that the type used
22 is required to conform to the laws of another state in which
23 the insurer is authorized; ~~and~~

24 ~~E. the exceptions and reductions of indemnity are~~
25 ~~adequately captioned and clearly set forth in the policy or~~

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1 ~~contract; and~~

2 ~~F.]~~ (5) each [~~such~~] form, including riders and
3 endorsements, shall be identified by a form number in the lower
4 left-hand corner of the first page thereof; and

5 [~~G.]~~ (6) if any policy is issued by an insurer
6 domiciled in this state for delivery to a person residing in
7 another state, and if the official having responsibility for
8 the administration of insurance laws of such other state shall
9 have advised the superintendent that any such policy is not
10 subject to approval or disapproval by such official, the
11 superintendent may by ruling require that such policy meet the
12 standards set forth in Sections [~~424 through 446 of this~~
13 ~~article~~] 59A-22-3 through 59A-22-25 NMSA 1978."

14 SECTION 5. Section 59A-22-5 NMSA 1978 (being Laws 1984,
15 Chapter 127, Section 426, as amended) is amended to read:

16 "59A-22-5. TIME LIMIT ON CERTAIN DEFENSES.--

17 A. There shall be a provision for individual and
18 group comprehensive major medical policies and plans as
19 follows: As of the date of issue of this policy [~~no~~
20 ~~misstatements, except willful or fraudulent misstatements, made~~
21 ~~by the applicant in the application for this policy, shall be~~
22 ~~used to void the~~] or plan, a policy or [to deny] plan shall not
23 be rescinded, nor shall a claim for loss incurred or disability
24 [~~as defined in the policy~~] be denied, except when a covered
25 individual:

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1 (1) engages in conduct that constitutes fraud;

2 or

3 (2) makes an intentional misrepresentation of
4 material fact that is prohibited by the terms of the policy or
5 plan.

6 B. In the event [~~a misstatement in an application~~
7 ~~is made that is not fraudulent or willful~~] a misrepresentation
8 of a material fact that is not intentional is made in an
9 application, the issuer of the policy or plan may prospectively
10 rate and collect from the insured the premium that would have
11 been charged to the insured at the time the policy or plan was
12 issued had [~~such misstatement~~] the misrepresentation not been
13 made.

14 ~~[B. There shall be a provision for policies other~~
15 ~~than comprehensive major medical policies as follows: After~~
16 ~~two years from the date of issue of this policy, no~~
17 ~~misstatements, except fraudulent misstatements, made by the~~
18 ~~applicant in the application for this policy shall be used to~~
19 ~~void the policy or to deny a claim for loss incurred or~~
20 ~~disability, as defined in the policy, commencing after the~~
21 ~~expiration of such two-year period.]~~

22 C. The foregoing policy and plan provisions shall
23 not be so construed as to affect any initial two-year period
24 nor to limit the application of Sections 59A-22-17 through
25 59A-22-19, 59A-22-21 and 59A-22-22 NMSA 1978 in the event of

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1 misstatement with respect to age or occupation or other
2 insurance.

3 ~~[D. A policy that the insured has the right to~~
4 ~~continue in force subject to its terms by the timely payment of~~
5 ~~premium:~~

6 ~~(1) until at least age fifty; or~~

7 ~~(2) in the case of a policy issued after age~~
8 ~~forty-four, for at least five years from its date of issue, may~~
9 ~~contain in lieu of the foregoing the following provision, from~~
10 ~~which the clause in parentheses may be omitted at the insurance~~
11 ~~company's option, under the caption "Incontestable". After~~
12 ~~this policy has been in force for a period of two years during~~
13 ~~the lifetime of the insured, excluding any period during which~~
14 ~~the insured is disabled, it shall become incontestable as to~~
15 ~~the statements contained in the application.~~

16 ~~E. For individual policies that do not reimburse or~~
17 ~~pay as a result of hospitalization, medical or surgical~~
18 ~~expenses, no claim for loss incurred or disability (as defined~~
19 ~~in the policy) shall be reduced or denied on the ground that a~~
20 ~~disease or physical condition disclosed on the application and~~
21 ~~not excluded from coverage by name or a specific description~~
22 ~~effective on the date of loss had existed prior to the~~
23 ~~effective date of coverage of this policy. As an alternative,~~
24 ~~those policies may contain provisions under which coverage may~~
25 ~~be excluded for a period of six months following the effective~~

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1 ~~date of coverage as to a given covered insured for a~~
2 ~~preexisting condition, provided that:~~

3 ~~(1) the condition manifested itself within a~~
4 ~~period of six months prior to the effective date of coverage in~~
5 ~~a manner that would cause a reasonably prudent person to seek~~
6 ~~diagnosis, care or treatment; or~~

7 ~~(2) medical advice or treatment relating to~~
8 ~~the condition was recommended or received within a period of~~
9 ~~six months prior to the effective date of coverage.~~

10 ~~F. Individual policies that reimburse or pay as a~~
11 ~~result of hospitalization, medical or surgical expenses may~~
12 ~~contain provisions under which coverage is excluded during a~~
13 ~~period of six months following the effective date of coverage~~
14 ~~as to a given covered insured for a preexisting condition,~~
15 ~~provided that:~~

16 ~~(1) the condition manifested itself within a~~
17 ~~period of six months prior to the effective date of coverage in~~
18 ~~a manner that would cause a reasonably prudent person to seek~~
19 ~~diagnosis, care or treatment; or~~

20 ~~(2) medical advice or treatment relating to~~
21 ~~the condition was recommended or received within a period of~~
22 ~~six months prior to the effective date of coverage.~~

23 ~~G. The preexisting condition exclusions authorized~~
24 ~~in Subsections E and F of this section shall be waived to the~~
25 ~~extent that similar conditions have been satisfied under any~~

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1 ~~prior health insurance coverage if the application for new~~
2 ~~coverage is made not later than thirty-one days following the~~
3 ~~termination of prior coverage. In that case, the new coverage~~
4 ~~shall be effective from the date on which the prior coverage~~
5 ~~terminated.~~

6 ~~H. Nothing in this section shall be construed to~~
7 ~~require the use of preexisting conditions or prohibit the use~~
8 ~~of preexisting conditions that are more favorable to the~~
9 ~~insured than those specified in this section.]"~~

10 SECTION 6. Section 59A-22-6 NMSA 1978 (being Laws 1984,
11 Chapter 127, Section 427) is amended to read:

12 "59A-22-6. GRACE PERIOD.--There shall be a provision as
13 follows:

14 A grace period of..... (insert a number not
15 less than "7" for weekly premium policies, "10" for
16 monthly premium policies and "31" for all other
17 policies) days will be granted for the payment of
18 each premium falling due after the first premium,
19 during which grace period the policy shall continue
20 in force.

21 ~~[A policy in which the insurer reserves the right to~~
22 ~~refuse any renewal shall have, at the beginning of the above~~
23 ~~provision, "Unless not less than five days prior to the premium~~
24 ~~due date the insurance company has delivered to the insured or~~
25 ~~has mailed to his last address as shown by the records of the~~

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1 ~~insurer written notice of its intention not to renew this~~
2 ~~policy beyond the period for which the premium has been~~
3 ~~accepted.".]"~~

4 SECTION 7. Section 59A-22-30.1 NMSA 1978 (being Laws
5 2005, Chapter 41, Section 1) is amended to read:

6 "59A-22-30.1. MAXIMUM AGE OF ~~[DEPENDENT]~~ CHILD.--An
7 individual or group health plan, policy or certificate of
8 insurance delivered, issued for delivery or renewed in New
9 Mexico that provides coverage for an insured's ~~[dependent]~~
10 child shall not terminate coverage of ~~[an unmarried dependent]~~
11 a child by reason of the ~~[dependent's]~~ child's age before the
12 ~~[dependent's twenty-fifth]~~ child's twenty-sixth birthday
13 ~~[regardless of whether the dependent is enrolled in an~~
14 ~~educational institution]."~~

15 SECTION 8. Section 59A-22-33 NMSA 1978 (being Laws 1984,
16 Chapter 127, Section 455) is amended to read:

17 "59A-22-33. ~~[HANDICAPPED]~~ DISABLED CHILDREN--COVERAGE
18 CONTINUED.--

19 A. An individual or group hospital or medical
20 expense insurance policy or plan delivered or issued for
21 delivery in this state ~~[which]~~ that provides that coverage of a
22 ~~[dependent]~~ child of an insured, or of an employee or other
23 member of the covered group, shall terminate upon attainment of
24 the limiting age for ~~[dependent]~~ children specified in the
25 policy or plan shall also provide, in substance, that

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1 attainment of the limiting age shall not operate to terminate
2 the coverage of a child while the child is, and continues to
3 be, both incapable of self-sustaining employment, by reason of
4 [~~mental retardation~~] cognitive or physical [~~handicap~~]
5 disability, and chiefly dependent upon the policyholder or plan
6 holder for support and maintenance. However, proof of the
7 incapacity and dependency of the child must be furnished to the
8 insurer by the insured employee or member within thirty-one
9 [~~(31)~~] days of the child's attainment of the limiting age and
10 subsequently, as may be required by the insurer, but not more
11 frequently than annually after the two-year period following
12 the child's attainment of the limiting age.

13 B. No limiting age shall be set before age twenty-
14 six."

15 **SECTION 9.** Section 59A-22-34.2 NMSA 1978 (being Laws
16 1994, Chapter 64, Section 2, as amended) is amended to read:

17 "59A-22-34.2. COVERAGE OF CHILDREN.--

18 A. An insurer shall not deny enrollment of a child
19 under the health plan or policy of the child's parent on the
20 grounds that the child:

- 21 (1) was born out of wedlock;
22 (2) is not claimed as a dependent on the
23 parent's federal tax return; or
24 (3) does not reside with the parent or in the
25 insurer's service area.

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1 B. When a child has health coverage through an
2 insurer of a noncustodial parent, the insurer shall:

3 (1) provide such information to the custodial
4 parent as may be necessary for the child to obtain benefits
5 through that coverage;

6 (2) permit the custodial parent or the
7 provider, with the custodial parent's approval, to submit
8 claims for covered services without the approval of the
9 noncustodial parent; and

10 (3) make payments on claims submitted in
11 accordance with Paragraph (2) of this subsection directly to
12 the custodial parent, the provider or the state medicaid
13 agency.

14 C. When a parent is required by a court or
15 administrative order to provide health coverage for a child and
16 the parent is eligible for family health coverage, the insurer
17 shall be required:

18 (1) to permit the parent to enroll, under the
19 family coverage, a child who is otherwise eligible for the
20 coverage without regard to any enrollment season restrictions;

21 (2) if the parent is enrolled but fails to
22 make application to obtain coverage for the child, to enroll
23 the child under family coverage upon application of the child's
24 other parent, the state agency administering the medicaid
25 program or the state agency administering 42 U.S.C. Sections

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1 651 through 669, the child support enforcement program; and

2 (3) not to disenroll or eliminate coverage of
3 the child unless the insurer is provided satisfactory written
4 evidence that:

5 (a) the court or administrative order is
6 no longer in effect; or

7 (b) the child is or will be enrolled in
8 comparable health coverage through another insurer that will
9 take effect not later than the effective date of disenrollment.

10 D. An insurer shall not impose requirements on a
11 state agency that has been assigned the rights of an individual
12 eligible for medical assistance under the medicaid program and
13 covered for health benefits from the insurer that are different
14 from requirements applicable to an agent or assignee of any
15 other individual so covered.

16 E. An insurer shall provide coverage for children,
17 from birth through three years of age, for or under the family,
18 infant, toddler program administered by the department of
19 health; provided that eligibility criteria are met [~~for a~~
20 ~~maximum benefit of three thousand five hundred dollars (\$3,500)~~
21 ~~annually~~] for medically necessary early intervention services
22 provided as part of an individualized family service plan and
23 delivered by certified and licensed personnel as defined in
24 7.30.8 NMAC who are working in early intervention programs
25 approved by the department of health. [~~No payment under this~~

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1 ~~subsection shall be applied against any maximum lifetime or~~
2 ~~annual limits specified in the policy, health benefits plan or~~
3 ~~contract.]"~~

4 SECTION 10. A new section of Chapter 59A, Article 22 NMSA
5 1978 is enacted to read:

6 "[NEW MATERIAL] ALCOHOL DEPENDENCY AND MISUSE COVERAGE.--

7 A. Each insurer that delivers or issues for
8 delivery in this state a group health insurance policy shall
9 offer and make available benefits for the necessary care and
10 treatment of alcohol dependency and misuse. These benefits
11 shall provide necessary care and treatment in an alcohol
12 dependency and misuse treatment center and outpatient visits
13 for alcohol dependency and misuse treatment.

14 B. For purposes of this section, "alcohol
15 dependency and misuse treatment center" means a facility that
16 provides a program for the treatment of alcohol dependency and
17 misuse pursuant to a written treatment plan approved and
18 monitored by a physician or meeting the quality standards of
19 the behavioral health services division of the human services
20 department and which facility also:

21 (1) is affiliated with a hospital under a
22 contractual agreement with an established system for patient
23 referral;

24 (2) is accredited as such a facility by the
25 joint commission; or

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1 (3) meets at least the minimum standards
2 adopted by the behavioral health services division for
3 treatment of alcohol dependency and misuse in regional
4 treatment centers.

5 C. This section applies to policies delivered or
6 issued for delivery or renewed, extended or amended in this
7 state on or after July 1, 1983 or upon expiration of a
8 collective bargaining agreement applicable to a particular
9 policyholder, whichever is later; provided that this section
10 does not apply to blanket, short-term travel, accident-only,
11 limited or specified disease or individual conversion policies
12 or policies designed for issuance to persons eligible for
13 coverage under Title 18 of the federal Social Security Act,
14 known as medicare, or any other similar coverage under state or
15 federal governmental plans. With respect to any policy forms
16 approved by the insurance division of the commission prior to
17 the effective date of this section, an insurer is authorized to
18 comply with this section by the use of endorsements or riders;
19 provided that such endorsements or riders are approved by the
20 insurance division as being in compliance with this section and
21 applicable provisions of the Insurance Code.

22 D. If an organization offering group health
23 benefits to its members makes more than one health insurance
24 policy or nonprofit health care plan available to its members
25 on a member option basis, the organization shall not require

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1 alcohol dependency and misuse coverage from one health insurer
2 or health care plan without requiring the same level of alcohol
3 dependency and misuse coverage for all other health insurance
4 policies or health care plans that the organization makes
5 available to its members."

6 SECTION 11. Section 59A-22-34.3 NMSA 1978 (being Laws
7 1997, Chapter 250, Section 1) is amended to read:

8 "59A-22-34.3. CHILDHOOD IMMUNIZATION COVERAGE REQUIRED.--

9 A. Each individual and group health insurance
10 policy, health care plan and certificate of health insurance
11 delivered or issued for delivery in this state shall provide
12 coverage for childhood immunizations, as well as coverage for
13 medically necessary booster doses of all immunizing agents used
14 in child immunizations, in accordance with the current schedule
15 of immunizations recommended by the American academy of
16 pediatrics or the advisory committee on immunization practices
17 of the federal centers for disease control and prevention,
18 whichever provides greater coverage.

19 B. The provisions of this section shall not apply
20 to short-term travel, accident-only or limited or specified
21 disease policies.

22 [~~G. Coverage for childhood immunizations and
23 necessary booster doses may be subject to deductibles and co-
24 insurance consistent with those imposed on other benefits under
25 the same policy, plan or certificate.]~~"]

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1 SECTION 12. Section 59A-22-40 NMSA 1978 (being Laws 1992,
2 Chapter 56, Section 2, as amended) is amended to read:

3 "59A-22-40. COVERAGE FOR CYTOLOGIC AND HUMAN
4 PAPILOMAVIRUS SCREENING.--

5 A. Each individual and group health insurance
6 policy, health care plan and certificate of health insurance
7 delivered or issued for delivery in this state shall provide
8 coverage for cytologic and human papillomavirus screening for
9 determining the presence of precancerous or cancerous
10 conditions and other health problems. The coverage shall make
11 available cytologic screening, as determined by the health care
12 provider in accordance with national medical standards and
13 United States preventive services task force "A"-rated and "B"-
14 rated recommendations, whichever provides greater coverage, for
15 women who are eighteen years of age or older and for women who
16 are at risk of cancer or at risk of other health conditions
17 that can be identified through cytologic screening. The
18 coverage shall make available human papillomavirus screening
19 once every three years for women aged thirty and older.

20 B. Coverage for cytologic and human papillomavirus
21 screening may be subject to deductibles and coinsurance
22 consistent with those imposed on other benefits under the same
23 policy, plan or certificate.

24 C. The provisions of this section shall not apply
25 to short-term travel, accident-only or limited or specified-

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1 disease policies or plans.

2 D. For the purposes of this section:

3 (1) "cytologic screening" means a Papanicolaou
4 test and a pelvic exam for asymptomatic as well as symptomatic
5 women;

6 (2) "health care provider" means any person
7 licensed within the scope of [~~his~~] the person's practice to
8 perform cytologic and human papillomavirus screening, including
9 physicians, physician assistants, certified nurse-midwives and
10 certified nurse practitioners; and

11 (3) "human papillomavirus screening" means a
12 test approved by the federal food and drug administration for
13 detection of the human papillomavirus."

14 SECTION 13. Section 59A-22-44 NMSA 1978 (being Laws 2003,
15 Chapter 337, Section 1) is amended to read:

16 "59A-22-44. COVERAGE FOR SMOKING CESSATION TREATMENT.--

17 A. An individual or group health insurance policy,
18 health care plan or certificate of health insurance that is
19 delivered or issued for delivery in this state and that offers
20 maternity benefits shall offer coverage for smoking cessation
21 treatment and shall offer augmented counseling tailored to
22 pregnant women who smoke.

23 [~~B. Coverage for smoking cessation treatment may be~~
24 ~~subject to deductibles and coinsurance consistent with those~~
25 ~~imposed on other benefits under the same policy, plan or~~

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1 ~~certificate.]~~

2 B. An individual or group health insurance policy,
3 health care plan or certificate of health insurance that is
4 delivered or issued for delivery in this state shall:

5 (1) offer tobacco cessation intervention
6 coverage for those who use tobacco products;

7 (2) provide for screening of pregnant women
8 for tobacco use in accordance with the United States preventive
9 services task force guidelines; and

10 (3) provide diagnostic, therapy and counseling
11 services and pharmacotherapy, including the coverage of
12 prescription and nonprescription tobacco cessation agents
13 approved by the federal food and drug administration for
14 cessation of tobacco use by pregnant women.

15 C. The provisions of this section shall not apply
16 to short-term travel, accident-only or limited or specified-
17 disease policies or plans."

18 SECTION 14. Section 59A-22-47 NMSA 1978 (being Laws 2007,
19 Chapter 17, Section 1) is amended to read:

20 "59A-22-47. COVERAGE OF COLORECTAL CANCER SCREENING.--

21 A. An individual or group health insurance policy,
22 health care plan and certificate of health insurance that is
23 delivered, issued for delivery or renewed in this state shall
24 provide coverage for colorectal screening for determining the
25 presence of precancerous or cancerous conditions and other

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1 health problems. The coverage shall make available colorectal
2 cancer screening, as determined by the health care provider in
3 accordance with ~~[the evidence-based recommendations established~~
4 ~~by]~~ practices that have, in effect, a rating of "A" or "B" in
5 the current recommendations of the United States preventive
6 services task force.

7 ~~[B. Coverage for colorectal screening may be~~
8 ~~subject to deductibles and coinsurance consistent with those~~
9 ~~imposed on other benefits under the same policy, plan or~~
10 ~~certificate.~~

11 ~~G.]~~ B. The provisions of this section shall not
12 apply to short-term travel, accident-only or limited or
13 specified-disease policies or plans."

14 SECTION 15. Section 59A-22-49 NMSA 1978 (being Laws 2009,
15 Chapter 74, Section 1) is amended to read:

16 "59A-22-49. COVERAGE FOR AUTISM SPECTRUM DISORDER
17 DIAGNOSIS AND TREATMENT.--

18 A. An individual or group health insurance policy,
19 health care plan or certificate of health insurance that is
20 delivered, issued for delivery or renewed in this state shall
21 provide coverage to an eligible individual who is nineteen
22 years of age or younger or an eligible individual who is
23 twenty-two years of age or younger and is enrolled in high
24 school for:

25 (1) well-baby and well-child screening for

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1 diagnosing the presence of autism spectrum disorder; and

2 (2) treatment of autism spectrum disorder
3 through speech therapy, occupational therapy, physical therapy
4 and applied behavioral analysis.

5 B. Coverage required pursuant to Subsection A of
6 this section:

7 (1) shall be limited to treatment that is
8 prescribed by the insured's treating physician in accordance
9 with a treatment plan;

10 ~~[(2) shall be limited to thirty-six thousand~~
11 ~~dollars (\$36,000) annually and shall not exceed two hundred~~
12 ~~thousand dollars (\$200,000) in total lifetime benefits.~~

13 ~~Beginning January 1, 2011, the maximum benefit shall be~~
14 ~~adjusted annually on January 1 to reflect any change from the~~
15 ~~previous year in the medical component of the then-current~~
16 ~~consumer price index for all urban consumers published by the~~
17 ~~bureau of labor statistics of the United States department of~~
18 ~~labor;~~

19 ~~(3)]~~ (2) shall not be denied on the basis that
20 the services are habilitative or rehabilitative in nature;

21 ~~[(4)]~~ (3) may be subject to other general
22 exclusions and limitations of the insurer's policy or plan,
23 including, but not limited to, coordination of benefits,
24 participating provider requirements, restrictions on services
25 provided by family or household members and utilization review

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1 of health care services, including the review of medical
2 necessity, case management and other managed care provisions;
3 and

4 [~~(5)~~] (4) may be limited to exclude coverage
5 for services received under the federal Individuals with
6 Disabilities Education Improvement Act of 2004 and related
7 state laws that place responsibility on state and local school
8 boards for providing specialized education and related services
9 to children three to twenty-two years of age who have autism
10 spectrum disorder.

11 C. The coverage required pursuant to Subsection A
12 of this section shall not be subject to dollar limits,
13 deductibles or coinsurance provisions that are less favorable
14 to an insured than the dollar limits, deductibles or
15 coinsurance provisions that apply to physical illnesses that
16 are generally covered under the individual or group health
17 insurance policy, health care plan or certificate of health
18 insurance, except as otherwise provided in Subsection B of this
19 section.

20 D. An insurer shall not deny or refuse to issue
21 health insurance coverage for medically necessary services or
22 refuse to contract with, renew, reissue or otherwise terminate
23 or restrict health insurance coverage for an individual because
24 the individual is diagnosed as having autism spectrum disorder.

25 E. The treatment plan required pursuant to

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1 Subsection B of this section shall include all elements
2 necessary for the health insurance policy or plan to pay claims
3 appropriately. These elements include, but are not limited to:

- 4 (1) the diagnosis;
5 (2) the proposed treatment by types;
6 (3) the frequency and duration of treatment;
7 (4) the anticipated outcomes stated as goals;
8 (5) the frequency with which the treatment
9 plan will be updated; and
10 (6) the signature of the treating physician.

11 F. This section shall not be construed as limiting
12 benefits and coverage otherwise available to an insured under a
13 health insurance policy or plan.

14 G. The provisions of this section shall not apply
15 to policies or plans intended to supplement major medical
16 group-type coverages such as medicare supplement, long-term
17 care, disability income, specified disease, accident-only,
18 hospital indemnity, other limited-benefit health insurance
19 policies or plans.

20 H. As used in this section:

- 21 (1) "autism spectrum disorder" means a
22 condition that meets the diagnostic criteria for the pervasive
23 developmental disorders published in the *Diagnostic and*
24 *Statistical Manual of Mental Disorders*, fourth edition, text
25 revision, also known as DSM-IV-TR, published by the American

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1 psychiatric association, including autistic disorder;
2 Asperger's disorder; pervasive development disorder not
3 otherwise specified; Rett's disorder; and childhood
4 disintegrative disorder;

5 (2) "habilitative or rehabilitative services"
6 means treatment programs that are necessary to develop,
7 maintain and restore to the maximum extent practicable the
8 functioning of an individual; and

9 (3) "high school" means a school providing
10 instruction for any of the grades nine through twelve."

11 SECTION 16. Section 59A-22-50 NMSA 1978 (being Laws 2010,
12 Chapter 94, Section 1) is amended to read:

13 "59A-22-50. HEALTH INSURERS--DIRECT SERVICES.--

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

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

25 C. An insurer that fails to comply with the

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

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

21 E. For the purposes of this section:

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

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

9 (2) "health insurer" means a person duly
10 authorized to transact the business of health insurance in the
11 state pursuant to the Insurance Code but does not include a
12 person that only issues a limited-benefit policy intended to
13 supplement major medical coverage, including medicare
14 supplement, vision, dental, disease-specific, accident-only or
15 hospital indemnity-only insurance policies, or that only issues
16 policies for long-term care or disability income; and

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

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1 SECTION 17. A new section of Chapter 59A, Article 22 NMSA
2 1978 is enacted to read:

3 "[NEW MATERIAL] CHILD DEFINED.--As used in Chapter 59A,
4 Article 22 NMSA 1978, "child" means an individual under twenty-
5 six years of age whom the principal insured covers or whom the
6 applicant for coverage applies to cover, regardless of the
7 individual's financial dependency, residency with a parent,
8 student status, employment and marital status."

9 SECTION 18. A new section of Chapter 59A, Article 22 NMSA
10 1978 is enacted to read:

11 "[NEW MATERIAL] GRANDFATHERED HEALTH PLAN OR GRANDFATHERED
12 HEALTH POLICY COVERAGE.--

13 A. For the purposes of Chapter 59A, Article 22 NMSA
14 1978, "grandfathered health plan" or "grandfathered health
15 policy" means individual coverage provided by a health insurer,
16 health maintenance organization or nonprofit health plan that
17 was in effect on March 23, 2010 and that remains in effect
18 through the original term of coverage or through renewal of the
19 original term.

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

24 C. A group health plan or policy that provides
25 coverage on March 23, 2010 may provide for the enrolling of new

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1 employees and their dependents in that grandfathered health
2 plan.

3 D. Coverage provided by a health insurer, health
4 maintenance organization or nonprofit health plan pursuant to
5 one or more collective bargaining agreements between employee
6 representatives and one or more employers that was ratified
7 before March 23, 2010 constitutes a grandfathered health plan
8 or policy until the date on which the last of the collective
9 bargaining agreements relating to the coverage terminates. Any
10 coverage amendment made pursuant to a collective bargaining
11 agreement that relates to the coverage and amends the coverage
12 solely to conform to any requirement of Chapter 59A, Article 22
13 NMSA 1978 shall not be treated as a termination of the
14 collective bargaining agreement."

15 SECTION 19. A new section of Chapter 59A, Article 22 NMSA
16 1978 is enacted to read:

17 "[NEW MATERIAL] GUARANTEED ISSUE--GUARANTEED
18 RENEWABILITY--MAXIMUM WAITING PERIOD--BAN ON PREEXISTING
19 CONDITION EXCLUSIONS.--

20 A. A health insurer shall issue coverage to any
21 individual who requests and offers to purchase the coverage
22 without permanent exclusion of preexisting conditions.

23 B. A health insurer shall renew any health care
24 policy or plan at the individual's option, except as provided
25 pursuant to rules that the superintendent has promulgated.

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1 C. A health insurer may impose a waiting period not
2 to exceed ninety days before payment for any service related to
3 a preexisting condition.

4 D. A health insurer shall offer or make a referral
5 to a transition product to provide coverage during the waiting
6 period due to a preexisting condition.

7 E. A health insurer may continue and renew a
8 grandfathered health plan or policy that has a permanent
9 exclusion of payment for preexisting conditions.

10 F. A health insurer may restrict enrollment in
11 coverage described in Subsection A of this section to open or
12 special enrollment periods; provided that any special
13 enrollment period shall comply with the provisions of Section
14 21 of this 2013 act and rules the superintendent has
15 promulgated.

16 G. For the purposes of this section:

17 (1) "coverage" means a health insurance
18 policy, health care plan, health maintenance organization
19 contract or certificate of insurance issued for delivery in the
20 state. "Coverage" does not mean a short-term, accident, fixed
21 indemnity or specified disease policy; disability income;
22 limited benefit insurance; credit insurance; workers'
23 compensation; or automobile or medical insurance under which
24 benefits are payable with or without regard to fault and that
25 is required by law to be contained in any liability insurance

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1 policy; and

2 (2) "preexisting condition" means a physical
3 or mental condition for which medical advice, medication,
4 diagnosis, care or treatment was recommended for or received by
5 an applicant for health insurance within six months before the
6 effective date of coverage, except that pregnancy is not
7 considered a preexisting condition for federally defined
8 individuals."

9 SECTION 20. A new section of Chapter 59A, Article 22 NMSA
10 1978 is enacted to read:

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

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

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

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

22 B. With respect to plan years beginning prior to
23 January 1, 2014, a group health plan, health insurance issuer
24 offering group or individual health insurance coverage, health
25 maintenance organization, fraternal benefit society or

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1 nonprofit organization shall establish a restricted annual
2 limit on the dollar value of benefits for any participant or
3 beneficiary only with respect to the scope of benefits that are
4 essential health benefits, as the superintendent defines
5 "essential health benefits" by rule.

6 C. Subsection A of this section shall not be
7 construed to prevent a group health plan, health insurance
8 issuer offering group or individual health insurance coverage,
9 health maintenance organization, fraternal benefit society or
10 nonprofit organization from placing annual or lifetime per
11 beneficiary limits on specific covered benefits that are not
12 essential health benefits to the extent that these limits are
13 otherwise permitted under federal or state law.

14 D. The provisions of this section shall not apply
15 to policies or plans intended to supplement major medical
16 group-type coverages such as medicare supplement, long-term
17 care, disability income, specified disease, accident-only,
18 hospital indemnity or other limited-benefit health insurance
19 policies or plans."

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

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

25 A. For health insurance policy, health plan or

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1 certificate of health insurance years beginning on or after
2 September 23, 2010, if a child's coverage ended or did not
3 begin for the reasons described in Subsection E of this
4 section, a health insurer shall provide the child an
5 opportunity to enroll in a health plan or policy for which
6 coverage continues for at least sixty days and shall provide
7 written notice of the opportunity to enroll as described in
8 Subsection B of this section no later than the first day of the
9 plan or policy year.

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

18 C. For an individual who enrolls in an individual
19 health insurance policy, health plan or certificate of health
20 insurance, the coverage shall take effect not later than the
21 first day of the first plan or policy year.

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

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

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

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

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

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

24 "[NEW MATERIAL] GRANDFATHERED HEALTH PLANS--ADULT CHILD
25 DEPENDENT ELIGIBLE FOR EMPLOYER-SPONSORED HEALTH BENEFIT PLAN--

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1 EXCLUSION FROM DEPENDENT COVERAGE ELIGIBILITY PERMITTED.--

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

11 B. For the purposes of this section "adult child"
12 means an individual eighteen to twenty-six years of age."

13 SECTION 23. A new section of Chapter 59A, Article 22 NMSA
14 1978 is enacted to read:

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

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

23 B. When a health insurer offers individual or group
24 health insurance coverage that only covers individuals under
25 age nineteen, that insurer shall offer the coverage

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1 continuously throughout the year or during one or more open
2 enrollment periods as the superintendent prescribes by rule.

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

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

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

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

23 "[NEW MATERIAL] EMERGENCY SERVICES.--

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

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1 delivered or issued for delivery in this state and that
2 provides or covers any benefits with respect to services in an
3 emergency department of a hospital shall cover emergency
4 services:

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

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

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

21 C. If emergency services are provided out of
22 network, the cost-sharing requirement, expressed as a copayment
23 amount or coinsurance rate, shall be the same requirement that
24 would apply if the emergency services were provided in-network
25 and without regard to any other term or condition of such

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1 coverage, other than exclusion or coordination of benefits, or
2 an affiliation or waiting period other than the applicable
3 cost-sharing otherwise permitted pursuant to state or federal
4 law.

5 D. The provisions of this section shall not apply
6 to:

7 (1) policies or plans intended to supplement
8 major medical group-type coverages such as medicare supplement,
9 long-term care, disability income, specified disease, accident-
10 only, hospital indemnity or other limited-benefit health
11 insurance policies or plans; or

12 (2) health insurance policies, plans,
13 certificates or subscriber agreements that are governed by the
14 provisions of Section 59A-22A-5 NMSA 1978.

15 E. As used in this section:

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

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

25 (b) serious impairment to bodily

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1 functions; or

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

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

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

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

18 (3) "stabilize" means:

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

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

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1 SECTION 25. A new section of Chapter 59A, Article 22 NMSA
2 1978 is enacted to read:

3 "[NEW MATERIAL] OPTION FOR PEDIATRICIAN AS PRIMARY CARE
4 PHYSICIAN.--

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

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

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

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1 maintains the continuity of care when appropriate."

2 SECTION 26. A new section of Chapter 59A, Article 22 NMSA
3 1978 is enacted to read:

4 "[NEW MATERIAL] OBSTETRICAL AND GYNECOLOGICAL CARE
5 OPTION.--

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

22 B. A health insurer shall treat the provision of
23 obstetrical and gynecological care, and the ordering of related
24 obstetrical and gynecological items and services by a
25 participating health care professional who specializes in

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1 obstetrics or gynecology, as the authorization of the primary
2 care provider.

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

5 (1) waive any exclusions of coverage under the
6 terms and conditions of the health insurance policy, health
7 care plan or certificate of health insurance with respect to
8 coverage of obstetrical or gynecological care; or

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

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

20 SECTION 27. A new section of Chapter 59A, Article 22 NMSA
21 1978 is enacted to read:

22 "[NEW MATERIAL] PREVENTIVE ITEMS AND SERVICES--PROHIBITION
23 ON COST-SHARING.--

24 A. A health insurer providing coverage under an
25 individual health benefit policy or plan, except for a

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1 grandfathered health policy or plan, shall provide coverage for
2 items and services pursuant to Sections 59A-22-34.3, 59A-22-40,
3 59A-22-44 and 59A-22-47 NMSA 1978 and Sections 28 through 30 of
4 this 2013 act and shall not impose any cost-sharing
5 requirements, such as a copayment, coinsurance or deductible.

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

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

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

20 E. The superintendent shall at least annually
21 revise the preventive services standards established pursuant
22 to Sections 59A-22-44 and 59A-22-47 NMSA 1978 and Sections 28
23 through 30 of this 2013 act to ensure that they are
24 respectively consistent with the current "A"-rated and "B"-
25 rated recommendations of the United States preventive services

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1 task force, the advisory committee on immunization practices of
2 the federal centers for disease control and prevention and the
3 guidelines with respect to infants, children, adolescents and
4 women of evidence-based preventive care and screenings by the
5 federal health resources and services administration. When
6 changes are made to any of these guidelines or recommendations,
7 the superintendent shall make recommendations to the
8 legislature for legislative changes to conform these standards
9 to current guidelines and recommendations.

10 F. A health insurer may impose cost-sharing
11 requirements with respect to an office visit if a preventive
12 item or service provided pursuant to this section is billed
13 separately or is tracked as individual encounter data
14 separately from the office visit.

15 G. A health insurer shall not impose cost-sharing
16 requirements with respect to an office visit for an item or
17 service provided pursuant to this section if an item or service
18 is not billed separately or is not tracked as individual
19 encounter data separately from the office visit and the primary
20 purpose of the office visit is the delivery of the preventive
21 item or service.

22 H. A health insurer may impose cost-sharing
23 requirements with respect to an office visit if a preventive
24 item or service provided pursuant to this section is not billed
25 separately or is not tracked as individual encounter data

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1 separately from the office visit and the primary purpose of the
2 office visit is not the delivery of the preventive item or
3 service.

4 I. The provisions of this section shall not apply
5 to policies or plans intended to supplement major medical
6 group-type coverages such as medicare supplement, long-term
7 care, disability income, specified disease, accident-only,
8 hospital indemnity or other limited-benefit health insurance
9 policies or plans."

10 SECTION 28. A new section of Chapter 59A, Article 22 NMSA
11 1978 is enacted to read:

12 "[NEW MATERIAL] PREVENTIVE SERVICES BENEFITS--ASPIRIN
13 REGIMEN--HIGH BLOOD PRESSURE SCREENING--BREAST CANCER
14 SCREENING--LIPID DISORDERS SCREENING--COLORECTAL CANCER
15 SCREENING--DEPRESSION SCREENING--BEHAVIORAL DIETARY
16 COUNSELING--OBESITY COUNSELING AND SCREENING--OSTEOPOROSIS
17 SCREENING.--

18 A. An individual or group health insurance policy,
19 health care plan or certificate of health insurance that is
20 delivered or issued for delivery in this state shall provide
21 the following benefits that have, in effect, a rating of "A" or
22 "B" in the current recommendations of the United States
23 preventive services task force, for:

24 (1) a one-time screening for abdominal aortic
25 aneurysm by ultrasonography in men who have ever smoked and who

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1 are between the ages of sixty-five and seventy-five;

2 (2) an aspirin regimen for men between the
3 ages of forty-five and seventy-nine when the potential benefit
4 due to a reduction in myocardial infarctions outweighs the
5 potential harm due to an increase in gastrointestinal
6 hemorrhage;

7 (3) an aspirin regimen for women between the
8 ages of fifty-five and seventy-nine when the potential benefit
9 of a reduction in ischemic strokes outweighs the potential harm
10 due to an increase in gastrointestinal hemorrhage;

11 (4) screening for high blood pressure in
12 adults aged eighteen and older;

13 (5) genetic counseling and evaluation for
14 breast cancer BRCA-gene testing for women whose family
15 histories are associated with an increased risk for deleterious
16 mutations in BRCA1 or BRCA2 genes. Nothing in this paragraph
17 shall be construed as a waiver or exception to the Genetic
18 Information Privacy Act;

19 (6) screening of lipid disorders for:
20 (a) men who are thirty-five years of age
21 or older; and
22 (b) women who are twenty years of age or
23 older who are at increased risk of coronary heart disease;

24 (7) screening of individuals over eighteen
25 years of age for colorectal cancer using fecal occult blood

1 testing, sigmoidoscopy or colonoscopy;

2 (8) screening of individuals eighteen years of
3 age or older for depression;

4 (9) screening of individuals twelve to
5 eighteen years of age for major depressive disorder;

6 (10) behavioral dietary counseling for adults
7 with hyperlipidemia and other known risk factors for
8 cardiovascular and diet-related chronic disease;

9 (11) screening and counseling for obesity for:

10 (a) individuals eighteen years of age
11 and older who are obese; and

12 (b) individuals six to eighteen years of
13 age; and

14 (12) screening for osteoporosis for:

15 (a) women who are sixty-five years of
16 age and older; and

17 (b) women who are sixty to sixty-five
18 years of age who are at increased risk for osteoporotic
19 fractures.

20 B. The provisions of this section shall not apply
21 to health insurance policies or plans intended to supplement
22 major medical group-type coverages such as medicare supplement,
23 long-term care, disability income, specified disease, accident-
24 only, hospital indemnity or other limited-benefit health
25 insurance policies or plans."

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1 SECTION 29. A new section of Chapter 59A, Article 22 NMSA
2 1978 is enacted to read:

3 "[NEW MATERIAL] PREVENTIVE SERVICES FOR CHILDREN.--

4 A. An individual or group health insurance policy,
5 health care plan or certificate of health insurance that is
6 delivered or issued for delivery in this state shall provide
7 the following benefits that have, in effect, a rating of "A" or
8 "B" in the current recommendations of the United States
9 preventive services task force, for:

10 (1) oral fluoride supplementation at currently
11 recommended doses to children six months of age to five years
12 of age whose primary water sources are deficient in fluoride;

13 (2) prophylactic ocular topical medication
14 against gonococcal ophthalmia neonatorum for newborns;

15 (3) screening for hearing loss in newborns;

16 (4) screening for sickle cell disease for
17 newborns;

18 (5) screening for congenital hypothyroidism
19 for newborns;

20 (6) iron supplementation for asymptomatic
21 children six to twelve months of age who are at increased risk
22 for iron deficiency anemia;

23 (7) screening for phenylketonuria in newborns;

24 and

25 (8) screening to detect amblyopia, strabismus

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1 and defects in visual acuity in children less than five years
2 of age.

3 B. The provisions of this section shall not apply
4 to health insurance policies or plans intended to supplement
5 major medical group-type coverages such as medicare supplement,
6 long-term care, disability income, specified disease, accident-
7 only, hospital indemnity or other limited-benefit health
8 insurance policies or plans."

9 SECTION 30. A new section of Chapter 59A, Article 22 NMSA
10 1978 is enacted to read:

11 "[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--
12 REPRODUCTIVE HEALTH.--

13 A. An individual or group health insurance policy,
14 health care plan or certificate of health insurance that is
15 delivered or issued for delivery in this state shall provide
16 the following benefits that have, in effect, a rating of "A" or
17 "B" in the current recommendations of the United States
18 preventive services task force, for:

19 (1) screening for asymptomatic bacteriuria
20 with a urine culture for pregnant women;

21 (2) interventions during pregnancy and after
22 birth to promote and support breastfeeding;

23 (3) screening for cervical cancer in women who
24 have been sexually active and have a cervix;

25 (4) screening for chlamydial infection for:

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- 1 (a) all sexually active young women
2 twenty-four years of age and younger; and
3 (b) older women who are at increased
4 risk of chlamydial infection;
- 5 (5) a daily supplement containing four hundred
6 to eight hundred micrograms of folic acid for any woman
7 planning a pregnancy or capable of pregnancy;
- 8 (6) screening of all sexually active women who
9 are at increased risk for infection, including those who are
10 pregnant, for gonorrheal infection;
- 11 (7) screening for iron deficiency anemia in
12 asymptomatic pregnant women;
- 13 (8) Rh (D) blood typing and antibody testing
14 for:
- 15 (a) all pregnant women; and
16 (b) all unsensitized Rh (D) negative
17 women at twenty-four to twenty-eight weeks' gestation;
- 18 (9) behavioral counseling to prevent sexually
19 transmitted infections in:
- 20 (a) all sexually active adolescents; and
21 (b) individuals aged eighteen years and
22 older at increased risk for sexually transmitted infections;
- 23 (10) screening for hepatitis B virus infection
24 in pregnant women;
- 25 (11) screening for human immunodeficiency

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1 virus for individuals twelve years of age and older who are at
2 risk of human immunodeficiency virus infection;

3 (12) screening for iron deficiency anemia in
4 asymptomatic pregnant women; and

5 (13) screening for syphilis for:

6 (a) any individual at increased risk for
7 syphilis infection; and

8 (b) any pregnant woman.

9 B. The provisions of this section shall not apply
10 to health insurance policies or plans intended to supplement
11 major medical group-type coverages such as medicare supplement,
12 long-term care, disability income, specified disease, accident-
13 only, hospital indemnity or other limited-benefit health
14 insurance policies or plans."

15 SECTION 31. Section 59A-23-6 NMSA 1978 (being Laws 1983,
16 Chapter 64, Section 1, as amended) is amended to read:

17 "59A-23-6. ALCOHOL DEPENDENCY AND MISUSE COVERAGE.--

18 A. Each insurer that delivers or issues for
19 delivery in this state a group health insurance policy shall
20 offer and make available benefits for the necessary care and
21 treatment of alcohol dependency [~~Such~~] and misuse. These
22 benefits shall

23 [~~(1) be subject to annual deductibles and~~
24 ~~coinsurance consistent with those imposed on other benefits~~
25 ~~within the same policy;~~

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1 ~~(2)~~ provide ~~[no less than thirty days]~~
2 necessary care and treatment in an alcohol dependency and
3 misuse treatment center and ~~[thirty]~~ outpatient visits for
4 alcohol dependency and misuse treatment ~~[and~~

5 ~~(3) be offered for benefit periods of no more~~
6 ~~than one year and may be limited to a lifetime maximum of no~~
7 ~~less than two benefit periods. Such offer of benefits shall be~~
8 ~~subject to the rights of the group health insurance holder to~~
9 ~~reject the coverage or to select any alternative level of~~
10 ~~benefits if that right is offered by or negotiated with that~~
11 ~~insurer].~~

12 B. For purposes of this section, "alcohol
13 dependency and misuse treatment center" means a facility that
14 provides a program for the treatment of alcohol dependency and
15 misuse pursuant to a written treatment plan approved and
16 monitored by a physician or meeting the quality standards of
17 the behavioral health services division of the human services
18 department and which facility also:

19 (1) is affiliated with a hospital under a
20 contractual agreement with an established system for patient
21 referral;

22 (2) is accredited as such a facility by the
23 joint commission ~~[on accreditation of hospitals]~~; or

24 (3) meets at least the minimum standards
25 adopted by the behavioral health services division for

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1 treatment of [~~alcoholism~~] alcohol dependency and misuse in
2 regional treatment centers.

3 C. This section applies to policies delivered or
4 issued for delivery or renewed, extended or amended in this
5 state on or after July 1, 1983 or upon expiration of a
6 collective bargaining agreement applicable to a particular
7 policyholder, whichever is later; provided that this section
8 does not apply to blanket, short-term travel, accident-only,
9 limited or specified disease, individual conversion policies or
10 policies designed for issuance to persons eligible for coverage
11 under Title 18 of the Social Security Act, known as medicare,
12 or any other similar coverage under state or federal
13 governmental plans. With respect to any policy forms approved
14 by the insurance division of the public regulation commission
15 prior to the effective date of this section, an insurer is
16 authorized to comply with this section by the use of
17 endorsements or riders, provided such endorsements or riders
18 are approved by the insurance division as being in compliance
19 with this section and applicable provisions of the Insurance
20 Code.

21 D. If an organization offering group health
22 benefits to its members makes more than one health insurance
23 policy or nonprofit health care plan available to its members
24 on a member option basis, the organization shall not require
25 alcohol dependency and misuse coverage from one health insurer

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1 or health care plan without requiring the same level of alcohol
2 dependency and misuse coverage for all other health insurance
3 policies or health care plans that the organization makes
4 available to its members."

5 SECTION 32. Section 59A-23-7.2 NMSA 1978 (being Laws
6 1994, Chapter 64, Section 5, as amended) is amended to read:

7 "59A-23-7.2. COVERAGE OF CHILDREN.--

8 A. An insurer shall not deny enrollment of a child
9 under the health plan or policy of the child's parent on the
10 grounds that the child:

11 (1) was born out of wedlock;

12 (2) is not claimed as a dependent on the
13 parent's federal tax return; or

14 (3) does not reside with the parent or in the
15 insurer's service area.

16 B. When a child has health coverage through an
17 insurer of a noncustodial parent, the insurer shall:

18 (1) provide such information to the custodial
19 parent as may be necessary for the child to obtain benefits
20 through that coverage;

21 (2) permit the custodial parent or the
22 provider, with the custodial parent's approval, to submit
23 claims for covered services without the approval of the
24 noncustodial parent; and

25 (3) make payments on claims submitted in

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1 accordance with Paragraph (2) of this subsection directly to
2 the custodial parent, the provider or the state medicaid
3 agency.

4 C. When a parent is required by a court or
5 administrative order to provide health coverage for a child and
6 the parent is eligible for family health coverage, the insurer
7 shall be required:

8 (1) to permit the parent to enroll, under the
9 family coverage, a child who is otherwise eligible for the
10 coverage without regard to any enrollment season restrictions;

11 (2) if the parent is enrolled but fails to
12 make application to obtain coverage for the child, to enroll
13 the child under family coverage upon application of the child's
14 other parent, the state agency administering the medicaid
15 program or the state agency administering 42 U.S.C. Sections
16 651 through 669, the child support enforcement program; and

17 (3) not to disenroll or eliminate coverage of
18 the child unless the insurer is provided satisfactory written
19 evidence that:

20 (a) the court or administrative order is
21 no longer in effect; or

22 (b) the child is or will be enrolled in
23 comparable health coverage through another insurer or plan that
24 will take effect not later than the effective date of
25 disenrollment.

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1 D. An insurer shall not impose requirements on a
2 state agency that has been assigned the rights of an individual
3 eligible for medical assistance under the medicaid program and
4 covered for health benefits from the insurer that are different
5 from requirements applicable to an agent or assignee of any
6 other individual so covered.

7 E. An insurer shall provide coverage for children,
8 from birth through three years of age, for or under the family,
9 infant, toddler program administered by the department of
10 health, provided that eligibility criteria are met [~~for a~~
11 ~~maximum benefit of three thousand five hundred dollars (\$3,500)~~
12 ~~annually~~] for medically necessary early intervention services
13 provided as part of an individualized family service plan and
14 delivered by certified and licensed personnel as defined in
15 7.30.8 NMAC who are working in early intervention programs
16 approved by the department of health. [~~No payment under this~~
17 ~~subsection shall be applied against any maximum lifetime or~~
18 ~~annual limits specified in the policy, health benefits plan or~~
19 ~~contract.~~]"

20 SECTION 33. Section 59A-23-7.3 NMSA 1978 (being Laws
21 2003, Chapter 391, Section 3) is amended to read:

22 "59A-23-7.3. MAXIMUM AGE OF [~~DEPENDENT~~] CHILD.--Each
23 blanket or group health policy or plan or certificate of
24 insurance delivered, issued for delivery or renewed in New
25 Mexico on or after July 1, 2003 that provides coverage for an

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1 insured's [~~dependent~~] child shall not terminate coverage of [~~an~~
2 ~~unmarried dependent~~] a child by reason of the [~~dependent's~~]
3 child's age before the [~~dependent's twenty-fifth~~] child's
4 twenty-sixth birthday [~~regardless of whether the dependent is~~
5 ~~enrolled in an educational institution~~]."

6 SECTION 34. Section 59A-23-7.9 NMSA 1978 (being Laws
7 2009, Chapter 74, Section 2) is amended to read:

8 "59A-23-7.9. COVERAGE FOR AUTISM SPECTRUM DISORDER
9 DIAGNOSIS AND TREATMENT.--

10 A. A blanket or group health insurance policy, plan
11 or contract that is delivered, issued for delivery or renewed
12 in this state shall provide coverage to an eligible individual
13 who is nineteen years of age or younger or an eligible
14 individual who is twenty-two years of age or younger and is
15 enrolled in high school for:

16 (1) well-baby and well-child screening for
17 diagnosing the presence of autism spectrum disorder; and

18 (2) treatment of autism spectrum disorder
19 through speech therapy, occupational therapy, physical therapy
20 and applied behavioral analysis.

21 B. Coverage required pursuant to Subsection A of
22 this section:

23 (1) shall be limited to treatment that is
24 prescribed by the insured's treating physician in accordance
25 with a treatment plan;

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1 [~~(2)~~] shall be limited to thirty-six thousand
2 dollars (~~\$36,000~~) annually and shall not exceed two hundred
3 thousand dollars (~~\$200,000~~) in total lifetime benefits.
4 Beginning January 1, 2011, the maximum benefit shall be
5 adjusted annually on January 1 to reflect any change from the
6 previous year in the medical component of the then-current
7 consumer price index for all urban consumers published by the
8 bureau of labor statistics of the United States department of
9 labor;

10 ~~(3)~~] (2) shall not be denied on the basis that
11 the services are habilitative or rehabilitative in nature;

12 [~~(4)~~] (3) may be subject to other general
13 exclusions and limitations of the insurer's policy or plan,
14 including, but not limited to, coordination of benefits,
15 participating provider requirements, restrictions on services
16 provided by family or household members and utilization review
17 of health care services, including the review of medical
18 necessity, case management and other managed care provisions;
19 and

20 [~~(5)~~] (4) may be limited to exclude coverage
21 for services received under the federal Individuals with
22 Disabilities Education Improvement Act of 2004 and related
23 state laws that place responsibility on state and local school
24 boards for providing specialized education and related services
25 to children three to twenty-two years of age who have autism

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1 spectrum disorder.

2 C. The coverage required pursuant to Subsection A
3 of this section shall not be subject to dollar limits,
4 deductibles or coinsurance provisions that are less favorable
5 to an insured than the dollar limits, deductibles or
6 coinsurance provisions that apply to physical illnesses that
7 are generally covered under the blanket or group health
8 insurance policy or contract, except as otherwise provided in
9 Subsection B of this section.

10 D. An insurer shall not deny or refuse to issue
11 health insurance coverage for medically necessary services or
12 refuse to contract with, renew, reissue or otherwise terminate
13 or restrict health insurance coverage for an individual because
14 the individual is diagnosed as having autism spectrum disorder.

15 E. The treatment plan required pursuant to
16 Subsection B of this section shall include all elements
17 necessary for the health insurance plan, policy or contract to
18 pay claims appropriately. These elements include, but are not
19 limited to:

- 20 (1) the diagnosis;
21 (2) the proposed treatment by types;
22 (3) the frequency and duration of treatment;
23 (4) the anticipated outcomes stated as goals;
24 (5) the frequency with which the treatment
25 plan will be updated; and

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1 (6) the signature of the treating physician.

2 F. This section shall not be construed as limiting
3 benefits and coverage otherwise available to an insured under a
4 health insurance plan, policy or contract.

5 G. The provisions of this section shall not apply
6 to plans or policies intended to supplement major medical
7 group-type coverages such as medicare supplement, long-term
8 care, disability income, specified disease, accident-only,
9 hospital indemnity or other limited-benefit health insurance
10 plans or policies.

11 H. As used in this section:

12 (1) "autism spectrum disorder" means a
13 condition that meets the diagnostic criteria for the pervasive
14 developmental disorders published in the *Diagnostic and*
15 *Statistical Manual of Mental Disorders*, fourth edition, text
16 revision, also known as DSM-IV-TR, published by the American
17 psychiatric association, including autistic disorder;
18 Asperger's disorder; pervasive development disorder not
19 otherwise specified; Rett's disorder; and childhood
20 disintegrative disorder;

21 (2) "habilitative or rehabilitative services"
22 means treatment programs that are necessary to develop,
23 maintain and restore to the maximum extent practicable the
24 functioning of an individual; and

25 (3) "high school" means a school providing

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1 instruction for any of the grades nine through twelve."

2 SECTION 35. A new section of Chapter 59A, Article 23 NMSA
3 1978 is enacted to read:

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

6 A. Notwithstanding any other provision of law, a
7 group or blanket health policy, plan or certificate of
8 insurance that is issued or delivered in the state shall not
9 establish:

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

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

15 B. With respect to health insurance policy or plan
16 years beginning prior to January 1, 2014, a group health policy
17 or plan or health insurance issuer offering group or blanket
18 coverage shall establish a restricted annual limit on the
19 dollar value of benefits for any participant or beneficiary
20 only with respect to the scope of benefits that are essential
21 health benefits, as the superintendent defines "essential
22 health benefits" by rule.

23 C. Subsection A of this section shall not be
24 construed to prevent a group or blanket insurer offering group
25 or blanket health insurance coverage from placing annual or

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

4 D. The provisions of this section shall not apply
5 to policies or plans intended to supplement major medical
6 group-type coverages such as medicare supplement, long-term
7 care, disability income, specified disease, accident only,
8 hospital indemnity or other limited-benefit health insurance
9 policies or plans."

10 SECTION 36. A new section of Chapter 59A, Article 23 NMSA
11 1978 is enacted to read:

12 "[NEW MATERIAL] CHILD DEFINED.--For the purposes of
13 Chapter 59A, Article 23 NMSA 1978, "child" means an individual
14 under twenty-six years of age whom the principal insured covers
15 or whom the applicant for coverage applies to cover, regardless
16 of the individual's financial dependency, residency with a
17 parent, student status, employment or marital status."

18 SECTION 37. A new section of Chapter 59A, Article 23 NMSA
19 1978 is enacted to read:

20 "[NEW MATERIAL] GRANDFATHERED HEALTH PLAN OR GRANDFATHERED
21 HEALTH POLICY COVERAGE.--

22 A. For the purposes of Chapter 59A, Article 23 NMSA
23 1978, "grandfathered health plan" or "grandfathered health
24 policy" means individual coverage provided by a health insurer,
25 health maintenance organization or nonprofit health plan that

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1 was in effect on March 23, 2010 and that remains in effect
2 through the original term of coverage or through renewal of the
3 original term.

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

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

13 D. Coverage provided by a health insurer, health
14 maintenance organization or nonprofit health plan pursuant to
15 one or more collective bargaining agreements between employee
16 representatives and one or more employers that was ratified
17 before March 23, 2010 constitutes a grandfathered health plan
18 or policy until the date on which the last of the collective
19 bargaining agreements relating to the coverage terminates. Any
20 coverage amendment made pursuant to a collective bargaining
21 agreement that relates to the coverage and amends the coverage
22 solely to conform to any requirement of Chapter 59A, Article 23
23 NMSA 1978 shall not be treated as a termination of the
24 collective bargaining agreement."

25 SECTION 38. A new section of Chapter 59A, Article 23 NMSA

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1 1978 is enacted to read:

2 "[NEW MATERIAL] DIRECT SERVICES.--

3 A. A health insurer shall make reimbursement for
4 direct services at a level not less than eighty-five percent of
5 premiums across all health product lines over the preceding
6 three calendar years, but not earlier than calendar year 2010,
7 as determined by reports filed with the insurance division of
8 the commission. Nothing in this subsection shall be construed
9 to preclude a purchaser from negotiating an agreement with a
10 health insurer that requires a higher amount of premiums paid
11 to be used for reimbursement for direct services for one or
12 more products or for one or more years.

13 B. An insurer that fails to comply with the
14 eighty-five percent reimbursement requirement in Subsection A
15 of this section shall issue a rebate to all policyholders in an
16 amount sufficient to assure that the benefits paid in the
17 preceding three calendar years plus the amount of the dividends
18 or credits equal eighty-five percent of the premiums collected
19 in the 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 enforce
22 the requirements and may pursue any other penalties as provided
23 by law, including general penalties pursuant to Section
24 59A-1-18 NMSA 1978.

25 C. After notice and hearing, the superintendent may

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

3 D. For the purposes of this section:

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

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

24 (3) "premium" means all income received from
25 individuals and private and public payers or sources for the

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

8 SECTION 39. A new section of Chapter 59A, Article 23 NMSA
9 1978 is enacted to read:

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

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

19 (1) engages in conduct that constitutes fraud;

20 or

21 (2) makes an intentional misrepresentation of
22 material fact, as prohibited by the terms of the plan or
23 policy.

24 B. A health insurer shall provide at least thirty
25 days' advance written notice to each plan or policy enrollee,

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1 or for individual health insurance coverage, to each primary
2 subscriber, who would be affected by the proposed rescission of
3 coverage before coverage under the plan or policy may be
4 rescinded in accordance with Subsection A of this section,
5 regardless, in the case of group health insurance coverage, of
6 whether the rescission applies to the entire group or only to
7 an individual within the group.

8 C. The provisions of this section apply regardless
9 of any applicable contestability period."

10 SECTION 40. A new section of Chapter 59A, Article 23 NMSA
11 1978 is enacted to read:

12 "[NEW MATERIAL] GUARANTEED ISSUE--MAXIMUM WAITING PERIOD--
13 BAN ON PREEXISTING CONDITION EXCLUSIONS.--

14 A. Except as provided pursuant to Subsection B of
15 this section, a health insurer that offers a health benefit
16 plan providing group coverage in the state shall issue coverage
17 to any employer that applies for such plan and agrees to make
18 the required premium payments and to satisfy the other
19 reasonable provisions of the coverage. An insurer:

20 (1) shall offer coverage to all of the
21 eligible employees of the employer and their children and
22 dependents who apply for enrollment during the period in which
23 the employee first becomes eligible to enroll under the terms
24 of the plan; and

25 (2) shall not offer coverage to only certain

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1 individuals or certain children or dependents of employees in
2 the group or to only part of the group.

3 B. A health insurer that offers coverage through a
4 network plan shall not be required to offer coverage under that
5 plan or accept applications for that plan pursuant to
6 Subsection A of this section under the following circumstances:

7 (1) to an employer, where the employer is not
8 physically located in the insurer's established geographic
9 service area for the network plan;

10 (2) to an employee, when the employee does not
11 live, work or reside within the insurer's established
12 geographic service area for the network plan; or

13 (3) within the geographic service area for the
14 network plan where the insurer reasonably anticipates, and
15 demonstrates to the satisfaction of the superintendent, that it
16 will not have the capacity within its established geographic
17 service area to deliver service adequately to the members of
18 the groups because of its obligations to existing group
19 policyholders and enrollees.

20 C. A health insurer may restrict enrollment in
21 coverage described in Subsection A of this section to open or
22 special enrollment periods; provided that any special
23 enrollment period shall comply with the provisions of Section
24 41 of this 2013 act and rules that the superintendent has
25 promulgated.

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1 D. A health insurer may impose a waiting period not
2 to exceed ninety days before payment for any service related to
3 a preexisting condition. A health insurer shall offer or make
4 a referral to a transition product to provide coverage during
5 the waiting period due to a preexisting condition.

6 E. A health insurer may continue and renew a
7 grandfathered plan or policy that has a permanent exclusion of
8 payment for preexisting conditions.

9 F. A health insurer shall renew any coverage at the
10 option of the employer, except as the superintendent has
11 provided by rule.

12 G. For the purposes of this section:

13 (1) "coverage" means a health insurance
14 policy, health care plan, health maintenance organization
15 contract or certificate of insurance issued for delivery in the
16 state. "Coverage" does not mean a short-term, accident, fixed
17 indemnity or specified disease policy; disability income;
18 limited benefit insurance; credit insurance; workers'
19 compensation; or automobile or medical insurance under which
20 benefits are payable with or without regard to fault and that
21 is required by law to be contained in any liability insurance
22 policy; and

23 (2) "preexisting condition" means a physical
24 or mental condition for which medical advice, medication,
25 diagnosis, care or treatment was recommended for or received by

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1 an applicant for health insurance within six months before the
2 effective date of coverage, except that pregnancy is not
3 considered a preexisting condition for federally defined
4 individuals."

5 SECTION 41. A new section of Chapter 59A, Article 23 NMSA
6 1978 is enacted to read:

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

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

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

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

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

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

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1 similarly situated individuals who did not lose coverage by
2 reason of cessation of dependent status.

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

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

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

15 SECTION 42. A new section of Chapter 59A, Article 23 NMSA
16 1978 is enacted to read:

17 "[NEW MATERIAL] PROHIBITION OF DISCRIMINATION IN FAVOR OF
18 HIGHLY COMPENSATED INDIVIDUALS--EXCLUSIONS.--

19 A. A blanket or group health insurance policy, plan
20 or contract that is delivered, issued for delivery or renewed
21 in this state on behalf of an employer shall not discriminate
22 in favor of highly compensated individuals as to eligibility to
23 participate or as to the benefits offered. The benefits
24 provided for participants who are highly compensated
25 individuals shall be provided for all other participants.

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1 B. An employer shall ensure that any employer-
2 sponsored group health coverage it offers is offered to:

3 (1) seventy percent or more of all of that
4 employer's employees;

5 (2) eighty percent or more of all of that
6 employer's employees who are eligible to benefit under the
7 policy, plan or contract if seventy percent or more of all
8 employees are eligible to benefit; or

9 (3) any employees that qualify under a
10 classification that the employer has established and that the
11 secretary of the United States department of health and human
12 services has approved.

13 C. An employer may exclude the following types of
14 employees from an offering of health coverage under Subsections
15 A and B of this section:

16 (1) employees who have not completed three
17 years of service;

18 (2) employees who have not attained twenty-
19 five years of age;

20 (3) part-time or seasonal employees;

21 (4) employees not included in the policy, plan
22 or contract who are included in a unit of employees covered by
23 an agreement between employee representatives and one or more
24 employers that the secretary of the United States department of
25 health and human services has found to be a collective

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1 bargaining agreement, if accident and health benefits were the
2 subject of good-faith bargaining between these employee
3 representatives and the employer or employers; and

4 (5) employees who are nonresident aliens of
5 the United States and who receive no earned income, within the
6 meaning of Section 911(d)(2) of the federal Internal Revenue
7 Code of 1986, from the employer, that constitutes income from
8 sources within the United States, as defined in Section
9 861(a)(3) of the federal Internal Revenue Code of 1986.

10 D. As used in this section, "highly compensated
11 individual" means an individual who is:

12 (1) one of the five highest paid officers of
13 an employer;

14 (2) a shareholder who owns more than ten
15 percent in the value of the employer's stock, pursuant to
16 Section 318 of the federal Internal Revenue Code of 1986; or

17 (3) among the highest paid twenty-five percent
18 of all employees who do not belong to any category listed in
19 Subsection C of this section."

20 SECTION 43. A new section of Chapter 59A, Article 23 NMSA
21 1978 is enacted to read:

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

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

10 B. For the purposes of this section, "adult child"
11 means an individual eighteen to twenty-six years of age."

12 **SECTION 44.** A new section of Chapter 59A, Article 23 NMSA
13 1978 is enacted to read:

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

16 A. A group health insurance policy, health care
17 plan or certificate of health insurance that is delivered or
18 issued for delivery in this state shall not limit or exclude
19 coverage under a group health benefit plan for an individual
20 under the age of nineteen by imposing a preexisting condition
21 exclusion on that individual.

22 B. When a health insurer offers individual or group
23 health insurance coverage that only covers individuals under
24 the age of nineteen, that insurer shall offer the coverage
25 continuously throughout the year or during one or more open

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1 enrollment periods as the superintendent prescribes by rule.

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

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

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

20 SECTION 45. A new section of Chapter 59A, Article 23 NMSA
21 1978 is enacted to read:

22 "[NEW MATERIAL] EMERGENCY SERVICES.--

23 A. A group health insurance policy, health care
24 plan or certificate of health insurance that is delivered or
25 issued for delivery in this state and that provides or covers

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1 any benefits with respect to services in an emergency
2 department of a hospital shall cover emergency services:

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

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

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

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

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1 cost-sharing otherwise permitted pursuant to state or federal
2 law.

3 D. The provisions of this section shall not apply
4 to:

5 (1) policies or plans intended to supplement
6 major medical group-type coverages such as medicare supplement,
7 long-term care, disability income, specified disease, accident-
8 only, hospital indemnity or other limited-benefit health
9 insurance policies or plans; or

10 (2) health insurance policies, plans,
11 certificates or subscriber agreements that are governed by the
12 provisions of Section 59A-22A-5 NMSA 1978.

13 E. As used in this section:

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

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

23 (b) serious impairment to bodily
24 functions; or

25 (c) serious dysfunction of any bodily

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1 organ or part;

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

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

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

16 (3) "stabilize" means:

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

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

24 SECTION 46. A new section of Chapter 59A, Article 23 NMSA
25 1978 is enacted to read:

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1 "[NEW MATERIAL] OPTION FOR PEDIATRICIAN AS PRIMARY CARE

2 PROVIDER.--

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

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

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

24 SECTION 47. A new section of Chapter 59A, Article 23 NMSA
25 1978 is enacted to read:

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1 "[NEW MATERIAL] OBSTETRICAL AND GYNECOLOGICAL CARE

2 OPTION.--

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

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

25 C. Nothing in Subsection A of this section shall be

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1 construed to:

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

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

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

17 SECTION 48. A new section of Chapter 59A, Article 23 NMSA
18 1978 is enacted to read:

19 "[NEW MATERIAL] COVERAGE FOR PREVENTIVE ITEMS AND
20 SERVICES--PROHIBITION ON COST-SHARING.--

21 A. A health insurer providing coverage under a
22 group or blanket health insurance policy, plan or certificate
23 of coverage, except for a grandfathered health plan, shall
24 provide coverage for all of the preventive items and services
25 pursuant to Sections 49 through 53 of this 2013 act, and shall

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1 not impose any cost-sharing requirements, such as a copayment,
2 coinsurance or deductible.

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

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

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

17 E. The superintendent shall at least annually
18 revise the preventive services standards established pursuant
19 to Sections 49 through 53 of this 2013 act to ensure that they
20 are consistent with the recommendations of the United States
21 preventive services task force, the advisory committee on
22 immunization practices of the federal centers for disease
23 control and prevention and the guidelines with respect to
24 infants, children, adolescents and women of evidence-based
25 preventive care and screenings by the federal health resources

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1 and services administration. When changes are made to any of
2 these guidelines or recommendations, the superintendent shall
3 make recommendations to the legislature for legislative changes
4 to conform these standards to current guidelines and
5 recommendations.

6 F. A health insurer may impose cost-sharing
7 requirements with respect to an office visit if a preventive
8 item or service provided pursuant to this section is billed
9 separately or is tracked as individual encounter data
10 separately from the office visit.

11 G. A health insurer shall not impose cost-sharing
12 requirements with respect to an office visit for an item or
13 service provided pursuant to this section if an item or service
14 is not billed separately or is not tracked as individual
15 encounter data separately from the office visit and the primary
16 purpose of the office visit is the delivery of the preventive
17 item or service.

18 H. A health insurer may impose cost-sharing
19 requirements with respect to an office visit if a preventive
20 item or service provided pursuant to this section is not billed
21 separately or is not tracked as individual encounter data
22 separately from the office visit and the primary purpose of the
23 office visit is not the delivery of the preventive item or
24 service.

25 I. The provisions of this section shall not apply

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1 to policies or plans intended to supplement major medical
2 group-type coverages such as medicare supplement, long-term
3 care, disability income, specified disease, accident-only,
4 hospital indemnity or other limited-benefit health insurance
5 policies or plans."

6 SECTION 49. A new section of Chapter 59A, Article 23 NMSA
7 1978 is enacted to read:

8 "[NEW MATERIAL] COVERAGE FOR SMOKING AND TOBACCO CESSATION
9 TREATMENT.--

10 A. A group or blanket health insurance policy,
11 health care plan or certificate of health insurance that is
12 delivered or issued for delivery in this state and that offers
13 maternity benefits shall offer coverage for smoking cessation
14 treatment and shall offer augmented counseling tailored to
15 pregnant women who smoke.

16 B. A group or blanket health insurance policy,
17 health care plan or certificate of health insurance that is
18 delivered or issued for delivery in this state shall:

19 (1) offer tobacco cessation intervention
20 coverage for those who use tobacco products;

21 (2) provide for screening of pregnant women
22 for tobacco use in accordance with the United States preventive
23 services task force guidelines; and

24 (3) provide diagnostic, therapy and counseling
25 services and pharmacotherapy, including the coverage of

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1 prescription and nonprescription tobacco cessation agents
2 approved by the federal food and drug administration for
3 cessation of tobacco use by pregnant women.

4 C. The provisions of this section shall not apply
5 to short-term travel, accident-only or limited or specified-
6 disease policies, plans, contracts or certificates."

7 SECTION 50. A new section of Chapter 59A, Article 23 NMSA
8 1978 is enacted to read:

9 "[NEW MATERIAL] PREVENTIVE SERVICES BENEFITS--ASPIRIN
10 REGIMEN--HIGH BLOOD PRESSURE SCREENING--BREAST CANCER
11 SCREENING--LIPID DISORDERS SCREENING--COLORECTAL CANCER
12 SCREENING--DEPRESSION SCREENING--BEHAVIORAL DIETARY
13 COUNSELING--OBESITY COUNSELING AND SCREENING--OSTEOPOROSIS
14 SCREENING.--

15 A. A group health insurance policy, health care
16 plan or certificate of health insurance that is delivered or
17 issued for delivery in this state shall provide the following
18 benefits that have, in effect, a rating of "A" or "B" in the
19 current recommendations of the United States preventive
20 services task force, for:

21 (1) a one-time screening for abdominal aortic
22 aneurysm by ultrasonography in men who have ever smoked and who
23 are between the ages of sixty-five and seventy-five;

24 (2) an aspirin regimen for men between the
25 ages of forty-five and seventy-nine when the potential benefit

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1 due to a reduction in myocardial infarctions outweighs the
2 potential harm due to an increase in gastrointestinal
3 hemorrhage;

4 (3) an aspirin regimen for women between the
5 ages of fifty-five and seventy-nine when the potential benefit
6 of a reduction in ischemic strokes outweighs the potential harm
7 due to an increase in gastrointestinal hemorrhage;

8 (4) screening for high blood pressure in
9 adults aged eighteen and older;

10 (5) genetic counseling and evaluation for
11 breast cancer BRCA-gene testing for women whose family
12 histories are associated with an increased risk for deleterious
13 mutations in BRCA1 or BRCA2 genes. Nothing in this paragraph
14 shall be construed as a waiver or exception to the Genetic
15 Information Privacy Act;

16 (6) screening of lipid disorders for:

17 (a) men who are thirty-five years of age
18 or older; and

19 (b) women who are twenty years of age or
20 older who are at increased risk of coronary heart disease;

21 (7) screening of individuals over eighteen
22 years of age for colorectal cancer using fecal occult blood
23 testing, sigmoidoscopy or colonoscopy;

24 (8) screening of individuals eighteen years of
25 age or older for depression;

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1 (9) screening of individuals twelve to
2 eighteen years of age for major depressive disorder;

3 (10) behavioral dietary counseling for adults
4 with hyperlipidemia and other known risk factors for
5 cardiovascular and diet-related chronic disease;

6 (11) screening and counseling for obesity for:

7 (a) individuals eighteen years of age
8 and older who are obese; and

9 (b) individuals six to eighteen years of
10 age; and

11 (12) screening for osteoporosis for:

12 (a) women who are sixty-five years of
13 age and older; and

14 (b) women who are sixty to sixty-five
15 years of age who are at increased risk for osteoporotic
16 fractures.

17 B. The provisions of this section shall not apply
18 to policies or plans intended to supplement major medical
19 group-type coverages such as medicare supplement, long-term
20 care, disability income, specified disease, accident-only,
21 hospital indemnity or other limited-benefit health insurance
22 policies or plans."

23 SECTION 51. A new section of Chapter 59A, Article 23 NMSA
24 1978 is enacted to read:

25 "[NEW MATERIAL] PREVENTIVE SERVICES FOR CHILDREN.--

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1 A. A group health insurance policy, health care
2 plan or certificate of health insurance that is delivered or
3 issued for delivery in this state shall provide the following
4 benefits that have, in effect, a rating of "A" or "B" in the
5 current recommendations of the United States preventive
6 services task force, for:

7 (1) oral fluoride supplementation at currently
8 recommended doses to children six months of age to five years
9 of age whose primary water sources are deficient in fluoride;

10 (2) prophylactic ocular topical medication
11 against gonococcal ophthalmia neonatorum for newborns;

12 (3) screening for hearing loss in newborns;

13 (4) screening for sickle cell disease for
14 newborns;

15 (5) screening for congenital hypothyroidism
16 for newborns;

17 (6) iron supplementation for asymptomatic
18 children six to twelve months of age who are at increased risk
19 for iron deficiency anemia;

20 (7) screening for phenylketonuria in newborns;

21 and

22 (8) screening to detect amblyopia, strabismus
23 and defects in visual acuity in children less than five years
24 of age.

25 B. The provisions of this section shall not apply

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1 to policies or plans intended to supplement major medical
2 group-type coverages such as medicare supplement, long-term
3 care, disability income, specified disease, accident-only,
4 hospital indemnity or other limited-benefit health insurance
5 policies or plans."

6 SECTION 52. A new section of Chapter 59A, Article 23 NMSA
7 1978 is enacted to read:

8 "[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--
9 REPRODUCTIVE HEALTH.--

10 A. A group health insurance policy, health care
11 plan or certificate of health insurance that is delivered or
12 issued for delivery in this state shall provide the following
13 benefits that have, in effect, a rating of "A" or "B" in the
14 current recommendations of the United States preventive
15 services task force, for:

16 (1) screening for asymptomatic bacteriuria
17 with a urine culture for pregnant women;

18 (2) interventions during pregnancy and after
19 birth to promote and support breastfeeding;

20 (3) screening for cervical cancer in women who
21 have been sexually active and have a cervix;

22 (4) screening for chlamydial infection for:

23 (a) all sexually active young women
24 twenty-four years of age and younger; and

25 (b) older women who are at increased

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1 risk of chlamydial infection;

2 (5) a daily supplement containing four hundred
3 to eight hundred micrograms of folic acid for any woman
4 planning a pregnancy or capable of pregnancy;

5 (6) screening of all sexually active women who
6 are at increased risk for infection, including those who are
7 pregnant, for gonorrheal infection;

8 (7) screening for iron deficiency anemia in
9 asymptomatic pregnant women;

10 (8) Rh (D) blood typing and antibody testing
11 for:

12 (a) all pregnant women; and

13 (b) all unsensitized Rh (D) negative
14 women at twenty-four to twenty-eight weeks' gestation;

15 (9) behavioral counseling to prevent sexually
16 transmitted infections in:

17 (a) all sexually active adolescents; and

18 (b) individuals aged eighteen years and
19 older at increased risk for sexually transmitted infections;

20 (10) screening for hepatitis B virus infection
21 in pregnant women;

22 (11) screening for human immunodeficiency
23 virus for individuals twelve years of age and older who are at
24 risk of human immunodeficiency virus infection;

25 (12) screening for iron deficiency anemia in

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1 asymptomatic pregnant women; and

2 (13) screening for syphilis for:

3 (a) any individual at increased risk for
4 syphilis infection; and

5 (b) any pregnant woman.

6 B. The provisions of this section shall not apply
7 to policies or plans intended to supplement major medical
8 group-type coverages such as medicare supplement, long-term
9 care, disability income, specified disease, accident-only,
10 hospital indemnity or other limited-benefit health insurance
11 policies or plans."

12 SECTION 53. A new section of Chapter 59A, Article 23 NMSA
13 1978 is enacted to read:

14 "[NEW MATERIAL] CHILDHOOD IMMUNIZATION COVERAGE
15 REQUIRED.--

16 A. Each group or blanket health insurance policy,
17 plan and certificate of health insurance delivered or issued
18 for delivery in this state shall provide coverage for childhood
19 immunizations, as well as coverage for medically necessary
20 booster doses of all immunizing agents used in child
21 immunizations, in accordance with the current schedule of
22 immunizations recommended by the American academy of
23 pediatrics, the advisory committee on immunization practices of
24 the federal centers for disease control and prevention or the
25 United States preventive services task force "A"-rated and "B"-

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1 rated recommendations, whichever provides greater coverage.

2 B. The provisions of this section shall not apply
3 to short-term travel, accident-only or limited or specified
4 disease plans or policies."

5 SECTION 54. Section 59A-23B-6 NMSA 1978 (being Laws 1991,
6 Chapter 111, Section 6, as amended) is amended to read:

7 "59A-23B-6. FORMS AND RATES--APPROVAL OF THE
8 SUPERINTENDENT--UNIFORM HEALTH COVERAGE DOCUMENTS--STANDARDIZED
9 DEFINITIONS--ADJUSTED COMMUNITY RATING.--

10 A. All health insurance policy or plan forms,
11 including applications, enrollment forms, policies, plans,
12 certificates, evidences of coverage, riders, amendments,
13 endorsements and disclosure forms, shall be submitted to the
14 superintendent for approval prior to use.

15 B. No health insurance policy or plan may be issued
16 in the state unless the rates have first been filed with and
17 approved by the superintendent. This subsection shall not
18 apply to policies or plans subject to the Small Group Rate and
19 Renewability Act.

20 C. A health insurer, health maintenance
21 organization or nonprofit health care plan that offers an
22 individual policy, plan, evidence of coverage or certificate of
23 insurance issued for delivery in the state shall comply with
24 the uniform standards that the superintendent has established
25 by rule for the following documents issued by each policy,

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1 plan, evidence of coverage or certificate issued in the state
2 relating to:

3 (1) a summary of benefits;

4 (2) an explanation of coverage;

5 (3) definitions of standard insurance terms
6 and medical terms;

7 (4) exceptions, reductions and limitations on
8 coverage;

9 (5) cost-sharing provisions, including
10 deductible, coinsurance and copayment obligations;

11 (6) the renewability and continuation of
12 coverage provisions;

13 (7) a coverage facts disclosure that includes
14 examples that are based on nationally recognized clinical
15 practice guidelines to illustrate common benefits scenarios,
16 including pregnancy and serious or chronic medical conditions
17 and related cost-sharing;

18 (8) a statement of whether the policy, plan,
19 evidence of coverage or certificate:

20 (a) provides minimum essential coverage,
21 as defined under Section 5000A(f) of the federal Internal
22 Revenue Code of 1986; and

23 (b) ensures that the policy's, plan's,
24 evidence of coverage's or certificate's share of the total
25 allowed costs of benefits provided under the policy, plan,

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1 evidence of coverage or certificate is not less than sixty
2 percent of those costs; and

3 (9) a contact number for the consumer to call
4 with additional questions and an internet web address where a
5 copy of the actual individual or group health policy, plan,
6 evidence of coverage or certificate can be reviewed and
7 obtained.

8 D. Prior to any enrollment restriction, an insurer,
9 health maintenance organization or nonprofit health care plan
10 shall provide a summary of benefits and coverage explanation
11 required pursuant to Subsection A of this section to the
12 following persons:

13 (1) an applicant, at the time of application;

14 (2) an enrollee or subscriber, prior to the
15 time of enrollment or re-enrollment, subscription or re-
16 subscription; and

17 (3) a policyholder, plan holder, evidence of
18 coverage holder, subscriber or certificate holder, at the time
19 of issuance of the policy, plan or evidence of coverage or the
20 delivery of the certificate.

21 ~~[G.]~~ E. In determining the initial year's premium
22 or rate charged for coverage under a policy or plan, the only
23 rating factors that may be used are age, ~~[gender pursuant to~~
24 ~~this subsection]~~ geographic area of the place of employment and
25 smoking practices, except that for individual policies the

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1 rating factor of the individual's place of residence may be
2 used instead of the geographic area of the individual's place
3 of employment. [~~In determining the initial and any subsequent~~
4 ~~year's rate, the difference in rates in any one age group that~~
5 ~~may be charged on the basis of a person's gender shall not~~
6 ~~exceed another person's rate in the age group by more than the~~
7 ~~following percentage of the lower rate for policies issued or~~
8 ~~delivered in the respective year; provided, however, that~~
9 ~~gender shall not be used as a rating factor for policies issued~~
10 ~~or delivered on or after January 1, 2014:~~

- 11 (1) ~~twenty percent for calendar year 2010;~~
- 12 (2) ~~fifteen percent for calendar year 2011;~~
- 13 (3) ~~ten percent for calendar year 2012; and~~
- 14 (4) ~~five percent for calendar year 2013.~~

15 ~~D.]~~ F. No person's rate shall exceed the rate of
16 any other person [~~with similar family composition~~] by more than
17 two hundred fifty percent of the lower rate, except that the
18 rates for children under the age of nineteen or children aged
19 nineteen to twenty-five who are full-time students may be as
20 much as three hundred percent lower than the [~~bottom~~] highest
21 age-based rates [~~in the two hundred fifty percent band. The~~
22 ~~rating factor restrictions shall not prohibit an insurer,~~
23 ~~society, organization or plan from offering rates that differ~~
24 ~~depending upon family composition].~~

25 G. No person's rate shall exceed the rate of any

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1 other person on the basis of geographic rating area by an
2 amount that the superintendent shall establish by rule, after
3 review by the United States department of health and human
4 services.

5 H. The rate difference between any one person who
6 smokes and any person who does not use tobacco shall not differ
7 by more than one hundred fifty percent.

8 ~~[E.]~~ I. The provisions of this section do not
9 preclude an insurer, fraternal benefit society, health
10 maintenance organization or nonprofit health care plan from
11 using health status or occupational or industry classification
12 in establishing:

- 13 (1) rates for individual policies; or
14 (2) the amount an employer may be charged for
15 coverage under a group health plan.

16 ~~[F. As used in Subsection E of this section,~~
17 ~~"health status" does not include genetic information.~~

18 ~~G.]~~ J. The superintendent shall adopt regulations
19 to implement the provisions of this section."

20 **SECTION 55.** Section 59A-23C-5.1 NMSA 1978 (being Laws
21 1994, Chapter 75, Section 33, as amended) is amended to read:

22 "59A-23C-5.1. ADJUSTED COMMUNITY RATING.--

23 A. A health benefit plan that is offered by a
24 carrier to a small employer shall be offered without regard to
25 the health status of any individual in the group, except as

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1 provided in the Small Group Rate and Renewability Act. The
2 only rating factors that may be used to determine the initial
3 year's premium charged a group, subject to the maximum rate
4 variation provided in this section for all rating factors, are
5 the group members':

6 (1) ages;

7 [~~(2)~~] ~~genders pursuant to Subsection B of this~~
8 ~~section;~~

9 ~~(3)]~~ (2) geographic areas of the place of
10 employment; or

11 [~~(4)]~~ (3) smoking practices.

12 [~~B. In determining the initial and any subsequent~~
13 ~~year's rate, the difference in rates in any one age group that~~
14 ~~may be charged on the basis of a person's gender shall not~~
15 ~~exceed another person's rate in the age group by more than the~~
16 ~~following percentage of the lower rate for policies issued or~~
17 ~~delivered in the respective year; provided, however, that~~
18 ~~gender shall not be used as a rating factor for policies issued~~
19 ~~or delivered on or after January 1, 2014:~~

20 (1) ~~twenty percent for calendar year 2010;~~

21 (2) ~~fifteen percent for calendar year 2011;~~

22 (3) ~~ten percent for calendar year 2012; and~~

23 (4) ~~five percent for calendar year 2013.~~

24 G.] B. No person's rate shall exceed the rate of
25 any other person [~~with similar family composition~~] on the basis

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1 of age by more than two hundred fifty percent of the lower
2 rate, except that the rates for children under the age of
3 nineteen or children aged nineteen to twenty-five who are full-
4 time students may be as much as three hundred percent lower
5 than the ~~[bottom]~~ highest age-based rates ~~[in the two hundred~~
6 ~~fifty percent band. The rating factor restrictions shall not~~
7 ~~prohibit a carrier from offering rates that differ depending~~
8 ~~upon family composition].~~

9 C. No person's rate shall exceed the rate of any
10 other person on the basis of geographic rating area by an
11 amount that the superintendent shall establish by rule, after
12 review by the United States department of health and human
13 services.

14 D. The rate difference between any one person who
15 smokes and any person who does not use tobacco shall not differ
16 by more than one hundred fifty percent.

17 ~~[D.]~~ E. The provisions of this section do not
18 preclude a carrier from using health status or occupational or
19 industry classification in establishing the amount an employer
20 may be charged for coverage under a group health plan.

21 ~~[E. As used in Subsection D of this section,~~
22 ~~"health status" does not include genetic information.]~~

23 F. The superintendent shall adopt regulations to
24 implement the provisions of this section."

25 SECTION 56. Section 59A-23C-6 NMSA 1978 (being Laws 1991,

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1 Chapter 153, Section 6) is amended to read:

2 "59A-23C-6. PROVISIONS ON RENEWABILITY OF COVERAGE.--

3 A. Except as provided in Subsection B of this
4 section, a health benefit plan subject to the Small Group Rate
5 and Renewability Act shall be renewable to all eligible
6 employees and dependents at the option of the small employer,
7 except for the following reasons:

8 (1) nonpayment of required premiums;

9 (2) ~~[fraud or misrepresentation of the small
10 employer, or with respect to coverage of an insured individual,
11 fraud or misrepresentation by the insured individual or that
12 individual's representative]~~ an act by a covered employee or
13 dependent that constitutes:

14 (a) fraud; or

15 (b) an intentional misrepresentation of
16 material fact that is prohibited by the terms of the plan;

17 (3) noncompliance with plan provisions;

18 (4) the number of individuals covered under
19 the plan is less than the number or percentage of eligible
20 individuals required by percentage requirements under the plan;
21 or

22 (5) the small employer is no longer actively
23 engaged in the business in which it was engaged on the
24 effective date of the plan.

25 Eligibility classifications may not be changed if any

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1 individual is eliminated, due to the change, who was insured
2 immediately prior to the change without first receiving the
3 approval of the superintendent.

4 B. A small employer carrier may cease to renew all
5 plans under a class of business. The carrier shall provide
6 notice to all affected health benefit plans and to the
7 superintendent in each state in which an affected insured
8 individual is known to reside at least ninety days prior to
9 termination of coverage. A carrier [~~which~~] that exercises its
10 right to cease to renew all plans in a class of business shall
11 not:

12 (1) establish a new class of business for a
13 period of five years after the nonrenewal of the plans without
14 prior approval of the superintendent; or

15 (2) transfer or otherwise provide coverage to
16 any of the employers from the nonrenewed class of business
17 unless the insurer offers to transfer or provide coverage to
18 all affected employers and eligible employees and dependents
19 without regard to case characteristics, claim experience,
20 health status or duration of coverage.

21 C. A small employer carrier may not change
22 eligibility classifications upon renewal or replacement within
23 twelve months of its termination of its own coverage if the
24 change in classification eliminates from coverage any
25 individual who was insured previous to the change and would

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1 have continued to be insured if the change in eligibility had
2 not occurred."

3 SECTION 57. Section 59A-23C-10 NMSA 1978 (being Laws
4 2010, Chapter 94, Section 2) is amended to read:

5 "59A-23C-10. HEALTH INSURERS--DIRECT SERVICES.--

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

21 B. For individually underwritten health care
22 policies, plans or contracts, the superintendent shall
23 establish, after notice and informal hearing, the level of
24 reimbursement for direct services, as determined by the reports
25 filed with the insurance division, as a percent of premiums.

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

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

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

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

13 E. For the purposes of this section:

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

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

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

18 **SECTION 58.** Section 59A-23D-2 NMSA 1978 (being Laws 1995,
19 Chapter 93, Section 2, as amended) is amended to read:

20 "59A-23D-2. DEFINITIONS.--As used in the Medical Care
21 Savings Account Act:

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

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

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

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

6 (4) a person approved by the federal secretary
7 of health and human services;

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

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

14 D. "dependent" means:

15 (1) a spouse;

16 (2) [~~an unmarried or unemancipated~~] a child of
17 the employee who is [~~a minor~~] under the age of twenty-six and
18 who is:

19 (a) a natural child;

20 (b) a legally adopted child;

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

24 (d) a child for whom the employee is the
25 legal guardian and who is primarily dependent on the employee

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1 for maintenance and support, as long as evidence of the
2 guardianship is evidenced in a court order or decree; or

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

6 [~~(3) an unmarried child described in~~
7 ~~Subparagraphs (a) through (e) of Paragraph (2) of this~~
8 ~~subsection who is between the ages of eighteen and twenty-five]~~
9 or

10 [~~(4)~~] (3) a child over the age of [~~eighteen~~
11 ~~twenty-six~~] who is incapable of self-sustaining employment by
12 reason of [~~mental retardation~~] cognitive or physical [~~handicap~~
13 ~~disability~~] and who is chiefly dependent on the employee for
14 support and maintenance;

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

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

19 (2) is not, while covered under a qualified
20 higher deductible health plan, covered under any health plan
21 that:

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

24 (b) provides coverage for any benefit
25 that is covered under the qualified higher deductible health

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1 plan; and

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

6 F. "eligible medical expense" means an expense paid
7 by the employee for medical care described in Section 213(d) of
8 the Internal Revenue Code of 1986 that is deductible for
9 federal income tax purposes to the extent that those amounts
10 are not compensated for by insurance or otherwise;

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

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

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

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

21 (a) unless it is in cash; or

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

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1 Account Act;

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

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

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

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

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

17 (1) self-only coverage with an annual
18 deductible of not less than one thousand five hundred dollars
19 (\$1,500) or more than two thousand two hundred fifty dollars
20 (\$2,250) and a maximum annual out-of-pocket expense requirement
21 of three thousand dollars (\$3,000), not including premiums;

22 (2) family coverage with an annual deductible
23 of not less than three thousand dollars (\$3,000) or more than
24 four thousand five hundred dollars (\$4,500) and a maximum
25 annual out-of-pocket expense requirement of five thousand five

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1 hundred dollars (\$5,500), not including premiums; and
2 (3) preventive care coverage may be provided
3 within the policies without the preventive care being subjected
4 to the qualified higher deductibles."

5 SECTION 59. Section 59A-23E-19 NMSA 1978 (being Laws
6 1998, Chapter 41, Section 23) is amended to read:

7 "59A-23E-19. INDIVIDUAL HEALTH INSURANCE COVERAGE--
8 GUARANTEED RENEWABILITY--EXCEPTIONS.--

9 A. Except as otherwise provided in this section, a
10 health insurance issuer that provides individual health
11 insurance coverage to an individual shall renew or continue
12 that coverage in force at the option of the individual.

13 B. A health insurance issuer may refuse to renew or
14 discontinue health insurance coverage of an individual in the
15 individual market if:

16 (1) the individual has failed to pay premiums
17 or contributions in accordance with the terms of the health
18 insurance coverage or the issuer has not received timely
19 premium payments;

20 (2) the individual has ~~[performed an act or~~
21 ~~practice]~~ engaged in conduct that constitutes:

22 (a) fraud; or ~~[has made]~~

23 (b) an intentional misrepresentation of
24 a material fact ~~[under]~~ as prohibited by the terms of the
25 coverage;

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1 (3) the issuer is ceasing to offer coverage in
2 the individual market in accordance with Subsection C of this
3 section;

4 (4) in the case of a health insurance issuer
5 that offers health insurance coverage in the market through a
6 network plan, the individual no longer lives, resides or works
7 in the service area of the issuer or the area for which the
8 issuer is authorized to do business, but only if the coverage
9 is terminated pursuant to this paragraph uniformly without
10 regard to any health status related factor of covered
11 individuals; and

12 (5) in the case of health insurance coverage
13 that is made available to the individual market only through
14 one or more bona fide associations, the membership of the
15 individual in the association on the basis of which the
16 coverage is provided ceases, but only if the coverage is
17 terminated pursuant to this paragraph uniformly without regard
18 to any health status related factor of covered individuals.

19 C. A health insurance issuer may discontinue
20 offering a particular type of group health insurance coverage
21 offered in the individual market only if:

22 (1) the issuer provides notice to each covered
23 individual provided coverage of this type in the market of the
24 discontinuation at least ninety days prior to the date of the
25 discontinuation;

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1 (2) the issuer offers to each individual in
2 the individual market provided coverage of this type the option
3 to purchase any other individual health insurance coverage
4 currently being offered by the issuer for individuals in that
5 market; and

6 (3) in exercising the option to discontinue
7 coverage of this type and in offering the option of coverage
8 pursuant to Paragraph (2) of this subsection, the issuer acts
9 uniformly without regard to any health status related factor of
10 enrolled individuals or individuals who may become eligible for
11 that coverage.

12 D. If a health insurance issuer elects to
13 discontinue offering all health insurance coverage, the
14 individual coverage may be discontinued only if:

15 (1) the issuer provides notice to the
16 superintendent and to each individual of the discontinuation at
17 least one hundred eighty days prior to the date of the
18 expiration of the coverage; and

19 (2) all health insurance issued or delivered
20 for issuance in the state in the market is discontinued and
21 coverage is not renewed.

22 E. After discontinuation pursuant to Subsection D
23 of this section, the health insurance issuer shall not provide
24 for the issuance of any health insurance coverage in the market
25 involved during the five-year period beginning on the date of

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1 the discontinuation of the last health insurance coverage not
2 renewed.

3 F. At the time of coverage renewal pursuant to
4 Subsection A of this section, a health insurance issuer may
5 modify the coverage for a policy form offered to individuals in
6 the individual market if the modification is consistent with
7 law and effective on a uniform basis among all individuals with
8 that policy form.

9 G. If health insurance coverage is made available
10 by a health insurance issuer in the individual market to an
11 individual only through one or more associations, a reference
12 to an "individual" is deemed to include a reference to that
13 association."

14 SECTION 60. Section 59A-44-19 NMSA 1978 (being Laws 1989,
15 Chapter 388, Section 19) is amended to read:

16 "59A-44-19. THE BENEFIT CONTRACT.--

17 A. Every society authorized to do business in this
18 state shall issue to each owner of a benefit contract a
19 certificate specifying the amount of benefits provided thereby.
20 The certificate, together with any riders or endorsements
21 attached thereto, the laws of the society, the application for
22 membership, the application for insurance and declaration of
23 insurability, if any, signed by the applicant, and all
24 amendments to each thereof, shall constitute the benefit
25 contract, as of the date of issuance, between the society and

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1 the owner, and the certificate shall so state. A copy of the
2 application for insurance and declaration of insurability, if
3 any, shall be endorsed upon or attached to the certificate.
4 All statements on the application shall be representations and
5 not warranties. Any waiver of this provision shall be void.

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

16 C. Any person upon whose life a certificate is
17 issued prior to attaining the age of majority shall be bound by
18 the terms of the application and certificate and by all the
19 laws and rules of the society to the same extent as though the
20 age of majority had been attained at the time of application.

21 D. A society shall provide in its laws that if its
22 reserves as to all or any class of certificates become
23 impaired, its board of directors or corresponding body shall
24 require that there shall be paid by the owner to the society
25 the amount of the owner's equitable proportion of such

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1 deficiency as ascertained by its board, and that if the payment
2 is not made, either:

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

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

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

16 F. No certificate shall be delivered or issued for
17 delivery in this state unless a copy of the form and rates and
18 rate increases applicable to accident and health insurance have
19 been filed with and approved by the superintendent in
20 accordance with Sections 59A-18-12, 59A-18-13 and 59A-18-14
21 NMSA 1978. Every life or accident and health insurance
22 certificate and every annuity certificate issued on or after
23 one year from [~~the effective date of this act~~] January 1, 1990
24 shall meet the standard contract provision requirements
25 consistent with Chapter 59A, Article 44 NMSA 1978, as specified

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1 in Chapter 59A, Articles 20 and 22 NMSA 1978, except that a
2 society may provide for a grace period for payment of premiums
3 of one full month in its certificates. The certificate shall
4 also contain a provision stating the amount of premiums [~~which~~]
5 that are payable under the certificate and a provision reciting
6 or setting forth the substance of any sections of the society's
7 laws or rules in force at the time of issuance of the
8 certificate [~~which~~] that, if violated, will result in the
9 termination or reduction of benefits payable under the
10 certificate. If the laws of the society provide for expulsion
11 or suspension of a member, the certificate shall also contain a
12 provision that any member so expelled or suspended, except for
13 nonpayment of a premium or within the contestable period for
14 engaging in conduct that constitutes fraud or an intentional
15 material misrepresentation [~~in the application for membership~~
16 ~~or insurance~~] of fact that is prohibited by the terms of
17 membership, shall have the privilege of maintaining the
18 certificate in force by continuing payment of the required
19 premium.

20 G. Certificates issued on the lives of persons
21 below the society's minimum age for adult membership may
22 provide for transfer of control of ownership to the insured at
23 an age specified in the certificate. A society may require
24 approval of an application for membership in order to effect
25 this transfer and may provide in all other respects for the

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1 regulation, government and control of such certificates and all
2 rights, obligations and liabilities incident thereto and
3 connected therewith. Ownership rights prior to such transfer
4 shall be specified in the certificate.

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

7 SECTION 61. Section 59A-46-2 NMSA 1978 (being Laws 1993,
8 Chapter 266, Section 2, as amended) is amended to read:

9 "59A-46-2. DEFINITIONS.--As used in the Health
10 Maintenance Organization Law:

11 A. "basic health care services":

12 (1) means medically necessary services
13 consisting of preventive care, emergency care, inpatient and
14 outpatient hospital and physician care, diagnostic laboratory,
15 diagnostic and therapeutic radiological services and services
16 of pharmacists and pharmacist clinicians; but

17 (2) does not include mental health services or
18 services for alcohol or drug abuse, dental or vision services
19 or long-term rehabilitation treatment;

20 B. "capitated basis" means fixed per member per
21 month payment or percentage of premium payment wherein the
22 provider assumes the full risk for the cost of contracted
23 services without regard to the type, value or frequency of
24 services provided and includes the cost associated with
25 operating staff model facilities;

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1 C. "carrier" means a health maintenance
2 organization, an insurer, a nonprofit health care plan or other
3 entity responsible for the payment of benefits or provision of
4 services under a group contract;

5 D. "child" means an individual who is related to a
6 principal enrollee or applicant for insurance or other coverage
7 pursuant to the Health Maintenance Organization Law by birth or
8 adoption;

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

12 ~~[E.]~~ F. "deductible" means the amount an enrollee
13 is responsible to pay out-of-pocket before the health
14 maintenance organization begins to pay the costs associated
15 with treatment;

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

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

23 ~~[H.]~~ I. "extension of benefits" means the
24 continuation of coverage under a particular benefit provided
25 under a contract or group contract following termination with

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1 respect to an enrollee who is totally disabled on the date of
2 termination;

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

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

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

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

22 ~~[M.]~~ N. "health maintenance organization" means any
23 person who undertakes to provide or arrange for the delivery of
24 basic health care services to enrollees on a prepaid basis,
25 except for enrollee responsibility for copayments or

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1 deductibles;

2 ~~[N-]~~ Q. "health maintenance organization agent"
3 means a person who solicits, negotiates, effects, procures,
4 delivers, renews or continues a policy or contract for health
5 maintenance organization membership or who takes or transmits a
6 membership fee or premium for such a policy or contract, other
7 than for ~~[himself]~~ that person, or a person who advertises or
8 otherwise ~~[holds himself out]~~ makes any representation to the
9 public as such;

10 ~~[O-]~~ P. "individual contract" means a contract for
11 health care services issued to and covering an individual, and
12 it may include dependents of the subscriber;

13 ~~[P-]~~ Q. "insolvent" or "insolvency" means that the
14 organization has been declared insolvent and placed under an
15 order of liquidation by a court of competent jurisdiction;

16 ~~[Q-]~~ R. "managed hospital payment basis" means
17 agreements in which the financial risk is related primarily to
18 the degree of utilization rather than to the cost of services;

19 ~~[R-]~~ S. "net worth" means the excess of total
20 admitted assets over total liabilities, but the liabilities
21 shall not include fully subordinated debt;

22 ~~[S-]~~ T. "participating provider" means a provider
23 as defined in Subsection ~~[U]~~ V of this section who, under an
24 express contract with the health maintenance organization or
25 with its contractor or subcontractor, has agreed to provide

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1 health care services to enrollees with an expectation of
2 receiving payment, other than copayment or deductible, directly
3 or indirectly from the health maintenance organization;

4 ~~[T.]~~ U. "person" means an individual or other legal
5 entity;

6 ~~[U.]~~ V. "provider" means a physician, pharmacist,
7 pharmacist clinician, hospital or other person licensed or
8 otherwise authorized to furnish health care services;

9 ~~[V.]~~ W. "replacement coverage" means the benefits
10 provided by a succeeding carrier;

11 ~~[W.]~~ X. "subscriber" means an individual whose
12 employment or other status, except family dependency, is the
13 basis for eligibility for enrollment in the health maintenance
14 organization or, in the case of an individual contract, the
15 person in whose name the contract is issued;

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

23 ~~[Y.]~~ Z. "pharmacist" means a person licensed as a
24 pharmacist pursuant to the Pharmacy Act; and

25 ~~[Z.]~~ AA. "pharmacist clinician" means a pharmacist

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1 who exercises prescriptive authority pursuant to the Pharmacist
2 Prescriptive Authority Act."

3 SECTION 62. Section 59A-46-38.1 NMSA 1978 (being Laws
4 1994, Chapter 64, Section 9, as amended) is amended to read:

5 "59A-46-38.1. COVERAGE OF CHILDREN.--

6 A. [~~An insurer~~] A health maintenance organization
7 shall not deny enrollment of a child under the health plan or
8 membership of the child's parent on the grounds that the child:

- 9 (1) was born out of wedlock;
- 10 (2) is not claimed as a dependent on the
11 parent's federal tax return; or
- 12 (3) does not reside with the parent or in the
13 insurer's service area.

14 B. When a child has health coverage through [~~an~~
15 ~~insurer~~] a health maintenance organization of a noncustodial
16 parent, the [~~insurer~~] health maintenance organization shall:

- 17 (1) provide such information to the custodial
18 parent as may be necessary for the child to obtain benefits
19 through that coverage;
- 20 (2) permit the custodial parent or the
21 provider, with the custodial parent's approval, to submit
22 claims for covered services without the approval of the
23 noncustodial parent; and
- 24 (3) make payments on claims submitted in
25 accordance with Paragraph (2) of this subsection directly to

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1 the custodial parent, the provider or the state medicaid
2 agency.

3 C. When a parent is required by a court or
4 administrative order to provide health coverage for a child and
5 the parent is eligible for family health coverage, the
6 ~~[insurer]~~ health maintenance organization shall be required:

7 (1) to permit the parent to enroll, under the
8 family coverage, a child who is otherwise eligible for the
9 coverage without regard to any enrollment season restrictions;

10 (2) if the parent is enrolled but fails to
11 make application to obtain coverage for the child, to enroll
12 the child under family coverage upon application of the child's
13 other parent, the state agency administering the medicaid
14 program or the state agency administering 42 U.S.C. Sections
15 651 through 669, the child support enforcement program; and

16 (3) not to disenroll or eliminate coverage of
17 the child unless the ~~[insurer]~~ health maintenance organization
18 is provided satisfactory written evidence that:

19 (a) the court or administrative order is
20 no longer in effect; or

21 (b) the child is or will be enrolled in
22 comparable health coverage through another ~~[insurer]~~ health
23 maintenance organization that will take effect not later than
24 the effective date of disenrollment.

25 D. ~~[An insurer]~~ A health maintenance organization

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1 shall not impose requirements on a state agency that has been
2 assigned the rights of an individual eligible for medical
3 assistance under the medicaid program and covered for health
4 benefits from the ~~[insurer]~~ health maintenance organization
5 that are different from requirements applicable to an agent or
6 assignee of any other individual so covered.

7 E. ~~[An insurer]~~ A health maintenance organization
8 shall provide coverage for children, from birth through three
9 years of age, for or under the family, infant, toddler program
10 administered by the department of health, provided that
11 eligibility criteria are met ~~[for a maximum benefit of three~~
12 ~~thousand five hundred dollars (\$3,500) annually]~~ for medically
13 necessary early intervention services provided as part of an
14 individualized family service plan and delivered by certified
15 and licensed personnel as defined in 7.30.8 NMAC who are
16 working in early intervention programs approved by the
17 department of health. ~~[No payment under this subsection shall~~
18 ~~be applied against any maximum lifetime or annual limits~~
19 ~~specified in the policy, health benefits plan or contract.]"~~

20 SECTION 63. Section 59A-46-38.2 NMSA 1978 (being Laws
21 1997, Chapter 250, Section 4) is amended to read:

22 "59A-46-38.2. CHILDHOOD IMMUNIZATION COVERAGE REQUIRED.--

23 A. Each individual and group health maintenance
24 contract delivered or issued for delivery in this state shall
25 provide coverage for childhood immunizations in accordance with

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1 the current schedule of immunizations recommended by the
2 American academy of pediatrics, [~~including coverage for all~~
3 ~~medically necessary booster doses of all immunizing agents used~~
4 ~~in childhood immunizations]~~ the advisory committee on
5 immunization practices of the federal centers for disease
6 control and prevention or the United States preventive services
7 task force "A"-rated and "B"-rated recommendations, whichever
8 provides greater coverage.

9 B. The provisions of this section shall not apply
10 to short-term travel, accident-only or limited or specified
11 disease policies.

12 [~~B. Coverage for childhood immunizations and~~
13 ~~necessary booster doses may be subject to deductibles and~~
14 ~~coinsurance consistent with those imposed on other benefits~~
15 ~~under the same contract.]"~~

16 SECTION 64. Section 59A-46-38.3 NMSA 1978 (being Laws
17 2003, Chapter 391, Section 5, as amended) is amended to read:

18 "59A-46-38.3. MAXIMUM AGE OF [DEPENDENT] CHILD.--Each
19 individual or group health maintenance organization contract
20 delivered or issued for delivery or renewed in New Mexico that
21 provides coverage for an enrollee's [~~dependents~~] child shall
22 not terminate coverage of [~~an unmarried dependent~~] a child by
23 reason of the [~~dependent's~~] child's age before the [~~dependent's~~
24 ~~twenty-fifth~~] child's twenty-sixth birthday [~~regardless of~~
25 ~~whether the dependent is enrolled in an educational~~

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1 ~~institution~~]; provided that this requirement does not apply to
2 the medicaid managed care system."

3 SECTION 65. Section 59A-46-42 NMSA 1978 (being Laws 1992,
4 Chapter 56, Section 1, as amended) is amended to read:

5 "59A-46-42. COVERAGE FOR CYTOLOGIC AND HUMAN
6 PAPILOMAVIRUS SCREENING.--

7 A. Each individual and group health maintenance
8 organization contract delivered or issued for delivery in this
9 state shall provide coverage for cytologic and human
10 papillomavirus screening to determine the presence of
11 precancerous or cancerous conditions and other health problems.
12 The coverage shall make available cytologic screening, as
13 determined by the health care provider, in accordance with
14 national medical standards and United States preventive
15 services task force "A"-rated and "B"-rated recommendations,
16 whichever provides greater coverage, for women who are eighteen
17 years of age or older and for women who are at risk of cancer
18 or at risk of other health conditions that can be identified
19 through cytologic screening. The coverage shall make available
20 human papillomavirus screening once every three years for women
21 aged thirty and older.

22 B. Coverage for cytologic and human papillomavirus
23 screening may be subject to deductibles and coinsurance
24 consistent with those imposed on other benefits under the same
25 contract.

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1 C. For the purposes of this section:

2 (1) "cytologic screening" means a Papanicolaou
3 test and pelvic exam for asymptomatic as well as symptomatic
4 women;

5 (2) "health care provider" means any person
6 licensed within the scope of ~~[his]~~ the person's practice to
7 perform cytologic and human papillomavirus screening, including
8 physicians, physician assistants, certified nurse-midwives and
9 certified nurse practitioners; and

10 (3) "human papillomavirus screening" means a
11 test approved by the federal food and drug administration for
12 detection of the human papillomavirus."

13 SECTION 66. Section 59A-46-45 NMSA 1978 (being Laws 2003,
14 Chapter 337, Section 4) is amended to read:

15 "59A-46-45. COVERAGE FOR SMOKING CESSATION TREATMENT.--

16 A. An individual or group health maintenance
17 organization contract that is delivered or issued for delivery
18 in this state and that offers maternity benefits shall offer
19 coverage for smoking cessation treatment and shall offer
20 augmented counseling tailored to pregnant women who smoke.

21 ~~[B. Coverage for smoking cessation treatment may be~~
22 ~~subject to deductibles and coinsurance consistent with those~~
23 ~~imposed on other benefits under the same contract.]~~

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

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1 delivered or issued for delivery in this state shall:

2 (1) offer tobacco cessation intervention
3 coverage for those who use tobacco products;

4 (2) provide for screening of pregnant women
5 for tobacco use in accordance with the United States preventive
6 services task force guidelines; and

7 (3) provide diagnostic, therapy and counseling
8 services and pharmacotherapy, including the coverage of
9 prescription and nonprescription tobacco cessation agents
10 approved by the federal food and drug administration for
11 cessation of tobacco use by pregnant women.

12 C. The provisions of this section shall not apply
13 to short-term travel, accident-only or limited or specified-
14 disease policies, plans, contracts or certificates."

15 SECTION 67. Section 59A-46-50 NMSA 1978 (being Laws 2009,
16 Chapter 74, Section 3) is amended to read:

17 "59A-46-50. COVERAGE FOR AUTISM SPECTRUM DISORDER
18 DIAGNOSIS AND TREATMENT.--

19 A. An individual or group health maintenance
20 contract that is delivered, issued for delivery or renewed in
21 this state shall provide coverage to an eligible individual who
22 is nineteen years of age or younger, or an eligible individual
23 who is twenty-two years of age or younger and is enrolled in
24 high school, for:

25 (1) well-baby and well-child screening for

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1 diagnosing the presence of autism spectrum disorder; and

2 (2) treatment of autism spectrum disorder
3 through speech therapy, occupational therapy, physical therapy
4 and applied behavioral analysis.

5 B. Coverage required pursuant to Subsection A of
6 this section:

7 (1) shall be limited to treatment that is
8 prescribed by the insured's treating physician in accordance
9 with a treatment plan;

10 ~~[(2) shall be limited to thirty-six thousand~~
11 ~~dollars (\$36,000) annually and shall not exceed two hundred~~
12 ~~thousand dollars (\$200,000) in total lifetime benefits.~~

13 ~~Beginning January 1, 2011, the maximum benefit shall be~~
14 ~~adjusted annually on January 1 to reflect any change from the~~
15 ~~previous year in the medical component of the then-current~~
16 ~~consumer price index for all urban consumers published by the~~
17 ~~bureau of labor statistics of the United States department of~~
18 ~~labor;~~

19 ~~(3)]~~ (2) shall not be denied on the basis that
20 the services are habilitative or rehabilitative in nature;

21 ~~[(4)]~~ (3) may be subject to other general
22 exclusions and limitations of the insurer's policy or plan,
23 including, but not limited to, coordination of benefits,
24 participating provider requirements, restrictions on services
25 provided by family or household members and utilization review

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1 of health care services, including the review of medical
2 necessity, case management and other managed care provisions;
3 and

4 [~~(5)~~] (4) may be limited to exclude coverage
5 for services received under the federal Individuals with
6 Disabilities Education Improvement Act of 2004 and related
7 state laws that place responsibility on state and local school
8 boards for providing specialized education and related services
9 to children three to twenty-two years of age who have autism
10 spectrum disorder.

11 C. The coverage required pursuant to Subsection A
12 of this section shall not be subject to dollar limits,
13 deductibles or coinsurance provisions that are less favorable
14 to an insured than the dollar limits, deductibles or
15 coinsurance provisions that apply to physical illnesses that
16 are generally covered under the individual or group health
17 maintenance contract, except as otherwise provided in
18 Subsection B of this section.

19 D. [~~An insurer~~] A carrier shall not deny or refuse
20 to issue health insurance coverage for medically necessary
21 services or refuse to contract with, renew, reissue or
22 otherwise terminate or restrict health insurance coverage for
23 an individual because the individual is diagnosed as having
24 autism spectrum disorder.

25 E. The treatment plan required pursuant to

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1 Subsection B of this section shall include all elements
2 necessary for the health insurance plan to pay claims
3 appropriately. These elements include, but are not limited to:

- 4 (1) the diagnosis;
5 (2) the proposed treatment by types;
6 (3) the frequency and duration of treatment;
7 (4) the anticipated outcomes stated as goals;
8 (5) the frequency with which the treatment
9 plan will be updated; and
10 (6) the signature of the treating physician.

11 F. This section shall not be construed as limiting
12 benefits and coverage otherwise available to an insured under a
13 health insurance plan or policy.

14 G. The provisions of this section shall not apply
15 to plans or policies intended to supplement major medical
16 group-type coverages such as medicare supplement, long-term
17 care, disability income, specified disease, accident-only,
18 hospital indemnity or other limited-benefit health insurance
19 plans or policies.

20 H. As used in this section:

21 (1) "autism spectrum disorder" means a
22 condition that meets the diagnostic criteria for the pervasive
23 developmental disorders published in the *Diagnostic and*
24 *Statistical Manual of Mental Disorders*, fourth edition, text
25 revision, also known as DSM-IV-TR, published by the American

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1 psychiatric association, including autistic disorder;
2 Asperger's disorder; pervasive development disorder not
3 otherwise specified; Rett's disorder; and childhood
4 disintegrative disorder;

5 (2) "habilitative or rehabilitative services"
6 means treatment programs that are necessary to develop,
7 maintain and restore to the maximum extent practicable the
8 functioning of an individual; and

9 (3) "high school" means a school providing
10 instruction for any of the grades nine through twelve."

11 **SECTION 68.** Section 59A-46-51 NMSA 1978 (being Laws 2010,
12 Chapter 94, Section 3) is amended to read:

13 "59A-46-51. HEALTH MAINTENANCE ORGANIZATIONS--DIRECT
14 SERVICES.--

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

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1 subsection shall be construed to preclude a purchaser from
2 negotiating an agreement with a health maintenance organization
3 that requires a higher amount of premiums paid to be used for
4 reimbursement for direct services for one or more products or
5 for one or more years.

6 B. For individually underwritten health care
7 policies, plans or contracts, the superintendent shall
8 establish, after notice and informal hearing, the level of
9 reimbursement for direct services, as determined by the reports
10 filed with the insurance division, as a percent of premiums.

11 Additional informal 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 or health maintenance organization writing these
18 policies, plans or contracts shall make reimbursement for
19 direct services at a level not less than that level established
20 by the superintendent pursuant to this subsection over the
21 three calendar years preceding the date upon which that rate is
22 established, but not earlier than calendar year 2010. Nothing
23 in this subsection shall be construed to preclude a purchaser
24 of one of these policies, plans or contracts from negotiating
25 an agreement with a health insurer or health maintenance

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1 organization that requires a higher amount of premiums paid to
2 be used for reimbursement for direct services.

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

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

25 E. For the purposes of this section:

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

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

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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 69. A new section of the Health Maintenance
8 Organization Law is enacted to read:

9 "[NEW MATERIAL] GRANDFATHERED HEALTH PLAN OR GRANDFATHERED
10 HEALTH POLICY COVERAGE.--

11 A. For the purposes of the Health Maintenance
12 Organization Law, "grandfathered health plan" or "grandfathered
13 health policy" means individual coverage provided by a health
14 maintenance organization that was in effect on March 23, 2010
15 and that remains in effect through the original term of
16 coverage or through renewal of the original term.

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

22 C. A group health maintenance organization plan
23 that provides coverage on March 23, 2010 may provide for the
24 enrolling of new employees and their dependents in that
25 grandfathered health plan or policy.

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1 D. Coverage provided by a health maintenance
2 organization pursuant to one or more collective bargaining
3 agreements between employee representatives and one or more
4 employers that was ratified before March 23, 2010 constitutes a
5 grandfathered health plan or policy until the date on which the
6 last of the collective bargaining agreements relating to the
7 coverage terminates. Any coverage amendment made pursuant to a
8 collective bargaining agreement that relates to the coverage
9 and amends the coverage solely to conform to any requirement of
10 the Health Maintenance Organization Law shall not be treated as
11 a termination of the collective bargaining agreement."

12 **SECTION 70.** A new section of the Health Maintenance
13 Organization Law is enacted to read:

14 "[NEW MATERIAL] GUARANTEED ISSUE--GUARANTEED
15 RENEWABILITY--MAXIMUM WAITING PERIOD--BAN ON PREEXISTING
16 CONDITION EXCLUSIONS.--

17 A. A carrier shall issue coverage to any individual
18 who requests and offers to purchase the coverage without
19 permanent exclusion of preexisting conditions.

20 B. Except as provided in to Subsection C of this
21 section, a health maintenance organization that offers a health
22 benefit plan or contract providing group health insurance
23 coverage in the state shall issue any health benefit plan or
24 contract to any employer that applies for such plan and agrees
25 to make the required premium payments and satisfy the other

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1 reasonable provisions of the health plan or contract. A
2 carrier:

3 (1) shall offer coverage to all of the
4 eligible employees of the employer and the employees' children
5 and dependents who apply for enrollment during the period in
6 which the employee first becomes eligible to enroll under the
7 terms of the plan or contract; and

8 (2) shall not offer coverage to only certain
9 individuals or certain children or dependents of employees in
10 the group or to only part of the group.

11 C. A carrier that offers through a network plan or
12 contract shall not be required to offer coverage under that
13 plan or contract or accept applications for that plan or
14 contract pursuant to Subsection A of this section under the
15 following circumstances:

16 (1) to an employer, where the employer is not
17 physically located in the carrier's established geographic
18 service area for the network plan or contract;

19 (2) to an employee, when the employee does not
20 live, work or reside within the carrier's established
21 geographic service area for the network plan or contract; or

22 (3) within the geographic service area for the
23 network plan or contract where the carrier reasonably
24 anticipates, and demonstrates to the satisfaction of the
25 superintendent, that it will not have the capacity within its

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1 established geographic service area to deliver service
2 adequately to the members of the groups because of its
3 obligations to existing group plan holders and enrollees.

4 D. A carrier may restrict enrollment in coverage
5 described in Subsection B of this section to open or special
6 enrollment periods; provided that any special enrollment period
7 shall comply with the provisions of Section 74 of this 2013 act
8 and rules the superintendent has promulgated.

9 E. A carrier may impose a waiting period not to
10 exceed ninety days before payment for any service related to a
11 preexisting condition. A carrier shall offer or make a
12 referral to a transition product to provide coverage during the
13 waiting period due to a preexisting condition.

14 F. A carrier shall renew any health benefit plan or
15 contract at the option of the employer, except as the
16 superintendent has provided by rule.

17 G. A carrier may continue and renew a grandfathered
18 plan or policy that has a permanent exclusion of payment for
19 preexisting conditions.

20 H. For the purposes of this section:

21 (1) "coverage" means a health insurance
22 policy, health care plan, health maintenance organization
23 contract or certificate of insurance issued for delivery in the
24 state. "Coverage" does not mean a short-term, accident, fixed
25 indemnity or specified disease policy; disability income;

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1 limited benefit insurance; credit insurance; workers'
2 compensation; or automobile or medical insurance under which
3 benefits are payable with or without regard to fault and that
4 is required by law to be contained in any liability insurance
5 policy; and

6 (2) "preexisting condition" means a physical
7 or mental condition for which medical advice, medication,
8 diagnosis, care or treatment was recommended for or received by
9 an applicant for health insurance within six months before the
10 effective date of coverage, except that pregnancy is not
11 considered a preexisting condition for federally defined
12 individuals."

13 SECTION 71. A new section of the Health Maintenance
14 Organization Law is enacted to read:

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

16 A. Notwithstanding any other provision of law, a
17 health maintenance organization shall not establish:

18 (1) lifetime limits on the dollar value of
19 benefits for any enrollee; or

20 (2) except as provided in Subsection B of this
21 section, annual limits on the dollar value of benefits for any
22 enrollee.

23 B. With respect to contract years beginning prior
24 to January 1, 2014, a health maintenance organization shall
25 establish a restricted annual limit on the dollar value of

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1 benefits for any enrollee only with respect to the scope of
2 benefits that are essential health benefits, as the
3 superintendent defines "essential health benefits" by rule.

4 C. Subsection A of this section shall not be
5 construed to prevent a health maintenance organization from
6 placing annual or lifetime per enrollee limits on specific
7 covered benefits that are not essential health benefits to the
8 extent that these limits are otherwise permitted under federal
9 or state law.

10 D. The provisions of this section shall not apply
11 to health insurance policies or plans intended to supplement
12 major medical group-type coverages such as medicare supplement,
13 long-term care, disability income, specified disease, accident-
14 only, hospital indemnity or other limited-benefit health
15 insurance policies or plans."

16 SECTION 72. A new section of the Health Maintenance
17 Organization Law is enacted to read:

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

19 A. A health maintenance organization contract or a
20 grandfathered health plan or policy offered shall not rescind
21 coverage under a contract, plan or policy with respect to an
22 individual, including a group to which the individual belongs
23 or family coverage in which the individual is included, after
24 the individual is covered under the contract, plan or policy,
25 unless:

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1 (1) the individual or a person seeking
2 coverage on behalf of the individual engages in conduct that
3 constitutes fraud; or

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

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

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

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

23 SECTION 73. A new section of the Health Maintenance
24 Organization Law is enacted to read:

25 "[NEW MATERIAL] PROHIBITION OF DISCRIMINATION IN FAVOR OF

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1 HIGHLY COMPENSATED INDIVIDUALS--EXCLUSIONS.--

2 A. A group health maintenance organization contract
3 that is delivered, issued for delivery or renewed in this state
4 on behalf of an employer shall not discriminate in favor of
5 highly compensated individuals as to eligibility to participate
6 or as to the benefits offered. The benefits provided for
7 participants who are highly compensated individuals shall be
8 provided for all other participants.

9 B. An employer shall ensure that any employer-
10 sponsored group health coverage it offers is offered to:

11 (1) seventy percent or more of all of that
12 employer's employees;

13 (2) eighty percent or more of all of that
14 employer's employees who are eligible to benefit under the
15 policy, plan or contract if seventy percent or more of all
16 employees are eligible to benefit; or

17 (3) any employees who qualify under a
18 classification that the employer has established and that the
19 secretary of the United States department of health and human
20 services has approved.

21 C. An employer may exclude the following types of
22 employees from an offering of health coverage under Subsections
23 A and B of this section:

24 (1) employees who have not completed three
25 years of service;

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1 (2) employees who have not attained twenty-
2 five years of age;

3 (3) part-time or seasonal employees;

4 (4) employees not included in the plan who are
5 included in a unit of employees covered by an agreement between
6 employee representatives and one or more employers that the
7 secretary of the United States department of health and human
8 services has found to be a collective bargaining agreement, if
9 accident and health benefits were the subject of good faith
10 bargaining between these employee representatives and the
11 employer or employers; and

12 (5) employees who are nonresident aliens of
13 the United States and who receive no earned income, within the
14 meaning of section 911(d)(2) of the federal Internal Revenue
15 Code of 1986, from the employer that constitutes income from
16 sources within the United States, as defined in Section
17 861(a)(3) of the federal Internal Revenue Code of 1986.

18 D. As used in this section, "highly compensated
19 individual" means an individual who is:

20 (1) one of the five highest paid officers of
21 an employer;

22 (2) a shareholder who owns more than ten
23 percent in the value of the employer's stock, pursuant to
24 Section 318 of the federal Internal Revenue Code of 1986; or

25 (3) among the highest paid twenty-five percent

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1 of all employees who do not belong to any category listed in
2 Subsection C of this section."

3 SECTION 74. A new section of the Health Maintenance
4 Organization Law is enacted to read:

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

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

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

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1 organization contract, the notice may be included with other
2 enrollment materials that the carrier distributes to employees;
3 provided that the statement is prominent. If the notice is
4 provided to an employee whose child is entitled to an
5 enrollment opportunity pursuant to Subsection A of this
6 section, the obligation to provide the notice of enrollment
7 opportunity pursuant to this subsection is satisfied for both
8 the individual or group health maintenance organization
9 contract.

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

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

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

3 (1) whose coverage ended, or who was denied
4 coverage or was not eligible for coverage under an individual
5 or group health maintenance organization contract delivered,
6 issued for delivery or renewed in this state because, under the
7 terms of coverage, the availability of dependent coverage of a
8 child ended before the child reached the age of twenty-six; or

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

13 **SECTION 75.** A new section of the Health Maintenance
14 Organization Law is enacted to read:

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

19 A. For contract years beginning before January 1,
20 2014, a group health maintenance organization contract
21 delivered, issued for delivery or renewed in this state that
22 provides group health maintenance organization coverage that is
23 a grandfathered health maintenance organization contract and
24 makes available dependent coverage of children may exclude an
25 adult child under twenty-six years of age from coverage only if

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

5 B. For the purposes of this section, "adult child"
6 means an individual eighteen to twenty-six years of age."

7 SECTION 76. A new section of the Health Maintenance
8 Organization Law is enacted to read:

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

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

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

22 C. During an open enrollment period, a carrier
23 shall not deny or unreasonably delay the issuance of a policy,
24 refuse to issue a policy or issue a policy with any preexisting
25 condition exclusion rider or endorsement to an applicant or

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1 insured who is under the age of nineteen on the basis of a
2 preexisting condition.

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

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

14 SECTION 77. A new section of the Health Maintenance
15 Organization Law is enacted to read:

16 "[NEW MATERIAL] EMERGENCY SERVICES.--

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

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

24 (2) whether or not the health care provider
25 furnishing emergency services is a participating provider with

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1 respect to emergency services.

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

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

22 D. The provisions of this section shall not apply
23 to:

24 (1) policies or plans intended to supplement
25 major medical group-type coverages such as medicare supplement,

1 long-term care, disability income, specified disease, accident-
2 only, hospital indemnity or other limited-benefit health
3 insurance policies or plans; or

4 (2) health insurance policies, plans,
5 certificates or subscriber agreements that are governed by the
6 provisions of Section 59A-22A-5 NMSA 1978.

7 E. As used in this section:

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

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

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

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

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

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

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

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

10 (3) "stabilize" means:

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

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

18 SECTION 78. A new section of the Health Maintenance
19 Organization Law is enacted to read:

20 "[NEW MATERIAL] OPTION FOR PEDIATRICIAN AS PRIMARY CARE
21 PHYSICIAN.--

22 A. An individual or group health maintenance
23 organization contract delivered, issued for delivery or renewed
24 in this state that requires or provides for the designation of
25 a participating primary care provider shall allow a principal

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1 insured to designate for the principal insured's dependent
2 child who is a covered individual an allopathic or osteopathic
3 physician who specializes in pediatrics as the principal
4 insured child's primary care provider if the provider
5 participates in the network of the carrier.

6 B. Nothing in Subsection A of this section shall be
7 construed to waive any exclusions of coverage under the terms
8 and conditions of the contract with respect to coverage of
9 pediatric care.

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

17 SECTION 79. A new section of the Health Maintenance
18 Organization Law is enacted to read:

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

21 A. An individual or group health maintenance
22 organization contract delivered, issued for delivery or renewed
23 in this state that provides coverage for obstetrical and
24 gynecological care and that requires that covered individuals
25 designate a primary care provider shall not require

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1 authorization or referral by the carrier or any person,
2 including a primary care provider, when a female covered
3 individual seeks coverage for obstetrical or gynecological care
4 provided by a participating health care professional who
5 specializes in obstetrics or gynecology. The obstetrical or
6 gynecological health care provider shall agree otherwise to
7 adhere to the contract's or issuer's policies and procedures,
8 including procedures regarding referrals, obtaining prior
9 authorization and providing services pursuant to a treatment
10 plan approved by the carrier.

11 B. A health maintenance organization shall treat
12 the provision of obstetrical and gynecological care, and the
13 ordering of related obstetrical and gynecological items and
14 services by a participating health care professional who
15 specializes in obstetrics or gynecology, as the authorization
16 of the primary care provider.

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

19 (1) waive any exclusions of coverage under the
20 terms and conditions of the contract with respect to coverage
21 of obstetrical or gynecological care; or

22 (2) preclude the carrier from requiring that
23 the obstetrical or gynecological provider notify the covered
24 individual's primary care health care professional or the
25 carrier of treatment decisions.

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

8 **SECTION 80.** A new section of the Health Maintenance
9 Organization Law is enacted to read:

10 "[NEW MATERIAL] COST-SHARING FOR PREVENTIVE ITEMS AND
11 SERVICES.--

12 A. An individual or group health maintenance
13 organization contract delivered, issued for delivery or renewed
14 in this state, except for a grandfathered health policy or
15 plan, shall provide coverage for all of the items and services
16 required under Sections 59A-46-38.2, 59A-46-42 and 59A-46-45
17 NMSA 1978 and Sections 81 through 83 of this 2013 act, and
18 shall not impose any cost-sharing requirements, such as a
19 copayment, coinsurance or deductible.

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

25 C. Other provisions of state or federal law may

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1 apply in connection with a carrier's ceasing to provide
2 coverage for any such items or services.

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

9 E. The superintendent shall at least annually
10 revise the preventive services standards established pursuant
11 to Sections 59A-46-38.2, 59A-46-42 and 59A-46-45 NMSA 1978 and
12 Sections 81 through 83 of this 2013 act to ensure that they are
13 consistent with the "A"-rated and "B"-rated recommendations of
14 the United States preventive services task force, the advisory
15 committee on immunization practices of the federal centers for
16 disease control and prevention and the guidelines with respect
17 to infants, children, adolescents and women of evidence-based
18 preventive care and screenings by the federal health resources
19 and services administration. When changes are made to any of
20 these guidelines or recommendations, the superintendent shall
21 make recommendations to the legislature for legislative changes
22 to conform these standards to current guidelines and
23 recommendations.

24 F. A health maintenance organization may impose
25 cost-sharing requirements with respect to an office visit if a

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1 preventive item or service provided pursuant to this section is
2 billed separately or is tracked as individual encounter data
3 separately from the office visit.

4 G. A health maintenance organization shall not
5 impose cost-sharing requirements with respect to an office
6 visit for an item or service provided pursuant to this section
7 if an item or service is not billed separately or is not
8 tracked as individual encounter data separately from the office
9 visit and the primary purpose of the office visit is the
10 delivery of the preventive item or service.

11 H. A health maintenance organization may impose
12 cost-sharing requirements with respect to an office visit if a
13 preventive item or service provided pursuant to this section is
14 not billed separately or is not tracked as individual encounter
15 data separately from the office visit and the primary purpose
16 of the office visit is not the delivery of the preventive item
17 or service.

18 I. The provisions of this section shall not apply
19 to policies or plans intended to supplement major medical
20 group-type coverages such as medicare supplement, long-term
21 care, disability income, specified disease, accident-only,
22 hospital indemnity or other limited-benefit health insurance
23 policies or plans."

24 **SECTION 81.** A new section of the Health Maintenance
25 Organization Law is enacted to read:

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1 "[NEW MATERIAL] PREVENTIVE SERVICES BENEFITS--ASPIRIN
2 REGIMEN--HIGH BLOOD PRESSURE SCREENING--BREAST CANCER
3 SCREENING--LIPID DISORDERS SCREENING--COLORECTAL CANCER
4 SCREENING--DEPRESSION SCREENING--BEHAVIORAL DIETARY
5 COUNSELING--OBESITY COUNSELING AND SCREENING--OSTEOPOROSIS
6 SCREENING.--

7 A. An individual or group health maintenance
8 organization contract that is delivered, issued for delivery or
9 renewed in this state shall provide the following benefits that
10 have, in effect, a rating of "A" or "B" in the current
11 recommendations of the United States preventive services task
12 force, for:

13 (1) a one-time screening for abdominal aortic
14 aneurysm by ultrasonography in men who have ever smoked and who
15 are between the ages of sixty-five and seventy-five;

16 (2) an aspirin regimen for men between the
17 ages of forty-five and seventy-nine when the potential benefit
18 due to a reduction in myocardial infarctions outweighs the
19 potential harm due to an increase in gastrointestinal
20 hemorrhage;

21 (3) an aspirin regimen for women between the
22 ages of fifty-five and seventy-nine when the potential benefit
23 of a reduction in ischemic strokes outweighs the potential harm
24 due to an increase in gastrointestinal hemorrhage;

25 (4) screening for high blood pressure in

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1 adults aged eighteen and older;

2 (5) genetic counseling and evaluation for
3 breast cancer BRCA-gene testing for women whose family
4 histories are associated with an increased risk for deleterious
5 mutations in BRCA1 or BRCA2 genes. Nothing in this paragraph
6 shall be construed as a waiver or exception to the Genetic
7 Information Privacy Act;

8 (6) screening of lipid disorders for:

9 (a) men who are thirty-five years of age
10 or older; and

11 (b) women who are twenty years of age or
12 older who are at increased risk of coronary heart disease;

13 (7) screening of individuals over eighteen
14 years of age for colorectal cancer using fecal occult blood
15 testing, sigmoidoscopy or colonoscopy;

16 (8) screening of individuals eighteen years of
17 age or older for depression;

18 (9) screening of individuals twelve to
19 eighteen years of age for major depressive disorder;

20 (10) behavioral dietary counseling for adults
21 with hyperlipidemia and other known risk factors for
22 cardiovascular and diet-related chronic disease;

23 (11) screening and counseling for obesity for:

24 (a) individuals eighteen years of age
25 and older who are obese; and

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1 (b) individuals six to eighteen years of
2 age; and

3 (12) screening for osteoporosis for:

4 (a) women who are sixty-five years of
5 age and older; and

6 (b) women who are sixty to sixty-five
7 years of age who are at increased risk for osteoporotic
8 fractures.

9 B. The provisions of this section shall not apply
10 to policies or plans intended to supplement major medical
11 group-type coverages such as medicare supplement, long-term
12 care, disability income, specified disease, accident-only,
13 hospital indemnity or other limited-benefit health insurance
14 policies or plans."

15 SECTION 82. A new section of the Health Maintenance
16 Organization Law is enacted to read:

17 "[NEW MATERIAL] PREVENTIVE SERVICES FOR CHILDREN.--

18 A. An individual or group health maintenance
19 organization contract that is delivered or issued for delivery
20 in this state shall provide the following benefits that have,
21 in effect, a rating of "A" or "B" in the current
22 recommendations of the United States preventive services task
23 force, for:

24 (1) oral fluoride supplementation at currently
25 recommended doses to children six months of age to five years

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1 of age whose primary water sources are deficient in fluoride;

2 (2) prophylactic ocular topical medication
3 against gonococcal ophthalmia neonatorum for newborns;

4 (3) screening for hearing loss in newborns;

5 (4) screening for sickle cell disease for
6 newborns;

7 (5) screening for congenital hypothyroidism
8 for newborns;

9 (6) iron supplementation for asymptomatic
10 children six to twelve months of age who are at increased risk
11 for iron deficiency anemia;

12 (7) screening for phenylketonuria in newborns;
13 and

14 (8) screening to detect amblyopia, strabismus
15 and defects in visual acuity in children less than five years
16 of age.

17 B. The provisions of this section shall not apply
18 to policies or plans intended to supplement major medical
19 group-type coverages such as medicare supplement, long-term
20 care, disability income, specified disease, accident-only,
21 hospital indemnity or other limited-benefit health insurance
22 policies or plans."

23 SECTION 83. A new section of the Health Maintenance
24 Organization Law is enacted to read:

25 "[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--

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1 REPRODUCTIVE HEALTH.--

2 A. An individual or group health maintenance
3 organization contract that is delivered, issued for delivery or
4 renewed in this state shall provide the following benefits that
5 have, in effect, a rating of "A" or "B" in the current
6 recommendations of the United States preventive services task
7 force, for:

8 (1) screening for asymptomatic bacteriuria
9 with a urine culture for pregnant women;

10 (2) interventions during pregnancy and after
11 birth to promote and support breastfeeding;

12 (3) screening for cervical cancer in women who
13 have been sexually active and have a cervix;

14 (4) screening for chlamydial infection for:

15 (a) all sexually active young women
16 twenty-four years of age and younger; and

17 (b) older women who are at increased
18 risk of chlamydial infection;

19 (5) a daily supplement containing four hundred
20 to eight hundred micrograms of folic acid for any woman
21 planning a pregnancy or capable of pregnancy;

22 (6) screening of all sexually active women who
23 are at increased risk for infection, including those who are
24 pregnant, for gonorrheal infection;

25 (7) screening for iron deficiency anemia in

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1 asymptomatic pregnant women;

2 (8) Rh (D) blood typing and antibody testing
3 for:

4 (a) all pregnant women; and

5 (b) all unsensitized Rh (D) negative
6 women at twenty-four to twenty-eight weeks' gestation;

7 (9) behavioral counseling to prevent sexually
8 transmitted infections in:

9 (a) all sexually active adolescents; and

10 (b) individuals aged eighteen years and
11 older at increased risk for sexually transmitted infections;

12 (10) screening for hepatitis B virus infection
13 in pregnant women;

14 (11) screening for human immunodeficiency
15 virus for individuals twelve years of age and older who are at
16 risk of human immunodeficiency virus infection;

17 (12) screening for iron deficiency anemia in
18 asymptomatic pregnant women; and

19 (13) screening for syphilis for:

20 (a) any individual at increased risk for
21 syphilis infection; and

22 (b) any pregnant woman.

23 B. The provisions of this section shall not apply
24 to policies or plans intended to supplement major medical
25 group-type coverages such as medicare supplement, long-term

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1 care, disability income, specified disease, accident-only,
2 hospital indemnity or other limited-benefit health insurance
3 policies or plans."

4 SECTION 84. Section 59A-47-3 NMSA 1978 (being Laws 1984,
5 Chapter 127, Section 879.1, as amended) is amended to read:

6 "59A-47-3. DEFINITIONS.--As used in Chapter 59A, Article
7 47 NMSA 1978:

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

11 B. "item of health care" includes any services or
12 materials used in health care;

13 C. "health care expense payment" means a payment
14 for health care to a purveyor on behalf of a subscriber, or
15 such a payment to the subscriber;

16 D. "purveyor" means a person who furnishes any item
17 of health care and charges for that item;

18 E. "service benefit" means a payment that the
19 purveyor has agreed to accept as payment in full for health
20 care furnished the subscriber;

21 F. "indemnity benefit" means a payment that the
22 purveyor has not agreed to accept as payment in full for health
23 care furnished the subscriber;

24 G. "subscriber" means any individual who, because
25 of a contract with a health care plan entered into by or for

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1 the individual, is entitled to have health care expense
2 payments made on the individual's behalf or to the individual
3 by the health care plan;

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

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

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

22 K. "health care plan" means a nonprofit corporation
23 authorized by the superintendent to enter into contracts with
24 subscribers and to make health care expense payments;

25 L. "agent" means a person appointed by a health

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1 care plan authorized to transact business in this state to act
2 as its representative in any given locality for soliciting
3 health care policies and other related duties as may be
4 authorized;

5 M. "solicitor" means a person employed by the
6 licensed agent of a health care plan for the purpose of
7 soliciting health care policies and other related duties in
8 connection with the handling of the business of the agent as
9 may be authorized and paid for the person's services either on
10 a commission basis or salary basis or part by commission and
11 part by salary;

12 N. "chiropractor" means any person holding a
13 license provided for in the Chiropractic Physician Practice
14 Act;

15 O. "doctor of oriental medicine" means any person
16 licensed as a doctor of oriental medicine under the Acupuncture
17 and Oriental Medicine Practice Act;

18 P. "pharmacist" means a person licensed as a
19 pharmacist pursuant to the Pharmacy Act; ~~and~~

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

23 R. "child" means an individual under twenty-six
24 years of age whom the principal insured covers or whom the
25 applicant for coverage applies to cover, regardless of the

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1 individual's financial dependency, residency with a parent,
2 student status, employment or marital status."

3 SECTION 85. Section 59A-47-24 NMSA 1978 (being Laws
4 1984, Chapter 127, Section 879.22) is amended to read:

5 "59A-47-24. SUBSCRIBER CONTRACTS--REQUIREMENTS AND
6 PROVISIONS.--

7 A. Every health care expense payments contract
8 issued under [~~this article~~] the Nonprofit Health Care Plan
9 Law shall be in writing and shall comply with [requirements
10 ~~and]~~ standards that the superintendent has established by
11 rule pursuant to United States department of health and human
12 services regulations on uniform standards for the following
13 documents issued by each contract relating to:

- 14 (1) a summary of benefits;
- 15 (2) an explanation of coverage;
- 16 (3) definitions of standard insurance terms
17 and medical terms;
- 18 (4) exceptions, reductions and limitations
19 on coverage;
- 20 (5) cost-sharing provisions, including
21 deductible, coinsurance and copayment obligations;
- 22 (6) the renewability and continuation of
23 coverage provisions;
- 24 (7) a coverage facts disclosure that
25 includes examples that are based on nationally recognized

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1 clinical practice guidelines to illustrate common benefits
2 scenarios, including pregnancy and serious or chronic medical
3 conditions and related cost-sharing;

4 (8) a statement of whether the contract:

5 (a) provides minimum essential
6 coverage, as defined under Section 5000A(f) of the federal
7 Internal Revenue Code of 1986; and

8 (b) ensures that the coverage share of
9 the total allowed costs of benefits provided under the
10 contract is not less than sixty percent of those costs; and

11 (9) a contact number for the consumer to
12 call with additional questions and an internet web address
13 where a copy of the actual individual or group health
14 coverage contract can be reviewed and obtained.

15 B. A health care expense payments contract shall
16 contain provisions in substance as follows:

17 ~~[A.]~~ (1) a provision that the policy, the
18 application of the policyholder (if it or a copy thereof is
19 attached to the policy) and the individual applications, if
20 any, submitted in connection with ~~such~~ the policy by the
21 employees or members constitutes the entire contract between
22 the parties, that no statement therein is a warranty in the
23 absence of fraud and that no such statement shall avoid the
24 obligation of the health care plan provided in the policy or
25 reduce benefits thereunder unless contained in a written

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1 application for [~~such~~] the contract, attached to and made
2 part of the policy;

3 [~~B.~~] (2) if [~~such~~] the contract is a group
4 contract, a provision that the health care plan will furnish
5 to the subscriber, for delivery to each employee or member of
6 any covered group, an individual certificate, [~~or~~] an
7 identification card or other evidence of such coverage,
8 setting forth in summary form a statement of the essential
9 features of the contract of all persons included in the
10 coverage;

11 [~~G.~~] (3) if [~~such~~] the contract is a group
12 contract, a provision that eligible new employees or members
13 or dependents, as the case may be, may be added from time to
14 time to the group originally covered, in accordance with the
15 terms of the contract;

16 [~~D.~~] (4) the amount payable to the health
17 care plan by the subscriber and the time at which and manner
18 in which [~~such~~] the amount is to be paid;

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

23 [~~F.~~] (5) any specific term or condition to
24 the effect that the contract may be canceled or otherwise
25 terminated by the health care plan, including the manner and

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

8 [~~G.~~] (6) that the contract includes the
9 endorsements thereon and attached papers, if any, and
10 constitutes the entire contract;

11 [~~H.~~] (7) that [~~after two years no statement,~~
12 ~~except a fraudulent statement, by the subscriber in the~~
13 ~~application for a contract shall void the contract or~~] once
14 the subscriber is covered under the contract, only an act by
15 a subscriber that constitutes fraud or an intentional
16 misrepresentation of material fact that is prohibited by the
17 terms of the contract shall rescind the contract;

18 (8) that no statement, except a fraudulent
19 statement by the subscriber in the application for a
20 contract, shall be used against the subscriber in any legal
21 action or proceedings relating to the contract unless [~~such~~]
22 the application or a true copy thereof is included in or
23 attached to [~~such~~] the contract; a statement that no change
24 in the contract shall be valid until approved by an executive
25 officer of the health care plan and unless [~~such~~] the

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1 approval and countersignature be endorsed on or attached to
2 [~~such~~] the contract; and a statement that no agent has
3 authority to change the contract or waive any of its
4 provisions. No claim for loss incurred or disability, as
5 defined in the policy, shall be reduced or denied on the
6 ground that a disease or physical condition not excluded from
7 coverage by name or a specific description effective on the
8 date of loss had existed prior to the effective date of
9 coverage of [~~such~~] the policy;

10 [~~F.~~] (9) that if the subscriber defaults in
11 making any payment under the contract, the subsequent
12 acceptance of an application for reinstatement and
13 accompanying payment or its failure to take any action with
14 respect thereto within thirty days following receipt of
15 [~~such~~] the application for reinstatement, by [~~such~~] the
16 health care plan or any duly authorized agent thereof,
17 reinstates the contract. The reinstated policy shall cover
18 only loss resulting from such accidental injury as may be
19 sustained after the date of reinstatement and loss due to
20 such sickness as may begin more than ten days after [~~such~~]
21 that date. In all other respects, the subscriber and the
22 health care plan shall have the same rights thereunder as
23 they had under the policy immediately before the due date of
24 the defaulted premium, subject to any provisions endorsed
25 thereon or attached thereto in connection with the

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1 reinstatement. Any premium accepted in connection with a
2 reinstatement shall be applied to a period for which a
3 premium has not been previously paid, but not to any period
4 more than sixty days prior to the date of reinstatement.

5 (The last sentence of the above provision may be omitted from
6 any policy [~~which~~] that the insured has the right to continue
7 in force subject to its terms by the timely payment of
8 premiums:

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

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

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

18 C. Prior to any enrollment restriction, a health
19 care expense payments contract shall provide a summary of
20 benefits and coverage explanation required pursuant to
21 Subsection A of this section to the following persons:

22 (1) an applicant, at the time of
23 application;

24 (2) a subscriber, prior to the time of
25 enrollment or re-enrollment, subscription or re-subscription;

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1 and

2 (3) a subscriber, at the time of issuance of
3 the health care expense payments contract."

4 SECTION 86. Section 59A-47-35 NMSA 1978 (being Laws
5 1984, Chapter 127, Section 879.34, as amended) is amended to
6 read:

7 "59A-47-35. ALCOHOL DEPENDENCY AND MISUSE COVERAGE.--

8 A. Each health care plan that delivers or issues
9 for delivery in this state a group contract providing for
10 health care expense payments on a service benefit basis or an
11 indemnity benefit basis or both shall offer and make
12 available benefits for the necessary care and treatment of
13 alcohol dependency [~~Such~~] and misuse. These benefits shall

14 [~~(1) be subject to annual deductibles and~~
15 ~~coinsurance consistent with those imposed on other benefits~~
16 ~~within the same contract;~~

17 ~~(2)] provide [no less than thirty days]~~
18 necessary care and treatment in an alcohol dependency and
19 misuse treatment center and [~~thirty~~] outpatient visits for
20 alcohol dependency and misuse treatment [~~and~~

21 ~~(3) be offered for benefit periods of no~~
22 ~~more than one year and may be limited to a lifetime maximum~~
23 ~~of no less than two benefit periods.~~

24 ~~Such offer of benefits shall be subject to the rights of~~
25 ~~the group contract holder to reject the coverage or to select~~

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1 ~~any alternative level of benefits if that right is offered by~~
2 ~~or negotiated with that health care plan].~~

3 B. For purposes of this section, "alcohol
4 dependency and misuse treatment center" means a facility that
5 contracts with the health care plan and that provides a
6 program for the treatment of alcohol dependency and misuse
7 pursuant to a written treatment plan approved and monitored
8 by a physician or meeting the quality standards of the
9 department of health and which facility also:

10 (1) is affiliated with a hospital under a
11 contractual agreement with an established system for patient
12 referral;

13 (2) is accredited as such a facility by the
14 joint commission on accreditation of hospitals; or

15 (3) meets at least the minimum standards for
16 treatment of alcohol dependency and misuse adopted by the
17 department of health.

18 C. This section applies to contracts delivered or
19 issued for delivery or renewed, extended or amended in this
20 state on or after July 1, 1983 or upon expiration of a
21 collective bargaining agreement applicable to a particular
22 contract holder, whichever is later; provided that this
23 section does not apply to blanket, short-term travel,
24 accident-only, limited or specified disease, individual
25 conversion contracts or contracts designed for issuance to

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1 persons eligible for coverage under Title 18 of the Social
2 Security Act, known as medicare, or any other similar
3 coverage under state or federal governmental plans. With
4 respect to any contract forms approved by the insurance
5 division prior to the effective date of this section, an
6 insurer is authorized to comply with this section by the use
7 of endorsements or riders; provided [~~such~~] that those
8 endorsements or riders are approved by the insurance division
9 as being in compliance with this section and applicable
10 provisions of the Insurance Code.

11 D. If an organization offering group health
12 benefits to its members makes more than one health care plan
13 or health insurance plan policy available to its members on a
14 member option basis, the organization shall not require
15 alcohol dependency and misuse coverage from one health care
16 plan or health insurer without requiring the same level of
17 alcohol dependency and misuse coverage for all other health
18 care plans or health insurance policies that the organization
19 makes available to its members."

20 SECTION 87. Section 59A-47-37 NMSA 1978 (being Laws
21 1994, Chapter 64, Section 12, as amended) is amended to read:

22 "59A-47-37. COVERAGE OF CHILDREN.--

23 A. [~~An insurer~~] A health care plan shall not deny
24 enrollment of a child under the [~~health~~] plan of the child's
25 parent on the grounds that the child:

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1 (1) was born out of wedlock;

2 (2) is not claimed as a dependent on the
3 parent's federal tax return; or

4 (3) does not reside with the parent or in
5 the insurer's service area.

6 B. When a child has health coverage through an
7 insurer of a noncustodial parent, the ~~[insurer]~~ health care
8 plan shall:

9 (1) provide such information to the
10 custodial parent as may be necessary for the child to obtain
11 benefits through that coverage;

12 (2) permit the custodial parent or the
13 provider, with the custodial parent's approval, to submit
14 claims for covered services without the approval of the
15 noncustodial parent; and

16 (3) make payments on claims submitted in
17 accordance with Paragraph (2) of this subsection directly to
18 the custodial parent, the provider or the state medicaid
19 agency.

20 C. When a parent is required by a court or
21 administrative order to provide health coverage for a child,
22 and the parent is eligible for family health coverage, the
23 ~~[insurer]~~ health care plan shall be required:

24 (1) to permit the parent to enroll, under
25 the family coverage, a child who is otherwise eligible for

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1 the coverage without regard to any enrollment season
2 restrictions;

3 (2) if the parent is enrolled but fails to
4 make application to obtain coverage for the child, to enroll
5 the child under family coverage upon application of the
6 child's other parent, the state agency administering the
7 medicaid program or the state agency administering 42 U.S.C.
8 Sections 651 through 669, the child support enforcement
9 program; and

10 (3) not to disenroll or eliminate coverage
11 of the child unless the ~~[insurer]~~ health care plan is
12 provided satisfactory written evidence that:

13 (a) the court or administrative order
14 is no longer in effect; or

15 (b) the child is or will be enrolled
16 in comparable health coverage through another ~~[insurer]~~
17 health care plan that will take effect not later than the
18 effective date of disenrollment.

19 D. ~~[An insurer]~~ A health care plan shall not
20 impose requirements on a state agency that has been assigned
21 the rights of an individual eligible for medical assistance
22 under the medicaid program and covered for health benefits
23 from the ~~[insurer]~~ health care plan that are different from
24 requirements applicable to an agent or assignee of any other
25 individual so covered.

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1 E. ~~[An insurer]~~ A health care plan shall provide
2 coverage for children, from birth through three years of age,
3 for or under the family, infant, toddler program administered
4 by the department of health, provided eligibility criteria
5 are met [~~for a maximum benefit of three thousand five hundred~~
6 ~~dollars (\$3,500) annually~~] for medically necessary early
7 intervention services provided as part of an individualized
8 family service plan and delivered by certified and licensed
9 personnel as defined in 7.30.8 NMAC who are working in early
10 intervention programs approved by the department of health.
11 No payment under this subsection shall be applied against any
12 maximum lifetime or annual limits specified in the policy,
13 health benefits plan or contract."

14 SECTION 88. Section 59A-47-40 NMSA 1978 (being Laws
15 2003, Chapter 391, Section 7, as amended) is amended to read:

16 "59A-47-40. MAXIMUM AGE OF [DEPENDENT] CHILD.--An
17 individual or group health care coverage, including any form
18 of self-insurance, offered, issued or renewed under the
19 Health Care Purchasing Act that offers coverage of an
20 insured's [~~dependent~~] child shall not terminate coverage of
21 [~~an unmarried dependent~~] a child by reason of the
22 [~~dependent's~~] child's age before the [~~dependent's twenty-~~
23 ~~fifth~~] child's twenty-sixth birthday [~~regardless of whether~~
24 ~~the dependent is enrolled in an educational institution~~]."

25 SECTION 89. Section 59A-47-45 NMSA 1978 (being Laws

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1 2009, Chapter 74, Section 4) is amended to read:

2 "59A-47-45. COVERAGE FOR AUTISM SPECTRUM DISORDER
3 DIAGNOSIS AND TREATMENT.--

4 A. An individual or group health insurance
5 policy, health care plan or certificate of health insurance
6 that is delivered or issued for delivery in this state shall
7 provide coverage to an eligible individual who is nineteen
8 years of age or who is twenty-two years of age or younger and
9 is enrolled in high school, for:

10 (1) well-baby and well-child screening for
11 diagnosing the presence of autism spectrum disorder; and

12 (2) treatment of autism spectrum disorder
13 through speech therapy, occupational therapy, physical
14 therapy and applied behavioral analysis.

15 B. Coverage required pursuant to Subsection A of
16 this section:

17 (1) shall be limited to treatment that is
18 prescribed by the insured's treating physician in accordance
19 with a treatment plan;

20 ~~[(2) shall be limited to thirty-six thousand~~
21 ~~dollars (\$36,000) annually and shall not exceed two hundred~~
22 ~~thousand dollars (\$200,000) in total lifetime benefits.~~

23 ~~Beginning January 1, 2011, the maximum benefit shall be~~
24 ~~adjusted annually on January 1 to reflect any change from the~~
25 ~~previous year in the medical component of the then-current~~

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1 ~~consumer price index for all urban consumers published by the~~
2 ~~bureau of labor statistics of the United States department of~~
3 ~~labor;~~

4 ~~(3)~~ (2) shall not be denied on the basis
5 that the services are habilitative or rehabilitative in
6 nature;

7 [(4)] (3) may be subject to other general
8 exclusions and limitations of the insurer's policy or plan,
9 including, but not limited to, coordination of benefits,
10 participating provider requirements, restrictions on services
11 provided by family or household members and utilization
12 review of health care services, including the review of
13 medical necessity, case management and other managed care
14 provisions; and

15 [(5)] (4) may be limited to exclude coverage
16 for services received under the federal Individuals with
17 Disabilities Education Improvement Act of 2004 and related
18 state laws that place responsibility on state and local
19 school boards for providing specialized education and related
20 services to children three to twenty-two years of age who
21 have autism spectrum disorder.

22 C. The coverage required pursuant to Subsection A
23 of this section shall not be subject to dollar limits,
24 deductibles or coinsurance provisions that are less favorable
25 to an insured than the dollar limits, deductibles or

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1 coinsurance provisions that apply to physical illnesses that
2 are generally covered under the individual or group health
3 maintenance contract, except as otherwise provided in
4 Subsection B of this section.

5 D. ~~[An]~~ A health insurer shall not deny or refuse
6 to issue health insurance coverage for medically necessary
7 services or refuse to contract with, renew, reissue or
8 otherwise terminate or restrict health insurance coverage for
9 an individual because the individual is diagnosed as having
10 autism spectrum disorder.

11 E. The treatment plan required pursuant to
12 Subsection B of this section shall include all elements
13 necessary for the health insurance policy or plan to pay
14 claims appropriately. These elements include, but are not
15 limited to:

- 16 (1) the diagnosis;
17 (2) the proposed treatment by types;
18 (3) the frequency and duration of treatment;
19 (4) the anticipated outcomes stated as
20 goals;
21 (5) the frequency with which the treatment
22 plan will be updated; and
23 (6) the signature of the treating physician.

24 F. This section shall not be construed as
25 limiting benefits and coverage otherwise available to an

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1 insured under a health insurance plan.

2 G. The provisions of this section shall not apply
3 to policies or plans intended to supplement major medical
4 group-type coverages such as medicare supplement, long-term
5 care, disability income, specified disease, accident-only,
6 hospital indemnity or other limited-benefit health insurance
7 policies or plans.

8 H. As used in this section:

9 (1) "autism spectrum disorder" means a
10 condition that meets the diagnostic criteria for the
11 pervasive developmental disorders published in the *Diagnostic*
12 *and Statistical Manual of Mental Disorders*, fourth edition,
13 text revision, also known as DSM-IV-TR, published by the
14 American psychiatric association, including autistic
15 disorder; Asperger's disorder; pervasive development disorder
16 not otherwise specified; Rett's disorder; and childhood
17 disintegrative disorder;

18 (2) "habilitative or rehabilitative
19 services" means treatment programs that are necessary to
20 develop, maintain and restore to the maximum extent
21 practicable the functioning of an individual; and

22 (3) "high school" means a school providing
23 instruction for any of the grades nine through twelve."

24 **SECTION 90.** Section 59A-47-46 NMSA 1978 (being Laws
25 2010, Chapter 94, Section 4) is amended to read:

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1 "59A-47-46. HEALTH [~~INSURERS~~] CARE PLANS--DIRECT
2 SERVICES.--

3 A. A health care plan shall make reimbursement
4 for direct services at a level not less than eighty-five
5 percent of premiums across all health product lines, except
6 individually underwritten health care policies, contracts or
7 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. Reimbursement shall
10 be made for direct services provided over the preceding three
11 calendar years, but not earlier than calendar year 2010, as
12 determined by reports filed with the insurance division of
13 the commission. Nothing in this subsection shall be
14 construed to preclude a purchaser from negotiating an
15 agreement with a health insurer that requires a higher amount
16 of premiums paid to be used for reimbursement for direct
17 services for one or more products or for one or more years.

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

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

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

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

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1 rules the superintendent has promulgated. If the health
2 insurer fails to issue the [~~dividend or credit~~] rebate in
3 accordance with the requirements of this section, the
4 superintendent shall enforce these requirements and may
5 pursue any other penalties as provided by law, including
6 general penalties pursuant to Section 59A-1-18 NMSA 1978.

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

10 E. For the purposes of this section:

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

24 (2) "health care plan" means a nonprofit
25 corporation authorized by the superintendent to enter into

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1 contracts with subscribers and to make health care expense
2 payments but does not include a person that only issues a
3 limited-benefit policy intended to supplement major medical
4 coverage, including medicare supplement, vision, dental,
5 disease-specific, accident-only or hospital indemnity-only
6 insurance policies, or that only issues policies for long-
7 term care or disability income; and

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."

17 SECTION 91. A new section of the Nonprofit Health Care
18 Plan Law is enacted to read:

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

20 A. Notwithstanding any other provision of law, a
21 group individual or group health care plan or certificate of
22 health insurance shall not establish:

23 (1) lifetime limits on the dollar value of
24 benefits for any enrollee; or

25 (2) except as provided in Subsection B of

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1 this section, annual limits on the dollar value of benefits
2 for any enrollee.

3 B. With respect to plan years beginning prior to
4 January 1, 2014, an individual or group health care plan
5 shall establish a restricted annual limit on the dollar value
6 of benefits for any enrollee only with respect to the scope
7 of benefits that are essential health benefits, as the
8 superintendent defines "essential health benefits" by rule.

9 C. Subsection A of this section shall not be
10 construed to prevent a group health care plan from placing
11 annual or lifetime per enrollee limits on specific covered
12 benefits that are not essential health benefits to the extent
13 that these limits are otherwise permitted under federal or
14 state law.

15 D. The provisions of this section shall not apply
16 to policies or plans intended to supplement major medical
17 group-type coverages such as medicare supplement, long-term
18 care, disability income, specified disease, accident-only,
19 hospital indemnity, other limited-benefit health insurance
20 policies or plans."

21 SECTION 92. A new section of the Nonprofit Health Care
22 Plan Law is enacted to read:

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

25 A. A nonprofit health care plan providing

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

7 (1) the individual engages in conduct that
8 constitutes fraud; or

9 (2) the individual makes an intentional
10 misrepresentation of material fact that is prohibited by the
11 terms of the plan or coverage.

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

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

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

3 **SECTION 93.** A new section of the Nonprofit Health Care
4 Plan Law is enacted to read:

5 "[NEW MATERIAL] GRANDFATHERED HEALTH CARE PLAN.--

6 A. For the purposes of the Nonprofit Health Care
7 Plan Law, "grandfathered health care plan" means a nonprofit
8 health care plan that was in effect on March 23, 2010 and
9 that remains in effect through the original term of coverage
10 or through renewal of the original term.

11 B. A dependent of a subscriber enrolled in a
12 grandfathered health care plan may enroll in a grandfathered
13 health care plan if the terms of the plan in effect as of
14 March 23, 2010 permitted the dependent to enroll.

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

18 D. Coverage provided by a nonprofit health care
19 plan pursuant to one or more collective bargaining agreements
20 between employee representatives and one or more employers
21 that was ratified before March 23, 2010 constitutes a
22 grandfathered health care plan until the date on which the
23 last of the collective bargaining agreements relating to the
24 coverage terminates. Any coverage amendment made pursuant to
25 a collective bargaining agreement that relates to the

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1 coverage and amends the coverage solely to conform to any
2 requirement of the Nonprofit Health Care Plan Law shall not
3 be treated as a termination of the collective bargaining
4 agreement."

5 SECTION 94. A new section of the Nonprofit Health Care
6 Plan Law is enacted to read:

7 "[NEW MATERIAL] GUARANTEED ISSUE--GUARANTEED
8 RENEWABILITY--MAXIMUM WAITING PERIOD--BAN ON PREEXISTING
9 CONDITION EXCLUSIONS.--

10 A. A nonprofit health care plan shall issue
11 coverage to any individual who requests and offers to
12 purchase the coverage without permanent exclusion of
13 preexisting conditions.

14 B. Except as provided in Subsection C of this
15 section, a health care plan that offers a group health care
16 plan in the state shall issue any health care plan to any
17 employer that applies for such plan and agrees to make the
18 required premium payments and satisfy the other reasonable
19 provisions of the health care plan. A health care plan:

20 (1) shall offer coverage to all of the
21 eligible employees of the employer and the employees'
22 children and dependents who apply for enrollment during the
23 period in which the employee first becomes eligible to enroll
24 under the terms of the plan; and

25 (2) shall not offer coverage to only certain

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1 individuals or certain children or dependents of employees in
2 the group or to only part of the group.

3 C. A health care plan that offers through a
4 network plan shall not be required to offer coverage under
5 that plan or accept applications for that plan pursuant to
6 Subsection B of this section under the following
7 circumstances:

8 (1) to an employer, where the employer is
9 not physically located in the insurer's established
10 geographic service area for the network plan;

11 (2) to an employee, when the employee does
12 not live, work or reside within the insurer's established
13 geographic service area for the network plan; or

14 (3) within the geographic service area for
15 the network plan where the insurer reasonably anticipates,
16 and demonstrates to the satisfaction of the superintendent,
17 that it will not have the capacity within its established
18 geographic service area to deliver service adequately to the
19 members of the groups because of its obligations to existing
20 group plan holders and enrollees.

21 D. A health care plan may restrict enrollment in
22 coverage described in Subsection B of this section to open or
23 special enrollment periods; provided that any special
24 enrollment period shall comply with the provisions of Section
25 95 of this 2013 act and rules the superintendent has

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1 promulgated.

2 E. A health care plan may impose a waiting period
3 not to exceed ninety days before payment for any service
4 related to a preexisting condition.

5 F. A health care plan shall offer or make a
6 referral to a transition product to provide coverage during
7 the waiting period due to a preexisting condition.

8 G. A health insurer shall renew any health care
9 plan at the option of the employer, except as the
10 superintendent has provided by rule.

11 H. A health care plan may continue and renew a
12 grandfathered health care plan that has a permanent exclusion
13 of payment for preexisting conditions.

14 I. For the purposes of this section:

15 (1) "coverage" means a health insurance
16 policy, health care plan, health maintenance organization
17 contract or certificate of insurance issued for delivery in
18 the state. "Coverage" does not mean a short-term, accident,
19 fixed indemnity or specified disease policy; disability
20 income; limited benefit insurance; credit insurance; workers'
21 compensation; or automobile or medical insurance under which
22 benefits are payable with or without regard to fault and that
23 is required by law to be contained in any liability insurance
24 policy; and

25 (2) "preexisting condition" means a physical

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1 or mental condition for which medical advice, medication,
2 diagnosis, care or treatment was recommended for or received
3 by an applicant for health insurance within six months before
4 the effective date of coverage, except that pregnancy is not
5 considered a preexisting condition for federally defined
6 individuals."

7 SECTION 95. A new section of the Nonprofit Health Care
8 Plan Law is enacted to read:

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

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

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

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

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

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

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1 coverage than similarly situated individuals who did not lose
2 coverage by reason of cessation of dependent status.

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

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

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

15 SECTION 96. A new section of the Nonprofit Health Care
16 Plan Law is enacted to read:

17 "[NEW MATERIAL] PROHIBITION OF DISCRIMINATION IN FAVOR
18 OF HIGHLY COMPENSATED INDIVIDUALS--EXCLUSIONS.--

19 A. A group health care plan that is delivered,
20 issued for delivery or renewed in this state on behalf of an
21 employer shall not discriminate in favor of highly
22 compensated individuals as to eligibility to participate or
23 as to the benefits offered. Benefits provided for
24 participants who are highly compensated individuals shall be
25 provided for all other participants.

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1 B. An employer shall ensure that any employer-
2 sponsored group health coverage it offers is offered to:

3 (1) seventy percent or more of all of that
4 employer's employees;

5 (2) eighty percent or more of all of that
6 employer's employees who are eligible to benefit under the
7 policy, plan or contract if seventy percent or more of all
8 employees are eligible to benefit; or

9 (3) any employees who qualify under a
10 classification that the employer has established and that the
11 secretary of the United States department of health and human
12 services has approved.

13 C. An employer may exclude the following types of
14 employees from an offering of health coverage under
15 Subsections A and B of this section:

16 (1) employees who have not completed three
17 years of service;

18 (2) employees who have not attained twenty-
19 five years of age;

20 (3) part-time or seasonal employees;

21 (4) employees not included in the plan who
22 are included in a unit of employees covered by an agreement
23 between employee representatives and one or more employers
24 that the secretary of the United States department of health
25 and human services has found to be a collective bargaining

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1 agreement, if accident and health benefits were the subject
2 of good faith bargaining between these employee
3 representatives and the employer or employers; and

4 (5) employees who are nonresident aliens of
5 the United States and who receive no earned income, within
6 the meaning of Section 911(d)(2) of the federal Internal
7 Revenue Code of 1986, from the employer which constitutes
8 income from sources within the United States, as defined in
9 Section 861(a)(3) of the federal Internal Revenue Code of
10 1986.

11 D. As used in this section, "highly compensated
12 individual" means an individual who is:

13 (1) one of the five highest paid officers of
14 an employer;

15 (2) a shareholder who owns more than ten
16 percent in the value of the employer's stock, pursuant to
17 Section 318 of the federal Internal Revenue Code of 1986; or

18 (3) among the highest paid twenty-five
19 percent of all employees who do not belong to any category
20 listed in Subsection C of this section."

21 SECTION 97. A new section of the Nonprofit Health Care
22 Plan Law is enacted to read:

23 "[NEW MATERIAL] GRANDFATHERED HEALTH CARE PLANS--ADULT
24 CHILD DEPENDENT ELIGIBLE FOR EMPLOYER-SPONSORED HEALTH
25 BENEFIT PLAN--EXCLUSION FROM DEPENDENT COVERAGE ELIGIBILITY

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1 PERMITTED.--

2 A. For plan years beginning before January 1,
3 2014, a group health care plan providing group health
4 coverage that makes available dependent coverage of children
5 may exclude an adult child under twenty-six years of age from
6 coverage only if the adult child is eligible to enroll in an
7 eligible employer-sponsored health benefit plan, as defined
8 in Section 5000A(f)(2) of the federal Internal Revenue Code
9 of 1986, other than the group health care plan of a parent.

10 B. For the purposes of this section, "adult
11 child" means an individual eighteen to twenty-six years of
12 age."

13 SECTION 98. A new section of the Nonprofit Health Care
14 Plan Law is enacted to read:

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

17 A. An individual or group health care plan that
18 is delivered or issued for delivery in this state shall not
19 limit or exclude coverage under an individual or group health
20 benefit plan for an individual under the age of nineteen by
21 imposing a preexisting condition exclusion on that
22 individual.

23 B. When a health care plan offers individual or
24 group health insurance coverage that only covers individuals
25 under age nineteen, that plan shall offer the coverage

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1 continuously throughout the year or during one or more open
2 enrollment periods as the superintendent prescribes by rule.

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

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

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

20 SECTION 99. A new section of the Nonprofit Health Care
21 Plan Law is enacted to read:

22 "[NEW MATERIAL] EMERGENCY SERVICES.--

23 A. An individual or group health care plan that
24 is delivered or issued for delivery in this state and that
25 provides or covers any benefits with respect to services in

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1 an emergency department of a hospital shall cover emergency
2 services:

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

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

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

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

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1 other than the applicable cost-sharing otherwise permitted
2 pursuant to state or federal law.

3 D. The provisions of this section shall not apply
4 to:

5 (1) policies or plans intended to supplement
6 major medical group-type coverages such as medicare
7 supplement, long-term care, disability income, specified
8 disease, accident-only, hospital indemnity or other limited-
9 benefit health insurance policies or plans; or

10 (2) health insurance policies, plans,
11 certificates or subscriber agreements that are governed by
12 the provisions of Section 59A-22A-5 NMSA 1978.

13 E. As used in this section:

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

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

24 (b) serious impairment to bodily
25 functions; or

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

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

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

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

17 (3) "stabilize" means:

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

24 (b) with respect to a pregnant woman
25 who is having contractions, to deliver, including a

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1 placenta."

2 SECTION 100. A new section of the Nonprofit Health Care
3 Plan Law is enacted to read:

4 "[NEW MATERIAL] OPTION TO CHOOSE PEDIATRICIAN AS PRIMARY
5 CARE PHYSICIAN.--

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

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

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

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1 appropriate."

2 SECTION 101. A new section of the Nonprofit Health Care
3 Plan Law is enacted to read:

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

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

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

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1 care provider.

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

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

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

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

20 SECTION 102. A new section of the Nonprofit Health Care
21 Plan Law is enacted to read:

22 "[NEW MATERIAL] COST-SHARING FOR PREVENTIVE ITEMS AND
23 SERVICES.--

24 A. A health care plan providing coverage under an
25 individual or group health plan, except for grandfathered

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1 health care plan coverage, shall provide coverage for all of
2 the following items and services pursuant to Sections 103
3 through 107 of this 2013 act, and shall not impose any
4 cost-sharing requirements, such as a copayment, coinsurance
5 or deductible.

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

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

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

21 E. The superintendent shall at least annually
22 revise the preventive services standards established pursuant
23 to Sections 103 through 107 of this 2013 act to ensure that
24 they are consistent with the recommendations of the United
25 States preventive services task force, the advisory committee

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1 on immunization practices of the federal centers for disease
2 control and prevention and the guidelines with respect to
3 infants, children, adolescents and women of evidence-based
4 preventive care and screenings by the federal health
5 resources and services administration. When changes are made
6 to any of these guidelines or recommendations, the
7 superintendent shall make recommendations to the legislature
8 for legislative changes to conform these standards to current
9 guidelines and recommendations.

10 F. A health care plan may impose cost-sharing
11 requirements with respect to an office visit if a preventive
12 item or service provided pursuant to this section is billed
13 separately or is tracked as individual encounter data
14 separately from the office visit.

15 G. A health care plan shall not impose
16 cost-sharing requirements with respect to an office visit for
17 an item or service provided pursuant to this section if an
18 item or service is not billed separately or is not tracked as
19 individual encounter data separately from the office visit
20 and the primary purpose of the office visit is the delivery
21 of the preventive item or service.

22 H. A health care plan may impose cost-sharing
23 requirements with respect to an office visit if a preventive
24 item or service provided pursuant to this section is not
25 billed separately or is not tracked as individual encounter

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

4 I. The provisions of this section shall not apply
5 to policies or plans intended to supplement major medical
6 group-type coverages such as medicare supplement, long-term
7 care, disability income, specified disease, accident-only,
8 hospital indemnity or other limited-benefit health insurance
9 policies or plans."

10 SECTION 103. A new section of the Nonprofit Health Care
11 Plan Law is enacted to read:

12 "[NEW MATERIAL] COVERAGE FOR SMOKING AND TOBACCO
13 CESSATION TREATMENT.--

14 A. A health care plan or contract that is
15 delivered or issued for delivery in this state and that
16 offers maternity benefits shall offer coverage for smoking
17 cessation treatment and shall offer augmented counseling
18 tailored to pregnant women who smoke.

19 B. A health care plan shall:

20 (1) offer tobacco cessation intervention
21 coverage for those who use tobacco products;

22 (2) provide for screening of pregnant women
23 for tobacco use in accordance with the United States
24 preventive services task force guidelines; and

25 (3) provide diagnostic, therapy and

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1 counseling services and pharmacotherapy, including the
2 coverage of prescription and nonprescription tobacco
3 cessation agents approved by the federal food and drug
4 administration for cessation of tobacco use by pregnant
5 women.

6 C. The provisions of this section shall not apply
7 to short-term travel, accident-only or limited or specified-
8 disease health care plans, policies, contracts or
9 certificates of insurance."

10 SECTION 104. A new section of the Nonprofit Health Care
11 Plan Law is enacted to read:

12 "[NEW MATERIAL] CHILDHOOD IMMUNIZATION COVERAGE
13 REQUIRED.--

14 A. A health care plan shall provide coverage for
15 childhood immunizations, as well as coverage for medically
16 necessary booster doses of all immunizing agents used in
17 child immunizations, in accordance with the current schedule
18 of immunizations recommended by the American academy of
19 pediatrics, the advisory committee on immunization practices
20 of the federal centers for disease control and prevention or
21 the United States preventive services task force "A"-rated
22 and "B"-rated recommendations, whichever provides greater
23 coverage.

24 B. The provisions of this section shall not apply
25 to short-term travel, accident-only or limited or specified

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1 disease plans or policies."

2 SECTION 105. A new section of the Nonprofit Health Care
3 Plan Law is enacted to read:

4 "[NEW MATERIAL] PREVENTIVE SERVICES BENEFITS--ASPIRIN
5 REGIMEN--HIGH BLOOD PRESSURE SCREENING--BREAST CANCER
6 SCREENING--LIPID DISORDERS SCREENING--COLORECTAL CANCER
7 SCREENING--DEPRESSION SCREENING--BEHAVIORAL DIETARY
8 COUNSELING--OBESITY COUNSELING AND SCREENING--OSTEOPOROSIS
9 SCREENING.--

10 A. A health care plan that is delivered or issued
11 for delivery in this state shall provide the following
12 benefits that have, in effect, a rating of "A" or "B" in the
13 current recommendations of the United States preventive
14 services task force, for:

15 (1) a one-time screening for abdominal
16 aortic aneurysm by ultrasonography in men who have ever
17 smoked and who are between the ages of sixty-five and
18 seventy-five;

19 (2) an aspirin regimen for men between the
20 ages of forty-five and seventy-nine when the potential
21 benefit due to a reduction in myocardial infarctions
22 outweighs the potential harm due to an increase in
23 gastrointestinal hemorrhage;

24 (3) an aspirin regimen for women between the
25 ages of fifty-five and seventy-nine when the potential

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1 benefit of a reduction in ischemic strokes outweighs the
2 potential harm due to an increase in gastrointestinal
3 hemorrhage;

4 (4) screening for high blood pressure in
5 adults aged eighteen and older;

6 (5) genetic counseling and evaluation for
7 breast cancer BRCA-gene testing for women whose family
8 histories are associated with an increased risk for
9 deleterious mutations in BRCA1 or BRCA2 genes. Nothing in
10 this paragraph shall be construed as a waiver or exception to
11 the Genetic Information Privacy Act;

12 (6) screening of lipid disorders for:

13 (a) men who are thirty-five years of
14 age or older; and

15 (b) women who are twenty years of age
16 or older who are at increased risk of coronary heart disease;

17 (7) screening of individuals over eighteen
18 years of age for colorectal cancer using fecal occult blood
19 testing, sigmoidoscopy or colonoscopy;

20 (8) screening of individuals eighteen years
21 of age or older for depression;

22 (9) screening of individuals twelve to
23 eighteen years of age for major depressive disorder;

24 (10) behavioral dietary counseling for
25 adults with hyperlipidemia and other known risk factors for

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1 cardiovascular and diet-related chronic disease;

2 (11) screening and counseling for obesity
3 for:

4 (a) individuals eighteen years of age
5 and older who are obese; and

6 (b) individuals six to eighteen years
7 of age; and

8 (12) screening for osteoporosis for:

9 (a) women who are sixty-five years of
10 age and older; and

11 (b) women who are sixty to sixty-five
12 years of age who are at increased risk for osteoporotic
13 fractures.

14 B. The provisions of this section shall not apply
15 to policies or plans intended to supplement major medical
16 group-type coverages such as medicare supplement, long-term
17 care, disability income, specified disease, accident-only,
18 hospital indemnity or other limited-benefit health insurance
19 policies or plans."

20 SECTION 106. A new section of the Nonprofit Health Care
21 Plan Law is enacted to read:

22 "[NEW MATERIAL] PREVENTIVE SERVICES FOR CHILDREN.--

23 A. An individual or group health care plan that
24 is delivered or issued for delivery in this state shall
25 provide the following benefits that have, in effect, a rating

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1 of "A" or "B" in the current recommendations of the United
2 States preventive services task force, for:

3 (1) oral fluoride supplementation at
4 currently recommended doses to children six months of age to
5 five years of age whose primary water sources are deficient
6 in fluoride;

7 (2) prophylactic ocular topical medication
8 against gonococcal ophthalmia neonatorum for newborns;

9 (3) screening for hearing loss in newborns;

10 (4) screening for sickle cell disease for
11 newborns;

12 (5) screening for congenital hypothyroidism
13 for newborns;

14 (6) iron supplementation for asymptomatic
15 children six to twelve months of age who are at increased
16 risk for iron deficiency anemia;

17 (7) screening for phenylketonuria in
18 newborns; and

19 (8) screening to detect amblyopia,
20 strabismus and defects in visual acuity in children less than
21 five years of age.

22 B. The provisions of this section shall not apply
23 to policies or plans intended to supplement major medical
24 group-type coverages such as medicare supplement, long-term
25 care, disability income, specified disease, accident-only,

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1 hospital indemnity or other limited-benefit health insurance
2 policies or plans."

3 SECTION 107. A new section of the Nonprofit Health Care
4 Plan Law is enacted to read:

5 "[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--
6 REPRODUCTIVE HEALTH.--

7 A. An individual or group health care plan that
8 is delivered or issued for delivery in this state shall
9 provide the following benefits that have, in effect, a rating
10 of "A" or "B" in the current recommendations of the United
11 States preventive services task force, for:

12 (1) screening for asymptomatic bacteriuria
13 with a urine culture for pregnant women;

14 (2) interventions during pregnancy and after
15 birth to promote and support breastfeeding;

16 (3) screening for cervical cancer in women
17 who have been sexually active and have a cervix;

18 (4) screening for chlamydial infection for:

19 (a) all sexually active young women
20 twenty-four years of age and younger; and

21 (b) older women who are at increased
22 risk of chlamydial infection;

23 (5) a daily supplement containing four
24 hundred to eight hundred micrograms of folic acid for any
25 woman planning a pregnancy or capable of pregnancy;

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1 (6) screening of all sexually active women
2 who are at increased risk for infection, including those who
3 are pregnant, for gonorrheal infection;

4 (7) screening for iron deficiency anemia in
5 asymptomatic pregnant women;

6 (8) Rh (D) blood typing and antibody testing
7 for:

8 (a) all pregnant women; and

9 (b) all unsensitized Rh (D) negative
10 women at twenty-four to twenty-eight weeks' gestation;

11 (9) behavioral counseling to prevent
12 sexually transmitted infections in:

13 (a) all sexually active adolescents;

14 and

15 (b) individuals aged eighteen years
16 and older at increased risk for sexually transmitted
17 infections;

18 (10) screening for hepatitis B virus
19 infection in pregnant women;

20 (11) screening for human immunodeficiency
21 virus for individuals twelve years of age and older who are
22 at risk of human immunodeficiency virus infection;

23 (12) screening for iron deficiency anemia in
24 asymptomatic pregnant women; and

25 (13) screening for syphilis for:

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1 (a) any individual at increased risk
2 for syphilis infection; and

3 (b) any pregnant woman.

4 B. The provisions of this section shall not apply
5 to policies or plans intended to supplement major medical
6 group-type coverages such as medicare supplement, long-term
7 care, disability income, specified disease, accident-only,
8 hospital indemnity or other limited-benefit health insurance
9 policies or plans."

10 SECTION 108. Section 59A-56-3 NMSA 1978 (being Laws
11 1994, Chapter 75, Section 3, as amended) is amended to read:

12 "59A-56-3. DEFINITIONS.--As used in the Health
13 Insurance Alliance Act:

14 A. "alliance" means the New Mexico health
15 insurance alliance;

16 B. "approved health plan" means any arrangement
17 for the provisions of health insurance offered through and
18 approved by the alliance;

19 C. "board" means the board of directors of the
20 alliance;

21 D. "child" means [~~a dependent unmarried~~] an
22 individual who is less than [~~twenty-five~~] twenty-six years of
23 age;

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

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- 1 (1) a group health plan;
- 2 (2) health insurance coverage;
- 3 (3) Part A or Part B of Title 18 of the
- 4 federal Social Security Act;
- 5 (4) Title 19 of the federal Social Security
- 6 Act except coverage consisting solely of benefits pursuant to
- 7 Section 1928 of that title;
- 8 (5) 10 USCA Chapter 55;
- 9 (6) a medical care program of the Indian
- 10 health service or of an Indian nation, tribe or pueblo;
- 11 (7) the Medical Insurance Pool Act;
- 12 (8) a health plan offered pursuant to 5 USCA
- 13 Chapter 89;
- 14 (9) a public health plan as defined in
- 15 federal regulations; or
- 16 (10) a health benefit plan offered pursuant
- 17 to Section 5(e) of the federal Peace Corps Act;
- 18 F. "department" means the insurance division of
- 19 the commission;
- 20 G. "director" means an individual who serves on
- 21 the board;
- 22 H. "earned premiums" means premiums paid or due
- 23 during a calendar year for coverage under an approved health
- 24 plan less any unearned premiums at the end of that calendar
- 25 year plus any unearned premiums from the end of the

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1 immediately preceding calendar year;

2 I. "eligible expenses" means the allowable
3 charges for a health care service covered under an approved
4 health plan;

5 J. "eligible individual":

6 (1) means an individual who:

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

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

24 (2) does not include an individual who:

25 (a) has or is eligible for coverage

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1 under a group health plan;

2 (b) is eligible for coverage under
3 medicare or a state plan under Title 19 of the federal Social
4 Security Act or any successor program;

5 (c) has health insurance coverage as
6 defined in Subsection R of Section 59A-23E-2 NMSA 1978;

7 (d) during the most recent coverage
8 within the coverage period described in Subparagraph (a) of
9 Paragraph (1) of this subsection was terminated from coverage
10 as a result of nonpayment of premium or fraud; or

11 (e) has been offered the option of
12 coverage under a COBRA continuation provision as that term is
13 defined in Subsection F of Section 59A-23E-2 NMSA 1978, or
14 under a similar state program, except for continuation
15 coverage under Section 59A-56-20 NMSA 1978, and did not
16 exhaust the coverage available under the offered program;

17 K. "enrollment date" means, with respect to an
18 individual covered under a group health plan or health
19 insurance coverage, the date of enrollment of the individual
20 in the plan or coverage or, if earlier, the first day of the
21 waiting period for that enrollment;

22 L. "gross earned premiums" means premiums paid or
23 due during a calendar year for all health insurance written
24 in the state less any unearned premiums at the end of that
25 calendar year plus any unearned premiums from the end of the

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1 immediately preceding calendar year;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 the current calendar year;

2 X. "superintendent" means the superintendent of
3 insurance;

4 Y. "total premiums" means the total premiums for
5 business written in the state received during a calendar
6 year; and

7 Z. "unearned premiums" means the portion of a
8 premium previously paid for which the coverage period is in
9 the future."

10 SECTION 109. Section 59A-56-14 NMSA 1978 (being Laws
11 1994, Chapter 75, Section 14, as amended) is amended to read:

12 "59A-56-14. ELIGIBILITY--GUARANTEED ISSUE--PLAN
13 PROVISIONS.--

14 A. A small employer is eligible for an approved
15 health plan if on the effective date of coverage or renewal:

16 (1) at least fifty percent of its employees
17 not otherwise insured elect to be covered under the approved
18 health plan;

19 (2) the small employer has not terminated
20 coverage with an approved health plan within three years of
21 the date of application for coverage except to change to
22 another approved health plan; and

23 (3) the small employer does not offer other
24 general group health insurance coverage to its employees.

25 For the purposes of this paragraph, general group health

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1 insurance coverage excludes coverage that:

2 (a) is offered by a state or federal
3 agency to a small employer's employee whose eligibility for
4 alternative coverage is based on the employee's income; or

5 (b) provides only a specific limited
6 form of health insurance such as accident or disability
7 income insurance coverage or a specific health care service
8 such as dental care.

9 B. An individual is eligible for an approved
10 health plan if on the effective date of coverage or renewal
11 the individual meets the definition of an eligible individual
12 under Section 59A-56-3 NMSA 1978.

13 C. An approved health plan shall provide in
14 substance that attainment of the limiting age by an unmarried
15 dependent individual does not operate to terminate coverage
16 when the individual continues to be incapable of self-
17 sustaining employment by reason of developmental disability
18 or physical handicap and the individual is primarily
19 dependent for support and maintenance upon the employee.
20 Proof of incapacity and dependency shall be furnished to the
21 alliance and the member that offered the approved health plan
22 within one hundred twenty days of attainment of the limiting
23 age. The board may require subsequent proof annually after a
24 two-year period following attainment of the limiting age.

25 D. An approved health plan shall provide that the

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1 health insurance benefits applicable for eligible dependents
2 are payable with respect to a newly born child of the family
3 member or the individual in whose name the contract is issued
4 from the moment of birth, including the necessary care and
5 treatment of medically diagnosed congenital defects and birth
6 abnormalities. If payment of a specific premium is required
7 to provide coverage for the child, the contract may require
8 that notification of the birth of a child and payment of the
9 required premium shall be furnished to the member within
10 thirty-one days after the date of birth in order to have the
11 coverage from birth. An approved health plan shall provide
12 that the health insurance benefits applicable for eligible
13 dependents are payable for an adopted child in accordance
14 with the provisions of Section 59A-22-34.1 NMSA 1978.

15 E. ~~[Except as provided in Subsections G, H and I~~
16 ~~of this section]~~ An approved health plan offered to a small
17 employer shall not contain a preexisting condition exclusion
18 that relates to an individual under nineteen years of age.
19 An approved health plan may contain a preexisting condition
20 exclusion that relates to an individual over nineteen years
21 of age only if:

22 (1) the exclusion relates to a condition,
23 physical or mental, regardless of the cause of the condition,
24 for which medical advice, diagnosis, care or treatment was
25 recommended or received within the six-month period ending on

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1 the enrollment date;

2 (2) the exclusion extends for a period of
3 not more than six months after the enrollment date; and

4 (3) the period of the exclusion is reduced
5 by the aggregate of the periods of creditable coverage
6 applicable to the participant or beneficiary as of the
7 enrollment date.

8 F. As used in this section, "preexisting
9 condition exclusion" means a limitation or exclusion of
10 benefits relating to a condition based on the fact that the
11 condition was present before the date of enrollment for
12 coverage for the benefits whether or not any medical advice,
13 diagnosis, care or treatment was recommended or received
14 before that date, but genetic information is not included as
15 a preexisting condition for the purposes of limiting or
16 excluding benefits in the absence of a diagnosis of the
17 condition related to the genetic information.

18 G. An insurer shall not impose a preexisting
19 condition exclusion:

20 (1) in the case of an individual who, as of
21 the last day of the thirty-day period beginning with the date
22 of birth, is covered under creditable coverage;

23 [~~(2) that excludes a child who is adopted or~~
24 ~~placed for adoption before the child's eighteenth birthday~~
25 ~~and who, as of the last day of the thirty-day period~~

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1 ~~beginning on and following the date of the adoption or~~
2 ~~placement for adoption, is covered under creditable coverage]~~
3 or

4 [~~3~~] (2) that relates to or includes
5 pregnancy as a preexisting condition.

6 H. The provisions of [~~Paragraphs~~] Paragraph (1)
7 [~~and (2)~~] of Subsection G of this section do not apply to any
8 individual after the end of the first continuous sixty-three-
9 day period during which the individual was not covered under
10 any creditable coverage.

11 I. The preexisting condition exclusions described
12 in Subsection E of this section shall be waived to the extent
13 to which similar exclusions have been satisfied under any
14 prior health insurance coverage if the effective date of
15 coverage for health insurance through the alliance is made
16 not later than sixty-three days following the termination of
17 the prior coverage. In that case, coverage through the
18 alliance shall be effective from the date on which the prior
19 coverage was terminated. This subsection does not prohibit
20 preexisting conditions coverage in an approved health plan
21 that is more favorable to the covered individual than that
22 specified in this subsection.

23 J. An approved health plan issued to an eligible
24 individual shall not contain any preexisting condition
25 exclusion.

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1 K. An individual is not eligible for coverage by
2 the alliance under an approved health plan issued to a small
3 employer if the individual:

4 (1) is eligible for medicare; provided,
5 however, that if an individual has health insurance coverage
6 from an employer whose group includes twenty or more
7 individuals, an individual eligible for medicare who
8 continues to be employed may choose to be covered through an
9 approved health plan;

10 (2) has voluntarily terminated health
11 insurance issued through the alliance within the past twelve
12 months unless it was due to a change in employment; or

13 (3) is an inmate of a public institution.

14 L. The alliance shall provide for an open
15 enrollment period of sixty days from the initial offering of
16 an approved health plan. Individuals enrolled during the
17 open enrollment period shall not be subject to the
18 preexisting conditions limitation.

19 M. If an insured covered by an approved health
20 plan switches to another approved health plan that provides
21 increased or additional benefits such as lower deductible or
22 copayment requirements, the member offering the approved
23 health plan with increased or additional benefits may require
24 the six-month period for preexisting conditions provided in
25 Subsection E of this section to be satisfied prior to receipt

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1 of the additional benefits."

2 SECTION 110. A new section of the Health Insurance
3 Alliance Act is enacted to read:

4 "[NEW MATERIAL] ELIGIBILITY--GUARANTEED ISSUE--
5 GUARANTEED RENEWABILITY--MAXIMUM WAITING PERIOD--PLAN
6 PROVISIONS.--

7 A. A small employer who applies for an approved
8 health plan and agrees to make the required premium payments
9 and to satisfy the other reasonable provisions of the
10 approved health plan is eligible for an approved health plan.
11 The alliance shall:

12 (1) offer coverage to all of the eligible
13 employees of the employer and their children and dependents
14 who apply for enrollment during the period in which the
15 employee first becomes eligible to enroll under the terms of
16 the plan; and

17 (2) not offer coverage only to certain
18 individuals or certain children or dependents of employees in
19 the group or only to part of the group.

20 B. An approved health plan that offers coverage
21 through a network plan shall not be required to offer
22 coverage under that plan or accept applications for that plan
23 pursuant to Subsection A of this section under the following
24 circumstances:

25 (1) to an employer, where the employer is

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1 not physically located in the insurer's established
2 geographic service area for the network plan;

3 (2) to an employee, when the employee does
4 not live, work or reside within the insurer's established
5 geographic service area for the network plan; or

6 (3) within the geographic service area for
7 the network plan where the insurer reasonably anticipates,
8 and demonstrates to the satisfaction of the superintendent,
9 that it will not have the capacity within its established
10 geographic service area to deliver service adequately to the
11 members of the groups because of its obligations to existing
12 group policyholders and enrollees.

13 C. An approved health plan may restrict
14 enrollment in coverage described in Subsection A of this
15 section to open or special enrollment periods; provided that
16 any special enrollment period shall comply with the
17 provisions of Section 111 of this 2013 act and rules that the
18 superintendent has promulgated.

19 D. An approved health plan may impose a waiting
20 period not to exceed ninety days before payment for any
21 service related to a preexisting condition. An approved
22 health plan shall offer or make a referral to a transition
23 product to provide coverage during the waiting period due to
24 a preexisting condition.

25 E. An approved health plan may continue and renew

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1 a grandfathered approved health plan that has a permanent
2 exclusion of payment for preexisting conditions.

3 F. An approved health plan shall renew any health
4 benefit plan at the option of the employer, except as the
5 superintendent has provided by rule.

6 G. An approved health plan shall provide in
7 substance that attainment of the limiting age by an unmarried
8 dependent individual does not operate to terminate coverage
9 when the individual continues to be incapable of
10 self-sustaining employment by reason of developmental
11 disability or physical handicap and the individual is
12 primarily dependent for support and maintenance upon the
13 employee. Proof of incapacity and dependency shall be
14 furnished to the alliance and the member that offered the
15 approved health plan within one hundred twenty days of
16 attainment of the limiting age. The board may require
17 subsequent proof annually after a two-year period following
18 attainment of the limiting age.

19 H. An approved health plan shall provide that the
20 health insurance benefits applicable for eligible dependents
21 are payable with respect to a newly born child of the family
22 member or the individual in whose name the contract is issued
23 from the moment of birth, including the necessary care and
24 treatment of medically diagnosed congenital defects and birth
25 abnormalities. If payment of a specific premium is required

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1 to provide coverage for the child, the contract may require
2 that notification of the birth of a child and payment of the
3 required premium shall be furnished to the member within
4 thirty-one days after the date of birth in order to have the
5 coverage from birth. An approved health plan shall provide
6 that the health insurance benefits applicable for eligible
7 dependents are payable for an adopted child in accordance
8 with the provisions of Section 59A-22-34.1 NMSA 1978.

9 I. If an insured covered by an approved health
10 plan switches to another approved health plan that provides
11 increased or additional benefits such as lower deductible or
12 copayment requirements, the member offering the approved
13 health plan with increased or additional benefits may require
14 the ninety-day period for preexisting conditions provided in
15 Subsection E of this section to be satisfied prior to receipt
16 of the additional benefits.

17 J. For the purposes of this section:

18 (1) "coverage" means a health insurance
19 policy, health care plan, health maintenance organization
20 contract or certificate of insurance issued for delivery in
21 the state. "Coverage" does not mean a short-term, accident,
22 fixed indemnity or specified disease policy; disability
23 income; limited benefit insurance; credit insurance; workers'
24 compensation; or automobile or medical insurance under which
25 benefits are payable with or without regard to fault and that

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1 is required by law to be contained in any liability insurance
2 policy;

3 (2) "grandfathered approved health plan"
4 means an approved health plan that was in effect on March 23,
5 2010 and that remains in effect through the original term of
6 coverage or through renewal of the original term; and

7 (3) "preexisting condition" means a physical
8 or mental condition for which medical advice, medication,
9 diagnosis, care or treatment was recommended for or received
10 by an applicant for health insurance within six months before
11 the effective date of coverage, except that pregnancy is not
12 considered a preexisting condition for federally defined
13 individuals."

14 SECTION 111. A new section of the Health Insurance
15 Alliance Act is enacted to read:

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

19 A. For health plan or policy years beginning on
20 or after September 23, 2010, if a child's coverage ended or
21 did not begin for the reasons described in Subsection E of
22 this section, an approved health plan shall provide the child
23 an opportunity to enroll in the approved health plan for
24 which coverage continues for at least sixty days and provide
25 written notice of the opportunity to enroll, as described in

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1 Subsection B of this section, no later than the first day of
2 the plan year.

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

18 C. For an individual who enrolls in an approved
19 health plan pursuant to Subsection A of this section, the
20 coverage shall take effect not later than the first day of
21 the first plan year.

22 D. A child enrolling pursuant to this section in
23 an approved health plan shall be considered a "special
24 enrollee" pursuant to Section 59A-23E-8 NMSA 1978. The child
25 and the principal insured shall be offered all of the benefit

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

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

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

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

19 SECTION 112. Section 59A-57-2 NMSA 1978 (being Laws
20 1998, Chapter 107, Section 2) is amended to read:

21 "59A-57-2. PURPOSE OF ACT.--The purpose of the Patient
22 Protection Act is to regulate aspects of health insurance by
23 specifying patient and provider rights and confirming and
24 clarifying the authority of the department to adopt
25 regulations to provide protections to persons enrolled in

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1 ~~[managed]~~ health insurance policies or health care plans.
2 The insurance protections should ensure that ~~[managed]~~ health
3 insurance policies or health care plans treat patients fairly
4 and arrange for the delivery of good quality services."

5 SECTION 113. Section 59A-57-3 NMSA 1978 (being Laws
6 1998, Chapter 107, Section 3) is amended to read:

7 "59A-57-3. DEFINITIONS.--As used in the Patient
8 Protection Act:

9 A. "continuous quality improvement" means an
10 ongoing and systematic effort to measure, evaluate and
11 improve a ~~[managed]~~ health insurance policy's or health care
12 plan's process in order to improve continually the quality of
13 health care services provided to enrollees;

14 B. "covered person", "enrollee", "patient" or
15 "consumer" means an individual who is entitled to receive
16 health care benefits provided by a ~~[managed]~~ health insurance
17 policy or health care plan;

18 C. "department" means the insurance department;

19 D. "emergency care" means health care procedures,
20 treatments or services delivered to a covered person after
21 the sudden onset of what reasonably appears to be a medical
22 condition that manifests itself by symptoms of sufficient
23 severity, including severe pain, that the absence of
24 immediate medical attention could be reasonably expected by a
25 reasonable layperson to result in jeopardy to a person's

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1 health, serious impairment of bodily functions, serious
2 dysfunction of a bodily organ or part or disfigurement to a
3 person;

4 E. "health care facility" means an institution
5 providing health care services, including a hospital or other
6 licensed inpatient center; an ambulatory surgical or
7 treatment center; a skilled nursing center; a residential
8 treatment center; a home health agency; a diagnostic,
9 laboratory or imaging center; and a rehabilitation or other
10 therapeutic health setting;

11 F. "health care insurer" means a person that has
12 a valid certificate of authority in good standing under the
13 Insurance Code to act as an insurer, health maintenance
14 organization, nonprofit health care plan or prepaid dental
15 plan;

16 G. "health care professional" means a physician
17 or other health care practitioner, including a pharmacist,
18 who is licensed, certified or otherwise authorized by the
19 state to provide health care services consistent with state
20 law;

21 H. "health care provider" or "provider" means a
22 person that is licensed or otherwise authorized by the state
23 to furnish health care services and includes health care
24 professionals and health care facilities;

25 I. "health care services" includes, to the extent

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1 offered by the health insurance policy or health care plan,
2 physical health or community-based mental health or
3 developmental disability services, including services for
4 developmental delay;

5 J. "managed health care plan" [~~or "plan"~~] means a
6 health care insurer or a provider service network when
7 offering a benefit that either requires a covered person to
8 use, or creates incentives, including financial incentives,
9 for a covered person to use, health care providers managed,
10 owned, under contract with or employed by the health care
11 insurer or provider service network; [~~"Managed health care
12 plan" or "plan" does not include a health care insurer or
13 provider service network offering a traditional fee-for-
14 service indemnity benefit or a benefit that covers only
15 short-term travel, accident-only, limited benefit, student
16 health plan or specified disease policies]~~]

17 health insurance policy" or "health care
18 plan" means a hospital, surgical and medical expense-incurred
19 policy, plan or contract offered by a health insurer,
20 nonprofit health service provider, health maintenance
21 organization, managed care organization or provider service
22 organization; "health insurance policy" or "health care plan"
23 does not include a policy or plan intended to supplement
24 major medical group-type coverage, such as medicare, long-
25 term care, disability income, specified disease, accident-

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1 only, hospital indemnity or any other limited-benefit health
2 insurance policy or health care plan;

3 ~~[K.]~~ L. "person" means an individual or other
4 legal entity;

5 ~~[L.]~~ M. "point-of-service plan" or "open plan"
6 means a ~~[managed]~~ health care plan that allows enrollees to
7 use health care providers other than providers under direct
8 contract with or employed by the health care plan, even if
9 the plan provides incentives, including financial incentives,
10 for covered persons to use the plan's designated
11 participating providers;

12 ~~[M.]~~ N. "provider service network" means two or
13 more health care providers affiliated for the purpose of
14 providing health care services to covered persons on a
15 capitated or similar prepaid flat-rate basis that hold a
16 certificate of authority pursuant to the Provider Service
17 Network Act;

18 ~~[N.]~~ O. "superintendent" means the superintendent
19 of insurance; and

20 ~~[O.]~~ P. "utilization review" means a system for
21 reviewing the appropriate and efficient allocation of health
22 care services given or proposed to be given to a patient or
23 group of patients."

24 **SECTION 114.** Section 59A-57-4 NMSA 1978 (being Laws
25 1998, Chapter 107, Section 4) is amended to read:

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1 "59A-57-4. PATIENT RIGHTS--DISCLOSURES--RIGHTS TO
2 BASIC AND COMPREHENSIVE HEALTH CARE SERVICES--GRIEVANCE
3 PROCEDURE-- UTILIZATION REVIEW PROGRAM--CONTINUOUS QUALITY
4 PROGRAM.--

5 A. Each covered person enrolled in a ~~managed~~
6 health insurance policy or health care plan has the right to
7 be treated fairly. A ~~managed~~ health insurance policy or
8 health care plan shall arrange for the delivery of good
9 quality and appropriate health care services to enrollees as
10 defined in the particular subscriber agreement. The
11 department shall adopt regulations to implement the
12 provisions of the Patient Protection Act and shall monitor
13 and oversee a ~~managed~~ health insurance policy or health
14 care plan to ensure that each covered person enrolled in a
15 health insurance policy or plan is treated fairly and in
16 accordance with the requirements of the Patient Protection
17 Act. In adopting regulations to implement the provisions of
18 Subparagraphs (a) and (b) of Paragraph (3) and Paragraphs (5)
19 and (6) of Subsection B of this section regarding health care
20 standards and specialists, utilization review programs and
21 continuous quality improvement programs, the department shall
22 cooperate with and seek advice from the department of health.

23 B. The regulations adopted by the department to
24 protect patient rights shall provide at a minimum that:

25 (1) prior to or at the time of enrollment, a

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1 ~~managed~~ health insurance policy or health care plan shall
2 provide a summary of benefits and exclusions, premium
3 information and a provider listing. Within a reasonable time
4 after enrollment and at subsequent periodic times as
5 appropriate, a ~~managed~~ health insurance policy or health
6 care plan shall provide written material that contains, in a
7 clear, conspicuous and readily understandable form, a full
8 and fair disclosure of the policy's or plan's benefits,
9 limitations, exclusions, conditions of eligibility, prior
10 authorization requirements, enrollee financial responsibility
11 for payments, grievance procedures, appeal rights and the
12 patients' rights generally available to all covered persons;

13 (2) a ~~managed~~ health insurance policy or
14 health care plan shall provide health care services that are
15 reasonably accessible and available in a timely manner to
16 each covered person;

17 (3) in providing reasonably accessible
18 health care services that are available in a timely manner, a
19 ~~managed~~ health insurance policy or health care plan shall
20 ensure that:

21 (a) the policy or plan offers
22 sufficient numbers and types of qualified and adequately
23 staffed health care providers at reasonable hours of service
24 to provide health care services to the policy's or plan's
25 enrollees;

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1 (b) health care providers that are
2 specialists may act as primary care providers for patients
3 with chronic medical conditions, provided the specialists
4 offer all basic health care services that are required of
5 them by a ~~[managed]~~ health insurance policy or health care
6 plan;

7 (c) reasonable access is provided to
8 out-of-network health care providers if medically necessary
9 covered services are not reasonably available through
10 participating health care providers or if necessary to
11 provide continuity of care during brief transition periods;

12 (d) emergency care is immediately
13 available without prior authorization requirements, and
14 appropriate out-of-network emergency care is not subject to
15 additional costs; and

16 (e) the policy or plan, through
17 provider selection, provider education, the provision of
18 additional resources or other means, reasonably addresses the
19 cultural and linguistic diversity of its enrollee population;

20 (4) a ~~[managed]~~ health insurance policy or
21 health care plan shall adopt and implement a prompt and fair
22 grievance procedure for resolving patient complaints and
23 addressing patient questions and concerns regarding any
24 aspect of the policy or plan, including the quality of and
25 access to health care, the choice of health care provider or

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1 treatment and the adequacy of the policy's or plan's provider
2 network. The grievance procedure shall notify patients of
3 their right to obtain review by the policy or plan, their
4 right to obtain review by the superintendent, their right to
5 expedited review of emergent utilization decisions and their
6 rights under the Patient Protection Act;

7 (5) a [~~managed~~] health insurance policy or
8 health care plan shall adopt and implement a comprehensive
9 utilization review program. The basis of a decision to deny
10 care shall be disclosed to an affected enrollee. The
11 decision to approve or deny care to an enrollee shall be made
12 in a timely manner, and the final decision shall be made by a
13 qualified health care professional. A policy's or plan's
14 utilization review program shall ensure that enrollees have
15 proper access to health care services, including referrals to
16 necessary specialists. A decision made in a policy's or
17 plan's utilization review program shall be subject to the
18 policy's or plan's grievance procedure and appeal to the
19 superintendent; and

20 (6) a [~~managed~~] health insurance policy or
21 health care plan shall adopt and implement a continuous
22 quality improvement program that monitors the quality and
23 appropriateness of the health care services provided by the
24 policy or plan."

25 SECTION 115. Section 59A-57-5 NMSA 1978 (being Laws

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1 1998, Chapter 107, Section 5) is amended to read:

2 "59A-57-5. CONSUMER ASSISTANCE--CONSUMER ADVISORY
3 BOARDS [~~OMBUDSMAN OFFICE~~]~~--REPORTS TO CONSUMERS--~~
4 SUPERINTENDENT'S ORDERS TO PROTECT CONSUMERS.--

5 A. Each [~~managed~~] health insurance policy or
6 health care plan shall establish and adequately staff a
7 consumer assistance office. The purpose of the consumer
8 assistance office is to respond to consumer questions and
9 concerns and assist patients in exercising their rights and
10 protecting their interests as consumers of health care.

11 B. Each [~~managed~~] health insurance policy or
12 health care plan shall establish a consumer advisory board.
13 The board shall meet at least quarterly and shall advise the
14 policy or plan about the policy's or plan's general
15 operations from the perspective of the insured or enrollee as
16 a consumer of health care. The board shall also review the
17 operations of and be advisory to the plan's consumer
18 assistance office.

19 [~~D.~~] C. The department shall prepare an annual
20 report assessing the operations of [~~managed~~] health insurance
21 policies or health care plans subject to the department's
22 oversight, including information about consumer complaints.

23 [~~E.~~] D. A person adversely affected may file a
24 complaint with the superintendent regarding a violation of
25 the Patient Protection Act. Prior to issuing any remedial

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1 order regarding violations of the Patient Protection Act or
2 its regulations, the superintendent shall hold a hearing in
3 accordance with the provisions of Chapter 59A, Article 4 NMSA
4 1978. The superintendent may issue any order ~~[he]~~ that the
5 superintendent deems necessary or appropriate, including
6 ordering the delivery of appropriate care, to protect
7 consumers and enforce the provisions of the Patient
8 Protection Act. The superintendent shall adopt special
9 procedures to govern the submission of emergency appeals to
10 ~~[him]~~ the superintendent in health emergencies."

11 SECTION 116. Section 59A-57-6 NMSA 1978 (being Laws
12 1998, Chapter 107, Section 6) is amended to read:

13 "59A-57-6. FAIRNESS TO HEALTH CARE PROVIDERS--GAG
14 RULES PROHIBITED--GRIEVANCE PROCEDURE FOR PROVIDERS.--

15 A. ~~[No managed]~~ A health insurance policy or
16 health care plan ~~[may]~~ shall not:

17 (1) adopt a gag rule or practice that
18 prohibits a health care provider from discussing a treatment
19 option with an insured or enrollee even if the plan does not
20 approve of the option;

21 (2) include in any of its contracts with
22 health care providers any provisions that offer an
23 inducement, financial or otherwise, to provide less than
24 medically necessary services to an enrollee; or

25 (3) require a health care provider to

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1 violate any recognized fiduciary duty of [~~his~~] the provider's
2 profession or place [~~his~~] the provider's license in jeopardy.

3 B. A health insurance policy or health care plan
4 that proposes to terminate a health care provider from the
5 [~~managed health care~~] policy or plan shall explain in writing
6 the rationale for its proposed termination and deliver
7 reasonable advance written notice to the provider prior to
8 the proposed effective date of the termination.

9 C. A [~~managed~~] health insurance policy or health
10 care plan shall adopt and implement a process pursuant to
11 which health care providers may raise with the policy or plan
12 concerns that they may have regarding operation of the policy
13 or plan, including concerns regarding quality of and access
14 to health care services, the choice of [~~health care~~]
15 providers and the adequacy of the policy's or plan's provider
16 network. The process shall include, at a minimum, the right
17 of the provider to present the provider's concerns to a
18 policy or plan committee responsible for the substantive area
19 addressed by the concern and the assurance that the concern
20 will be conveyed to the policy's or plan's governing body.
21 In addition, a [~~managed~~] health insurance policy or health
22 care plan shall adopt and implement a fair hearing plan that
23 permits a health care provider to dispute the existence of
24 adequate cause to terminate the provider's participation with
25 the policy or plan to the extent that the relationship is

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1 terminated for cause and shall include in each provider
2 contract a dispute resolution mechanism."

3 SECTION 117. Section 59A-57-8 NMSA 1978 (being Laws
4 1998, Chapter 107, Section 8) is amended to read:

5 "59A-57-8. ADMINISTRATIVE COSTS AND BENEFIT COSTS
6 DISCLOSURES.--The department shall adopt regulations to
7 ensure that both the administrative costs and the direct
8 costs of providing health care services of each ~~[managed]~~
9 health insurance policy or health care plan are fully and
10 fairly disclosed to consumers in a uniform manner that allows
11 meaningful cost comparisons among plans."

12 SECTION 118. Section 59A-57-9 NMSA 1978 (being Laws
13 1998, Chapter 107, Section 9) is amended to read:

14 "59A-57-9. PRIVATE REMEDIES TO ENFORCE PATIENT AND
15 PROVIDER INSURANCE RIGHTS--ENROLLEE AS THIRD-PARTY
16 BENEFICIARY TO ENFORCE RIGHTS.--

17 A. A person who suffers a loss as a result of a
18 violation of a right protected pursuant to the provisions of
19 the Patient Protection Act, its regulations or a ~~[managed]~~
20 health insurance policy or health care plan may bring an
21 action to recover actual damages or the sum of one hundred
22 dollars (\$100), whichever is greater.

23 B. A person likely to be damaged by a denial of a
24 right protected pursuant to the provisions of the Patient
25 Protection Act or its regulations may be granted an

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1 injunction under the principles of equity and on terms that
2 the court considers reasonable. Proof of monetary damage or
3 intent to violate a right is not required.

4 C. To protect and enforce an enrollee's rights in
5 a ~~[managed]~~ health insurance policy or health care plan, an
6 individual enrollee participating in or eligible to
7 participate in a ~~[managed]~~ health insurance policy or health
8 care plan shall be treated as a third-party beneficiary of
9 the ~~[managed]~~ health insurance policy or health care plan
10 contract between the policy or plan and the party with which
11 the policy or plan directly contracts. An individual
12 enrollee may sue to enforce the rights provided in the
13 contract that governs the ~~[managed]~~ health insurance policy
14 or health care plan; provided, however, that the policy or
15 plan and the party to the contract may amend the terms of, or
16 terminate the provisions of, the contract without the
17 insured's or enrollee's consent.

18 D. The relief provided pursuant to this section
19 is in addition to other remedies available against the same
20 conduct under the common law or other statutes of this state.

21 E. In any class action filed pursuant to this
22 section, the court may award damages to the named plaintiffs
23 as provided in this section and may award members of the
24 class the actual damages suffered by each member of the class
25 as a result of the unlawful practice.

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1 F. Nothing in the Patient Protection Act is
2 intended to make a policy or plan vicariously liable for the
3 actions of independent contractor health care providers."

4 SECTION 119. Section 59A-57-11 NMSA 1978 (being Laws
5 1998, Chapter 107, Section 11) is amended to read:

6 "59A-57-11. PENALTY.--In addition to any other
7 penalties provided by law, a civil administrative penalty of
8 up to ten thousand dollars (\$10,000) may be imposed for each
9 violation of the Patient Protection Act. An administrative
10 penalty shall be imposed by written order of the
11 superintendent made after holding a formal hearing as
12 provided for in Chapter 59A, Article 4 NMSA 1978."

13 SECTION 120. A new section of the Patient Protection
14 Act is enacted to read:

15 "[NEW MATERIAL] INTERNAL GRIEVANCE PROCEDURE.--

16 A. A health insurer, health maintenance
17 organization or nonprofit health care plan shall establish
18 and maintain a written internal grievance procedure that has
19 been approved by the superintendent to provide procedures for
20 the resolution of internal grievances initiated by insureds,
21 covered individuals, enrollees or subscribers.

22 B. The superintendent or the superintendent's
23 designee may examine the health insurer's, health maintenance
24 organization's or nonprofit health care plan's written
25 internal grievance procedures and any records relating to

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1 internal grievances filed with the health insurer, health
2 maintenance organization or nonprofit health care plan.

3 C. The health insurer, health maintenance
4 organization or nonprofit health care plan shall maintain
5 records regarding internal grievances it has received since
6 the last date on which the superintendent or the
7 superintendent's designee examined the records of internal
8 grievances filed with the health insurer, health maintenance
9 organization or nonprofit health care plan.

10 D. The provisions of this section shall not apply
11 to policies, plans or evidence of coverage intended to
12 supplement major medical group-type coverages such as
13 medicare supplement, long-term care, disability income,
14 specified disease, accident-only, hospital indemnity or other
15 limited-benefit health insurance policies, plans or evidence
16 of coverage."

17 SECTION 121. TEMPORARY PROVISION--RULEMAKING.--The
18 superintendent of insurance shall adopt and promulgate rules
19 pursuant to the provisions of this act.

20 SECTION 122. DELAYED REPEAL.--Effective January 1,
21 2014, Sections 23, 44, 76, 98 and 109 of this act are
22 repealed.

23 SECTION 123. EFFECTIVE DATE.--

24 A. The effective date of the provisions of
25 Sections 1, 3 through 5, 7 through 18, 20 through 39, 41, 43

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1 through 54, 56 through 69, 71, 72, 74 through 93, 95, 97
2 through 109 and 111 through 121 of this act is June 14, 2013.

3 B. The effective date of the provisions of
4 Sections 2, 6, 19, 40, 42, 55, 70, 73, 94, 96 and 110 of this
5 act is January 1, 2014.