

1 HOUSE BILL 436

2 **54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019**

3 INTRODUCED BY

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10 AN ACT

11 RELATING TO INSURANCE; AMENDING SECTIONS OF THE NEW MEXICO
12 INSURANCE CODE, THE SMALL GROUP RATE AND RENEWABILITY ACT, THE
13 HEALTH INSURANCE PORTABILITY ACT, THE HEALTH MAINTENANCE
14 ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO
15 ALIGN PROVISIONS RELATING TO THE ACCESSIBILITY OF HEALTH CARE
16 COVERAGE TO FEDERAL LAW; ENACTING A NEW SECTION OF THE NEW
17 MEXICO INSURANCE CODE TO REQUIRE THE SUPERINTENDENT OF
18 INSURANCE TO SEEK FEDERAL HEALTH COVERAGE ACCESS AND
19 AFFORDABILITY WAIVER AUTHORIZATION AND FUNDING.
20

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

22 SECTION 1. Section 59A-18-13.1 NMSA 1978 (being Laws
23 1994, Chapter 75, Section 26, as amended) is amended to read:

24 "59A-18-13.1. ADJUSTED COMMUNITY RATING.--

25 A. Every insurer, fraternal benefit society,

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1 multiple employer welfare arrangement, health maintenance
2 organization or nonprofit health care plan that provides
3 primary health insurance or health care coverage insuring or
4 covering major medical expenses shall, in determining the
5 initial year's premium charged for an individual, use only the
6 rating factors of age, [~~gender pursuant to Subsection B of this~~
7 ~~section~~] geographic area of the place of employment and smoking
8 practices, except that for individual policies the rating
9 factor of the individual's place of residence may be used
10 instead of the geographic area of the individual's place of
11 employment.

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 rates 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. Separately for an insurer's individual and
25 group policies, no person's rate shall exceed the rate of any

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1 other person with similar family composition by more than two
2 hundred fifty percent of the lower rate, except that the rates
3 for children under ~~[the age of]~~ nineteen years of age or
4 children ~~[aged]~~ nineteen to twenty-five years of age who are
5 full-time students may ~~[be]~~ have rates that are lower than the
6 bottom rates in the two hundred fifty percent band. The rating
7 factor restrictions shall not prohibit an insurer, multiple
8 employer welfare arrangement, fraternal benefit society, health
9 maintenance organization or nonprofit health care plan from
10 offering rates that differ depending upon family composition.
11 For the purposes of this subsection, "family composition"
12 refers only to whether coverage covers an individual or a
13 family.

14 ~~[D-]~~ C. The provisions of this section do not
15 preclude an insurer, multiple employer welfare arrangement,
16 fraternal benefit society, health maintenance organization or
17 nonprofit health care plan from using health status or
18 occupational or industry classification 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]~~ a large group health
22 benefits plan may be charged for coverage.

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

25 ~~[F-]~~ E. The superintendent shall adopt regulations

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1 to implement the provisions of this section."

2 SECTION 2. Section 59A-18-16 NMSA 1978 (being Laws 1984,
3 Chapter 127, Section 345.1, as amended) is amended to read:

4 "59A-18-16. CONTINUATION OF COVERAGE AND CONVERSION
5 RIGHTS--ACCIDENT AND HEALTH INSURANCE POLICIES--NOTICE.--

6 Subject to the provisions of the Health Insurance Portability
7 Act:

8 A. every accident and health insurance policy that
9 provides hospital, surgical and medical expense benefits and
10 that is delivered, issued for delivery or renewed in this state
11 on or after January 1, 1985 shall provide:

12 (1) if an individual policy, covered family
13 members the right to continue such policy as the named insured
14 or through a conversion policy upon the death of the named
15 insured or upon the divorce, annulment or dissolution of
16 marriage or legal separation of the spouse from the named
17 insured; or

18 (2) if a group policy:

19 (a) each member or employee of the group
20 insured the right to continue such coverage for a period of six
21 months and thereafter through a conversion policy upon
22 termination of membership or employment with the group insured;
23 and

24 (b) covered family members of an
25 employee or member of the group insured the right to continue

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1 such coverage through a converted or separate policy upon the
2 death of the member or employee of the group insured or upon
3 the divorce, annulment or dissolution of marriage or legal
4 separation of the spouse from the member or employee of the
5 group insured.

6 Where a continuation of coverage or conversion is made in
7 the name of the spouse of the named insured or the spouse of
8 the employee or member of the group insured, such coverage may,
9 at the option of the spouse, include coverage for dependent
10 children for whom the spouse has responsibility for care and
11 support;

12 B. the right to a continuation of coverage or
13 conversion pursuant to this section shall not exist with
14 respect to any member or employee of the group insured or any
15 covered family member in the event the coverage terminates for
16 nonpayment of premium, nonrenewal of the policy or the
17 expiration of the term for which the policy is issued. With
18 respect to any member or employee of the group insured or any
19 covered family member who is eligible for medicare or any other
20 similar federal or state health insurance program, the right to
21 a continuation of coverage or conversion shall be limited to
22 coverage under a medicare supplement insurance policy as
23 defined by the rules and regulations adopted by the
24 superintendent;

25 C. coverage continued through the issuance of a

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1 converted or separate policy shall be provided at a reasonable,
2 nondiscriminatory rate to the insured and shall consist of a
3 form of coverage then being offered by the insurer as a
4 conversion policy in the jurisdiction where the person
5 exercising the conversion right resides that most nearly
6 approximates the coverage of the policy from which conversion
7 is exercised. Continued and converted coverages shall contain
8 renewal provisions that are not less favorable to the insured
9 than those contained in the policy from which the conversion is
10 made, except that the person who exercises the right of
11 conversion is entitled only to have included a right to
12 coverage under a medicare supplement insurance policy, as
13 defined by the rules and regulations adopted by the
14 superintendent, after the attainment of the age of eligibility
15 for medicare or any other similar federal or state health
16 insurance program;

17 D. at the time of inception of coverage, the
18 insurer shall furnish to each covered family member who is
19 eighteen years of age or over and to each employee or member of
20 the group insured a statement setting forth in summary form the
21 continuation of coverage and conversion provisions of the
22 policy;

23 E. the insurer shall notify in writing each
24 employee or member, upon that employee's or member's
25 termination of employment or membership with the group insured,

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1 of the continuation and conversion provisions of the policy.
2 The employer may give the written notice specified herein. The
3 employer should notify the insurer of the employee's or
4 member's change of status and last known address. Under no
5 circumstances shall the employer have any civil liability under
6 the conversion provisions of the Insurance Code;

7 F. the eligible employee or member of the group
8 insured or covered family member exercising the continuation or
9 conversion right shall notify the employer or insurer and make
10 payment of the applicable premium within thirty days following
11 the date of the notification given by the insurer pursuant to
12 Subsection E of this section. There shall be no lapse of
13 coverage during the period in which conversion is available;

14 G. coverage shall be provided through continuation
15 or conversion without additional evidence of insurability and
16 shall not impose any preexisting condition, limitations or
17 other contractual time limitations [~~other than those remaining~~
18 ~~unexpired under the policy or contract from which continuation~~
19 ~~or conversion is exercised~~];

20 H. benefits otherwise payable under a converted or
21 separate policy may be reduced so they are not, during the
22 first policy year of the converted or separate policy, in
23 excess of those that would have been payable under the policy
24 from which conversion is exercised. Benefits, if any,
25 otherwise payable under a converted or separate policy are not

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1 payable for a loss claimed under the policy from which
2 conversion is exercised; and

3 I. any probationary or waiting period set forth in
4 the converted or separate policy is deemed to commence on the
5 effective date of the applicant's coverage under the original
6 policy."

7 SECTION 3. Section 59A-18-16.2 NMSA 1978 (being Laws
8 2011, Chapter 144, Section 12) is amended to read:

9 "59A-18-16.2. HEALTH INSURANCE OR HEALTH PLAN FORM AND
10 RATE FILINGS--SUPERINTENDENT--RULEMAKING--COMPLIANCE WITH
11 FEDERAL LAW.--

12 A. A group health plan and a health insurance
13 issuer offering a group or individual health insurance plan
14 that provides benefits other than excepted benefits shall:

15 (1) provide the essential health benefits
16 defined by the superintendent under Subsection B of this
17 section;

18 (2) limit cost sharing for such coverage in
19 accordance with Subsection D of this section; and

20 (3) provide coverage without cost sharing for
21 preventive benefits in accordance with Subsection E of this
22 section.

23 B. The superintendent shall define by rule the
24 essential health benefits package to include at least the
25 following general categories and the items and services covered

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1 within the categories:

2 (1) ambulatory patient services;

3 (2) emergency services;

4 (3) hospitalization;

5 (4) maternity and newborn care;

6 (5) mental health and substance use disorder
7 services, including behavioral health treatment;

8 (6) prescription drugs;

9 (7) rehabilitative and habilitative services
10 and devices;

11 (8) laboratory services;

12 (9) preventive and wellness services and
13 chronic disease management; and

14 (10) pediatric services, including oral and
15 vision care.

16 C. In defining the essential health benefits
17 pursuant to Subsection B of this section, the superintendent
18 shall:

19 (1) ensure that such essential health benefits
20 reflect an appropriate balance among the categories described
21 in that subsection, so that benefits are not unduly weighted
22 toward any category;

23 (2) not make coverage decisions, determine
24 reimbursement rates, establish incentive programs or design
25 benefits in ways that discriminate against individuals because

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1 of their age, disability or expected length of life;

2 (3) take into account the health care needs of
3 diverse segments of the population, including women, children,
4 persons with disabilities and other groups;

5 (4) ensure that health benefits established as
6 essential not be subject to denial to individuals against their
7 wishes on the basis of the individual's age or expected length
8 of life or of the individual's present or predicted disability,
9 degree of medical dependency or quality of life;

10 (5) provide that if a plan is offered through
11 the New Mexico health insurance exchange, another health
12 insurance plan offered through the New Mexico health insurance
13 exchange shall not fail to be treated as a qualified health
14 plan solely because the plan does not offer coverage of
15 benefits offered through the standalone plan that are otherwise
16 required; and

17 (6) periodically update the essential health
18 benefits under Subsection B of this section to address any gaps
19 in access to coverage or changes in the evidence base
20 identified by the superintendent.

21 D. A group health plan and a health insurance
22 issuer offering a group or individual health insurance plan
23 shall not establish a restricted lifetime or annual limit on
24 the dollar value of benefits for any participant or beneficiary
25 with respect to benefits that are essential health benefits, as

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1 determined by the superintendent. The provisions of this
2 subsection shall not be construed to prevent a group health
3 plan or health insurance plan from placing annual or lifetime
4 per-beneficiary limits on specific covered benefits that are
5 not essential health benefits, to the extent that these limits
6 are otherwise permitted under federal or state law.

7 E. The superintendent shall adopt and promulgate
8 rules specifying the maximum cost-sharing amounts for which an
9 insured may be held liable for payment of covered benefits
10 under any health insurance plan that provides benefits other
11 than excepted benefits, including deductibles, coinsurance,
12 copayments or similar charge, and any other expenditure
13 required of an insured individual with respect to essential
14 health benefits covered under the plan, but not including
15 premiums, balance billing amounts for non-network providers or
16 spending for non-covered services.

17 F. For plan years beginning in 2020, the office of
18 superintendent of insurance shall promulgate rules adopted
19 pursuant to this section by June 1, 2019.

20 G. For plan years beginning after 2020, the office
21 of superintendent of insurance shall promulgate rules updated
22 and adopted pursuant to this section by March 1 of the year
23 prior to the date that they are to go into effect.

24 H. A group health plan and a health insurance
25 issuer offering a group or individual health insurance plan

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1 that provides benefits other than excepted benefits shall
2 provide coverage for and shall not impose any cost-sharing
3 requirements for:

4 (1) items or services that have in effect a
5 rating of "A" or "B" in the current recommendations of the
6 United States preventive services task force;

7 (2) immunizations that have in effect a
8 recommendation from the advisory committee on immunization
9 practices of the federal centers for disease control and
10 prevention, with respect to the insured for which immunization
11 is considered;

12 (3) with respect to infants, children and
13 adolescents, preventive care and screenings provided for in the
14 comprehensive guidelines supported by the health resources and
15 services administration of the United States department of
16 health and human services; and

17 (4) with respect to women, additional
18 preventive care and screenings to those described in Paragraph
19 (1) of this subsection, as provided for in comprehensive
20 guidelines supported by the health resources and services
21 administration of the United States department of health and
22 human services.

23 I. The provisions of Subsection H of this section
24 shall not be construed to prohibit a health insurance plan or
25 health insurance issuer from providing coverage for services in

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1 addition to those recommended by the United States preventive
2 services task force or to deny coverage for services that are
3 not described in this section. The superintendent shall
4 establish by rule a minimum interval between the date on which
5 a recommendation described in Paragraphs (1) and (2) of
6 Subsection H of this section or a guideline under Paragraph (3)
7 of Subsection H of this section is issued and the plan year
8 with respect to which the requirement described in Subsection H
9 of this section is effective with respect to the service
10 described in such recommendation or guideline; provided that
11 the interval shall not be less than one year from the date the
12 federal recommendation or guideline is published.

13 J. If a health insurance plan is offered as a
14 qualified health plan through the New Mexico health insurance
15 exchange, the insurer offering the qualified health plan shall
16 also offer that plan through the health insurance exchange as a
17 plan that restricts enrollment to individuals who, as of the
18 beginning of a plan year, have not attained the age of twenty-
19 one years.

20 K. The superintendent shall adopt rules:

21 [A-] (1) to define terms used regarding forms,
22 rates, reviews and blocks of business that an insurer or health
23 care plan submits in filing matters;

24 [B-] (2) to govern any additional filing
25 requirements the superintendent deems appropriate;

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1 [~~G~~] (3) to provide notice of hearings and the
2 grounds on which the hearings have been requested;

3 [~~D~~] (4) to meet criteria for review in
4 accordance with federal law; and

5 [~~E~~] (5) that the superintendent deems
6 appropriate to carry out the provisions of Chapter 59A, Article
7 18 NMSA 1978.

8 L. As used in this section, "excepted benefits"
9 means benefits furnished pursuant to the following:

10 (1) coverage only accident or disability
11 income insurance;

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

14 (3) liability insurance;

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

17 (5) automobile medical payment insurance;

18 (6) credit-only insurance;

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

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

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

25 (a) limited scope dental or vision

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1 benefits;

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

5 (c) other similar limited benefits
6 specified in regulations;

7 (10) the following benefits, offered as
8 independent noncoordinated benefits:

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

11 (b) hospital indemnity or other fixed
12 indemnity insurance; and

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

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

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

22 SECTION 4. Section 59A-22-5 NMSA 1978 (being Laws 1984,
23 Chapter 127, Section 426, as amended) is amended to read:

24 "59A-22-5. TIME LIMIT ON CERTAIN DEFENSES.--

25 A. There shall be a provision for comprehensive

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1 major medical policies as follows: As of the date of issue of
2 this policy, no misstatements, except willful or fraudulent
3 misstatements, made by the applicant in the application for
4 this policy shall be used to void the policy or to deny a claim
5 for loss incurred or disability (as defined in the policy). In
6 the event a misstatement in an application is made that is not
7 fraudulent or willful, the issuer of the policy may
8 prospectively rate and collect from the insured the premium
9 that would have been charged to the insured at the time the
10 policy was issued had such misstatement not been made.

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

19 C. The foregoing policy provisions shall not be so
20 construed as to affect any initial two-year period nor to limit
21 the application of Sections 59A-22-17 through 59A-22-19,
22 59A-22-21 and 59A-22-22 NMSA 1978 in the event of misstatement
23 with respect to age or occupation or other insurance.

24 D. A policy that the insured has the right to
25 continue in force subject to its terms by the timely payment of

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1 premium (1) until at least age fifty or (2) in the case of a
2 policy issued after age forty-four, for at least five years
3 from its date of issue, may contain in lieu of the foregoing
4 the following provision, from which the clause in parentheses
5 may be omitted at the insurance company's option, under the
6 caption "Incontestable":

7 After this policy has been in force for a period of two
8 years during the lifetime of the insured (excluding any period
9 during which the insured is disabled), it shall become
10 incontestable as to the statements contained in the
11 application.

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

24 ~~(1) the condition manifested itself within a~~
25 ~~period of six months prior to the effective date of coverage in~~

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1 ~~a manner that would cause a reasonably prudent person to seek~~
2 ~~diagnosis, care or treatment; or~~

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

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

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

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

19 ~~G. The preexisting condition exclusions authorized~~
20 ~~in Subsections E and F of this section shall be waived to the~~
21 ~~extent that similar conditions have been satisfied under any~~
22 ~~prior health insurance coverage if the application for new~~
23 ~~coverage is made not later than thirty-one days following the~~
24 ~~termination of prior coverage. In that case, the new coverage~~
25 ~~shall be effective from the date on which the prior coverage~~

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1 ~~terminated.~~

2 ~~H. Nothing in this section shall be construed to~~
3 ~~require the use of preexisting conditions or prohibit the use~~
4 ~~of preexisting conditions that are more favorable to the~~
5 ~~insured than those specified in this section.]"~~

6 SECTION 5. Section 59A-23C-5.1 NMSA 1978 (being Laws
7 1994, Chapter 75, Section 33, as amended) is amended to read:

8 "59A-23C-5.1. ADJUSTED COMMUNITY RATING.--

9 A. A health benefit plan that is offered by a
10 carrier to a small employer shall be offered without regard to
11 the health status of any individual in the group, except as
12 provided in the Small Group Rate and Renewability Act. The
13 only rating factors that may be used to determine the initial
14 year's premium charged a group, subject to the maximum rate
15 variation provided in this section for all rating factors, are
16 the group members':

17 (1) ages;

18 [~~(2) genders pursuant to Subsection B of this~~
19 ~~section;~~

20 ~~(3)] (2) geographic areas of the place of~~
21 employment; or

22 [~~(4)] (3) smoking practices.~~

23 [~~B. In determining the initial and any subsequent~~
24 ~~year's rate, the difference in rates in any one age group that~~
25 ~~may be charged on the basis of a person's gender shall not~~

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1 ~~exceed another person's rate in the age group by more than the~~
2 ~~following percentage of the lower rate for policies issued or~~
3 ~~delivered in the respective year; provided, however, that~~
4 ~~gender shall not be used as a rating factor for policies issued~~
5 ~~or delivered on or after January 1, 2014:~~

- 6 (1) ~~twenty percent for calendar year 2010;~~
7 (2) ~~fifteen percent for calendar year 2011;~~
8 (3) ~~ten percent for calendar year 2012; and~~
9 (4) ~~five percent for calendar year 2013.~~

10 G.] B. Separately for an insurer's individual and
11 group policies, no person's rate shall exceed the rate of
12 any other person with similar family composition by more than
13 two hundred fifty percent of the lower rate, except that the
14 rates for children [~~under the age of~~] nineteen years of age or
15 children [~~aged~~] nineteen to twenty-five years of age who are
16 full-time students may [~~be~~] have rates that are lower than the
17 bottom rates in the two hundred fifty percent band. The rating
18 factor restrictions shall not prohibit [~~a carrier~~] an insurer,
19 multiple employer welfare arrangement, fraternal benefit
20 society, health maintenance organization or nonprofit health
21 care plan from offering rates that differ depending upon family
22 composition. For the purposes of this subsection, "family
23 composition" refers only to whether coverage covers an
24 individual or a family.

25 [~~D. The provisions of this section do not preclude~~

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1 ~~a carrier from using health status or occupational or industry~~
2 ~~classification in establishing the amount an employer may be~~
3 ~~charged for coverage under a group health plan.~~

4 ~~E. As used in Subsection D of this section, "health~~
5 ~~status" does not include genetic information.~~

6 ~~F.] C.~~ The superintendent shall adopt [~~regulations~~]
7 and promulgate rules to implement the provisions of this
8 section."

9 SECTION 6. Section 59A-23C-7 NMSA 1978 (being Laws 1991,
10 Chapter 153, Section 7) is amended to read:

11 "59A-23C-7. DISCLOSURE OF RATING PRACTICES AND
12 RENEWABILITY PROVISIONS.--Each small employer carrier shall
13 make reasonable disclosure in solicitation and sales materials
14 provided to small employers of the following:

15 ~~[A. the extent to which premium rates for a~~
16 ~~specific small employer are established or adjusted due to the~~
17 ~~claim experience, health status or duration of coverage of the~~
18 ~~employees or dependents of the small employer;~~

19 ~~B.] A.~~ the provisions concerning the carriers'
20 right to change premium rates and the factors [~~including case~~
21 ~~characteristics~~] that affect changes in premium rates; and

22 ~~[C. a description of the class of business in which~~
23 ~~the small employer is or will be included, including the~~
24 ~~applicable grouping of plans; and~~

25 ~~D.] B.~~ the provisions relating to renewability of

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1 coverage."

2 SECTION 7. Section 59A-23E-2 NMSA 1978 (being Laws 1997,
3 Chapter 243, Section 2, as amended) is amended to read:

4 "59A-23E-2. DEFINITIONS.--As used in the Health Insurance
5 Portability Act:

6 A. "affiliation period" means a period that must
7 expire before health insurance coverage offered by a health
8 maintenance organization becomes effective;

9 B. "beneficiary" means that term as defined in
10 Section 3(8) of the federal Employee Retirement Income Security
11 Act of 1974;

12 C. "bona fide association" means an association
13 that:

14 (1) has been actively in existence for five or
15 more years;

16 (2) has been formed and maintained in good
17 faith for purposes other than obtaining insurance;

18 (3) does not condition membership in the
19 association on any health status related factor relating to an
20 individual, including an employee or a dependent of an
21 employee;

22 (4) makes health insurance coverage offered
23 through the association available to all members regardless of
24 any health status related factor relating to the members or
25 individuals eligible for coverage through a member; and

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1 (5) does not offer health insurance coverage
2 to an individual through the association except in connection
3 with a member of the association;

4 D. "church plan" means that term as defined
5 pursuant to Section 3(33) of the federal Employee Retirement
6 Income Security Act of 1974;

7 E. "COBRA" means the federal Consolidated Omnibus
8 Budget Reconciliation Act of 1985;

9 F. "COBRA continuation provision" means:

10 (1) Section 4980 of the Internal Revenue Code
11 of 1986, except for Subsection (f)(1) of that section as it
12 relates to pediatric vaccines;

13 (2) Part 6 of Subtitle B of Title 1 of the
14 federal Employee Retirement Income Security Act of 1974 except
15 for Section 609 of that part; or

16 (3) Title 22 of the federal Health Insurance
17 Portability and Accountability Act of 1996;

18 G. "creditable coverage" means, with respect to an
19 individual, coverage of the individual pursuant to:

20 (1) a group health plan;

21 (2) health insurance coverage;

22 (3) Part A or Part B of Title 18 of the Social
23 Security Act;

24 (4) Title 19 of the Social Security Act except
25 coverage consisting solely of benefits pursuant to Section 1928

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1 of that title;

2 (5) 10 USCA Chapter 55;

3 (6) a medical care program of the Indian
4 health service or of an Indian nation, tribe or pueblo;

5 (7) the [~~Comprehensive Health~~] Medical
6 Insurance Pool Act;

7 (8) a health plan offered pursuant to 5 USCA
8 Chapter 89;

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

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

13 H. "employee" means that term as defined in Section
14 3(6) of the federal Employee Retirement Income Security Act of
15 1974;

16 I. "employer" means:

17 (1) a person who is an employer as that term
18 is defined in Section 3(5) of the federal Employee Retirement
19 Income Security Act of 1974, and who employs two or more
20 employees; and

21 (2) a partnership in relation to a partner
22 pursuant to Section 59A-23E-17 NMSA 1978;

23 J. "employer contribution rule" means a requirement
24 relating to the minimum level or amount of employer
25 contribution toward the premium for enrollment of participants

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1 and beneficiaries;

2 K. "enrollment date" means, with respect to an
3 individual covered under a group health plan or health
4 insurance coverage, the date of enrollment of the individual in
5 the plan or coverage or, if earlier, the first day of the
6 waiting period for enrollment;

7 L. "excepted benefits" means benefits furnished
8 pursuant to the following:

- 9 (1) coverage only accident or disability
10 income insurance;
- 11 (2) coverage issued as a supplement to
12 liability insurance;
- 13 (3) liability insurance;
- 14 (4) workers' compensation or similar
15 insurance;
- 16 (5) automobile medical payment insurance;
- 17 (6) credit-only insurance;
- 18 (7) coverage for on-site medical clinics;
- 19 (8) other similar insurance coverage specified
20 in regulations under which benefits for medical care are
21 secondary or incidental to other benefits;
- 22 (9) the following benefits if offered
23 separately:
 - 24 (a) limited scope dental or vision
25 benefits;

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

4 (c) other similar limited benefits
5 specified in regulations;

6 (10) the following benefits, offered as
7 independent noncoordinated benefits:

8 (a) coverage only for a specified
9 disease or illness; or

10 (b) hospital indemnity or other fixed
11 indemnity insurance; and

12 (11) the following benefits if offered as a
13 separate insurance policy:

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

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

21 M. "federal governmental plan" means a governmental
22 plan established or maintained for its employees by the United
23 States government or an instrumentality of that government;

24 N. "governmental plan" means that term as defined
25 in Section 3(32) of the federal Employee Retirement Income

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1 Security Act of 1974 and includes a federal governmental plan;

2 O. "group health insurance coverage" means health
3 insurance coverage offered in connection with a group health
4 plan or any other health insurance subject to the provisions of
5 Chapter 59A, Article 23 NMSA 1978;

6 P. "group health plan" means an employee welfare
7 benefit plan as defined in Section 3(1) of the federal Employee
8 Retirement Income Security Act of 1974 to the extent that the
9 plan provides medical care and includes items and services paid
10 for as medical care to employees or their dependents as defined
11 under the terms of the plan directly or through insurance,
12 reimbursement or otherwise;

13 Q. "group participation rule" means a requirement
14 relating to the minimum number of participants or beneficiaries
15 that must be enrolled in relation to a specified percentage or
16 number of eligible individuals or employees of an employer;

17 R. "health insurance coverage" means benefits
18 consisting of medical care provided directly, through insurance
19 or reimbursement, or otherwise, and items, including items and
20 services paid for as medical care, pursuant to any hospital or
21 medical service policy or certificate, hospital or medical
22 service plan contract or health maintenance organization
23 contract offered by a health insurance issuer;

24 S. "health insurance issuer" means an insurance
25 company, insurance service or insurance organization, including

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1 a health maintenance organization, that is licensed to engage
2 in the business of insurance in the state and that is subject
3 to state law that regulates insurance within the meaning of
4 Section 514(b)(2) of the federal Employee Retirement Income
5 Security Act of 1974, but "health insurance issuer" does not
6 include a group health plan;

7 T. "health maintenance organization" means:

8 (1) a federally qualified health maintenance
9 organization;

10 (2) an organization recognized pursuant to
11 state law as a health maintenance organization; or

12 (3) a similar organization regulated pursuant
13 to state law for solvency in the same manner and to the same
14 extent as a health maintenance organization defined in
15 Paragraph (1) or (2) of this subsection;

16 U. "health status related factor" means any of the
17 factors described in Section 2702(a)(1) of the federal Health
18 Insurance Portability and Accountability Act of 1996;

19 V. "individual health insurance coverage" means
20 health insurance coverage offered to an individual in the
21 individual market, but "individual health insurance coverage"
22 does not include short-term limited duration insurance;

23 W. "individual market" means the market for health
24 insurance coverage offered to individuals other than in
25 connection with a group health plan;

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1 X. "large employer" means, in connection with a
2 group health plan and with respect to a calendar year and a
3 plan year, an employer who employed an average of at least
4 fifty-one employees on business days during the preceding
5 calendar year and who employs at least two employees on the
6 first day of the plan year;

7 Y. "large group market" means the health insurance
8 market under which individuals obtain health insurance coverage
9 on behalf of themselves and their dependents through a group
10 health plan maintained by a large employer;

11 Z. "late enrollee" means, with respect to coverage
12 under a group health plan, a participant or beneficiary who
13 enrolls under the plan other than during:

14 (1) the first period in which the individual
15 is eligible to enroll under the plan; or

16 (2) a special enrollment period pursuant to
17 Sections 59A-23E-8 and 59A-23E-9 NMSA 1978;

18 AA. "medical care" means:

19 (1) services consisting of the diagnosis,
20 cure, mitigation, treatment or prevention of human disease or
21 provided for the purpose of affecting any structure or function
22 of the human body; and

23 (2) transportation services primarily for and
24 essential to provision of the services described in Paragraph
25 (1) of this subsection;

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1 BB. "network plan" means health insurance coverage
2 of a health insurance issuer under which the financing and
3 delivery of medical care are provided through a defined set of
4 providers under contract with the issuer;

5 CC. "nonfederal governmental plan" means a
6 governmental plan that is not a federal governmental plan;

7 DD. "participant" means:

8 (1) that term as defined in Section 3(7) of
9 the federal Employee Retirement Income Security Act of 1974;

10 (2) a partner in relationship to a partnership
11 in connection with a group health plan maintained by the
12 partnership; and

13 (3) a self-employed individual in connection
14 with a group health plan maintained by the self-employed
15 individual;

16 EE. "placed for adoption" means a child has been
17 placed with a person who assumes and retains a legal obligation
18 for total or partial support of the child in anticipation of
19 adoption of the child;

20 FF. "plan sponsor" means that term as defined in
21 Section 3(16)(B) of the federal Employee Retirement Income
22 Security Act of 1974;

23 GG. "preexisting condition exclusion" means a
24 limitation or exclusion of benefits relating to a condition
25 based on the fact that the condition was present before the

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1 date of the coverage for the benefits whether or not any
2 medical advice, diagnosis, care or treatment was recommended
3 before that date, but genetic information is not included as a
4 preexisting condition for the purposes of limiting or excluding
5 benefits in the absence of a diagnosis of the condition related
6 to the genetic information;

7 HH. "small employer" means, in connection with a
8 group health plan and with respect to a calendar year and a
9 plan year, an employer who employed an average of at least two
10 but not more than fifty employees on business days during the
11 preceding calendar year and who employs at least two employees
12 on the first day of the plan year;

13 II. "small group market" means the health insurance
14 market under which individuals obtain health insurance coverage
15 through a group health plan maintained by a small employer;

16 JJ. "state law" means laws, decisions, rules,
17 regulations or state action having the effect of law; and

18 KK. "waiting period" means, with respect to a group
19 health plan and an individual who is a potential participant or
20 beneficiary in the plan, the period that must pass with respect
21 to the individual before the individual is eligible to be
22 covered for benefits under the terms of the plan."

23 SECTION 8. Section 59A-23E-3 NMSA 1978 (being Laws 1997,
24 Chapter 243, Section 3, as amended) is amended to read:

25 "59A-23E-3. GROUP HEALTH PLAN--GROUP HEALTH

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1 INSURANCE--LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD
2 [~~CREDITING FOR PERIODS OF PREVIOUS COVERAGE~~]. -- [~~Except as~~
3 ~~provided in Section 59A-23E-4 NMSA 1978, a group health plan~~
4 ~~and a health insurance issuer offering group health insurance~~
5 ~~coverage may, with respect to a participant or beneficiary,~~
6 ~~impose a preexisting condition exclusion only if:~~

7 ~~A. the exclusion relates to a condition, physical~~
8 ~~or mental, regardless of the cause of the condition, for which~~
9 ~~medical advice, diagnosis, care or treatment was recommended or~~
10 ~~received within the six-month period ending on the enrollment~~
11 ~~date;~~

12 ~~B. the exclusion extends for a period of not more~~
13 ~~than six months, or eighteen months in the case of a late~~
14 ~~enrollee, after the enrollment date; and~~

15 ~~C. the period of the exclusion is reduced by the~~
16 ~~aggregate of the periods of creditable coverage applicable to~~
17 ~~the participant or beneficiary as of the enrollment date] A
18 health insurance issuer or health benefits plan offering group
19 health insurance, blanket health insurance or individual health
20 insurance shall impose any preexisting condition exclusion with
21 respect to that health insurance plan or coverage. A health
22 insurance issuer or health insurance plan offering group health
23 insurance, blanket health insurance or individual health
24 insurance shall not impose a waiting period in excess of ninety
25 days with respect to a health insurance plan or coverage."~~

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1 SECTION 9. Section 59A-23E-8 NMSA 1978 (being Laws 1997,
2 Chapter 243, Section 8, as amended) is amended to read:

3 "59A-23E-8. GROUP HEALTH PLAN--GROUP HEALTH
4 INSURANCE--SPECIAL ENROLLMENT PERIODS FOR INDIVIDUALS LOSING
5 OTHER COVERAGE.--

6 A. A group health plan and a health insurance
7 issuer offering group health insurance coverage in connection
8 with a group health plan shall permit an employee who is
9 eligible but not enrolled for coverage under the terms of the
10 plan, or a dependent of the employee if the dependent is
11 eligible but not enrolled for coverage, to enroll for coverage
12 under the terms of the plan if:

13 ~~[A.]~~ (1) the employee or dependent was covered
14 under a group health plan or had health insurance coverage at
15 the time coverage was previously offered to the employee or
16 dependent;

17 ~~[B.]~~ (2) the employee stated in writing at the
18 time coverage was offered that coverage under a group health
19 plan or health insurance coverage was the reason for declining
20 enrollment, but only if the plan sponsor or issuer required
21 such a statement at the time and provided the employee with
22 notice of that requirement and the consequences of the
23 requirement at the time;

24 ~~[C.]~~ (3) the employee's or dependent's
25 coverage described in Paragraph (1) of this subsection ~~[A of~~

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1 ~~this section~~] was:

2 [~~(1)~~] (a) under a COBRA continuation
3 provision and the coverage under that provision was exhausted;
4 or

5 [~~(2)~~] (b) not under a COBRA continuation
6 provision and either the coverage was terminated as a result of
7 loss of eligibility for the coverage, including as a result of
8 legal separation, divorce, death, termination of employment or
9 reduction in the number of hours of employment, or employer
10 contributions toward the coverage were terminated; and

11 [~~D-~~] (4) under the terms of the plan, the
12 employee requested enrollment not later than thirty days after
13 the date of exhaustion of coverage described in [~~Paragraph (1)~~]
14 Subparagraph (a) of [Subsection C] Paragraph (3) of this
15 [~~section~~] subsection or termination of coverage or employer
16 contribution described in [~~Paragraph (2) of Subsection C of~~
17 ~~this section~~] Subparagraph (b) of Paragraph (3) of this
18 subsection.

19 B. A group health plan or a health insurance issuer
20 offering group health insurance plan coverage shall permit an
21 eligible enrollee to enroll for coverage under the terms of the
22 plan if either of the following conditions is met:

23 (1) the eligible enrollee's medical assistance
24 provided pursuant to the Public Assistance Act is terminated;

25 or

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1 (2) the eligible enrollee becomes eligible for
2 medical assistance, with respect to coverage under the group
3 health plan or health insurance plan, under such medicaid plan
4 or state child health plan, including under any waiver or
5 demonstration project conducted under or in relation to such a
6 plan, if the employee requests coverage under the group health
7 plan or health insurance plan not later than sixty days after
8 the date the employee or dependent is determined to be eligible
9 for such assistance.

10 C. As used in this section, "eligible enrollee"
11 means an employee or dependent of an employee who is eligible,
12 but not enrolled, for coverage under the terms of an employer's
13 group health plan."

14 SECTION 10. Section 59A-23E-11 NMSA 1978 (being Laws
15 1997, Chapter 243, Section 11, as amended) is amended to read:

16 "59A-23E-11. [~~GROUP HEALTH PLAN--GROUP HEALTH INSURANCE~~]
17 PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS AGAINST
18 INDIVIDUAL PARTICIPANTS AND BENEFICIARIES [~~IN ELIGIBILITY TO~~
19 ~~ENROLL~~].--[~~A. Except as provided in Subsection B of this~~
20 ~~section~~] A group health plan and a health insurance issuer
21 offering group or individual health insurance coverage [~~in~~
22 ~~connection with a group health plan~~] shall not establish rules
23 for eligibility or continued eligibility of any individual to
24 enroll or continue to participate in a health plan, or
25 eligibility or continued eligibility for benefits, based on any

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1 of the following [~~health status related~~] factors in relation to
2 the individual or a dependent of the individual:

3 [~~(1)~~] A. health status;

4 [~~(2)~~] B. medical condition, including both physical
5 and mental illnesses;

6 [~~(3)~~] C. claims experience;

7 [~~(4)~~] D. receipt of health care;

8 [~~(5)~~] E. medical history;

9 [~~(6)~~] F. genetic information;

10 [~~(7)~~] G. evidence of insurability, including
11 conditions arising out of acts of domestic violence; [~~or~~

12 ~~(8)~~] H. disability;

13 [~~B. To the extent consistent with the provisions of~~
14 ~~Section 59A-23E-3 NMSA 1978, the provisions of Subsection A of~~
15 ~~this section do not require a group health plan or group health~~
16 ~~insurance coverage to provide particular benefits other than~~
17 ~~those provided under the terms of the plan or coverage or to~~
18 ~~prevent the plan or coverage from establishing limitations or~~
19 ~~restrictions on the amount, level, extent or nature of the~~
20 ~~benefits or coverage for similarly situated individuals~~
21 ~~enrolled in the plan or coverage.]~~

22 I. gender;

23 J. national origin;

24 K. sexual orientation; or

25 L. any other health status-related factor that the

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1 superintendent specifies in rules of the office of
2 superintendent of insurance."

3 SECTION 11. Section 59A-23E-12 NMSA 1978 (being Laws
4 1997, Chapter 243, Section 12, as amended) is amended to read:

5 "59A-23E-12. [~~GROUP HEALTH PLAN--GROUP HEALTH INSURANCE~~]
6 PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS AGAINST
7 INDIVIDUAL PARTICIPANTS AND BENEFICIARIES IN PREMIUM
8 CONTRIBUTIONS.--

9 A. [~~Except as provided in Subsection B of this~~
10 ~~section~~] A group health plan and a health insurance issuer
11 offering group or individual health insurance coverage [~~in~~
12 ~~connection with a group health plan~~] shall not require an
13 individual as a condition [~~to enroll or continue to participate~~
14 ~~in a health plan~~] of enrollment or continued enrollment under
15 the plan to pay a premium or contribution that is greater than
16 the premium or contribution for a similarly situated individual
17 enrolled in the plan on the basis of the health status related
18 [~~factors specified in Subsection A of Section 59A-23E-11 NMSA~~
19 ~~1978~~] factor in relation to the individual or a person enrolled
20 under the plan as a dependent of the individual.

21 B. The provisions of Subsection A of this section
22 [~~do~~] shall not be construed to:

23 (1) restrict the amount that an employer or an
24 individual may be charged for coverage under a group health
25 plan [~~and do not~~] or individual health coverage; or

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1 (2) prevent a group health plan or a health
2 insurance issuer offering group health insurance coverage from
3 establishing premium discounts or rebates or modifying
4 otherwise applicable copayments or deductibles in return for
5 adherence to programs of health promotion and disease
6 prevention.

7 C. A group health benefits plan or a health
8 insurance issuer that offers group health insurance coverage in
9 connection with a group health benefits plan shall not adjust
10 premiums or contribution amounts for the group covered under
11 the plan on the basis of genetic information."

12 SECTION 12. Section 59A-23E-13 NMSA 1978 (being Laws
13 1997, Chapter 243, Section 13, as amended) is amended to read:

14 "59A-23E-13. HEALTH INSURANCE ISSUERS--GUARANTEED
15 AVAILABILITY OF COVERAGE [~~FOR EMPLOYERS IN SMALL GROUP~~
16 ~~MARKET~~]-EXCEPTIONS FOR NETWORK PLANS, INSUFFICIENT FINANCIAL
17 CAPACITY AND BONA FIDE ASSOCIATIONS--EMPLOYER CONTRIBUTION
18 RULES.--

19 A. Except as provided in Subsections [B] C through
20 [~~G~~] E of this section, a health insurance issuer that offers
21 health insurance coverage in the individual or small group
22 [~~market~~] markets shall:

23 (1) accept [~~a small~~] every individual or
24 employer that applies for coverage;

25 (2) accept for enrollment under the offered

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1 coverage an eligible individual who applies for enrollment
2 during the period in which the individual first becomes
3 eligible to enroll under the terms of the group health plan or
4 during an open or special enrollment period as specified in
5 rules of the office of superintendent of insurance; and

6 (3) not place a restriction on an eligible
7 individual being a participant or a beneficiary that is
8 inconsistent with Sections 59A-23E-11 and 59A-23E-12 NMSA 1978.

9 B. The superintendent shall adopt and promulgate
10 rules relating to enrollment periods.

11 [~~B.~~] C. A health insurance issuer that offers
12 health insurance coverage in the [~~small~~] group [~~market~~] or
13 individual markets through a network plan may:

14 (1) limit the employers or individuals that
15 may apply for the coverage to those with eligible individuals
16 who live, work or reside in the service area for the network
17 plan; and

18 (2) within the service area of the network
19 plan, deny coverage to individuals or employers within the
20 service area for the network plan if the issuer has
21 demonstrated to the superintendent that it:

22 (a) will not have the capacity to
23 deliver services adequately to enrollees of any additional
24 groups or any additional individuals because of its obligations
25 to existing individuals, group contract holders and enrollees;

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1 and

2 (b) is applying this exception uniformly
3 to all employers and individuals without regard to the claims
4 experience of those individuals or those employers, their
5 employees and their dependents or any health status related
6 factor relating to those individuals, employees and dependents.

7 [~~G.~~] D. A health insurance issuer, upon denying
8 insurance coverage in any service area pursuant to the
9 provisions of Subsection [~~B~~] C of this section, shall not offer
10 coverage in the [~~small~~] group market or individual market
11 within the service area for a period of one hundred eighty days
12 after the date coverage is denied.

13 [~~D.~~] E. A health insurance issuer may deny health
14 insurance coverage in the [~~small~~] individual and group [~~market~~]
15 markets if the issuer has demonstrated to the superintendent
16 that it:

17 (1) does not have the financial reserves
18 necessary to underwrite additional coverage; and

19 (2) is applying this exception uniformly to
20 all individuals, employers and their employees in the [~~small~~]
21 individual and group [~~market~~] markets in the state consistent
22 with state law and without regard to the claims experience of
23 those individuals, employers, their employees and their
24 dependents or any health status related factor relating to
25 those individuals, employees and dependents.

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1 ~~[E. A health insurance issuer upon denying health~~
2 ~~insurance coverage in connection with group health plans~~
3 ~~pursuant to Subsection D of this section shall not offer~~
4 ~~coverage in connection with group health plans in the small~~
5 ~~group market in the state for a period of one hundred eighty~~
6 ~~days after the date coverage is denied or until the issuer has~~
7 ~~demonstrated to the superintendent that the issuer has~~
8 ~~sufficient financial reserves to underwrite the additional~~
9 ~~coverage, whichever is later. The superintendent may provide~~
10 ~~for the application of this subsection on a service-area-~~
11 ~~specific basis.~~

12 ~~F. The requirement of Subsection A of this section~~
13 ~~does not apply to health insurance coverage offered by a health~~
14 ~~insurance issuer if the coverage is made available in the small~~
15 ~~group market only through one or more bona fide associations.~~

16 ~~G. Subsection A of this section does not preclude a~~
17 ~~health insurance issuer from establishing employer contribution~~
18 ~~rules or group participation rules for the offering of health~~
19 ~~insurance coverage in connection with a group health plan in~~
20 ~~the small group market.]~~

21 F. A health insurance issuer, upon denying health
22 insurance coverage in accordance with Paragraphs (1) and (2) of
23 Subsection E of this section, shall not offer coverage in the
24 group or individual markets in the state for a period of one
25 hundred eighty days after the date the coverage is denied or

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1 until the issuer has demonstrated to the superintendent that
2 the carrier has sufficient financial reserves to underwrite
3 additional coverage, whichever is later. The superintendent
4 may provide for the application of this subsection on a
5 service-area-specific basis.

6 [H.] G. As used in this section, "eligible
7 individual" means, with respect to a health insurance issuer
8 [~~that offers health insurance coverage to a small employer in~~
9 ~~connection with a group health plan in the small group market~~]
10 offering an individual or group health plan, an individual
11 whose eligibility shall be determined:

- 12 (1) in accordance with the terms of the plan;
- 13 (2) as provided by the issuer under the rules
14 of the issuer that are uniformly applicable in the state to
15 [~~small employers in~~] the [~~small~~] individual and group [~~market~~]
16 markets; and

17 (3) in accordance with New Mexico Insurance
18 Code provisions governing the issuer and the small group
19 market."

20 SECTION 13. Section 59A-23E-14 NMSA 1978 (being Laws
21 1997, Chapter 243, Section 14, as amended) is amended to read:

22 "59A-23E-14. HEALTH INSURANCE ISSUERS--GUARANTEED
23 [~~RENEWABILITY OF COVERAGE FOR EMPLOYERS IN THE SMALL OR LARGE~~
24 ~~GROUP MARKET--REQUIREMENT AND EXCEPTIONS TO REQUIREMENT]~~
25 AVAILABILITY OF COVERAGE.--

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1 A. Except as provided in Subsections B through [G]
2 F of this section, a health insurance issuer that offers health
3 insurance coverage in the [~~small or large~~] individual or group
4 [~~market in connection with a group health plan~~] markets shall
5 renew or continue that coverage in force at the option of the
6 plan sponsor [~~of the plan~~] or the individual.

7 B. A health insurance issuer may refuse to renew or
8 may discontinue health insurance coverage offered pursuant to
9 Subsection A of this section if:

10 (1) the plan sponsor or individual has failed
11 to pay premiums or contributions in accordance with the terms
12 of the health insurance coverage or the issuer has not received
13 timely premium payments;

14 (2) the plan sponsor or individual has
15 performed an act or practice that constitutes fraud or made an
16 intentional misrepresentation of a material fact under the
17 terms of the coverage;

18 ~~[(3) the plan sponsor has failed to comply~~
19 ~~with a material plan provision relating to employer~~
20 ~~contribution or group participation rules permitted pursuant to~~
21 ~~Subsection G of Section 59A-23E-13 NMSA 1978;~~

22 ~~(4)]~~ (3) the issuer is ceasing to offer
23 coverage in the market in accordance with Subsection C of this
24 section; or

25 ~~(5)]~~ (4) in the case of a health insurance

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1 issuer that offers health insurance coverage in the market
2 through a network plan, there is no longer any enrollee in
3 connection with that plan who lives, resides or works in the
4 service area of the issuer or the area for which the issuer is
5 authorized to do business and [~~in the case of the small group~~
6 ~~market~~] the issuer would deny enrollment with respect to the
7 network plan pursuant to Paragraph (1) of Subsection [B] C of
8 Section 59A-23E-13 NMSA 1978 [~~or~~

9 ~~(6) in the case of health insurance coverage~~
10 ~~that is made available only through one or more bona fide~~
11 ~~associations, the membership of any employer in the association~~
12 ~~ceases, but only if the coverage is terminated pursuant to this~~
13 ~~paragraph uniformly without regard to any health status related~~
14 ~~factor relating to a covered individual].~~

15 C. A health insurance issuer may discontinue
16 offering a particular type of individual or group health
17 insurance coverage offered in the [~~small or large~~] group
18 [~~market~~] or individual markets only if:

19 (1) the issuer provides notice to each plan
20 sponsor or individual provided coverage of this type in the
21 market and to the participants and beneficiaries covered under
22 the coverage of the discontinuation at least ninety days prior
23 to the date of the discontinuation;

24 (2) the issuer offers to a plan sponsor or
25 individual provided coverage of this type in the market [~~the~~

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1 ~~option to purchase all, or in the case of the large group~~
2 ~~market, any, other health insurance]~~ the option to purchase any
3 other health insurance plan coverage currently being offered by
4 the issuer [~~to a group health plan~~] in that market; and

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

12 D. If a health insurance issuer elects to
13 discontinue offering all health insurance coverage in the
14 [~~small group market or the large~~] individual or group [~~market~~]
15 markets, coverage may be discontinued only if:

16 (1) the issuer provides notice to the
17 superintendent and to each plan sponsor [~~and to participants~~
18 ~~and beneficiaries covered under the plan]~~ or to the individual
19 and participants and beneficiaries covered under that coverage
20 of the discontinuation at least one hundred eighty days prior
21 to the date of discontinuation; and

22 (2) all health insurance issued or delivered
23 for issuance in the state in the market is discontinued and
24 coverage is not renewed.

25 E. After discontinuation pursuant to Subsection D

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1 of this section, the health insurance issuer shall not provide
2 for the issuance of any health insurance coverage in the market
3 involved during the five-year period beginning on the date of
4 the discontinuation of the last health insurance coverage not
5 renewed.

6 F. At the time of coverage renewal pursuant to
7 Subsection A of this section, a health insurance issuer may
8 modify the coverage for a [~~product offered~~] policy form offered
9 to a group [~~health plan~~]

10 ~~(1) in the large group market; or~~
11 ~~(2) in the small group market if, for coverage~~
12 ~~available in that market other than through a bona fide~~
13 ~~association, the modification is effective on a uniform basis~~
14 ~~among group health plans with that product.~~

15 ~~G. If health insurance coverage is made available~~
16 ~~by a health insurance issuer in the small or large group market~~
17 ~~to employers only through one or more associations, a reference~~
18 ~~to "plan sponsor" is deemed, with respect to coverage provided~~
19 ~~to an employer member of the association, to include a~~
20 ~~reference to that employer] or individual if the modification~~
21 ~~is effective on a uniform basis among all groups or~~
22 ~~individuals, as applicable, with that policy form."~~

23 SECTION 14. Section 59A-23E-15 NMSA 1978 (being Laws
24 1997, Chapter 243, Section 15, as amended) is amended to read:

25 "59A-23E-15. DISCLOSURE OF INFORMATION BY HEALTH

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1 INSURANCE ISSUERS [~~OFFERING HEALTH INSURANCE COVERAGE TO SMALL~~
2 ~~EMPLOYERS~~].--

3 A. A health insurance issuer when offering health
4 insurance coverage to [~~a small~~] an employer or individual
5 shall:

6 (1) make a reasonable disclosure to the small
7 employer or individual as part of its solicitation and sales
8 materials, of the availability of information described in
9 Subsection B of this section; and

10 (2) upon request of the [~~small~~] employer or
11 individual provide the information described.

12 B. Except as provided in Subsection D of this
13 section, a health insurance issuer offering a health plan to an
14 employer or individual shall provide information pursuant to
15 Subsection A of this section concerning:

16 (1) the provisions of coverage concerning the
17 issuer's right to change premium rates and the factors that may
18 affect changes in premium rates;

19 (2) the provisions of coverage relating to
20 renewability of coverage; and

21 [~~(3) the provisions of the coverage relating~~
22 ~~to preexisting condition exclusions; and~~

23 ~~(4)] (3) the benefits and premiums available~~

24 under all health insurance coverage for which the small

25 employer is qualified.

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1 C. Information furnished pursuant to this section
2 shall be provided to [~~small~~] employers or individuals in a
3 manner determined to be understandable by the average [~~small~~]
4 employer or individual and shall be sufficient to reasonably
5 inform [~~small~~] employers or individuals of their rights and
6 obligations under the health insurance coverage.

7 D. A health insurance issuer is not required by
8 this section to disclose information that is proprietary and
9 trade secret information."

10 SECTION 15. Section 59A-23E-16 NMSA 1978 (being Laws
11 1997, Chapter 243, Section 16, as amended) is amended to read:

12 "59A-23E-16. EXCLUSIONS, LIMITATIONS AND EXCEPTIONS FOR
13 CERTAIN GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE.--

14 ~~[A. The requirements of Sections 59A-23E-3 through~~
15 ~~59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply to~~
16 ~~any group health plan and health insurance coverage offered in~~
17 ~~connection with a group health plan if, on the first day of the~~
18 ~~plan year, the plan has fewer than two employees who are~~
19 ~~current employees.~~

20 B.] A. The requirements of Sections 59A-23E-3
21 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 shall
22 not apply with respect to a group health plan that is a
23 nonfederal governmental plan if the plan sponsor makes an
24 election under the provisions of this subsection in conformity
25 with regulations of the federal secretary of health and human

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1 services. The period of an election for exclusion made
2 pursuant to this subsection is for a single specified plan year
3 or, in the case of a plan provided pursuant to a collective
4 bargaining agreement, for the term of the agreement. The plan
5 for which an election is made shall provide under the terms of
6 the election for:

7 (1) notice to enrollees on an annual basis and
8 at the time of enrollment of the facts and consequences of the
9 election; and

10 (2) certification and disclosure of creditable
11 coverage under the plan with respect to enrollees in accordance
12 with Section 59A-23E-7 NMSA 1978.

13 ~~[G-]~~ B. The requirements of Sections 59A-23E-3
14 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not
15 apply to a group health plan and group health insurance
16 coverage offered in connection with a group health plan in
17 relation to its provision of excepted benefits described in
18 Paragraph (9) of Subsection L of Section 59A-23E-2 NMSA 1978 if
19 the benefits are:

20 (1) provided under a separate policy,
21 certificate or contract of insurance; or

22 (2) otherwise not an integral part of the
23 plan.

24 ~~[D-]~~ C. The requirements of Sections 59A-23E-3
25 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not

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1 apply to any group health plan and group health insurance
2 coverage offered in connection with a group health plan in
3 relation to its provision of excepted benefits described in
4 Paragraph (10) of Subsection L of Section 59A-23E-2 NMSA 1978
5 if:

6 (1) the benefits are provided under a separate
7 policy, certificate or contract of insurance;

8 (2) there is no coordination between the
9 provision of the benefits and any exclusion of benefits under
10 any group health plan maintained by the same plan sponsor; and

11 (3) the benefits are paid with respect to an
12 event without regard to whether benefits are provided with
13 respect to that event under any group health plan maintained by
14 the same plan sponsor.

15 [~~E-~~] D. The requirements of Sections 59A-23E-3
16 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not
17 apply to any group health plan and group health insurance
18 coverage offered in connection with a group health plan in
19 relation to its provision of excepted benefits described in
20 Paragraph (11) of Subsection L of Section 59A-23E-2 NMSA 1978
21 if the benefits are provided under a separate policy,
22 certificate or contract of insurance."

23 **SECTION 16.** Section 59A-23E-18 NMSA 1978 (being Laws
24 2000, Chapter 6, Section 1) is amended to read:

25 "59A-23E-18. REQUIREMENT FOR MENTAL HEALTH BENEFITS IN
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1 ~~[A] AN INDIVIDUAL OR~~ GROUP HEALTH PLAN, OR GROUP HEALTH
2 INSURANCE OFFERED IN CONNECTION WITH THE PLAN, FOR A PLAN YEAR
3 OF AN EMPLOYER.--

4 A. A group health plan ~~[for a plan year of an~~
5 ~~employer beginning or renewed on or after October 1, 2000]~~ or
6 group or individual health insurance ~~[offered in connection~~
7 ~~with that plan, shall provide both medical and surgical~~
8 ~~benefits and mental health benefits. The plan]~~ shall not
9 impose ~~[treatment limitations or financial]~~ restrictions,
10 limitations or requirements on the provision of mental health
11 benefits ~~[if identical]~~ restrictions, limitations or
12 requirements ~~[are not]~~ that are identical to and in common with
13 those imposed on coverage of benefits for other conditions.

14 B. A group health plan ~~[for a plan year of an~~
15 ~~employer beginning on or after October 1, 2000]~~ or group or
16 individual health insurance offered in connection with that
17 plan, may:

18 (1) require pre-admission screening prior to
19 the authorization of mental health benefits whether inpatient
20 or outpatient; or

21 (2) apply limitations that restrict mental
22 health benefits provided under the plan to those that are
23 medically necessary.

24 ~~[G. A group health plan for a plan year of an~~
25 ~~employer beginning or renewed on or after January 1, 2000, or~~

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1 ~~group health insurance offered in connection with that plan,~~
2 ~~may not be changed through amendment or on renewal to exclude~~
3 ~~or decrease the mental health benefits existing as of that~~
4 ~~date.~~

5 ~~D. An employer, having at least two but not more~~
6 ~~than forty-nine employees, that is required by the provisions~~
7 ~~of Subsection A of this section to provide mental health~~
8 ~~benefits coverage in a group health plan, or group health~~
9 ~~insurance offered in connection with that plan on renewal of an~~
10 ~~existing plan, may, if a premium increase of more than one and~~
11 ~~one-half percent in the plan year results from the change in~~
12 ~~coverage:~~

13 ~~(1) pay the premium increase;~~

14 ~~(2) reach agreement with the employees to~~
15 ~~cost-share that amount of the premium above one and one-half~~
16 ~~percent;~~

17 ~~(3) negotiate a reduction in coverage, but not~~
18 ~~below the coverage existing before the renewal, to reduce the~~
19 ~~premium increase to no more than one and one-half percent; or~~

20 ~~(4) after demonstrating to the satisfaction of~~
21 ~~the insurance division that the amount of the premium increase~~
22 ~~above one and one-half percent is due exclusively to the~~
23 ~~additional coverage required by the provisions of Subsection A~~
24 ~~of this section, receive written permission from the division~~
25 ~~to not increase coverage.~~

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1 ~~E. An employer, having at least fifty employees,~~
2 ~~that is required by the provisions of Subsection A of this~~
3 ~~section to provide mental health benefits coverage in a group~~
4 ~~health plan, or group health insurance offered in connection~~
5 ~~with that plan on renewal of an existing plan, may, if a~~
6 ~~premium increase of more than two and one-half percent in the~~
7 ~~plan year results from the change in coverage:~~

8 ~~(1) pay the premium increase;~~

9 ~~(2) reach agreement with the employees to~~
10 ~~cost-share that amount of the premium above two and one-half~~
11 ~~percent;~~

12 ~~(3) negotiate a reduction in coverage, but not~~
13 ~~below the coverage existing before applying parity~~
14 ~~requirements, to reduce the premium increase to no more than~~
15 ~~two and one-half percent; or~~

16 ~~(4) after demonstrating to the satisfaction of~~
17 ~~the insurance division that the amount of the premium increase~~
18 ~~above two and one-half percent is due exclusively to the~~
19 ~~additional coverage provided because of the provisions of~~
20 ~~Subsection A of this section, receive written permission from~~
21 ~~the division to not increase coverage.~~

22 ~~F.]~~ C. As used in this section, "mental health
23 benefits" means mental health benefits as described in the
24 group health plan, or group health insurance offered in
25 connection with the plan; but does not include benefits with

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1 respect to treatment of substance abuse, chemical dependency or
2 gambling addiction."

3 SECTION 17. Section 59A-46-2 NMSA 1978 (being Laws 1993,
4 Chapter 266, Section 2, as amended) is amended to read:

5 "59A-46-2. DEFINITIONS.--As used in the Health
6 Maintenance Organization Law:

7 A. "basic health care services" [~~+~~] means
8 medically necessary services consisting of preventive care,
9 emergency care, inpatient and outpatient hospital and physician
10 care, diagnostic laboratory, diagnostic and therapeutic
11 radiological services and services of pharmacists and
12 pharmacist clinicians [~~but~~

13 ~~(2) does not include mental health services or~~
14 ~~services for alcohol or drug abuse, dental or vision services~~
15 ~~or long-term rehabilitation treatment];~~

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

22 C. "carrier" means a health maintenance
23 organization, an insurer, a nonprofit health care plan or other
24 entity responsible for the payment of benefits or provision of
25 services under a group contract;

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1 D. "copayment" means an amount an enrollee must pay
2 in order to receive a specific service that is not fully
3 prepaid;

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

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

11 G. "enrollee" means an individual who is covered by
12 a health maintenance organization;

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

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

23 J. "grievance" means a written complaint submitted
24 in accordance with the health maintenance organization's formal
25 grievance procedure by or on behalf of the enrollee regarding

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1 any aspect of the health maintenance organization relative to
2 the enrollee;

3 K. "group contract" means a contract for health
4 care services that by its terms limits eligibility to members
5 of a specified group and may include coverage for dependents;

6 L. "group contract holder" means the person to whom
7 a group contract has been issued;

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

16 N. "health maintenance organization" means any
17 person who undertakes to provide or arrange for the delivery of
18 basic health care services to enrollees on a prepaid basis,
19 except for enrollee responsibility for copayments or
20 deductibles;

21 O. "health maintenance organization agent" means a
22 person who solicits, negotiates, effects, procures, delivers,
23 renews or continues a policy or contract for health maintenance
24 organization membership or who takes or transmits a membership
25 fee or premium for such a policy or contract, other than for

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1 that person, or a person who advertises or otherwise makes any
2 representation to the public as such;

3 P. "individual contract" means a contract for
4 health care services issued to and covering an individual and
5 it may include dependents of the subscriber;

6 Q. "insolvent" or "insolvency" means that the
7 organization has been declared insolvent and placed under an
8 order of liquidation by a court of competent jurisdiction;

9 R. "managed hospital payment basis" means
10 agreements in which the financial risk is related primarily to
11 the degree of utilization rather than to the cost of services;

12 S. "net worth" means the excess of total admitted
13 assets over total liabilities, but the liabilities shall not
14 include fully subordinated debt;

15 T. "participating provider" means a provider as
16 defined in Subsection X of this section who, under an express
17 contract with the health maintenance organization or with its
18 contractor or subcontractor, has agreed to provide health care
19 services to enrollees with an expectation of receiving payment,
20 other than copayment or deductible, directly or indirectly from
21 the health maintenance organization;

22 U. "person" means an individual or other legal
23 entity;

24 V. "pharmacist" means a person licensed as a
25 pharmacist pursuant to the Pharmacy Act;

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1 W. "pharmacist clinician" means a pharmacist who
2 exercises prescriptive authority pursuant to the Pharmacist
3 Prescriptive Authority Act;

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

7 Y. "replacement coverage" means the benefits
8 provided by a succeeding carrier;

9 Z. "subscriber" means an individual whose
10 employment or other status, except family dependency, is the
11 basis for eligibility for enrollment in the health maintenance
12 organization or, in the case of an individual contract, the
13 person in whose name the contract is issued; and

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

21 SECTION 18. Section 59A-46-32 NMSA 1978 (being Laws 1984,
22 Chapter 127, Section 876.1) is amended to read:

23 "59A-46-32. CONTINUATION OF COVERAGE AND CONVERSION
24 RIGHTS--HEALTH CARE PLANS.--

25 A. Every individual or group contract entered into
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1 by a health maintenance organization and that is delivered,
2 issued for delivery or renewed in this state on or after
3 January 1, 1985 shall provide covered family members of
4 subscribers the right to continue such coverage through a
5 converted or separate contract upon the death of the subscriber
6 or upon the divorce, annulment or dissolution of marriage or
7 legal separation of the spouse from the subscriber. Where a
8 continuation of coverage or conversion is made in the name of
9 the spouse of the subscriber, such coverage may, at the option
10 of the spouse, include coverage to dependent children for whom
11 the spouse has responsibility for care and support.

12 B. The right to a continuation of coverage or
13 conversion pursuant to this section shall not exist with
14 respect to any covered family member of a subscriber in the
15 event the coverage terminates for nonpayment of premium,
16 nonrenewal of the contract or the expiration of the term for
17 which the contract is issued. With respect to any covered
18 family member who is eligible for medicare or any other similar
19 federal or state health insurance program, the right to a
20 continuation of coverage or conversion shall be limited to
21 coverage under a medicare supplement insurance contract as
22 defined by the rules and regulations adopted by the
23 superintendent of insurance.

24 C. Coverage continued through the issuance of a
25 converted or separate contract shall be provided at a

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1 reasonable, nondiscriminatory rate to the insured and shall
2 consist of a form of coverage then being offered by the health
3 maintenance organization as a conversion contract. Continued
4 and converted coverages shall contain renewal provisions that
5 are not less favorable to the subscriber than those contained
6 in the contract from which the conversion is made, except that
7 the person who exercises the right of conversion is entitled
8 only to have included a right to coverage under a medicare
9 supplement insurance contract, as defined by the rules and
10 regulations adopted by the superintendent of insurance, after
11 the attainment of the age of eligibility for medicare or any
12 other similar federal or state health insurance program.

13 D. At the time of inception of coverage, the health
14 maintenance organization shall provide each covered family
15 member eighteen years of age or older a statement setting forth
16 in summary form the continuation of coverage and conversion
17 provisions of the subscriber's contract.

18 E. The eligible covered family member exercising
19 the continuation or conversion right ~~[and]~~ must notify the
20 health maintenance organization and make payment of the
21 applicable premium within thirty days following the date such
22 coverage otherwise terminates as specified in the contract from
23 which continuation or conversion is being exercised.

24 F. Coverage shall be provided through continuation
25 or conversion without additional evidence of insurability and

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1 shall not impose any preexisting condition, limitations or
2 other contractual time limitations [~~other than those remaining~~
3 ~~unexpired under the contract from which continuation or~~
4 ~~conversion is exercised~~].

5 G. Any probationary or waiting period set forth in
6 the converted or separate contract is deemed to commence on the
7 effective date of the applicant's coverage under the original
8 contract."

9 SECTION 19. Section 59A-47-34 NMSA 1978 (being Laws 1984,
10 Chapter 127, Section 879.33) is amended to read:

11 "59A-47-34. CONTINUATION OF COVERAGE AND CONVERSION
12 RIGHTS--HEALTH CARE PLANS.--

13 A. Every individual or group contract entered into
14 by a health care plan that provides for health care expense
15 payments on a service benefit basis or an indemnity benefit
16 basis or both and that is delivered, issued for delivery or
17 renewed in this state on or after July 1, 1984 shall provide
18 covered family members of subscribers the right to continue
19 such coverage through a converted or separate contract upon the
20 death of the subscriber or upon the divorce, annulment or
21 dissolution of marriage or legal separation of the spouse from
22 the subscriber. Where a continuation of coverage or conversion
23 is made in the name of the spouse of the subscriber, such
24 coverage may, at the option of the spouse, include coverage to
25 dependent children for whom the spouse has responsibility for

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1 care and support.

2 B. The right to a continuation of coverage or
3 conversion pursuant to this section shall not exist with
4 respect to any covered family member of a subscriber in the
5 event the coverage terminates for nonpayment of premium,
6 nonrenewal of the contract or the expiration of the term for
7 which the contract is issued. With respect to any covered
8 family member who is eligible for medicare or any other similar
9 federal or state health insurance program, the right to a
10 continuation of coverage or conversion shall be limited to
11 coverage under a medicare supplement insurance contract as
12 defined by the rules and regulations adopted by the
13 superintendent of insurance.

14 C. Coverage continued through the issuance of a
15 converted or separate contract shall be provided at a
16 reasonable, nondiscriminatory rate to the insured and shall
17 consist of a form of coverage then being offered by the health
18 care plan as a conversion contract in the jurisdiction where
19 the person exercising the conversion right resides that most
20 nearly approximates the coverage of the contract from which
21 conversion is exercised. Continued and converted coverages
22 shall contain renewal provisions that are not less favorable to
23 the subscriber than those contained in the policy from which
24 the conversion is made, except that the person who exercises
25 the right of conversion is entitled only to have included a

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1 right to coverage under a medicare supplement insurance
2 contract, as defined by the rules and regulations adopted by
3 the superintendent of insurance, after the attainment of the
4 age of eligibility for medicare or any other similar federal or
5 state health insurance program.

6 D. At the time of inception of coverage, the health
7 care plan shall provide each covered family member eighteen
8 years of age or older a statement setting forth in summary form
9 the continuation of coverage and conversion provisions of the
10 subscriber's contract.

11 E. The eligible covered family member exercising
12 the continuation or conversion right must notify the health
13 care plan and make payment of the applicable premium within
14 thirty days following the date such coverage otherwise
15 terminates as specified in the contract from which continuation
16 or conversion is being exercised.

17 F. Coverage shall be provided through continuation
18 or conversion without additional evidence of insurability and
19 shall not impose any preexisting condition, limitations or
20 other contractual time limitations [~~other than those remaining~~
21 ~~unexpired under the contract from which continuation or~~
22 ~~conversion is exercised~~].

23 G. Any probationary or waiting period set forth in
24 the converted or separate contract is deemed to commence on the
25 effective date of the applicant's coverage under the original

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1 contract."

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

4 "[NEW MATERIAL] STATE INNOVATION WAIVER APPLICATION.--The
5 superintendent, in consultation with and pursuant to approval
6 by the governor, is authorized to submit a state innovation
7 waiver application pursuant to Section 1332 of the federal
8 Patient Protection and Affordable Care Act to establish a
9 program relating to access and affordability of health
10 insurance coverage. In applying for a waiver pursuant to
11 Section 1332 of the federal Patient Protection and Affordable
12 Care Act, the superintendent shall seek any federal funding
13 available to implement the waiver."

14 SECTION 21. REPEAL.--Sections 59A-22-37, 59A-23B-1
15 through 59A-23B-12, 59A-23C-5, 59A-23C-7.1 and 59A-23E-4
16 through 59A-23E-7 NMSA 1978 (being Laws 1984, Chapter 127,
17 Section 459, Laws 1991, Chapter 111, Sections 1 through 10,
18 Laws 1994, Chapter 64, Section 7, Laws 1991, Chapter 111,
19 Section 11, Laws 2003, Chapter 252, Section 2, Laws 1991,
20 Chapter 153, Section 5, Laws 1994, Chapter 75, Section 32 and
21 Laws 1997, Chapter 243, Sections 4 through 7, as amended) are
22 repealed.