AN ACT

RELATING TO INSURANCE; AMENDING SECTIONS OF THE NEW MEXICO INSURANCE CODE, THE SMALL GROUP RATE AND RENEWABILITY ACT, THE HEALTH INSURANCE PORTABILITY ACT, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO ALIGN PROVISIONS RELATING TO THE ACCESSIBILITY OF HEALTH CARE COVERAGE TO FEDERAL LAW; ENACTING NEW SECTIONS OF THE NEW MEXICO INSURANCE CODE TO REQUIRE THE SUPERINTENDENT OF INSURANCE TO SEEK FEDERAL HEALTH COVERAGE ACCESS AND AFFORDABILITY WAIVER AUTHORIZATION AND FUNDING AND TO EXCEPT CERTAIN PLANS.

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

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

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

A. Every insurer, fraternal benefit society, multiple employer welfare arrangement, health maintenance organization or nonprofit health care plan that provides primary health insurance or health care coverage insuring or covering major medical expenses shall, in determining the initial year's premium charged for an individual, use only the rating factors of age, geographic area of the place of employment and smoking practices, except that for individual policies the rating factor of the individual's place of

residence may be used instead of the geographic area of the individual's place of employment.

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

C. The provisions of this section do not preclude an insurer, multiple employer welfare arrangement, fraternal benefit society, health maintenance organization or nonprofit health care plan from using health status or occupational or industry classification in establishing the amount a large group health benefits plan may be charged for coverage.

D. As used in Subsection C of this section, "health status" does not include genetic information.

E. The superintendent shall adopt regulations to implement the provisions of this section."

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

"59A-18-16. CONTINUATION OF COVERAGE AND CONVERSION RIGHTS--ACCIDENT AND HEALTH INSURANCE POLICIES--NOTICE.--Subject to the provisions of the Health Insurance Portability Act:

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

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

(2) if a group policy:

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

(b) covered family members of an employee or member of the group insured the right to continue such coverage through a converted or separate policy upon the death of the member or employee of the group insured or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the member or employee of the group insured.

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

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

superintendent;

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

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

E. the insurer shall notify in writing each

employee or member, upon that employee's or member's termination of employment or membership with the group insured, of the continuation and conversion provisions of the policy. The employer may give the written notice specified herein. The employer should notify the insurer of the employee's or member's change of status and last known address. Under no circumstances shall the employer have any civil liability under the conversion provisions of the Insurance Code;

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

G. coverage shall be provided through continuation or conversion without additional evidence of insurability and shall not impose any preexisting condition, limitations or other contractual time limitations;

H. benefits otherwise payable under a converted or separate policy may be reduced so they are not, during the first policy year of the converted or separate policy, in excess of those that would have been payable under the policy

from which conversion is exercised. Benefits, if any, otherwise payable under a converted or separate policy are not payable for a loss claimed under the policy from which conversion is exercised; and

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

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

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

A. A small group health plan and a health insurance issuer or multiple employer welfare arrangement offering a small group or individual health insurance plan that provides benefits other than excepted benefits shall:

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

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

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

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

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

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

(2) not make coverage decisions, determine reimbursement rates, establish incentive programs or design benefits in ways that discriminate against individuals because of their age, disability or expected length of life;

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

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

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

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

D. A group health plan and a health insurance issuer offering a group or individual health insurance plan

shall not establish a restricted lifetime or annual limit on the dollar value of benefits for any participant or beneficiary with respect to benefits that are essential health benefits, as determined by the superintendent. The provisions of this subsection shall not be construed to prevent a group health plan or health insurance plan from placing annual or lifetime per-beneficiary limits on specific covered benefits that are not essential health benefits, to the extent that these limits are otherwise permitted under federal or state law.

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

F. Any rules that the office of superintendent of insurance intends to adopt and promulgate pursuant to this section shall be adopted no later than the first day of February of the year prior to the first plan year for which the rules would be effective.

G. A group health plan and a health insurance issuer offering a group or individual health insurance plan that provides benefits other than excepted benefits shall provide coverage for and shall not impose any cost-sharing requirements for:

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

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

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

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

H. The provisions of Subsection G of this section

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

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

J. The superintendent shall adopt rules:

(1) to define terms used regarding forms, rates, reviews and blocks of business that an insurer or

health care plan submits in filing matters;

(2) to govern any additional filing requirements the superintendent deems appropriate;

(3) to provide notice of hearings and the grounds on which the hearings have been requested;

(4) to meet criteria for review in accordance with federal law; and

(5) that the superintendent deems appropriate to carry out the provisions of Chapter 59A, Article 18 NMSA 1978.

K. Except as provided by state or federal rule or law, nothing in this section shall be construed to prohibit a health insurance carrier from appropriately using reasonable health care cost management techniques.

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

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

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

(3) liability insurance;

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

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

(9) the following benefits if offered separately:

(a) limited scope dental or vision benefits;

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

(c) other similar limited benefits specified in regulations;

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

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

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

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

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

(b) coverage supplemental to the

coverage provided pursuant to Chapter 55 of Title 10 USCA and similar supplemental coverage provided to coverage pursuant to a group health plan."

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

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

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

B. There shall be a provision for policies other than comprehensive major medical policies as follows: After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for this policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the

expiration of such two-year period.

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

D. A policy that the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age fifty or (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision, from which the clause in parentheses may be omitted at the insurance company's option, under the caption "Incontestable":

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

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

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

A. A health benefit plan that is offered by a carrier to a small employer shall be offered without regard

to the health status of any individual in the group, except as provided in the Small Group Rate and Renewability Act. The only rating factors that may be used to determine the initial year's premium charged a group, subject to the maximum rate variation provided in this section for all rating factors, are the group members':

(1) ages;

(2) geographic areas of the place of employment; or

(3) smoking practices.

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

C. The superintendent shall adopt and promulgate rules to implement the provisions of this section."

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

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

A. the provisions concerning the carriers' right to change premium rates and the factors that affect changes in premium rates; and

B. the provisions relating to renewability of coverage."

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

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

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

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

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

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

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

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

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

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

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

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

F. "COBRA continuation provision" means:

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

(2) Part 6 of Subtitle B of Title 1 of the

federal Employee Retirement Income Security Act of 1974 except for Section 609 of that part; or

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

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

(1) a group health plan;

(2) health insurance coverage;

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

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

(5) 10 USCA Chapter 55;

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

(7) the Medical Insurance Pool Act;

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

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

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

H. "employee" means that term as defined in Section 3(6) of the federal Employee Retirement Income

Security Act of 1974;

I. "employer" means:

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

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

J. "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries;

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

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

(1) coverage only accident or disability income insurance;

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

(3) liability insurance;

(4) workers' compensation or similar

insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

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

(9) the following benefits if offered separately:

(a) limited scope dental or vision benefits;

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

(c) other similar limited benefits specified in regulations;

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

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

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

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

(a) medicare supplemental health

insurance as defined pursuant to Section 1882(g)(1) of the Social Security Act; and

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

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

N. "governmental plan" means that term as defined in Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and includes a federal governmental plan;

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

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

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

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

S. "health insurance issuer" means an insurance company, insurance service or insurance organization, including a health maintenance organization, that is licensed to engage in the business of insurance in the state and that is subject to state law that regulates insurance within the meaning of Section 514(b)(2) of the federal Employee Retirement Income Security Act of 1974, but "health insurance issuer" does not include a group health plan;

T. "health maintenance organization" means:

(1) a federally qualified health maintenance organization;

(2) an organization recognized pursuant to

state law as a health maintenance organization; or

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

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

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

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

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

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

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

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

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

AA. "medical care" means:

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

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

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

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

DD. "participant" means:

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

(2) a partner in relationship to a

partnership in connection with a group health plan maintained by the partnership; and

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

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

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

GG. "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of the coverage for the benefits whether or not any medical advice, diagnosis, care or treatment was recommended before that date, but genetic information is not included as a preexisting condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the condition related to the genetic information;

HH. "small employer" means, in connection with a group health plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during

the preceding calendar year and who employs at least two employees on the first day of the plan year;

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

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

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

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

"59A-23E-3. LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD.--A health insurance issuer or health benefits plan offering group health insurance, blanket health insurance or individual health insurance shall not impose any preexisting condition exclusion with respect to that health insurance plan or coverage. A health insurance issuer or health insurance plan offering group health insurance, blanket health insurance or individual health insurance shall not impose a waiting period in excess of ninety days with

respect to a health insurance plan or coverage."

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

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

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

(1) the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

(2) the employee stated in writing at the time coverage was offered that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer required such a statement at the time and provided the employee with notice of that requirement and the consequences of the requirement at the time;

(3) the employee's or dependent's coverage

described in Paragraph (1) of this subsection was:

(a) under a COBRA continuation provision and the coverage under that provision was exhausted; or

(b) not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment, or employer contributions toward the coverage were terminated; and

(4) under the terms of the plan, the employee requested enrollment not later than thirty days after the date of exhaustion of coverage described in Subparagraph (a) of Paragraph (3) of this subsection or termination of coverage or employer contribution described in Subparagraph (b) of Paragraph (3) of this subsection.

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

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

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

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

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

"59A-23E-11. PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not establish rules for eligibility or continued eligibility of any individual to enroll or continue to participate in a health plan, or eligibility or continued eligibility for benefits, based on any of the following factors in relation to the individual or a dependent of the individual:

A. health status;

B. medical condition, including both physical and mental illnesses;

C. claims experience;

D. receipt of health care;

E. medical history;

F. genetic information;

G. evidence of insurability, including conditions arising out of acts of domestic violence;

H. disability;

I. gender;

J. national origin;

K. sexual orientation; or

L. any other health status-related factor that the superintendent specifies in rules of the office of superintendent of insurance."

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

"59A-23E-12. PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES IN PREMIUM CONTRIBUTIONS.--

A. A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not require an individual as a condition of enrollment

or continued enrollment under the plan to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of the health status related factor in relation to the individual or a person enrolled under the plan as a dependent of the individual.

B. The provisions of Subsection A of this section shall not be construed to:

(1) restrict the amount that an employer or an individual may be charged for coverage under a group health plan or individual health coverage; or

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

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

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

"59A-23E-13. HEALTH INSURANCE ISSUERS--GUARANTEED AVAILABILITY OF COVERAGE--EXCEPTIONS FOR NETWORK PLANS, INSUFFICIENT FINANCIAL CAPACITY AND BONA FIDE ASSOCIATIONS--EMPLOYER CONTRIBUTION RULES.--

A. Except as provided in Subsections C through E of this section, a health insurance issuer that offers health insurance coverage in the individual or small group markets shall:

(1) accept every individual or employer that applies for coverage;

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

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

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

C. A health insurance issuer that offers health insurance coverage in the group or individual markets through a network plan may:

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

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

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

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

D. A health insurance issuer, upon denying insurance coverage in any service area pursuant to the provisions of Subsection C of this section, shall not offer coverage in the group market or individual market within the service area for a period of one hundred eighty days after the date coverage is denied.

E. A health insurance issuer may deny health insurance coverage in the individual and group markets if the issuer has demonstrated to the superintendent that it:

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

(2) is applying this exception uniformly to all individuals, employers and their employees in the individual and group markets in the state consistent with state law and without regard to the claims experience of those individuals, employers, their employees and their dependents or any health status related factor relating to those individuals, employees and dependents.

F. A health insurance issuer, upon denying health insurance coverage in accordance with Paragraphs (1) and (2) of Subsection E of this section, shall not offer coverage in the group or individual markets in the state for a period of one hundred eighty days after the date the coverage is denied or until the issuer has demonstrated to the superintendent that the carrier has sufficient financial reserves to underwrite additional coverage, whichever is later. The superintendent may provide for the application of this subsection on a service-area-specific basis.

G. As used in this section, "eligible individual" means, with respect to a health insurance issuer offering an individual or group health plan, an individual whose

eligibility shall be determined:

(1) in accordance with the terms of the plan;

(2) as provided by the issuer under the rules of the issuer that are uniformly applicable in the state to the individual and group markets; and

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

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

"59A-23E-14. HEALTH INSURANCE ISSUERS--GUARANTEED AVAILABILITY OF COVERAGE.--

A. Except as provided in Subsections B through F of this section, a health insurance issuer that offers health insurance coverage in the individual or group markets shall renew or continue that coverage in force at the option of the plan sponsor or the individual.

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

(1) the plan sponsor or individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has

not received timely premium payments;

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

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

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

C. A health insurance issuer may discontinue offering a particular type of individual or group health insurance coverage offered in the group or individual markets only if:

(1) the issuer provides notice to each plan sponsor or individual provided coverage of this type in the market and to the participants and beneficiaries covered under the coverage of the discontinuation at least ninety

days prior to the date of the discontinuation;

(2) the issuer offers to a plan sponsor or individual provided coverage of this type in the market the option to purchase any other health insurance plan coverage currently being offered by the issuer in that market; and

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

D. If a health insurance issuer elects to discontinue offering all health insurance coverage in the individual or group markets, coverage may be discontinued only if:

(1) the issuer provides notice to the superintendent and to each plan sponsor or to the individual and participants and beneficiaries covered under that coverage of the discontinuation at least one hundred eighty days prior to the date of discontinuation; and

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

E. After discontinuation pursuant to Subsection D

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

F. At the time of coverage renewal pursuant to Subsection A of this section, a health insurance issuer may modify the coverage for a policy form offered to a group or individual if the modification is effective on a uniform basis among all groups or individuals, as applicable, with that policy form."

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

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

A. A health insurance issuer when offering health insurance coverage to an employer or individual shall:

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

(2) upon request of the employer or individual provide the information described.

B. Except as provided in Subsection D of this

section, a health insurance issuer offering a health plan to an employer or individual shall provide information pursuant to Subsection A of this section concerning:

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

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

(3) the benefits and premiums available under all health insurance coverage for which the small employer is qualified.

C. Information furnished pursuant to this section shall be provided to employers or individuals in a manner determined to be understandable by the average employer or individual and shall be sufficient to reasonably inform employers or individuals of their rights and obligations under the health insurance coverage.

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

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

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

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

B. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 shall not apply with respect to a group health plan or group retiree health plan that is a nonfederal governmental plan if the plan sponsor makes an election under the provisions of this subsection in conformity with regulations of the federal secretary of health and human services. The period of an election for exclusion made pursuant to this subsection is for a single specified plan year or, in the case of a plan provided pursuant to a collective bargaining agreement, for the term of the agreement. The plan for which an election is made shall provide under the terms of the election for:

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

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

C. The requirements of Sections 59A-23E-3 through

59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply to a group health plan and group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in Paragraph (9) of Subsection L of Section 59A-23E-2 NMSA 1978 if the benefits are:

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

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

D. The requirements of Sections 59A-23E-3 through 59A-23E-15, 59A-23E-17 and 59A-23E-18 NMSA 1978 do not apply to any group health plan and group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in Paragraph (10) of Subsection L of Section 59A-23E-2 NMSA 1978 if:

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

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

(3) the benefits are paid with respect to an event without regard to whether benefits are provided with respect to that event under any group health plan maintained

by the same plan sponsor.

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

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

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

A. A group health plan or group or individual health insurance shall not impose treatment limitations or financial restrictions, limitations or requirements on the provision of mental health benefits that are more restrictive than the predominant restrictions, limitations or requirements that are imposed on coverage of benefits for other conditions.

B. A group health plan or group or individual health insurance offered in connection with that plan, may:

(1) require pre-admission screening prior to

the authorization of mental health benefits whether inpatient or outpatient; or

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

C. As used in this section, "mental health benefits" means mental health benefits as described in the group health plan, or group health insurance offered in connection with the plan; but does not include benefits with respect to treatment of substance abuse, chemical dependency or gambling addiction."

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

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

A. "basic health care services" means medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory, diagnostic and therapeutic radiological services and services of pharmacists and pharmacist clinicians;

B. "capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of

services provided and includes the cost associated with operating staff model facilities;

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

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

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

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

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

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

I. "extension of benefits" means the continuation

of coverage under a particular benefit provided under a contract or group contract following termination with respect to an enrollee who is totally disabled on the date of termination;

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

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

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

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

N. "health maintenance organization" means any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid

basis, except for enrollee responsibility for copayments or deductibles;

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

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

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

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

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

T. "participating provider" means a provider as defined in Subsection X of this section who, under an express contract with the health maintenance organization or with its

contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization;

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

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

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

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

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

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

AA. "uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance

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

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

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

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

B. The right to a continuation of coverage or conversion pursuant to this section shall not exist with respect to any covered family member of a subscriber in the event the coverage terminates for nonpayment of premium,

nonrenewal of the contract or the expiration of the term for which the contract is issued. With respect to any covered family member who is eligible for medicare or any other similar federal or state health insurance program, the right to a continuation of coverage or conversion shall be limited to coverage under a medicare supplement insurance contract as defined by the rules and regulations adopted by the superintendent of insurance.

C. Coverage continued through the issuance of a converted or separate contract shall be provided at a reasonable, nondiscriminatory rate to the insured and shall consist of a form of coverage then being offered by the health maintenance organization as a conversion contract. Continued and converted coverages shall contain renewal provisions that are not less favorable to the subscriber than those contained in the contract from which the conversion is made, except that the person who exercises the right of conversion is entitled only to have included a right to coverage under a medicare supplement insurance contract, as defined by the rules and regulations adopted by the superintendent of insurance, after the attainment of the age of eligibility for medicare or any other similar federal or state health insurance program.

D. At the time of inception of coverage, the health maintenance organization shall provide each covered

family member eighteen years of age or older a statement setting forth in summary form the continuation of coverage and conversion provisions of the subscriber's contract.

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

F. Coverage shall be provided through continuation or conversion without additional evidence of insurability and shall not impose any preexisting condition, limitations or other contractual time limitations.

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

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

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

A. Every individual or group contract entered into by a health care plan that provides for health care expense payments on a service benefit basis or an indemnity benefit basis or both and that is delivered, issued for delivery or

renewed in this state on or after July 1, 1984 shall provide covered family members of subscribers the right to continue such coverage through a converted or separate contract upon the death of the subscriber or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the subscriber. Where a continuation of coverage or conversion is made in the name of the spouse of the subscriber, such coverage may, at the option of the spouse, include coverage to dependent children for whom the spouse has responsibility for care and support.

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

C. Coverage continued through the issuance of a converted or separate contract shall be provided at a reasonable, nondiscriminatory rate to the insured and shall

consist of a form of coverage then being offered by the health care plan as a conversion contract in the jurisdiction where the person exercising the conversion right resides that most nearly approximates the coverage of the contract from which conversion is exercised. Continued and converted coverages shall contain renewal provisions that are not less favorable to the subscriber than those contained in the policy from which the conversion is made, except that the person who exercises the right of conversion is entitled only to have included a right to coverage under a medicare supplement insurance contract, as defined by the rules and regulations adopted by the superintendent of insurance, after the attainment of the age of eligibility for medicare or any other similar federal or state health insurance program.

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

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

F. Coverage shall be provided through continuation or conversion without additional evidence of insurability and shall not impose any preexisting condition, limitations or other contractual time limitations.

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

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

"STATE INNOVATION WAIVER APPLICATION.--The superintendent, in consultation with and pursuant to approval by the governor, is authorized to submit a state innovation waiver application pursuant to Section 1332 of the federal Patient Protection and Affordable Care Act to establish a program relating to access and affordability of health insurance coverage. In applying for a waiver pursuant to Section 1332 of the federal Patient Protection and Affordable Care Act, the superintendent shall seek any federal funding available to implement the waiver."

SECTION 21. A new section of the New Mexico Insurance Code is enacted to read:

"EXCLUSION PROHIBITION NOT APPLICABLE TO EXCEPTED BENEFIT PLANS OR POLICIES.--

A. Notwithstanding any other provisions of law, an

excepted benefits policy or plan shall not exclude coverage for losses incurred for a preexisting condition more than twelve months from the effective date of coverage. The policy or plan shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment recommended by or received from a physician within twelve months before the effective date of coverage.

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

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

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

(3) liability insurance;

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other similar insurance coverage specified in office of superintendent of insurance rules, under which benefits for medical care are secondary or incidental to other benefits;

(9) the following benefits if offered

separately:

(a) limited-scope dental or vision benefits;

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

(c) other similar limited benefits specified in office of superintendent of insurance rules;

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

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

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

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

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

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

SECTION 22. REPEAL.--Sections 59A-22-37, 59A-23B-1 through 59A-23B-12, 59A-23C-5, 59A-23C-7.1 and 59A-23E-4

through 59A-23E-7 NMSA 1978 (being Laws 1984, Chapter 127, Section 459, Laws 1991, Chapter 111, Sections 1 through 10, Laws 1994, Chapter 64, Section 7, Laws 1991, Chapter 111, Section 11, Laws 2003, Chapter 252, Section 2, Laws 1991, Chapter 153, Section 5, Laws 1994, Chapter 75, Section 32 and Laws 1997, Chapter 243, Sections 4 through 7, as amended) are repealed.