SENATE BILL 290

50TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2012

INTRODUCED BY

Dede Feldman

AN ACT

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

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

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

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

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

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

SECTION 2. 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, 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

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determining the initial year's premium charged for an individual, use only the rating factors of age, [~~gender pursuant to Subsection B of this section~~] 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. In determining the initial and any subsequent year's rate, [~~the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than the following percentage of the lower rate for policies issued or delivered in the respective year; provided, however, that gender shall not be used as a rating factor for policies issued or delivered on or after January 1, 2014:~~

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

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

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

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

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

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

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

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

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

(1) rates for individual policies; or

(2) the amount an employer may be charged for coverage under the group health plan.

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

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

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

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

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

(1) a summary of benefits;

(2) an explanation of coverage;

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

(4) exceptions, reductions and limitations on coverage;

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

(6) the renewability and continuation of coverage provisions;

(7) a coverage facts disclosure that includes examples that are based on nationally recognized clinical practice guidelines to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions

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and related cost-sharing;

(8) a statement that the health care plan:

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

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

(9) a contact number for the consumer to call with additional questions and an internet web address where a copy of the actual health care plan can be reviewed and obtained.

B. An insurer, health maintenance organization or nonprofit health care plan shall provide the following persons, prior to any enrollment restriction, a summary of benefits and coverage explanation required pursuant to Subsection A of this section:

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

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

(3) a policyholder, plan holder, evidence of coverage holder, enrollee, subscriber or certificate holder, at the time of issuance of the policy, plan or evidence of

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coverage or the delivery of the certificate."

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

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

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

(1) a summary of benefits;

(2) an explanation of coverage;

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

(4) exceptions, reductions of indemnity and limitations on coverage;

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

(6) the renewability and continuation of coverage provisions;

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

(8) a statement of whether the policy:

(a) provides minimum essential coverage, as defined under Section 5000A(f) of the federal Internal

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Revenue Code of 1986; and

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

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

B. An insurer shall provide the following persons, prior to any enrollment restriction, a summary of benefits and coverage explanation required pursuant to Subsection A of this section:

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

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

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

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

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

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

~~C.~~] (3) it purports to insure only one person,

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except as provided in Chapter 59A, Article 23 [~~of the Insurance Code~~] NMSA 1978, and except that a policy or contract may be issued upon application of the head of a family, who shall be deemed the policyholder, covering members of any one family, including husband, wife, [~~dependent~~] children [~~or any children~~] under the age of [~~nineteen (19)~~] twenty-six and [~~other~~] any dependents living with the family; [~~and~~

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

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

~~F.~~] (5) each [~~such~~] form, including riders and endorsements, shall be identified by a form number in the lower

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left-hand corner of the first page thereof; and

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

SECTION 5. 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 individual and group comprehensive major medical policies and plans 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~~] or plan, a policy or [~~to deny~~] plan shall not be rescinded, nor shall a claim for loss incurred or disability [~~as defined in the policy~~] be denied, except when a covered individual:

(1) engages in conduct that constitutes fraud; or

(2) makes an intentional misrepresentation of

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material fact that is prohibited by the terms of the policy.

B. In the event [~~a misstatement in an application is made that is not fraudulent or willful~~] a misrepresentation of a material fact that is not intentional is made in an application, the issuer of the policy or plan may prospectively rate and collect from the insured the premium that would have been charged to the insured at the time the policy or plan was issued had [~~such misstatement~~] the misrepresentation 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 and plan 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 or plan that the insured has the right to continue in force subject to its terms by the timely payment

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of premium [~~(1)~~] until at least age fifty or [~~(2)~~], in the case of a policy or plan 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.~~

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

~~(1) the condition manifested itself within a period of six months prior to the effective date of coverage in a manner that would cause a reasonably prudent person to seek~~

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~~diagnosis, care or treatment; or~~

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

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

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

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

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

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

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

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

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

[~~A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "Unless not less than five days prior to the premium due date the insurance company has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.".~~]"

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

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

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

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

A. An individual or group hospital or medical expense insurance policy or plan delivered or issued for delivery in this state [~~which~~] that provides that coverage of a [~~dependent~~] child of an insured, or of an employee or other member of the covered group, shall terminate upon attainment of the limiting age for [~~dependent~~] children specified in the policy or plan shall also provide, in substance, that attainment of the limiting age shall not operate to terminate the coverage of a child while the child is, and continues to be, both incapable of self-sustaining employment, by reason of [~~mental retardation~~] cognitive or physical [~~handicap~~] disability, and chiefly dependent upon the policyholder or plan

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holder for support and maintenance. However, proof of the incapacity and dependency of the child must be furnished to the insurer by the insured employee or member within thirty-one [~~(31)~~] days of the child's attainment of the limiting age and subsequently, as may be required by the insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

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

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

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

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

(1) was born out of wedlock;

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

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

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

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

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

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

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

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

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

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

(a) the court or administrative order is

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no longer in effect; or

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

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

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

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

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

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

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

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

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

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

C. This section applies to policies delivered or

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

D. If an organization offering group health benefits to its members makes more than one health insurance policy or nonprofit health care plan available to its members on a member option basis, the organization shall not require alcohol dependency and misuse coverage from one health insurer or health care plan without requiring the same level of alcohol dependency and misuse coverage for all other health insurance policies or health care plans that the organization makes available to its members."

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

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

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

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

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

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

"59A-22-40. COVERAGE FOR CYTOLOGIC AND HUMAN PAPILLOMAVIRUS SCREENING.--

A. Each individual and group health insurance

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

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

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

D. For the purposes of this section:

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

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

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

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

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

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

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

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

(1) offer tobacco cessation intervention

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coverage for those who use tobacco products;

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

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

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

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

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

A. An individual or group health insurance policy, health care plan and certificate of health insurance that is delivered, issued for delivery or renewed in this state shall provide coverage for colorectal screening for determining the presence of precancerous or cancerous conditions and other health problems. The coverage shall make available colorectal cancer screening, as determined by the health care provider in accordance with [~~the evidence-based recommendations established by~~] practices that have, in effect, a rating of "A" or "B" in the current recommendations of the United States preventive

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services task force.

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

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

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

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

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

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

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

B. Coverage required pursuant to Subsection A of

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this section:

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

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

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

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

[~~(5)~~] (4) may be limited to exclude coverage for services received under the federal Individuals with

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Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

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

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

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

(1) the diagnosis;

(2) the proposed treatment by types;

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(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

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

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

H. As used in this section:

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

(2) "habilitative or rehabilitative services"

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means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual; and

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

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

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

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

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

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

C. An insurer that fails to comply with the reimbursement requirements pursuant to this section shall issue a [~~dividend or credit against future premiums~~] rebate to all policyholders or plan holders in [~~an amount sufficient to assure that the benefits paid in the preceding three calendar years plus the amount of the dividends or credits are equal to~~

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

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

E. For the purposes of this section:

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

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services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

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

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

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

"[NEW MATERIAL] CHILD DEFINED.--As used in Chapter 59A, Article 22 NMSA 1978, "child" means an individual under twenty-six years of age whom the principal insured covers or whom the

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applicant for coverage applies to cover, regardless of the individual's financial dependency, residency with a parent, student status, employment and marital status."

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

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

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

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

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

D. Coverage provided by a health insurer, health maintenance organization or nonprofit health plan pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified

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before March 23, 2010 constitutes a grandfathered health plan until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement that relates to the coverage and amends the coverage solely to conform to any requirement of Chapter 59A, Article 22 NMSA 1978 shall not be treated as a termination of the collective bargaining agreement."

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

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

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

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

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

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

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

F. A health insurer may restrict enrollment in coverage described in Subsection A of this section to open or special enrollment periods; provided that any special enrollment period shall comply with the provisions of Section 21 of this 2012 act and rules the superintendent has promulgated.

G. For the purposes of this section:

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

(2) "preexisting condition" means a physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended for or received by an applicant for health insurance within six months before the effective date of coverage, except that pregnancy is not

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considered a preexisting condition for federally defined individuals."

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

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

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

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

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

B. With respect to plan years beginning prior to January 1, 2014, a group health plan, health insurance issuer offering group or individual health insurance coverage, health maintenance organization, fraternal benefit society or nonprofit organization shall establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary only with respect to the scope of benefits that are essential health benefits, as the superintendent defines "essential health benefits" by rule.

C. Subsection A of this section shall not be

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construed to prevent a group health plan, health insurance issuer offering group or individual health insurance coverage, health maintenance organization, fraternal benefit society or nonprofit organization 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.

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

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

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

A. For plan or policy years beginning on or after September 23, 2010, if a child's coverage ended or did not begin for the reasons described in Subsection E of this section, a health insurer shall provide the child an opportunity to enroll in a health plan or policy for which coverage continues for at least sixty days and provide written notice of the opportunity to enroll as described in Subsection

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B of this section no later than the first day of the plan or policy year.

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

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

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

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status.

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

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

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

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

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

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

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Internal Revenue Code of 1986, other than the group health plan of a parent.

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

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

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

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

B. When a health insurer offers individual or group health insurance coverage that only covers individuals under age nineteen, that insurer shall offer the coverage continuously throughout the year or during one or more open enrollment periods as the superintendent prescribes by rule.

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

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basis of a preexisting condition.

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

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

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

"[NEW MATERIAL] EMERGENCY SERVICES.--

A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered or issued for delivery in this state and that provides or covers any benefits with respect to services in an emergency department of a hospital shall cover emergency services:

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

(2) whether or not the health care provider furnishing emergency services is a participating provider with

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respect to emergency services.

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

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

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

(1) policies or plans intended to supplement major medical group-type coverages such as medicare supplement,

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long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies or plans; or

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

E. As used in this section:

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

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

(b) serious impairment to bodily functions; or

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

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

(a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to

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the emergency department to evaluate the emergency medical condition; and

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

(3) "stabilize" means:

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

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

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

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

A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered or issued for delivery in this state that requires or provides for the designation of a participating primary care

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provider shall allow a principal insured to designate for the principal insured's dependent child who is a covered individual an allopathic or osteopathic physician who specializes in pediatrics as the principal insured child's primary care provider if the provider participates in the network of the plan or issuer.

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

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

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

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

A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered or issued for delivery in this state that provides coverage for obstetrical and gynecological care and that

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requires that covered individuals designate a primary care provider shall not require authorization or referral by the plan or issuer or any person, including a primary care provider, when a female covered individual seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The obstetrical or gynecological health care provider shall agree otherwise to adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan approved by the plan or issuer.

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

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

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

(2) preclude the health insurer from requiring

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that the obstetrical or gynecological provider notify the covered individual's primary care health care professional or the plan or issuer of treatment decisions.

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

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

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

A. A health insurer providing coverage under an individual health benefit policy or plan, except for a grandfathered health policy or plan, shall provide coverage for items and services pursuant to Sections 59A-22-34.3, 59A-22-40, 59A-22-44 and 59A-22-47 NMSA 1978 and Sections 28 through 30 of this 2012 act and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible.

B. A health insurer is not required to provide coverage for any items or services specified in any recommendation or guideline described in Subsection A of this section after the recommendation or guideline is no longer

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described by a source listed in that subsection.

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

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

E. The superintendent shall at least annually revise the preventive services standards established pursuant to Sections 59A-22-44 and 59A-22-47 NMSA 1978 and Sections 28 through 30 of this 2012 act to ensure that they are respectively consistent with the current "A"-rated and "B"-rated recommendations of the United States preventive services task force, the advisory committee on immunization practices of the federal centers for disease control and prevention and the guidelines with respect to infants, children, adolescents and women of evidence-based preventive care and screenings by the federal health resources and services administration. When changes are made to any of these guidelines or recommendations, the superintendent shall make recommendations to the legislature for legislative changes to conform these standards to current guidelines and recommendations.

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

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

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

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

SECTION 28. A new section of Chapter 59A, Article 22 NMSA

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1978 is enacted to read:

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

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

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

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

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

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

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

(6) screening of lipid disorders for:

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

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

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

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

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

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

(11) screening and counseling for obesity for:

(a) individuals eighteen years of age

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and older who are obese; and

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

(12) screening for osteoporosis for:

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

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

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

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

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

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

(1) oral fluoride supplementation at currently

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recommended doses to children six months of age to five years of age whose primary water sources are deficient in fluoride;

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

(3) screening for hearing loss in newborns;

(4) screening for sickle cell disease for newborns;

(5) screening for congenital hypothyroidism for newborns;

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

(7) screening for phenylketonuria in newborns; and

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

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

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

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

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

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

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

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

(4) screening for chlamydial infection for:

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

(b) older women who are at increased risk of chlamydial infection;

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

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

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

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

(a) all pregnant women; and

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

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

(a) all sexually active adolescents; and

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

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

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

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

(13) screening for syphilis for:

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

(b) any pregnant woman.

B. The provisions of this section shall not apply to policies or plans intended to supplement major medical

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group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies or plans."

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

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

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

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

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

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

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~~insurer~~].

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

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

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

(3) meets at least the minimum standards adopted by the behavioral health services division for treatment of [~~alcoholism~~] alcohol dependency and misuse in regional treatment centers.

C. This section applies to policies delivered or issued for delivery or renewed, extended or amended in this state on or after July 1, 1983 or upon expiration of a collective bargaining agreement applicable to a particular policyholder, whichever is later; provided that this section does not apply to blanket, short-term travel, accident-only, limited or specified disease, individual conversion policies or policies designed for issuance to persons eligible for coverage

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under Title 18 of the Social Security Act, known as medicare, or any other similar coverage under state or federal governmental plans. With respect to any policy forms approved by the insurance division of the public regulation commission prior to the effective date of this section, an insurer is authorized to comply with this section by the use of endorsements or riders, provided such endorsements or riders are approved by the insurance division as being in compliance with this section and applicable provisions of the Insurance Code.

D. If an organization offering group health benefits to its members makes more than one health insurance policy or nonprofit health care plan available to its members on a member option basis, the organization shall not require alcohol dependency and misuse coverage from one health insurer or health care plan without requiring the same level of alcohol dependency and misuse coverage for all other health insurance policies or health care plans that the organization makes available to its members."

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

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

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

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(1) was born out of wedlock;

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

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

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

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

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

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

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

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

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

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

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

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

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

E. An insurer shall provide coverage for children, from birth through three years of age, for or under the family, infant, toddler program administered by the department of health, provided that eligibility criteria are met [~~for a~~

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~~maximum benefit of three thousand five hundred dollars ($3,500) annually~~] for medically necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in 7.30.8 NMAC who are working in early intervention programs approved by the department of health. [~~No payment under this subsection shall be applied against any maximum lifetime or annual limits specified in the policy, health benefits plan or contract.~~]"

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

"59A-23-7.3. MAXIMUM AGE OF [~~DEPENDENT~~] CHILD.--Each blanket or group health policy or certificate of insurance delivered, issued for delivery or renewed in New Mexico on or after July 1, 2003 that provides coverage for an insured's [~~dependent~~] child shall not terminate coverage of [~~an unmarried dependent~~] a child by reason of the [~~dependent's~~] child's age before the [~~dependent's twenty-fifth~~] child's twenty-sixth birthday [~~regardless of whether the dependent is enrolled in an educational institution~~]."

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

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

A. A blanket or group health insurance policy or

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contract that is delivered, issued for delivery or renewed in this state shall provide coverage to an eligible individual who is nineteen years of age or younger or an eligible individual who is twenty-two years of age or younger and is enrolled in high school for:

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

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

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

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

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

~~(3)~~] (2) shall not be denied on the basis that

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the services are habilitative or rehabilitative in nature;

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

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

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

D. An insurer shall not deny or refuse to issue

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health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

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

(1) the diagnosis;

(2) the proposed treatment by types;

(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

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

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

H. As used in this section:

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

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

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

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

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

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

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

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

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

C. Subsection A of this section shall not be construed to prevent a group or blanket insurer offering group or blanket health insurance coverage 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.

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

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

"[NEW MATERIAL] CHILD DEFINED.--For the purposes of

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Chapter 59A, Article 23 NMSA 1978, "child" means an individual under twenty-six years of age whom the principal insured covers or whom the applicant for coverage applies to cover, regardless of the individual's financial dependency, residency with a parent, student status, employment or marital status."

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

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

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

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

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

D. Coverage provided by a health insurer, health maintenance organization or nonprofit health plan pursuant to

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one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010 constitutes a grandfathered health plan until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement that relates to the coverage and amends the coverage solely to conform to any requirement of Chapter 59A, Article 23 NMSA 1978 shall not be treated as a termination of the collective bargaining agreement."

SECTION 38. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] DIRECT SERVICES.--

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

B. An insurer that fails to comply with the eighty-five percent reimbursement requirement in Subsection A

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of this section shall issue a dividend or credit against future premiums to all policyholders in an amount sufficient to assure that the benefits paid in the preceding three calendar years plus the amount of the dividends or credits equal eighty-five percent of the premiums collected in the preceding three calendar years. If the insurer fails to issue the dividend or credit in accordance with the requirements of this section, the superintendent shall enforce the requirements and may pursue any other penalties as provided by law, including general penalties pursuant to Section 59A-1-18 NMSA 1978.

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

D. For the purposes of this section:

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

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utilization or services;

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

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

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

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

A. A health insurer or insurer providing coverage under a group or blanket health benefit plan or policy or a grandfathered health plan shall not rescind coverage under a group or blanket health benefit policy or with respect to an

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individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan or policy, unless a covered individual:

(1) engages in conduct that constitutes fraud; or

(2) makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

B. A health insurer shall provide at least thirty days' advance written notice to each plan or policy enrollee, or for individual health insurance coverage, to each primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan or policy may be rescinded in accordance with Subsection A of this section, regardless, in the case of group health insurance coverage, of whether the rescission applies to the entire group or only to an individual within the group.

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

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

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

A. Except as provided pursuant to Subsection B of

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this section, a health insurer that offers a health benefit plan providing group health insurance coverage in the state shall issue any health benefit plan to any employer that applies for such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health policy or plan. An insurer:

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

(2) shall not offer coverage to only certain individuals or certain children or dependents of employees in the group or to only part of the group.

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

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

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

(3) within the geographic service area for the

network plan where the insurer reasonably anticipates, and demonstrates to the satisfaction of the superintendent, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of the groups because of its obligations to existing group policyholders and enrollees.

C. A health insurer may restrict enrollment in coverage described in Subsection A of this section to open or special enrollment periods; provided that any special enrollment period shall comply with the provisions of Section 41 of this 2012 act and rules that the superintendent has promulgated.

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

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

F. A health insurer shall renew any health benefit plan at the option of the employer, except as the superintendent has provided by rule.

G. For the purposes of this section:

(1) "coverage" means a health insurance

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

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

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

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

A. For plan or policy years beginning on or after September 23, 2010, if a child's coverage ended or did not begin for the reasons described in Subsection E of this section, a health insurer shall provide the child an

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opportunity to enroll in a health plan or policy for which coverage continues for at least sixty days and provide written notice of the opportunity to enroll, as described in Subsection B of this section, no later than the first day of the plan or policy year.

B. A written notice of the opportunity to enroll provided pursuant to this section shall include a statement that children whose coverage ended, who were denied coverage or who were not eligible for coverage because dependent coverage of children was unavailable before the child reached twenty-six years of age are eligible to enroll in coverage. This notice may be provided to a principal insured on behalf of the principal insured's child. For a group plan or policy, the notice may be included with other enrollment materials that the health insurer distributes to employees, provided the statement is prominent. If the notice is provided to an employee whose child is entitled to an enrollment opportunity under Subsection A of this section, the obligation to provide the notice of enrollment opportunity under this subsection is satisfied for both the individual or group health insurance policy, health care plan or certificate of health insurance and the health insurer.

C. For an individual who enrolls in a group health insurance policy, health care plan or certificate of health insurance pursuant to Subsection A of this section, the

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coverage shall take effect not later than the first day of the first plan or policy year.

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

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

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

(2) who became eligible, or is required to become eligible, for coverage on the first day of the first plan or policy year, beginning on or after September 23, 2010,

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by reason of the provisions of this section."

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

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

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

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

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

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

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

C. An employer may exclude the following types of

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employees from an offering of health coverage under Subsections A and B of this section:

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

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

(3) part-time or seasonal employees;

(4) employees not included in the plan who are included in a unit of employees covered by an agreement between employee representatives and one or more employers that the secretary of the United States department of health and human services has found to be a collective bargaining agreement, if accident and health benefits were the subject of good-faith bargaining between these employee representatives and the employer or employers; and

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

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

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

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

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

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

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

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

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

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

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

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

B. When a health insurer offers individual or group health insurance coverage that only covers individuals under the age of nineteen, that insurer shall offer the coverage continuously throughout the year or during one or more open enrollment periods as the superintendent prescribes by rule.

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

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

E. Each health insurer shall provide prior prominent public notice on its web site and written notice to

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each of its policyholders or plan holders annually at least ninety days before any open enrollment period of the open enrollment rights for individuals under the age of nineteen and shall provide information as to how an individual eligible for this open enrollment right may apply for coverage with the insurer during an open enrollment period."

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

"[NEW MATERIAL] EMERGENCY SERVICES.--

A. A group health insurance policy, health care plan or certificate of health insurance that is delivered or issued for delivery in this state and that provides or covers any benefits with respect to services in an emergency department of a hospital shall cover emergency services:

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

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

B. If emergency services are provided to a covered individual by a nonparticipating health care provider with or without prior authorization, the services shall be provided without imposing any requirement under the policy, plan or certificate for prior authorization of services or any limitation on coverage where the provider of services does not

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have a contractual relationship with the insurer for the provision of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the health insurer.

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

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

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

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

E. As used in this section:

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

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

(b) serious impairment to bodily functions; or

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

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

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

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

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examination or treatment required to stabilize the patient's emergency medical condition; and

(3) "stabilize" means:

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

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

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

"[NEW MATERIAL] OPTION FOR PEDIATRICIAN AS PRIMARY CARE PROVIDER.--

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

B. Nothing in Subsection A of this section shall be

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construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance policy with respect to coverage of pediatric care.

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

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

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

A. A group health insurance policy, health care plan or certificate of health insurance that is delivered or issued for delivery in this state that provides coverage for obstetrical and gynecological care and that requires that covered individuals designate a primary care provider shall not require authorization or referral by the plan or issuer or any person, including a primary care provider, when a female covered individual seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The obstetrical or gynecological health care provider shall agree

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otherwise to adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan approved by the plan or issuer.

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

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

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

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

D. As used in this section, "primary care provider" means a health care practitioner acting within the scope of the health care practitioner's license who provides the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, who initiates

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referrals to other health care practitioners and who maintains the continuity of care when appropriate."

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

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

A. A health insurer providing coverage under a group or blanket health insurance policy, plan or certificate of coverage, except for a grandfathered health plan, shall provide coverage for all of the preventive items and services pursuant to Sections 49 through 53 of this 2012 act, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible.

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

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

D. To the extent that a preventive care provision in this section conflicts with any other preventive health care law in New Mexico, the provision providing the greatest level of coverage shall apply. The preventive care provisions in

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this section are intended to supplement rather than supplant existing preventive health care provisions in this state.

E. The superintendent shall at least annually revise the preventive services standards established pursuant to Sections 49 through 53 of this 2012 act to ensure that they are consistent with the recommendations of the United States preventive services task force, the advisory committee on immunization practices of the federal centers for disease control and prevention and the guidelines with respect to infants, children, adolescents and women of evidence-based preventive care and screenings by the federal health resources and services administration. When changes are made to any of these guidelines or recommendations, the superintendent shall make recommendations to the legislature for legislative changes to conform these standards to current guidelines and recommendations.

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

G. An insurer shall not impose cost-sharing requirements with respect to an office visit for an item or service provided pursuant to this section if an item or service is not billed separately or is not tracked as individual

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encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the preventive item or service.

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

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

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

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

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

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

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

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

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

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

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

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

A. A group health insurance policy, health care

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plan or certificate of health insurance that is delivered or issued for delivery in this state shall provide the following benefits that have, in effect, a rating of "A" or "B" in the current recommendations of the United States preventive services task force, for:

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

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

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

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

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

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(6) screening of lipid disorders for:

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

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

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

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

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

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

(11) screening and counseling for obesity for:

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

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

(12) screening for osteoporosis for:

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

(b) women who are sixty to sixty-five years of age who are at increased risk for osteoporotic

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fractures.

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

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

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

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

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

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

(3) screening for hearing loss in newborns;

(4) screening for sickle cell disease for newborns;

(5) screening for congenital hypothyroidism

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for newborns;

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

(7) screening for phenylketonuria in newborns; and

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

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

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

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

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

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

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

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

(4) screening for chlamydial infection for:

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

(b) older women who are at increased risk of chlamydial infection;

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

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

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

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

(a) all pregnant women; and

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

(9) behavioral counseling to prevent sexually

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transmitted infections in:

(a) all sexually active adolescents; and

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

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

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

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

(13) screening for syphilis for:

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

(b) any pregnant woman.

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

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

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

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

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

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

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

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

B. No policy or plan may be issued in the state

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unless the rates have first been filed with and approved by the superintendent. This subsection shall not apply to policies or plans subject to the Small Group Rate and Renewability Act.

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

(1) a summary of benefits;

(2) an explanation of coverage;

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

(4) exceptions, reductions and limitations on coverage;

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

(6) the renewability and continuation of coverage provisions;

(7) a coverage facts disclosure that includes examples that are based on nationally recognized clinical practice guidelines to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions

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and related cost-sharing;

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

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

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

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

D. An insurer, health maintenance organization or nonprofit health care plan shall provide the following persons, prior to any enrollment restriction, a summary of benefits and coverage explanation required pursuant to Subsection A of this section:

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

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

(3) a policyholder, plan holder, evidence of

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coverage holder, subscriber or certificate holder, at the time of issuance of the policy, plan or evidence of coverage or the delivery of the certificate.

[~~C.~~] E. In determining the initial year's premium or rate charged for coverage under a policy or plan, the only rating factors that may be used are age, [~~gender pursuant to this subsection~~] 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. [~~In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rate in the age group by more than the following percentage of the lower rate for policies issued or delivered in the respective year; provided, however, that gender shall not be used as a rating factor for policies issued or delivered on or after January 1, 2014:~~

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

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

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

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

~~D.~~] F. 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

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rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be as much as three hundred percent lower than the [~~bottom~~] highest age-based rates [~~in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, society, organization or plan from offering rates that differ depending upon family composition~~].

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

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

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

(1) rates for individual policies; or

(2) the amount an employer may be charged for coverage under a group health plan.

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

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

SECTION 55. 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) genders pursuant to Subsection B of this section;~~

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

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

[~~B. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rate in the age group by more than the following percentage of the lower rate for policies issued or delivered in the respective year; provided, however, that~~

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~~gender shall not be used as a rating factor for policies issued or delivered on or after January 1, 2014:~~

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

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

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

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

~~C.~~] B. No person's rate shall exceed the rate of any other person [~~with similar family composition~~] on the basis of age by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be as much as three hundred percent lower than the [~~bottom~~] highest age-based rates [~~in the two hundred fifty percent band. The rating factor restrictions shall not prohibit a carrier from offering rates that differ depending upon family composition~~].

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

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

[~~D.~~] E. The provisions of this section do not

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

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

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

SECTION 56. Section 59A-23C-6 NMSA 1978 (being Laws 1991, Chapter 153, Section 6) is amended to read:

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

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

(1) nonpayment of required premiums;

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

(a) fraud; or

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

(3) noncompliance with plan provisions;

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

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

Eligibility classifications may not be changed if any individual is eliminated, due to the change, who was insured immediately prior to the change without first receiving the approval of the superintendent.

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

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

(2) transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the insurer offers to transfer or provide coverage to

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all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status or duration of coverage.

C. A small employer carrier may not change eligibility classifications upon renewal or replacement within twelve months of its termination of its own coverage if the change in classification eliminates from coverage any individual who was insured previous to the change and would have continued to be insured if the change in eligibility had not occurred."

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

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

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

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that requires a higher amount of premiums paid to be used for reimbursement for direct services for one or more products or for one or more years.

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

C. An insurer that fails to comply with the

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

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

E. For the purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

D. "dependent" means:

(1) a spouse;

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

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who is:

(a) a natural child;

(b) a legally adopted child;

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

(d) a child for whom the employee is the legal guardian and who is primarily dependent on the employee for maintenance and support, as long as evidence of the guardianship is evidenced in a court order or decree; or

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

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

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

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

(1) is covered under a qualified higher

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deductible health plan as of the first day of that month;

(2) is not, while covered under a qualified higher deductible health plan, covered under [~~any~~] a health plan that:

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

(b) provides coverage for any benefit that is covered under the qualified higher deductible health plan; and

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

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

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

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

I. "medical care savings account" or "savings account" means an account established by an employer in the United States exclusively for the purpose of paying the eligible medical expenses of the employee or dependent, but only if the written governing instrument creating the trust

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meets the following requirements:

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

(a) unless it is in cash; or

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

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

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

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

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

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

(1) self-only coverage with an annual

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deductible of not less than one thousand five hundred dollars ($1,500) or more than two thousand two hundred fifty dollars ($2,250) and a maximum annual out-of-pocket expense requirement of three thousand dollars ($3,000), not including premiums;

(2) family coverage with an annual deductible of not less than three thousand dollars ($3,000) or more than four thousand five hundred dollars ($4,500) and a maximum annual out-of-pocket expense requirement of five thousand five hundred dollars ($5,500), not including premiums; and

(3) preventive care coverage may be provided within the policies without the preventive care being subjected to the qualified higher deductibles."

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

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

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

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

(1) the individual has failed to pay premiums or contributions in accordance with the terms of the health

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insurance coverage or the issuer has not received timely premium payments;

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

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

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

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

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

(5) in the case of health insurance coverage that is made available to the individual market only through one or more bona fide associations, the membership of the individual in the association on the basis of which the coverage is provided ceases, but only if the coverage is terminated pursuant to this paragraph uniformly without regard

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to any health status related factor of covered individuals.

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

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

(2) the issuer offers to each individual in the individual market provided coverage of this type the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals 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 any health status related factor of enrolled individuals or individuals who may become eligible for that coverage.

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

(1) the issuer provides notice to the superintendent and to each individual of the discontinuation at least one hundred eighty days prior to the date of the

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expiration of the coverage; 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 individuals in the individual market if the modification is consistent with law and effective on a uniform basis among all individuals with that policy form.

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

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

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

A. Every society authorized to do business in this

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state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

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

C. Any person upon whose life a certificate is issued prior to attaining the age of majority shall be bound by

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the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

D. A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body shall require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made, either:

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

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

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

F. No certificate shall be delivered or issued for delivery in this state unless a copy of the form and rates and

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rate increases applicable to accident and health insurance have been filed with and approved by the superintendent in accordance with Sections 59A-18-12, 59A-18-13 and 59A-18-14 NMSA 1978. Every life or accident and health insurance certificate and every annuity certificate issued on or after one year from [~~the effective date of this act~~] January 1, 1990 shall meet the standard contract provision requirements consistent with Chapter 59A, Article 44 NMSA 1978, as specified in Chapter 59A, Articles 20 and 22 NMSA 1978, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums [~~which~~] that are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate [~~which~~] that, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for engaging in conduct that constitutes fraud or an intentional material misrepresentation [~~in the application for membership or insurance~~] that is prohibited by the terms of membership, shall have the privilege of maintaining the certificate in

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force by continuing payment of the required premium.

G. Certificates issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

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

SECTION 61. 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":

(1) 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; but

(2) does not include mental health services or services for alcohol or drug abuse, dental or vision services

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or long-term rehabilitation treatment;

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

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

[~~E.~~] 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;

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

[~~G.~~] H. "evidence of coverage" means a policy, contract or certificate showing the essential features and

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services of the health maintenance organization coverage that is given to the subscriber by the health maintenance organization or by the group contract holder;

[~~H.~~] 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;

[~~I.~~] 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;

[~~J.~~] 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;

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

[~~L.~~] 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

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physical or mental illness or injury;

[~~M.~~] 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;

[~~N.~~] 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 [~~himself~~] that person, or a person who advertises or otherwise [~~holds himself out~~] makes any representation to the public as such;

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

[~~P.~~] 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;

[~~Q.~~] 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;

[~~R.~~] S. "net worth" means the excess of total admitted assets over total liabilities, but the liabilities

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shall not include fully subordinated debt;

[~~S.~~] T. "participating provider" means a provider as defined in Subsection [~~U~~] V 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;

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

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

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

[~~W.~~] X. "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;

[~~X.~~] Y. "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

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alternative arrangements have been made that are acceptable to the superintendent;

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

[~~Z.~~] AA. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act."

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

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

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

(1) was born out of wedlock;

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

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

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

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

(2) permit the custodial parent or the provider,

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with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

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

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

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

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

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

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

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

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

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

SECTION 63. Section 59A-46-38.2 NMSA 1978 (being Laws

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1997, Chapter 250, Section 4) is amended to read:

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

A. Each individual and group health maintenance contract delivered or issued for delivery in this state shall provide coverage for childhood immunizations in accordance with the current schedule of immunizations recommended by the American academy of pediatrics, [~~including coverage for all medically necessary booster doses of all immunizing agents used in childhood immunizations~~] the advisory committee on immunization practices of the federal centers for disease control and prevention or the United States preventive services task force "A"-rated and "B"-rated recommendations, whichever provides greater coverage.

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

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

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

"59A-46-38.3. MAXIMUM AGE OF [~~DEPENDENT~~] CHILD.--Each individual or group health maintenance organization contract delivered or issued for delivery or renewed in New Mexico that

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provides coverage for an enrollee's [~~dependents~~] child shall not terminate coverage of [~~an unmarried dependent~~] a child by reason of the [~~dependent's~~] child's age before the [~~dependent's twenty-fifth~~] child's twenty-sixth birthday [~~regardless of whether the dependent is enrolled in an educational institution~~]; provided that this requirement does not apply to the medicaid managed care system."

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

"59A-46-42. COVERAGE FOR CYTOLOGIC AND HUMAN PAPILLOMAVIRUS SCREENING.--

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

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aged thirty and older.

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

C. For the purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. An individual or group health maintenance contract that is delivered, issued for delivery or renewed in this state

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shall provide coverage to an eligible individual who is nineteen years of age or younger, or an eligible individual who is twenty-two years of age or younger and is enrolled in high school, for:

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

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

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

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

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

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

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

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

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

D. [~~An insurer~~] A carrier shall not deny or refuse to issue health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or

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otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

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

(1) the diagnosis;

(2) the proposed treatment by types;

(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

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

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

H. As used in this section:

(1) "autism spectrum disorder" means a condition

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that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, also known as DSM-IV-TR, published by the American psychiatric association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder;

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

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

SECTION 68. Section 59A-46-51 NMSA 1978 (being Laws 2010, Chapter 94, Section 3) is amended to read:

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

A. A health maintenance organization shall make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines, except individually underwritten health insurance policies, contracts or plans, that are governed by the provisions of Chapter 59A, Article 22 NMSA 1978, the Health Maintenance Organization Law and the Nonprofit Health Care Plan

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

B. For individually underwritten health care policies, plans or contracts, the superintendent shall establish, after notice and informal hearing, the level of reimbursement for direct services, as determined by the reports filed with the insurance division, as a percent of premiums. Additional informal hearings may be held at the superintendent's discretion. In establishing the level of reimbursement for direct services, the superintendent shall consider the costs associated with the individual marketing and medical underwriting of these policies, plans or contracts at a level not less than seventy-five percent of premiums. A health insurer or health maintenance organization writing these policies, plans or contracts shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which that rate is

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established, but not earlier than calendar year 2010. Nothing in this subsection shall be construed to preclude a purchaser of one of these policies, plans or contracts from negotiating an agreement with a health insurer or health maintenance organization that requires a higher amount of premiums paid to be used for reimbursement for direct services.

C. A health maintenance organization that fails to comply with the reimbursement requirements pursuant to this section shall issue a [~~dividend or credit against future premiums~~] rebate to all policy, plan or contract holders in [~~an amount sufficient to assure that the benefits paid in the preceding three calendar years plus the amount of the dividends or credits are equal to the required direct services reimbursement level pursuant to Subsection A of this section for group health coverage and blanket health coverage or the required direct services reimbursement level pursuant to Subsection B of this section for individually underwritten health policies, contracts or plans for the preceding three calendar years~~] accordance with rules the superintendent has promulgated. If the [~~insurer~~] health maintenance organization fails to issue the [~~dividend or credit~~] rebate in accordance with the requirements of this section, the superintendent shall enforce these requirements and may pursue any other penalties as provided by law, including general penalties pursuant to Section 59A-1-18 NMSA 1978.

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

E. For the purposes of this section:

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

(2) "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, but does not include a person that only issues a limited-benefit policy or contract intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-

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term care or disability income; and

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

SECTION 69. A new section of the Health Maintenance Organization Law is enacted to read:

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

A. For the purposes of the Health Maintenance Organization Law, "grandfathered health plan" or "grandfathered health policy coverage" means individual coverage provided by a health maintenance organization that was in effect on March 23, 2010 and that remains in effect through the original term of coverage or through renewal of the original term.

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

C. A group health maintenance organization plan that

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provides coverage on March 23, 2010 may provide for the enrolling of new employees and their dependents in that grandfathered health plan.

D. Coverage provided by a health maintenance organization pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010 constitutes a grandfathered health plan until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement that relates to the coverage and amends the coverage solely to conform to any requirement of the Health Maintenance Organization Law shall not be treated as a termination of the collective bargaining agreement."

SECTION 70. A new section of the Health Maintenance Organization Law is enacted to read:

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

A. A carrier shall issue coverage to any individual who requests and offers to purchase the coverage without permanent exclusion of preexisting conditions.

B. Except as provided in to Subsection C of this section, a health maintenance organization that offers a health benefit plan or contract providing group health insurance

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coverage in the state shall issue any health benefit plan to any employer that applies for such plan and agrees to make the required premium payments and satisfy the other reasonable provisions of the health plan or contract. A carrier:

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

(2) shall not offer coverage to only certain individuals or certain children or dependents of employees in the group or to only part of the group.

C. A carrier that offers through a network plan or contract shall not be required to offer coverage under that plan or accept applications for that plan or contract pursuant to Subsection A of this section under the following circumstances:

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

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

(3) within the geographic service area for the network plan or contract where the carrier reasonably

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anticipates, and demonstrates to the satisfaction of the superintendent, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of the groups because of its obligations to existing group plan holders and enrollees.

D. A carrier may restrict enrollment in coverage described in Subsection B of this section to open or special enrollment periods; provided that any special enrollment period shall comply with the provisions of Section 74 of this 2012 act and rules the superintendent has promulgated.

E. A carrier may impose a waiting period not to exceed ninety days before payment for any service related to a preexisting condition. A carrier shall offer or make a referral to a transition product to provide coverage during the waiting period due to a preexisting condition.

F. A carrier shall renew any health benefit plan or contract at the option of the employer, except as the superintendent has provided by rule.

G. A carrier may continue and renew a grandfathered plan or policy that has a permanent exclusion of payment for preexisting conditions.

H. For the purposes of this section:

(1) "coverage" means a health insurance policy, health care plan, health maintenance organization contract or certificate of insurance issued for delivery in the state.

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"Coverage" does not mean a short-term, accident, fixed indemnity or specified disease policy; disability income; limited benefit insurance; credit insurance; workers' compensation; or automobile or medical insurance under which benefits are payable with or without regard to fault and that is required by law to be contained in any liability insurance policy; and

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

SECTION 71. A new section of the Health Maintenance Organization Law is enacted to read:

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

A. Notwithstanding any other provision of law, a health maintenance organization shall not establish:

(1) lifetime limits on the dollar value of benefits for any enrollee; or

(2) except as provided in Subsection B of this section, annual limits on the dollar value of benefits for any enrollee.

B. With respect to contract years beginning prior to

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January 1, 2014, a health maintenance organization shall establish a restricted annual limit on the dollar value of benefits for any enrollee only with respect to the scope of benefits that are essential health benefits, as the superintendent defines "essential health benefits" by rule.

C. Subsection A of this section shall not be construed to prevent a health maintenance organization from placing annual or lifetime per enrollee 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.

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

SECTION 72. A new section of the Health Maintenance Organization Law is enacted to read:

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

A. A health maintenance organization contract or a grandfathered health maintenance organization contract offered shall not rescind coverage under a contract with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after

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the individual is covered under the contract, unless:

(1) the individual or a person seeking coverage on behalf of the individual engages in conduct that constitutes fraud; or

(2) the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the contract or coverage.

B. For purposes of Paragraph (1) of Subsection A of this section, a person seeking coverage on behalf of an individual does not include an insurance producer or an employee or authorized representative of the carrier.

C. A health maintenance organization shall provide at least thirty days' advance written notice to each health maintenance organization enrollee, or for individual health maintenance organization coverage, to each primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the contract may be rescinded in accordance with Subsection A of this section, regardless, in the case of group health maintenance organization coverage, of whether the rescission applies to the entire group or only to an individual within the group.

D. The provisions of this section apply regardless of any applicable contestability period."

SECTION 73. A new section of the Health Maintenance Organization Law is enacted to read:

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

A. A group health maintenance organization contract that is delivered, issued for delivery or renewed in this state on behalf of an employer shall not discriminate in favor of highly compensated individuals as to eligibility to participate or as to the benefits offered. The benefits provided for participants who are highly compensated individuals shall be provided for all other participants.

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

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

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

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

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

(1) employees who have not completed three years

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of service;

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

(3) part-time or seasonal employees;

(4) employees not included in the plan who are included in a unit of employees covered by an agreement between employee representatives and one or more employers that the secretary of the United States department of health and human services has found to be a collective bargaining agreement, if accident and health benefits were the subject of good faith bargaining between these employee representatives and the employer or employers; and

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

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

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

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

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

SECTION 74. A new section of the Health Maintenance Organization Law is enacted to read:

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

A. For individual or group health maintenance organization contract years beginning on or after September 23, 2010, if a child's health maintenance organization coverage ended or did not begin for the reasons described in Subsection E of this section, a health maintenance organization shall provide the child an opportunity to enroll in a health maintenance organization contract for which coverage continues for at least sixty days and provide written notice of the opportunity to enroll as described in Subsection B of this section no later than the first day of the contract year.

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

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principal insured's child. For a group health maintenance organization contract, the notice may be included with other enrollment materials that the carrier distributes to employees, provided the statement is prominent. If the notice is provided to an employee whose child is entitled to an enrollment opportunity under Subsection A of this section, the obligation to provide the notice of enrollment opportunity under this subsection is satisfied for both the individual or group health maintenance organization contract.

C. For an individual who enrolls in an individual or a group health maintenance organization contract pursuant to Subsection A of this section, the coverage shall take effect not later than the first day of the first contract year.

D. A child enrolling pursuant to this section in a group health maintenance organization contract shall be considered a "special enrollee" pursuant to Section 59A-23E-8 NMSA 1978. The child and the principal insured shall be offered all of the benefit packages available to similarly situated individuals who were denied coverage or whose coverage ended by reason of cessation of dependent status. Any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

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

(1) whose coverage ended, or who was denied coverage or was not eligible for coverage under an individual or group health maintenance organization contract delivered, issued for delivery or renewed in this state because, under the terms of coverage, the availability of dependent coverage of a child ended before the child reached the age of twenty-six; or

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

SECTION 75. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] GRANDFATHERED HEALTH MAINTENANCE ORGANIZATION CONTRACTS--ADULT CHILD DEPENDENT ELIGIBLE FOR EMPLOYER-SPONSORED HEALTH BENEFIT CONTRACTS--EXCLUSION FROM DEPENDENT COVERAGE ELIGIBILITY PERMITTED.--

A. For contract years beginning before January 1, 2014, a group health maintenance organization contract delivered, issued for delivery or renewed in this state that provides group health maintenance organization coverage that is a grandfathered health maintenance organization contract and makes available dependent coverage of children may exclude an adult child under twenty-six years of age from coverage only if

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the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in Section 5000A(f)(2) of the federal Internal Revenue Code of 1986, other than the group contract of a parent.

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

SECTION 76. A new section of the Health Maintenance Organization Law is enacted to read:

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

A. An individual or group health maintenance organization contract delivered, issued for delivery or renewed in this state shall not limit or exclude coverage under an individual or group contract for an individual under the age of nineteen by imposing a preexisting condition exclusion on that individual.

B. When a carrier offers individual or group health insurance coverage that only covers individuals under age nineteen, that insurer shall offer the coverage continuously throughout the year or during one or more open enrollment periods as the superintendent prescribes by rule.

C. During an open enrollment period, a carrier shall not deny or unreasonably delay the issuance of a policy, refuse to issue a policy or issue a policy with any preexisting condition exclusion rider or endorsement to an applicant or

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insured who is under the age of nineteen on the basis of a preexisting condition.

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

E. Each carrier shall provide prior prominent public notice on its web site and written notice to each of its policyholders annually at least ninety days before any open enrollment period of the open enrollment rights for individuals under the age of nineteen and shall provide information as to how an individual eligible for this open enrollment right may apply for coverage with the insurer during an open enrollment period."

SECTION 77. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] EMERGENCY SERVICES.--

A. An individual or group health maintenance organization contract delivered, issued for delivery or renewed in this state and that provides or covers any benefits with respect to services in an emergency department of a hospital shall cover emergency services:

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

(2) whether or not the health care provider furnishing emergency services is a participating provider with

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respect to emergency services.

B. If emergency services are provided to a covered individual by a nonparticipating health care provider with or without prior authorization, the services shall be provided without imposing any requirement under the contract for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the carrier for the provision of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the carrier.

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

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

(1) policies or plans intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-

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only, hospital indemnity or other limited-benefit health insurance policies or plans; or

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

E. As used in this section:

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

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

(b) serious impairment to bodily functions; or

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

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

(a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical

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condition; and

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

(3) "stabilize" means:

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

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

SECTION 78. A new section of the Health Maintenance Organization Law is enacted to read:

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

A. An individual or group health maintenance organization contract delivered, issued for delivery or renewed in this state that requires or provides for the designation of a participating primary care provider shall allow a principal insured to designate for the principal insured's dependent

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child who is a covered individual an allopathic or osteopathic physician who specializes in pediatrics as the principal insured child's primary care provider if the provider participates in the network of the carrier.

B. Nothing in Subsection A of this section shall be construed to waive any exclusions of coverage under the terms and conditions of the contract with respect to coverage of pediatric care.

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

SECTION 79. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.--

A. An individual or group health maintenance organization contract delivered, issued for delivery or renewed in this state that provides coverage for obstetrical and gynecological care and that requires that covered individuals designate a primary care provider shall not require authorization or referral by the carrier or any person,

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including a primary care provider, when a female covered individual seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The obstetrical or gynecological health care provider shall agree otherwise to adhere to the contract's or issuer's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan approved by the carrier.

B. A health maintenance organization shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services by a participating health care professional who specializes in obstetrics or gynecology, as the authorization of the primary care provider.

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

(1) waive any exclusions of coverage under the terms and conditions of the contract with respect to coverage of obstetrical or gynecological care; or

(2) preclude the carrier from requiring that the obstetrical or gynecological provider notify the covered individual's primary care health care professional or the carrier of treatment decisions.

D. As used in this section, "primary care provider"

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means a health care practitioner acting within the scope of the health care practitioner's license who provides the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, who initiates referrals to other health care practitioners and who maintains the continuity of care when appropriate."

SECTION 80. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] COST-SHARING FOR PREVENTIVE ITEMS AND SERVICES.--

A. An individual or group health maintenance organization contract delivered, issued for delivery or renewed in this state, except for grandfathered health maintenance organization coverage, shall provide coverage for all of the following items and services required under Sections 59A-46-38.2, 59A-46-42 and 59A-46-45 NMSA 1978 and Sections 81 through 83 of this 2012 act, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible.

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

C. Other provisions of state or federal law may apply

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in connection with a carrier's ceasing to provide coverage for any such items or services.

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

E. The superintendent shall at least annually revise the preventive services standards established pursuant to Sections 59A-46-38.2, 59A-46-42 and 59A-46-45 NMSA 1978 and Sections 81 through 83 of this 2012 act to ensure that they are consistent with the "A"-rated and "B"-rated recommendations of the United States preventive services task force, the advisory committee on immunization practices of the federal centers for disease control and prevention and the guidelines with respect to infants, children, adolescents and women of evidence-based preventive care and screenings by the federal health resources and services administration. When changes are made to any of these guidelines or recommendations, the superintendent shall make recommendations to the legislature for legislative changes to conform these standards to current guidelines and recommendations.

F. A health maintenance organization may impose cost-sharing requirements with respect to an office visit if a

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preventive item or service provided pursuant to this section is billed separately or is tracked as individual encounter data separately from the office visit.

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

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

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

SECTION 81. A new section of the Health Maintenance Organization Law is enacted to read:

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

A. An individual or group health maintenance organization contract delivered, issued for delivery or renewed in this state shall provide the following benefits that have, in effect, a rating of "A" or "B" in the current recommendations of the United States preventive services task force, for:

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

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

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

(4) screening for high blood pressure in adults

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aged eighteen and older;

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

(6) screening of lipid disorders for:

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

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

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

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

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

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

(11) screening and counseling for obesity for:

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

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

(12) screening for osteoporosis for:

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

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

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

SECTION 82. A new section of the Health Maintenance Organization Law is enacted to read:

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

A. An individual or group health maintenance organization contract that is delivered or issued for delivery in this state shall provide the following benefits that have, in effect, a rating of "A" or "B" in the current recommendations of the United States preventive services task force, for:

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

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

(3) screening for hearing loss in newborns;

(4) screening for sickle cell disease for newborns;

(5) screening for congenital hypothyroidism for newborns;

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

(7) screening for phenylketonuria in newborns; and

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

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

SECTION 83. A new section of the Health Maintenance Organization Law is enacted to read:

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

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A. An individual or group health maintenance organization contract delivered, issued for delivery or renewed in this state shall provide the following benefits that have, in effect, a rating of "A" or "B" in the current recommendations of the United States preventive services task force, for:

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

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

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

(4) screening for chlamydial infection for:

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

(b) older women who are at increased risk of chlamydial infection;

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

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

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

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

(a) all pregnant women; and

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

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

(a) all sexually active adolescents; and

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

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

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

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

(13) screening for syphilis for:

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

(b) any pregnant woman.

B. The provisions of this section shall not apply to policies or plans intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital

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indemnity or other limited-benefit health insurance policies or plans."

SECTION 84. Section 59A-47-3 NMSA 1978 (being Laws 1984, Chapter 127, Section 879.1, as amended) is amended to read:

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

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

B. "item of health care" includes any services or materials used in health care;

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

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

E. "service benefit" means a payment that the purveyor has agreed to accept as payment in full for health care furnished the subscriber;

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

G. "subscriber" means any individual who, because of a contract with a health care plan entered into by or for the individual, is entitled to have health care expense payments

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made on the individual's behalf or to the individual by the health care plan;

H. "underwriting manual" means the health care plan's written criteria, approved by the superintendent, that defines the terms and conditions under which subscribers may be selected. The underwriting manual may be amended from time to time, but amendment will not be effective until approved by the superintendent. The superintendent shall notify the health care plan filing the underwriting manual or the amendment thereto of the superintendent's approval or disapproval thereof in writing within thirty days after filing or within sixty days after filing if the superintendent shall so extend the time. If the superintendent fails to act within such period, the filing shall be deemed to be approved;

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

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

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

L. "agent" means a person appointed by a health care plan authorized to transact business in this state to act as

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

M. "solicitor" means a person employed by the licensed agent of a health care plan for the purpose of soliciting health care policies and other related duties in connection with the handling of the business of the agent as may be authorized and paid for the person's services either on a commission basis or salary basis or part by commission and part by salary;

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

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

P. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act; [~~and~~]

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

R. "child" means an individual under twenty-six years of age whom the principal insured covers or whom the applicant for coverage applies to cover, regardless of the individual's financial dependency, residency with a parent, student status, employment or marital status."

SECTION 85. Section 59A-47-24 NMSA 1978 (being Laws

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1984, Chapter 127, Section 879.22) is amended to read:

"59A-47-24. SUBSCRIBER CONTRACTS--REQUIREMENTS AND PROVISIONS.--

A. Every health care expense payments contract issued under [~~this article~~] the Nonprofit Health Care Plan Law shall be in writing and shall comply with [~~requirements and~~] standards that the superintendent has established by rule pursuant to United States department of health and human services regulations on uniform standards for the following documents issued by each contract relating to:

(1) a summary of benefits;

(2) an explanation of coverage;

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

(4) exceptions, reductions and limitations on coverage;

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

(6) the renewability and continuation of coverage provisions;

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

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(8) a statement of whether the contract:

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

(b) ensures that the coverage share of the total allowed costs of benefits provided under the contract is not less than sixty percent of those costs; and

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

B. A health care expense payments contract shall contain provisions in substance as follows:

[~~A.~~] (1) a provision that the policy, the application of the policyholder (if it or a copy thereof is attached to the policy) and the individual applications, if any, submitted in connection with [~~such~~] the policy by the employees or members constitutes the entire contract between the parties, that no statement therein is a warranty in the absence of fraud and that no such statement shall avoid the obligation of the health care plan provided in the policy or reduce benefits thereunder unless contained in a written application for [~~such~~] the contract, attached to and made part of the policy;

[~~B.~~] (2) if [~~such~~] the contract is a group

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contract, a provision that the health care plan will furnish to the subscriber, for delivery to each employee or member of any covered group, an individual certificate, [~~or~~] an identification card or other evidence of such coverage, setting forth in summary form a statement of the essential features of the contract of all persons included in the coverage;

[~~C.~~] (3) if [~~such~~] the contract is a group contract, a provision that eligible new employees or members or dependents, as the case may be, may be added from time to time to the group originally covered, in accordance with the terms of the contract;

[~~D.~~] (4) the amount payable to the health care plan by the subscriber and the time at which and manner in which [~~such~~] the amount is to be paid;

[~~E. the nature of the benefits which will be furnished and the period during which they will be furnished and, if there are any benefits to be excepted, a detailed statement of such exceptions;~~

~~F.~~] (5) any specific term or condition to the effect that the contract may be canceled or otherwise terminated by the health care plan, including the manner and time of [~~such~~] the termination; provided that a contract may not be canceled during the period for which the premium has been paid unless written notice is delivered to the insured,

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or mailed to [~~his~~] the insured's last address as shown by the records of the health care plan, stating when, not less than five days thereafter [~~such~~] the cancellation shall be effective;

[~~G.~~] (6) that the contract includes the endorsements thereon and attached papers, if any, and constitutes the entire contract;

[~~H.~~] (7) that [~~after two years no statement, except a fraudulent statement, by the subscriber in the application for a contract shall void the contract or~~] once the subscriber is covered under the contract, only an act by a subscriber that constitutes fraud or an intentional misrepresentation of material fact that is prohibited by the terms of the contract shall rescind the contract;

(8) that no statement, except a fraudulent statement by the subscriber in the application for a contract, shall be used against the subscriber in any legal action or proceedings relating to the contract unless [~~such~~] the application or a true copy thereof is included in or attached to [~~such~~] the contract; a statement that no change in the contract shall be valid until approved by an executive officer of the health care plan and unless [~~such~~] the approval and countersignature be endorsed on or attached to [~~such~~] the contract; and a statement that no agent has authority to change the contract or waive any of its

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provisions. No claim for loss incurred or disability, as defined in the policy, shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of [~~such~~] the policy;

[~~I.~~] (9) that if the subscriber defaults in making any payment under the contract, the subsequent acceptance of an application for reinstatement and accompanying payment or its failure to take any action with respect thereto within thirty days following receipt of [~~such~~] the application for reinstatement, by [~~such~~] the health care plan or any duly authorized agent thereof, reinstates the contract. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after [~~such~~] that date. In all other respects, the subscriber and the health care plan shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed thereon or attached thereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which a premium has not been previously paid, but not to any period

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more than sixty days prior to the date of reinstatement. (The last sentence of the above provision may be omitted from any policy [~~which~~] that the insured has the right to continue in force subject to its terms by the timely payment of premiums:

[~~(1)~~] (a) until at least age fifty [~~(50)~~]; or

[~~(2)~~] (b) in the case of a policy issued after age forty-four [~~(44)~~], for at least five [~~(5)~~] years from the date of its issue); and

[~~J.~~] (10) the period of grace [~~which~~] that will be allowed the subscriber for making any payment due under the contract, which period shall not be less than ten [~~(10)~~] days.

C. A health care expense payments contract shall provide the following persons, prior to any enrollment restriction, a summary of benefits and coverage explanation required pursuant to Subsection A of this section:

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

(2) a subscriber, prior to the time of enrollment or re-enrollment, subscription or re-subscription; and

(3) a subscriber, at the time of issuance of the health care expense payments contract."

SECTION 86. Section 59A-47-35 NMSA 1978 (being Laws

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1984, Chapter 127, Section 879.34, as amended) is amended to read:

"59A-47-35. ALCOHOL DEPENDENCY AND MISUSE COVERAGE.--

A. Each health care plan that delivers or issues for delivery in this state a group contract providing for health care expense payments on a service benefit basis or an indemnity benefit basis or both shall offer and make available benefits for the necessary care and treatment of alcohol dependency [~~Such~~] and misuse. These benefits shall

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

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

~~(3) be offered for benefit periods of no more than one year and may be limited to a lifetime maximum of no less than two benefit periods.~~

~~Such offer of benefits shall be subject to the rights of the group contract holder to reject the coverage or to select any alternative level of benefits if that right is offered by or negotiated with that health care plan~~].

B. For purposes of this section, "alcohol dependency and misuse treatment center" means a facility that

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contracts with the health care plan and that provides a program for the treatment of alcohol dependency and misuse pursuant to a written treatment plan approved and monitored by a physician or meeting the quality standards of the department of health and which facility also:

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

(2) is accredited as such a facility by the joint commission on accreditation of hospitals; or

(3) meets at least the minimum standards for treatment of alcohol dependency and misuse adopted by the department of health.

C. This section applies to contracts delivered or issued for delivery or renewed, extended or amended in this state on or after July 1, 1983 or upon expiration of a collective bargaining agreement applicable to a particular contract holder, whichever is later; provided that this section does not apply to blanket, short-term travel, accident-only, limited or specified disease, individual conversion contracts or contracts designed for issuance to persons eligible for coverage under Title 18 of the Social Security Act, known as medicare, or any other similar coverage under state or federal governmental plans. With respect to any contract forms approved by the insurance

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division prior to the effective date of this section, an insurer is authorized to comply with this section by the use of endorsements or riders, provided such endorsements or riders are approved by the insurance division as being in compliance with this section and applicable provisions of the Insurance Code.

D. If an organization offering group health benefits to its members makes more than one health care plan or health insurance plan policy available to its members on a member option basis, the organization shall not require alcohol dependency and misuse coverage from one health care plan or health insurer without requiring the same level of alcohol dependency and misuse coverage for all other health care plans or health insurance policies that the organization makes available to its members."

SECTION 87. Section 59A-47-37 NMSA 1978 (being Laws 1994, Chapter 64, Section 12, as amended) is amended to read:

"59A-47-37. COVERAGE OF CHILDREN.--

A. [~~An insurer~~] A health care plan shall not deny enrollment of a child under the [~~health~~] plan of the child's parent on the grounds that the child:

(1) was born out of wedlock;

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

(3) does not reside with the parent or in the

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insurer's service area.

B. When a child has health coverage through an insurer of a noncustodial parent, the [~~insurer~~] health care plan shall:

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

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

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

C. When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the [~~insurer~~] health care plan shall be required:

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

(2) if the parent is enrolled but fails to make application to obtain coverage for the child, to enroll

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the child under family coverage upon application of the child's other parent, the state agency administering the medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and

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

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

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

D. [~~An insurer~~] A health care plan shall not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under the medicaid program and covered for health benefits from the [~~insurer~~] health care plan that are different from requirements applicable to an agent or assignee of any other individual so covered.

E. [~~An insurer~~] A health care plan shall provide coverage for children, from birth through three years of age, for or under the family, infant, toddler program administered by the department of health, provided eligibility criteria

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are met [~~for a maximum benefit of three thousand five hundred dollars ($3,500) annually~~] for medically necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in 7.30.8 NMAC who are working in early intervention programs approved by the department of health. No payment under this subsection shall be applied against any maximum lifetime or annual limits specified in the policy, health benefits plan or contract."

SECTION 88. Section 59A-47-40 NMSA 1978 (being Laws 2003, Chapter 391, Section 7, as amended) is amended to read:

"59A-47-40. MAXIMUM AGE OF [~~DEPENDENT~~] CHILD.--An individual or group health care coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act that offers coverage of an insured's [~~dependent~~] child shall not terminate coverage of [~~an unmarried dependent~~] a child by reason of the [~~dependent's~~] child's age before the [~~dependent's twenty-fifth~~] child's twenty-sixth birthday [~~regardless of whether the dependent is enrolled in an educational institution~~]."

SECTION 89. Section 59A-47-45 NMSA 1978 (being Laws 2009, Chapter 74, Section 4) is amended to read:

"59A-47-45. COVERAGE FOR AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT.--

A. An individual or group health insurance policy,

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health care plan or certificate of health insurance delivered or issued for delivery in this state shall provide coverage to an eligible individual who is nineteen years of age or who is twenty-two years of age or younger and is enrolled in high school, for:

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

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

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

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

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

~~(3)~~] (2) shall not be denied on the basis that

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the services are habilitative or rehabilitative in nature;

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

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

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

D. An insurer shall not deny or refuse to issue

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health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

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

(1) the diagnosis;

(2) the proposed treatment by types;

(3) the frequency and duration of treatment;

(4) the anticipated outcomes stated as goals;

(5) the frequency with which the treatment plan will be updated; and

(6) the signature of the treating physician.

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

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

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H. As used in this section:

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

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

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

SECTION 90. Section 59A-47-46 NMSA 1978 (being Laws 2010, Chapter 94, Section 4) is amended to read:

"59A-47-46. HEALTH [~~INSURERS~~] CARE PLANS--DIRECT SERVICES.--

A. A health care plan shall make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines, except individually underwritten health care policies, contracts or plans, that are governed by the provisions of Chapter 59A,

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Article 22 NMSA 1978, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law. Reimbursement shall be made for direct services provided over the preceding three calendar years, but not earlier than calendar year 2010, as determined by reports filed with the insurance division of the commission. Nothing in this subsection shall be construed to preclude a purchaser from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services for one or more products or for one or more years.

B. For individually underwritten health care policies, plans or contracts, the superintendent shall establish, after notice and informal hearing, the level of reimbursement for direct services as determined as a percent of premiums. Additional hearings may be held at the superintendent's discretion. In establishing the level of reimbursement for direct services, the superintendent shall consider the costs associated with the individual marketing and medical underwriting of these policies, plans or contracts at a level not less than seventy-five percent of premiums. A health insurer writing these policies, plans or contracts shall make reimbursement for direct services at a level not less than that level established by the superintendent pursuant to this subsection over the three calendar years preceding the date upon which that rate is

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established, but not earlier than calendar year 2010. Nothing in this subsection shall be construed to preclude a purchaser of one of these policies, plans or contracts from negotiating an agreement with a health insurer that requires a higher amount of premiums paid to be used for reimbursement for direct services.

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

D. After notice and hearing, the superintendent

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[~~may~~] shall adopt and promulgate reasonable rules necessary and proper to carry out the provisions of this section.

E. For the purposes of this section:

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

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

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

SECTION 91. A new section of the Nonprofit Health Care Plan Law is enacted to read:

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

A. Notwithstanding any other provision of law, a group individual or group health care plan or certificate of health insurance shall not establish:

(1) lifetime limits on the dollar value of benefits for any enrollee; or

(2) except as provided in Subsection B of this section, annual limits on the dollar value of benefits for any enrollee.

B. With respect to plan years beginning prior to January 1, 2014, an individual or group health care plan shall establish a restricted annual limit on the dollar value of benefits for any enrollee only with respect to the scope of benefits that are essential health benefits, as the

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superintendent defines "essential health benefits" by rule.

C. Subsection A of this section shall not be construed to prevent a group health care plan from placing annual or lifetime per enrollee 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.

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

SECTION 92. A new section of the Nonprofit Health Care Plan Law is enacted to read:

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

A. A nonprofit health care plan providing coverage under an individual health benefit plan or policy or a grandfathered health care plan shall not rescind coverage under a health benefit plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(1) the individual engages in conduct that

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constitutes fraud; or

(2) the individual makes an intentional misrepresentation of material fact that is prohibited by the terms of the plan or coverage.

B. For purposes of Paragraph (1) of Subsection A of this section, a person seeking coverage on behalf of an individual does not include an insurance producer or an employee or authorized representative of the health care plan.

C. A health care plan shall provide at least thirty days' advance written notice to each plan enrollee, or for individual health insurance coverage, to each primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with Subsection A of this section, regardless, in the case of group health insurance coverage, of whether the rescission applies to the entire group or only to an individual within the group.

D. The provisions of this section apply regardless of any applicable contestability period."

SECTION 93. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] GRANDFATHERED HEALTH CARE PLAN.--

A. For the purposes of the Nonprofit Health Care Plan Law, "grandfathered health care plan" means a nonprofit

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health care plan that was in effect on March 23, 2010 and that remains in effect through the original term of coverage or through renewal of the original term.

B. A dependent of a subscriber enrolled in a grandfathered health care plan may enroll in a grandfathered health care plan if the terms of the plan in effect as of March 23, 2010 permitted the dependent to enroll.

C. A group health plan that provides coverage on March 23, 2010 may provide for the enrolling of new employees and their dependents in that grandfathered health care plan.

D. Coverage provided by a nonprofit health plan pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010 constitutes a grandfathered health care plan until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement that relates to the coverage and amends the coverage solely to conform to any requirement of the Nonprofit Health Care Plan Law shall not be treated as a termination of the collective bargaining agreement."

SECTION 94. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] GUARANTEED ISSUE--GUARANTEED

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RENEWABILITY--MAXIMUM WAITING PERIOD--BAN ON PREEXISTING CONDITION EXCLUSIONS.--

A. A nonprofit health care plan shall issue coverage to any individual who requests and offers to purchase the coverage without permanent exclusion of preexisting conditions.

B. Except as provided in Subsection C of this section, a health care plan that offers a group health benefit plan in the state shall issue any health benefit plan to any employer that applies for such plan and agrees to make the required premium payments and satisfy the other reasonable provisions of the health care plan. A health care plan:

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

(2) shall not offer coverage to only certain individuals or certain children or dependents of employees in the group or to only part of the group.

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

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

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

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

D. A health care plan may restrict enrollment in coverage described in Subsection B of this section to open or special enrollment periods; provided that any special enrollment period shall comply with the provisions of Section 95 of this 2012 act and rules the superintendent has promulgated.

E. A health care plan may impose a waiting period not to exceed ninety days before payment for any service related to a preexisting condition.

F. A health care plan shall offer or make a referral to a transition product to provide coverage during the waiting period due to a preexisting condition.

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G. A health insurer shall renew any health benefit plan at the option of the employer, except as the superintendent has provided by rule.

H. A health care plan may continue and renew a grandfathered plan that has a permanent exclusion of payment for preexisting conditions.

I. For the purposes of this section:

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

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

SECTION 95. A new section of the Nonprofit Health Care

Plan Law is enacted to read:

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

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

B. A written notice of the opportunity to enroll provided pursuant to this section shall include a statement that children whose coverage ended, who were denied coverage or who were not eligible for coverage because dependent coverage of children was unavailable before the child reached twenty-six years of age, are eligible to enroll in coverage. This notice may be provided to a principal insured on behalf of the principal insured's child. For a group plan, the notice may be included with other enrollment materials that the health care plan distributes to employees, provided that the statement is prominent. If the notice is provided to an employee whose child is entitled to an enrollment opportunity

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under Subsection A of this section, the obligation to provide the notice of enrollment opportunity under this subsection is satisfied for both the individual or group health insurance policy, health care plan or certificate of health insurance and the health care plan.

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

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

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

(1) whose coverage ended, or who was denied coverage or was not eligible for coverage under an individual or a group health insurance policy, health care plan or

certificate of health insurance because, under the terms of coverage, the availability of dependent coverage of a child ended before the child reached the age of twenty-six; or

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

SECTION 96. A new section of the Nonprofit Health Care Plan Law is enacted to read:

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

A. A group health care plan that is delivered, issued for delivery or renewed in this state on behalf of an employer shall not discriminate in favor of highly compensated individuals as to eligibility to participate or as to the benefits offered. Benefits provided for participants who are highly compensated individuals shall be provided for all other participants.

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

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

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

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employees are eligible to benefit; or

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

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

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

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

(3) part-time or seasonal employees;

(4) employees not included in the plan who are included in a unit of employees covered by an agreement between employee representatives and one or more employers that the secretary of the United States department of health and human services has found to be a collective bargaining agreement, if accident and health benefits were the subject of good faith bargaining between these employee representatives and the employer or employers; and

(5) employees who are nonresident aliens of the United States and who receive no earned income, within the meaning of Section 911(d)(2) of the federal Internal Revenue Code of 1986, from the employer which constitutes

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income from sources within the United States, as defined in Section 861(a)(3) of the federal Internal Revenue Code of 1986.

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

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

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

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

SECTION 97. A new section of the Nonprofit Health Care Plan Law is enacted to read:

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

A. For plan years beginning before January 1, 2014, a group health care plan providing group health coverage that makes available dependent coverage of children may exclude an adult child under twenty-six years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in Section

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5000A(f)(2) of the federal Internal Revenue Code of 1986, other than the group health care plan of a parent.

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

SECTION 98. A new section of the Nonprofit Health Care Plan Law is enacted to read:

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

A. An individual or group health care plan that is delivered or issued for delivery in this state shall not limit or exclude coverage under an individual or group health benefit plan for an individual under the age of nineteen by imposing a preexisting condition exclusion on that individual.

B. When a health care plan offers individual or group health insurance coverage that only covers individuals under age nineteen, that plan shall offer the coverage continuously throughout the year or during one or more open enrollment periods as the superintendent prescribes by rule.

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

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

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

SECTION 99. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] EMERGENCY SERVICES.--

A. An individual or group health care plan that is delivered or issued for delivery in this state and that provides or covers any benefits with respect to services in an emergency department of a hospital shall cover emergency services:

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

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

B. If emergency services are provided to a covered

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individual by a nonparticipating health care provider with or without prior authorization, the services shall be provided without imposing any requirement under the policy, plan or certificate for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the provision of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the health care plan.

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

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

(1) policies or plans intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-

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benefit health insurance policies or plans; or

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

E. As used in this section:

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

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

(b) serious impairment to bodily functions; or

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

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

(a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical

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condition; and

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

(3) "stabilize" means:

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

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

SECTION 100. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] OPTION TO CHOOSE PEDIATRICIAN AS PRIMARY CARE PHYSICIAN.--

A. An individual or group health care plan that is delivered or issued for delivery in this state that requires or provides for the designation of a participating primary care provider shall allow a principal insured to designate

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for the principal insured's dependent child who is a covered individual an allopathic or osteopathic physician who specializes in pediatrics as the principal insured child's primary care provider if the provider participates in the network of the plan or issuer.

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

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

SECTION 101. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.--

A. An individual or group health care plan that is delivered or issued for delivery in this state that provides coverage for obstetrical and gynecological care and that requires that covered individuals designate a primary care

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provider shall not require authorization or referral by the plan or issuer or any person, including a primary care provider, when a female covered individual seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The obstetrical or gynecological health care provider shall agree otherwise to adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan approved by the plan or issuer.

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

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

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

(2) preclude the health care plan from requiring that the obstetrical or gynecological provider

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notify the covered individual's primary care health care professional or the plan or issuer of treatment decisions.

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

SECTION 102. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] COST-SHARING FOR PREVENTIVE ITEMS AND SERVICES.--

A. A health care plan providing coverage under an individual or group health benefit plan, except for grandfathered health care plan coverage, shall provide coverage for all of the following items and services pursuant to Sections 103 through 107 of this 2012 act, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible.

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

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

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

E. The superintendent shall at least annually revise the preventive services standards established pursuant to Sections 103 through 107 of this 2012 act to ensure that they are consistent with the recommendations of the United States preventive services task force, the advisory committee on immunization practices of the federal centers for disease control and prevention and the guidelines with respect to infants, children, adolescents and women of evidence-based preventive care and screenings by the federal health resources and services administration. When changes are made to any of these guidelines or recommendations, the superintendent shall make recommendations to the legislature for legislative changes to conform these standards to current guidelines and recommendations.

F. A health care plan may impose cost-sharing

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requirements with respect to an office visit if a preventive item or service provided pursuant to this section is billed separately or is tracked as individual encounter data separately from the office visit.

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

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

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

SECTION 103. A new section of the Nonprofit Health Care

Plan Law is enacted to read:

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

A. A health care plan or contract that is delivered or issued for delivery in this state and that offers maternity benefits shall offer coverage for smoking cessation treatment and shall offer augmented counseling tailored to pregnant women who smoke.

B. A health care plan shall:

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

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

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

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

SECTION 104. A new section of the Nonprofit Health Care Plan Law is enacted to read:

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

A. A health care plan shall provide coverage for childhood immunizations, as well as coverage for medically necessary booster doses of all immunizing agents used in child immunizations, in accordance with the current schedule of immunizations recommended by the American academy of pediatrics, the advisory committee on immunization practices of the federal centers for disease control and prevention or the United States preventive services task force "A"-rated and "B"-rated recommendations, whichever provides greater coverage.

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

SECTION 105. A new section of the Nonprofit Health Care Plan Law is enacted to read:

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

A. A health care plan that is delivered or issued for delivery in this state shall provide the following

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benefits that have, in effect, a rating of "A" or "B" in the current recommendations of the United States preventive services task force, for:

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

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

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

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

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

(6) screening of lipid disorders for:

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

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

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

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

(9) screening of individuals twelve to eighteen years of age for major depressive disorder;

(10) behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease;

(11) screening and counseling for obesity for:

(a) individuals eighteen years of age and older who are obese; and

(b) individuals six to eighteen years of age; and

(12) screening for osteoporosis for:

(a) women who are sixty-five years of age and older; and

(b) women who are sixty to sixty-five years of age who are at increased risk for osteoporotic fractures.

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B. The provisions of this section shall not apply to policies or plans intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies or plans."

SECTION 106. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] PREVENTIVE SERVICES FOR CHILDREN.--

A. An individual or group health care plan that is delivered or issued for delivery in this state shall provide the following benefits that have, in effect, a rating of "A" or "B" in the current recommendations of the United States preventive services task force, for:

(1) oral fluoride supplementation at currently recommended doses to children six months of age to five years of age whose primary water sources are deficient in fluoride;

(2) prophylactic ocular topical medication against gonococcal ophthalmia neonatorum for newborns;

(3) screening for hearing loss in newborns;

(4) screening for sickle cell disease for newborns;

(5) screening for congenital hypothyroidism for newborns;

(6) iron supplementation for asymptomatic

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children six to twelve months of age who are at increased risk for iron deficiency anemia;

(7) screening for phenylketonuria in newborns; and

(8) screening to detect amblyopia, strabismus and defects in visual acuity in children less than five years of age.

B. The provisions of this section shall not apply to policies or plans intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies or plans."

SECTION 107. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] PREVENTIVE SERVICES FOR PREGNANT WOMEN--REPRODUCTIVE HEALTH.--

A. An individual or group health care plan that is delivered or issued for delivery in this state shall provide the following benefits that have, in effect, a rating of "A" or "B" in the current recommendations of the United States preventive services task force, for:

(1) screening for asymptomatic bacteriuria with a urine culture for pregnant women;

(2) interventions during pregnancy and after

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birth to promote and support breastfeeding;

(3) screening for cervical cancer in women who have been sexually active and have a cervix;

(4) screening for chlamydial infection for:

(a) all sexually active young women twenty-four years of age and younger; and

(b) older women who are at increased risk of chlamydial infection;

(5) a daily supplement containing four hundred to eight hundred micrograms of folic acid for any woman planning a pregnancy or capable of pregnancy;

(6) screening of all sexually active women who are at increased risk for infection, including those who are pregnant, for gonorrheal infection;

(7) screening for iron deficiency anemia in asymptomatic pregnant women;

(8) Rh (D) blood typing and antibody testing for:

(a) all pregnant women; and

(b) all unsensitized Rh (D) negative women at twenty-four to twenty-eight weeks' gestation;

(9) behavioral counseling to prevent sexually transmitted infections in:

(a) all sexually active adolescents; and

(b) individuals aged eighteen years and

older at increased risk for sexually transmitted infections;

(10) screening for hepatitis B virus infection in pregnant women;

(11) screening for human immunodeficiency virus for individuals twelve years of age and older who are at risk of human immunodeficiency virus infection;

(12) screening for iron deficiency anemia in asymptomatic pregnant women; and

(13) screening for syphilis for:

(a) any individual at increased risk for syphilis infection; and

(b) any pregnant woman.

B. The provisions of this section shall not apply to policies or plans intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies or plans."

SECTION 108. Section 59A-56-3 NMSA 1978 (being Laws 1994, Chapter 75, Section 3, as amended) is amended to read:

"59A-56-3. DEFINITIONS.--As used in the Health Insurance Alliance Act:

A. "alliance" means the New Mexico health insurance alliance;

B. "approved health plan" means any arrangement for

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the provisions of health insurance offered through and approved by the alliance;

C. "board" means the board of directors of the alliance;

D. "child" means [~~a dependent unmarried~~] an individual who is less than [~~twenty-five~~] twenty-six years of age;

E. "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 federal Social Security Act;

(4) Title 19 of the federal 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;

F. "department" means the insurance division of the commission;

G. "director" means an individual who serves on the board;

H. "earned premiums" means premiums paid or due during a calendar year for coverage under an approved health plan less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year;

I. "eligible expenses" means the allowable charges for a health care service covered under an approved health plan;

J. "eligible individual":

(1) means an individual who:

(a) as of the date of the individual's application for coverage under an approved health plan, has an aggregate of eighteen or more months of creditable coverage, the most recent of which was under a group health plan, governmental plan or church plan as those plans are defined in Subsections P, N and D of Section 59A-23E-2 NMSA 1978, respectively, or health insurance offered in connection with any of those plans, but for the purposes of aggregating creditable coverage, a period of creditable coverage shall not be counted with respect to enrollment of an individual

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for coverage under an approved health plan if, after that period and before the enrollment date, there was a sixty-three-day or longer period during all of which the individual was not covered under any creditable coverage; or

(b) is entitled to continuation coverage pursuant to Section 59A-56-20 or 59A-23E-19 NMSA 1978; and

(2) does not include an individual who:

(a) has or is eligible for coverage under a group health plan;

(b) is eligible for coverage under medicare or a state plan under Title 19 of the federal Social Security Act or any successor program;

(c) has health insurance coverage as defined in Subsection R of Section 59A-23E-2 NMSA 1978;

(d) during the most recent coverage within the coverage period described in Subparagraph (a) of Paragraph (1) of this subsection was terminated from coverage as a result of nonpayment of premium or fraud; or

(e) has been offered the option of coverage under a COBRA continuation provision as that term is defined in Subsection F of Section 59A-23E-2 NMSA 1978, or under a similar state program, except for continuation coverage under Section 59A-56-20 NMSA 1978, and did not exhaust the coverage available under the offered program;

K. "enrollment date" means, with respect to an

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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 that enrollment;

L. "gross earned premiums" means premiums paid or due during a calendar year for all health insurance written in the state less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year;

M. "group health plan" means an employee welfare benefit plan to the extent the plan provides hospital, surgical or medical expenses benefits to employees or their dependents, as defined by the terms of the plan, directly through insurance, reimbursement or otherwise;

N. "health care service" means a service or product furnished an individual for the purpose of preventing, alleviating, curing or healing human illness or injury and includes services and products incidental to furnishing the described services or products;

O. "health insurance" means "health" insurance as defined in Section 59A-7-3 NMSA 1978; any hospital and medical expense-incurred policy; nonprofit health care plan service contract; health maintenance organization subscriber contract; short-term, accident, fixed indemnity, specified disease policy or disability income insurance contracts and

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limited health benefit or credit health insurance; coverage for health care services under uninsured arrangements of group or group-type contracts, including employer self-insured, cost-plus or other benefits methodologies not involving insurance or not subject to New Mexico premium taxes; coverage for health care services under group-type contracts that are not available to the general public and can be obtained only because of connection with a particular organization or group; coverage by medicare or other governmental programs providing health care services; but "health insurance" does not include insurance issued pursuant to provisions of the Workers' Compensation Act or similar law, automobile medical payment insurance or provisions by which benefits are payable with or without regard to fault and are required by law to be contained in any liability insurance policy;

P. "health maintenance organization" means a health maintenance organization as defined by Subsection M of Section 59A-46-2 NMSA 1978;

Q. "incurred claims" means claims paid during a calendar year plus claims incurred in the calendar year and paid prior to April 1 of the succeeding year, less claims incurred previous to the current calendar year and paid prior to April 1 of the current year;

R. "insured" means a small employer or its employee

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and an individual covered by an approved health plan, a former employee of a small employer who is covered by an approved health plan through conversion or an individual covered by an approved health plan that allows individual enrollment;

S. "medicare" means coverage under both Parts A and B of Title 18 of the federal Social Security Act;

T. "member" means a member of the alliance;

U. "nonprofit health care plan" means a health care plan as defined in Subsection K of Section 59A-47-3 NMSA 1978;

V. "premiums" means the premiums received for coverage under an approved health plan during a calendar year;

W. "small employer" means a person that is a resident of this state, that has employees at least fifty percent of whom are residents of this state, that is actively engaged in business and that, on at least fifty percent of its working days during either of the two preceding calendar years, employed no fewer than two and no more than fifty eligible employees; provided that:

(1) in determining the number of eligible employees, the spouse or dependent of an employee may, at the employer's discretion, be counted as a separate employee;

(2) companies that are affiliated companies or

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that are eligible to file a combined tax return for purposes of state income taxation shall be considered one employer; and

(3) in the case of an employer that was not in existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year;

X. "superintendent" means the superintendent of insurance;

Y. "total premiums" means the total premiums for business written in the state received during a calendar year; and

Z. "unearned premiums" means the portion of a premium previously paid for which the coverage period is in the future."

SECTION 109. Section 59A-56-14 NMSA 1978 (being Laws 1994, Chapter 75, Section 14, as amended) is amended to read:

"59A-56-14. ELIGIBILITY--GUARANTEED ISSUE--PLAN PROVISIONS.--

A. A small employer is eligible for an approved health plan if on the effective date of coverage or renewal:

(1) at least fifty percent of its employees not otherwise insured elect to be covered under the approved

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health plan;

(2) the small employer has not terminated coverage with an approved health plan within three years of the date of application for coverage except to change to another approved health plan; and

(3) the small employer does not offer other general group health insurance coverage to its employees. For the purposes of this paragraph, general group health insurance coverage excludes coverage that:

(a) is offered by a state or federal agency to a small employer's employee whose eligibility for alternative coverage is based on the employee's income; or

(b) provides only a specific limited form of health insurance such as accident or disability income insurance coverage or a specific health care service such as dental care.

B. An individual is eligible for an approved health plan if on the effective date of coverage or renewal the individual meets the definition of an eligible individual under Section 59A-56-3 NMSA 1978.

C. An approved health plan shall provide in substance that attainment of the limiting age by an unmarried dependent individual does not operate to terminate coverage when the individual continues to be incapable of self-sustaining employment by reason of developmental disability

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or physical handicap and the individual is primarily dependent for support and maintenance upon the employee. Proof of incapacity and dependency shall be furnished to the alliance and the member that offered the approved health plan within one hundred twenty days of attainment of the limiting age. The board may require subsequent proof annually after a two-year period following attainment of the limiting age.

D. An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable with respect to a newly born child of the family member or the individual in whose name the contract is issued from the moment of birth, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium shall be furnished to the member within thirty-one days after the date of birth in order to have the coverage from birth. An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable for an adopted child in accordance with the provisions of Section 59A-22-34.1 NMSA 1978.

E. [~~Except as provided in Subsections G, H and I of this section~~] An approved health plan offered to a small employer shall not contain a preexisting condition exclusion

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that relates to an individual under nineteen years of age. An approved health plan may contain a preexisting condition exclusion that relates to an individual over nineteen years of age only if:

(1) the exclusion relates to a condition, physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date;

(2) the exclusion extends for a period of not more than six months after the enrollment date; and

(3) the period of the exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

F. As used in this section, "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 enrollment for coverage for the benefits whether or not any medical advice, diagnosis, care or treatment was recommended or received 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.

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G. An insurer shall not impose a preexisting condition exclusion:

(1) in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;

[~~(2) that excludes a child who is adopted or placed for adoption before the child's eighteenth birthday and who, as of the last day of the thirty-day period beginning on and following the date of the adoption or placement for adoption, is covered under creditable coverage~~] or

[~~(3)~~] (2) that relates to or includes pregnancy as a preexisting condition.

H. The provisions of [~~Paragraphs~~] Paragraph (1) [~~and (2)~~] of Subsection G of this section do not apply to any individual after the end of the first continuous sixty-three-day period during which the individual was not covered under any creditable coverage.

I. The preexisting condition exclusions described in Subsection E of this section shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the effective date of coverage for health insurance through the alliance is made not later than sixty-three days following the termination of the prior coverage. In that case, coverage through the

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alliance shall be effective from the date on which the prior coverage was terminated. This subsection does not prohibit preexisting conditions coverage in an approved health plan that is more favorable to the covered individual than that specified in this subsection.

J. An approved health plan issued to an eligible individual shall not contain any preexisting condition exclusion.

K. An individual is not eligible for coverage by the alliance under an approved health plan issued to a small employer if the individual:

(1) is eligible for medicare; provided, however, that if an individual has health insurance coverage from an employer whose group includes twenty or more individuals, an individual eligible for medicare who continues to be employed may choose to be covered through an approved health plan;

(2) has voluntarily terminated health insurance issued through the alliance within the past twelve months unless it was due to a change in employment; or

(3) is an inmate of a public institution.

L. The alliance shall provide for an open enrollment period of sixty days from the initial offering of an approved health plan. Individuals enrolled during the open enrollment period shall not be subject to the

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preexisting conditions limitation.

M. If an insured covered by an approved health plan switches to another approved health plan that provides increased or additional benefits such as lower deductible or copayment requirements, the member offering the approved health plan with increased or additional benefits may require the six-month period for preexisting conditions provided in Subsection E of this section to be satisfied prior to receipt of the additional benefits."

SECTION 110. A new section of the Health Insurance Alliance Act is enacted to read:

"[NEW MATERIAL] ELIGIBILITY--GUARANTEED ISSUE--GUARANTEED RENEWABILITY--MAXIMUM WAITING PERIOD--PLAN PROVISIONS.--

A. A small employer who applies for an approved health plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the approved health plan is eligible for an approved health plan. The alliance shall:

(1) offer coverage to all of the eligible employees of the employer and their children and dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan; and

(2) not offer coverage only to certain

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individuals or certain children or dependents of employees in the group or only to part of the group.

B. An approved health plan that offers coverage through a network plan shall not be required to offer coverage under that plan or accept applications for that plan pursuant to Subsection A of this section under the following circumstances:

(1) to an employer, where the employer is not physically located in the insurer's established geographic service area for the network plan;

(2) to an employee, when the employee does not live, work or reside within the insurer's established geographic service area for the network plan; or

(3) within the geographic service area for the network plan where the insurer reasonably anticipates, and demonstrates to the satisfaction of the superintendent, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of the groups because of its obligations to existing group policyholders and enrollees.

C. An approved health plan may restrict enrollment in coverage described in Subsection A of this section to open or special enrollment periods; provided that any special enrollment period shall comply with the provisions of Section 111 of this 2012 act and rules that the superintendent has

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promulgated.

D. An approved health plan may impose a waiting period not to exceed ninety days before payment for any service related to a preexisting condition. An approved health plan shall offer or make a referral to a transition product to provide coverage during the waiting period due to a preexisting condition.

E. An approved health plan may continue and renew a grandfathered approved health plan that has a permanent exclusion of payment for preexisting conditions.

F. An approved health plan shall renew any health benefit plan at the option of the employer, except as the superintendent has provided by rule.

G. An approved health plan shall provide in substance that attainment of the limiting age by an unmarried dependent individual does not operate to terminate coverage when the individual continues to be incapable of self-sustaining employment by reason of developmental disability or physical handicap and the individual is primarily dependent for support and maintenance upon the employee. Proof of incapacity and dependency shall be furnished to the alliance and the member that offered the approved health plan within one hundred twenty days of attainment of the limiting age. The board may require subsequent proof annually after a two-year period following

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attainment of the limiting age.

H. An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable with respect to a newly born child of the family member or the individual in whose name the contract is issued from the moment of birth, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium shall be furnished to the member within thirty-one days after the date of birth in order to have the coverage from birth. An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable for an adopted child in accordance with the provisions of Section 59A-22-34.1 NMSA 1978.

I. If an insured covered by an approved health plan switches to another approved health plan that provides increased or additional benefits such as lower deductible or copayment requirements, the member offering the approved health plan with increased or additional benefits may require the ninety-day period for preexisting conditions provided in Subsection E of this section to be satisfied prior to receipt of the additional benefits.

J. For the purposes of this section:

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(1) "coverage" means a health insurance policy, health care plan, health maintenance organization contract or certificate of insurance issued for delivery in the state. "Coverage" does not mean a short-term, accident, fixed indemnity or specified disease policy; disability income; limited benefit insurance; credit insurance; workers' compensation; or automobile or medical insurance under which benefits are payable with or without regard to fault and that is required by law to be contained in any liability insurance policy;

(2) "grandfathered approved health plan" means an approved health plan that was in effect on March 23, 2010 and that remains in effect through the original term of coverage or through renewal of the original term; and

(3) "preexisting condition" means a physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended for or received by an applicant for health insurance within six months before the effective date of coverage, except that pregnancy is not considered a preexisting condition for federally defined individuals."

SECTION 111. A new section of the Health Insurance Alliance Act is enacted to read:

"[NEW MATERIAL] INDIVIDUALS WHOSE COVERAGE ENDED BY REASONS OF CESSATION OF DEPENDENT STATUS--APPLICABILITY--

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OPPORTUNITY TO ENROLL--WRITTEN NOTICE.--

A. For plan or policy years beginning on or after September 23, 2010, if a child's coverage ended or did not begin for the reasons described in Subsection E of this section, an approved health plan shall provide the child an opportunity to enroll in the approved health plan for which coverage continues for at least sixty days and provide written notice of the opportunity to enroll, as described in Subsection B of this section, no later than the first day of the plan year.

B. A written notice of the opportunity to enroll provided pursuant to this section shall include a statement that children whose coverage ended, who were denied coverage or who were not eligible for coverage because dependent coverage of children was unavailable before the child reached twenty-six years of age are eligible to enroll in coverage. This notice may be provided to a principal insured on behalf of the principal insured's child. The notice may be included with other enrollment materials that the approved health plan distributes to employees, provided the statement is prominent. If the notice is provided to an employee whose child is entitled to an enrollment opportunity under Subsection A of this section, the obligation to provide the notice of enrollment opportunity under this subsection is satisfied for the approved health plan.

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C. For an individual who enrolls in an approved health plan pursuant to Subsection A of this section, the coverage shall take effect not later than the first day of the first plan year.

D. A child enrolling pursuant to this section in an approved health plan shall be considered a "special enrollee" pursuant to Section 59A-23E-8 NMSA 1978. The child and the principal insured shall be offered all of the benefit packages available to similarly situated individuals who were denied coverage or whose coverage ended by reason of cessation of dependent status. Any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

E. The provisions of this section shall apply to a child:

(1) whose coverage ended, or who was denied coverage or was not eligible for coverage under an approved health plan, because under the terms of coverage the availability of dependent coverage of a child ended before the child reached the age of twenty-six; or

(2) who became eligible, or is required to become eligible, for coverage on the first day of the first plan year, beginning on or after September 23, 2010, by

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reason of the provisions of this section."

SECTION 112. Section 59A-57-2 NMSA 1978 (being Laws 1998, Chapter 107, Section 2) is amended to read:

"59A-57-2. PURPOSE OF ACT.--The purpose of the Patient Protection Act is to regulate aspects of health insurance by specifying patient and provider rights and confirming and clarifying the authority of the department to adopt regulations to provide protections to persons enrolled in [~~managed~~] health insurance policies or health care plans. The insurance protections should ensure that [~~managed~~] health insurance policies or health care plans treat patients fairly and arrange for the delivery of good quality services."

SECTION 113. Section 59A-57-3 NMSA 1978 (being Laws 1998, Chapter 107, Section 3) is amended to read:

"59A-57-3. DEFINITIONS.--As used in the Patient Protection Act:

A. "continuous quality improvement" means an ongoing and systematic effort to measure, evaluate and improve a [~~managed~~] health insurance policy's or health care plan's process in order to improve continually the quality of health care services provided to enrollees;

B. "covered person", "enrollee", "patient" or "consumer" means an individual who is entitled to receive health care benefits provided by a [~~managed~~] health insurance policy or health care plan;

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C. "department" means the insurance department;

D. "emergency care" means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in jeopardy to a person's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to a person;

E. "health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting;

F. "health care insurer" means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan;

G. "health care professional" means a physician or other health care practitioner, including a pharmacist, who

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is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law;

H. "health care provider" or "provider" means a person that is licensed or otherwise authorized by the state to furnish health care services and includes health care professionals and health care facilities;

I. "health care services" includes, to the extent offered by the health insurance policy or health care plan, physical health or community-based mental health or developmental disability services, including services for developmental delay;

J. "managed health care plan" [~~or "plan"~~] means a health care insurer or a provider service network when offering a benefit that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers managed, owned, under contract with or employed by the health care insurer or provider service network; [~~"Managed health care plan" or "plan" does not include a health care insurer or provider service network offering a traditional fee-for-service indemnity benefit or a benefit that covers only short-term travel, accident-only, limited benefit, student health plan or specified disease policies~~]

K. "health insurance policy" or "health care plan" means a hospital, surgical and medical expense-incurred

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policy, plan or contract offered by a health insurer, nonprofit health service provider, health maintenance organization, managed care organization or provider service organization; "health insurance policy" or "health care plan" does not include a policy or plan intended to supplement major medical group-type coverage, such as medicare, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy or health care plan;

[~~K.~~] L. "person" means an individual or other legal entity;

[~~L.~~] M. "point-of-service plan" or "open plan" means a [~~managed~~] health care plan that allows enrollees to use health care providers other than providers under direct contract with or employed by the health care plan, even if the plan provides incentives, including financial incentives, for covered persons to use the plan's designated participating providers;

[~~M.~~] N. "provider service network" means two or more health care providers affiliated for the purpose of providing health care services to covered persons on a capitated or similar prepaid flat-rate basis that hold a certificate of authority pursuant to the Provider Service Network Act;

[~~N.~~] O. "superintendent" means the superintendent

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of insurance; and

[~~O.~~] P. "utilization review" means a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients."

SECTION 114. Section 59A-57-4 NMSA 1978 (being Laws 1998, Chapter 107, Section 4) is amended to read:

"59A-57-4. PATIENT RIGHTS--DISCLOSURES--RIGHTS TO BASIC AND COMPREHENSIVE HEALTH CARE SERVICES--GRIEVANCE PROCEDURE--UTILIZATION REVIEW PROGRAM--CONTINUOUS QUALITY PROGRAM.--

A. Each covered person enrolled in a [~~managed~~] health insurance policy or health care plan has the right to be treated fairly. A [~~managed~~] health insurance policy or health care plan shall arrange for the delivery of good quality and appropriate health care services to enrollees as defined in the particular subscriber agreement. The department shall adopt regulations to implement the provisions of the Patient Protection Act and shall monitor and oversee a [~~managed~~] health insurance policy or health care plan to ensure that each covered person enrolled in a health insurance policy or plan is treated fairly and in accordance with the requirements of the Patient Protection Act. In adopting regulations to implement the provisions of Subparagraphs (a) and (b) of Paragraph (3) and Paragraphs (5) and (6) of Subsection B of this section regarding health care

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standards and specialists, utilization review programs and continuous quality improvement programs, the department shall cooperate with and seek advice from the department of health.

B. The regulations adopted by the department to protect patient rights shall provide at a minimum that:

(1) prior to or at the time of enrollment, a [~~managed~~] health insurance policy or health care plan shall provide a summary of benefits and exclusions, premium information and a provider listing. Within a reasonable time after enrollment and at subsequent periodic times as appropriate, a [~~managed~~] health insurance policy or health care plan shall provide written material that contains, in a clear, conspicuous and readily understandable form, a full and fair disclosure of the policy's or plan's benefits, limitations, exclusions, conditions of eligibility, prior authorization requirements, enrollee financial responsibility for payments, grievance procedures, appeal rights and the patients' rights generally available to all covered persons;

(2) a [~~managed~~] health insurance policy or health care plan shall provide health care services that are reasonably accessible and available in a timely manner to each covered person;

(3) in providing reasonably accessible health care services that are available in a timely manner, a [~~managed~~] health insurance policy or health care plan shall

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ensure that:

(a) the policy or plan offers sufficient numbers and types of qualified and adequately staffed health care providers at reasonable hours of service to provide health care services to the policy's or plan's enrollees;

(b) health care providers that are specialists may act as primary care providers for patients with chronic medical conditions, provided the specialists offer all basic health care services that are required of them by a [~~managed~~] health insurance policy or health care plan;

(c) reasonable access is provided to out-of-network health care providers if medically necessary covered services are not reasonably available through participating health care providers or if necessary to provide continuity of care during brief transition periods;

(d) emergency care is immediately available without prior authorization requirements, and appropriate out-of-network emergency care is not subject to additional costs; and

(e) the policy or plan, through provider selection, provider education, the provision of additional resources or other means, reasonably addresses the cultural and linguistic diversity of its enrollee population;

(4) a [~~managed~~] health insurance policy or

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health care plan shall adopt and implement a prompt and fair grievance procedure for resolving patient complaints and addressing patient questions and concerns regarding any aspect of the policy or plan, including the quality of and access to health care, the choice of health care provider or treatment and the adequacy of the policy's or plan's provider network. The grievance procedure shall notify patients of their right to obtain review by the policy or plan, their right to obtain review by the superintendent, their right to expedited review of emergent utilization decisions and their rights under the Patient Protection Act;

(5) a [~~managed~~] health insurance policy or health care plan shall adopt and implement a comprehensive utilization review program. The basis of a decision to deny care shall be disclosed to an affected enrollee. The decision to approve or deny care to an enrollee shall be made in a timely manner, and the final decision shall be made by a qualified health care professional. A policy's or plan's utilization review program shall ensure that enrollees have proper access to health care services, including referrals to necessary specialists. A decision made in a policy's or plan's utilization review program shall be subject to the policy's or plan's grievance procedure and appeal to the superintendent; and

(6) a [~~managed~~] health insurance policy or

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health care plan shall adopt and implement a continuous quality improvement program that monitors the quality and appropriateness of the health care services provided by the policy or plan."

SECTION 115. Section 59A-57-5 NMSA 1978 (being Laws 1998, Chapter 107, Section 5) is amended to read:

"59A-57-5. CONSUMER ASSISTANCE--CONSUMER ADVISORY BOARDS [~~OMBUDSMAN OFFICE~~]--REPORTS TO CONSUMERS--SUPERINTENDENT'S ORDERS TO PROTECT CONSUMERS.--

A. Each [~~managed~~] health insurance policy or health care plan shall establish and adequately staff a consumer assistance office. The purpose of the consumer assistance office is to respond to consumer questions and concerns and assist patients in exercising their rights and protecting their interests as consumers of health care.

B. Each [~~managed~~] health insurance policy or health care plan shall establish a consumer advisory board. The board shall meet at least quarterly and shall advise the policy or plan about the policy's or plan's general operations from the perspective of the insured or enrollee as a consumer of health care. The board shall also review the operations of and be advisory to the plan's consumer assistance office.

[~~D.~~] C. The department shall prepare an annual report assessing the operations of [~~managed~~] health insurance

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policies or health care plans subject to the department's oversight, including information about consumer complaints.

[~~E.~~] D. A person adversely affected may file a complaint with the superintendent regarding a violation of the Patient Protection Act. Prior to issuing any remedial order regarding violations of the Patient Protection Act or its regulations, the superintendent shall hold a hearing in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978. The superintendent may issue any order [~~he~~] the superintendent deems necessary or appropriate, including ordering the delivery of appropriate care, to protect consumers and enforce the provisions of the Patient Protection Act. The superintendent shall adopt special procedures to govern the submission of emergency appeals to [~~him~~] the superintendent in health emergencies."

SECTION 116. Section 59A-57-6 NMSA 1978 (being Laws 1998, Chapter 107, Section 6) is amended to read:

"59A-57-6. FAIRNESS TO HEALTH CARE PROVIDERS--GAG RULES PROHIBITED--GRIEVANCE PROCEDURE FOR PROVIDERS.--

A. [~~No managed~~] A health insurance policy or health care plan [~~may~~] shall not:

(1) adopt a gag rule or practice that prohibits a health care provider from discussing a treatment option with an insured or enrollee even if the plan does not approve of the option;

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(2) include in any of its contracts with health care providers any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary services to an enrollee; or

(3) require a health care provider to violate any recognized fiduciary duty of [~~his~~] the provider's profession or place [~~his~~] the provider's license in jeopardy.

B. A health insurance policy or health care plan that proposes to terminate a health care provider from the [~~managed health care~~] policy or plan shall explain in writing the rationale for its proposed termination and deliver reasonable advance written notice to the provider prior to the proposed effective date of the termination.

C. A [~~managed~~] health insurance policy or health care plan shall adopt and implement a process pursuant to which health care providers may raise with the policy or plan concerns that they may have regarding operation of the policy or plan, including concerns regarding quality of and access to health care services, the choice of [~~health care~~] providers and the adequacy of the policy's or plan's provider network. The process shall include, at a minimum, the right of the provider to present the provider's concerns to a policy or plan committee responsible for the substantive area addressed by the concern and the assurance that the concern will be conveyed to the policy's or plan's governing body.

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In addition, a [~~managed~~] health insurance policy or health care plan shall adopt and implement a fair hearing plan that permits a health care provider to dispute the existence of adequate cause to terminate the provider's participation with the policy or plan to the extent that the relationship is terminated for cause and shall include in each provider contract a dispute resolution mechanism."

SECTION 117. Section 59A-57-8 NMSA 1978 (being Laws 1998, Chapter 107, Section 8) is amended to read:

"59A-57-8. ADMINISTRATIVE COSTS AND BENEFIT COSTS DISCLOSURES.--The department shall adopt regulations to ensure that both the administrative costs and the direct costs of providing health care services of each [~~managed~~] health insurance policy or health care plan are fully and fairly disclosed to consumers in a uniform manner that allows meaningful cost comparisons among plans."

SECTION 118. Section 59A-57-9 NMSA 1978 (being Laws 1998, Chapter 107, Section 9) is amended to read:

"59A-57-9. PRIVATE REMEDIES TO ENFORCE PATIENT AND PROVIDER INSURANCE RIGHTS--ENROLLEE AS THIRD-PARTY BENEFICIARY TO ENFORCE RIGHTS.--

A. A person who suffers a loss as a result of a violation of a right protected pursuant to the provisions of the Patient Protection Act, its regulations or a [~~managed~~] health insurance policy or health care plan may bring an

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action to recover actual damages or the sum of one hundred dollars ($100), whichever is greater.

B. A person likely to be damaged by a denial of a right protected pursuant to the provisions of the Patient Protection Act or its regulations may be granted an injunction under the principles of equity and on terms that the court considers reasonable. Proof of monetary damage or intent to violate a right is not required.

C. To protect and enforce an enrollee's rights in a [~~managed~~] health insurance policy or health care plan, an individual enrollee participating in or eligible to participate in a [~~managed~~] health insurance policy or health care plan shall be treated as a third-party beneficiary of the [~~managed~~] health insurance policy or health care plan contract between the policy or plan and the party with which the policy or plan directly contracts. An individual enrollee may sue to enforce the rights provided in the contract that governs the [~~managed~~] health insurance policy or health care plan; provided, however, that the policy or plan and the party to the contract may amend the terms of, or terminate the provisions of, the contract without the insured's or enrollee's consent.

D. The relief provided pursuant to this section is in addition to other remedies available against the same conduct under the common law or other statutes of this state.

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E. In any class action filed pursuant to this section, the court may award damages to the named plaintiffs as provided in this section and may award members of the class the actual damages suffered by each member of the class as a result of the unlawful practice.

F. Nothing in the Patient Protection Act is intended to make a policy or plan vicariously liable for the actions of independent contractor health care providers."

SECTION 119. Section 59A-57-11 NMSA 1978 (being Laws 1998, Chapter 107, Section 11) is amended to read:

"59A-57-11. PENALTY.--In addition to any other penalties provided by law, a civil administrative penalty of up to ten thousand dollars ($10,000) may be imposed for each violation of the Patient Protection Act. An administrative penalty shall be imposed by written order of the superintendent made after holding a formal hearing as provided for in Chapter 59A, Article 4 NMSA 1978."

SECTION 120. A new section of the Patient Protection Act is enacted to read:

"[NEW MATERIAL] INTERNAL GRIEVANCE PROCEDURE.--

A. A health insurer, health maintenance organization or nonprofit health care plan shall establish and maintain a written internal grievance procedure that has been approved by the superintendent to provide procedures for the resolution of internal grievances initiated by insureds,

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covered individuals, enrollees or subscribers.

B. The superintendent or the superintendent's designee may examine the health insurer's, health maintenance organization's or nonprofit health care plan's written internal grievance procedures and any records relating to internal grievances filed with the health insurer, health maintenance organization or nonprofit health care plan.

C. The health insurer, health maintenance organization or nonprofit health care plan shall maintain records regarding internal grievances it has received since the last date on which the superintendent or the superintendent's designee examined the records of internal grievances filed with the health insurer, health maintenance organization or nonprofit health care plan.

D. The provisions of this section shall not apply to policies, plans or evidence of coverage intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policies, plans or evidence of coverage."

SECTION 121. TEMPORARY PROVISION--RULEMAKING.--The superintendent of insurance shall adopt and promulgate rules pursuant to the provisions of this act.

SECTION 122. DELAYED REPEAL.--Effective January 1,

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2014, Sections 23, 44, 76, 98 and 109 of this act are repealed.

SECTION 123. EFFECTIVE DATE.--

A. The effective date of the provisions of Sections 1, 3 through 5, 7 through 18, 20 through 39, 41, 43 through 54, 56 through 69, 71, 72, 74 through 93, 95, 97 through 109 and 111 through 121 of this act is May 16, 2012.

B. The effective date of the provisions of Sections 2, 6, 19, 40, 42, 55, 70, 73, 94, 96 and 110 of this act is January 1, 2014.

underscored material = new
[~~bracketed material~~] = delete