This rule was filed as 13 NMAC 10.9.

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 9 MINIMUM HEALTHCARE PROTECTION

13.10.9.1 ISSUING AGENCY: New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.
[7/1/97; Recompiled 11/30/01]

13.10.9.2 SCOPE: This rule applies to policies or plans issued after the effective date of this rule by health insurers, fraternal benefit societies, health maintenance organizations and nonprofit healthcare plans in accordance with the provisions of the Minimum Healthcare Protection Act, Section 59A-23B-1 NMSA 1978 , et seq. as amended.
[5/1/92; Recompiled 11/30/01]

13.10.9.3 STATUTORY AUTHORITY: 59A-2-9 and 59A-23B-11 NMSA 1978.
[5/1/92; Recompiled 11/30/01]

13.10.9.4 DURATION: Permanent.
[7/1/97; Recompiled 11/30/01]

13.10.9.5 EFFECTIVE DATE: May 1, 1992, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.
[5/1/92, 7/1/97; Recompiled 11/30/01]
[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.10.9.6 OBJECTIVE: This rule is intended to address limitations in access to healthcare by authorizing health insurers, fraternal benefit societies, health maintenance organizations and nonprofit healthcare plans to offer minimum healthcare services, policies or plans at affordable rates to those residents of the state who may not desire or be able to afford more comprehensive healthcare services, policies or plans.
[5/1/92; Recompiled 11/30/01]

13.10.9.7 DEFINITIONS: Policies or plans issued pursuant to the Minimum Healthcare Protection Act which contain the following terms shall define such terms in the following manner:

A. **"Group"** means a group of fewer than twenty members at initial enrollment formed for purposes other than obtaining insurance coverage. Where a group is an employer, group shall mean any person, firm, corporation, partnership or association actively engaged in business which, on at least fifty percent of its working days during the preceding year, employed fewer than twenty employees.

B. **"Home healthcare"** as defined in Section 59A-22-36D NMSA 1978, means health services provided on a part-time, intermittent basis to an individual confined to his or her home due to physical illness.

C. **"Hospital"** means a facility which is maintained by the state or any political subdivision of the state or any place which is currently licensed as an acute care hospital by the department of health and has accommodations for resident bed patients, a licensed professional registered nurse always on duty or call, a laboratory and an operating room where surgical operations are performed, but the term does not include convalescent, nursing or rest homes or facilities primarily for the treatment of substance abuse.

D. **"Medicare"** means the federal Health Insurance for the Aged Act.

E. **"Nurse midwife"** means any person licensed by the board of nursing as a registered nurse who is registered with the public health division of the department of health as a certified nurse midwife.

F. **"Nurse practitioner"** means any person licensed by the board of nursing as a registered nurse approved for expanded practice as a certified nurse practitioner pursuant to the Nursing Practice Act.

G. **"Physician"** means any person who holds a license provided for in Chapter 61, Article 6 or 10 NMSA 1978 authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, injury, disease, deformity or physical condition.

H. **"Physician assistant"** means an individual duly qualified under the laws of New Mexico and the rules of the medical examiners board who is in good standing with that board and is registered to practice under the direction and supervision of a board-approved physician.

I. **"Policy or plan"** as defined in Section 59A-23B-3A NMSA 1978, means a healthcare benefit policy or healthcare benefit plan that the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan chooses to offer to individuals, families or groups of fewer than twenty members formed for purposes other than obtaining insurance coverage and that meets the requirements of Section 59A-23B-3B NMSA 1978. For purposes of this rule, policy or plan shall not mean a healthcare policy or healthcare benefit plan that an insurer, health maintenance organization, fraternal benefit society or nonprofit healthcare plan chooses to offer outside the authority of the Minimum Healthcare Protection Act.

[5/1/92; Recompiled 11/30/01]

13.10.9.8 ELIGIBILITY CRITERIA:

A. Pursuant to Section 59A-23B-3B NMSA 1978, the individual, family or group obtaining coverage under the policy or plan shall have been without healthcare insurance, a health services plan or employer sponsored healthcare coverage for the six-month period immediately preceding the effective date of their coverage under a policy or plan except that for groups in existence for less than six months, the group has been without healthcare coverage since the formation of the group.

B. For purposes of the Minimum Healthcare Protection Act and this rule, a group which is otherwise eligible will be deemed to have been without healthcare coverage whether or not individuals within the group have other healthcare coverage either individually or as the dependents of other persons.

C. With respect to individuals eligible for medicaid benefits, the provisions of Sections 59A-18-31, 59A-22-38, 59A-23-7, 59A-46-34 and 59A-47-36 NMSA 1978 shall apply to policies or plans issued in the state on or after the effective date of the Minimum Healthcare Protection Act.

[5/1/92; Recompiled 11/30/01]

13.10.9.9 POLICY OR PLAN CRITERIA; MINIMUM REQUIREMENTS:

A. **Mandatory provisions:** Policies or plans issued pursuant to the Minimum Healthcare Protection Act shall meet the criteria set forth in Section 59A-23B-3B NMSA 1978 regarding eligibility, managed care provisions and minimum healthcare services to covered individuals.

B. **Optional provisions:** Policies or plans issued pursuant to the Minimum Healthcare Protection Act may include the managed care and cost control features provided in Section 59A-23B-3C NMSA 1978 regarding panels of healthcare service providers, second opinions before elective surgery, utilization review and a maximum limit on the cost of healthcare services covered in any calendar year of not less than $50,000. Pursuant to Section 59A-23B-3D NMSA 1978 a policy or plan may include additional managed care and cost control provisions that the superintendent of insurance determines to have the potential for controlling costs in a manner that does not cause discriminatory treatment of individuals, families or groups covered by the policy or plan.

C. **Pre-existing conditions:** Pursuant to Section 59A-23B-3E NMSA 1978, notwithstanding any other provisions of law, a policy or plan shall not exclude coverage for losses incurred for a pre-existing condition more than six months from the effective date of coverage. The policy or plan shall not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment recommended by or received from a physician within six months before the effective date of coverage.

D. **Home healthcare coverage:**

(1) For purposes of the Minimum Healthcare Protection Act and this rule, home healthcare coverage offered shall include:

(a) services provided by a registered nurse or a licensed practical nurse;

(b) health services provided by physical, occupational and respiratory therapists and speech pathologists;

(c) health services provided by a home health aide; and

(d) medical supplies, drugs and medicines and laboratory services, to the extent they would have been covered if provided to the insured on an inpatient basis.

(2) Home healthcare coverage may be limited to:

(a) services provided on the written order of a licensed physician, provided such order is renewed at least every sixty (60) days;

(b) services provided, directly or through contractual agreements, by a home health agency licensed in the state in which the home health services are delivered; and

(c) services, as set forth in 13 NMAC 10.9.9.4.1 [now Paragraph (1) of Subsection D of 13.10.9.9 NMAC], without which the insured would have to be hospitalized.

(3) A day of home healthcare shall consist of up to four (4) continuous hours of home healthcare services. Home healthcare services provided in hourly increments of less than four (4) hours shall be calculated in proportion to the relationship which the hours of service provided bear to a four (4) hour day, e.g., two (2) hours of home healthcare constitute one-half (½) day of home healthcare, etc.

(4) Provided, however, that home healthcare coverage, alone or in combination with inpatient hospitalization coverage, shall not exceed twenty five (25) days pursuant to the provisions of Section 59A-23B-3B(3)(a) NMSA 1978.

E. **Usual, customary and reasonable charges:**

(1) For purposes of a policy or plan issued pursuant to the Minimum Healthcare Protection Act and this rule, a usual, customary and reasonable charge shall be the lesser of:

(a) the customary charge which would be made by the healthcare services provider for the same service or medical supplies in the absence of insurance;

(b) the general level of charge for a comparable service or medical supplies made by other healthcare service providers in the same geographic area; or

(c) the actual charge made by the healthcare services provider.

(2) This provision does not apply to charges of providers who are paid under contractual arrangements at specified levels of reimbursement as permitted by Section 59A-23B-3C NMSA 1978.

F. **Enrollment waiting period:** A policy or plan issued pursuant to this rule which does not exclude coverage for pre-existing conditions as permitted by this rule may impose, in lieu of such exclusion, a six-month waiting period for enrollment of members of a group who have pre-existing medical conditions on the effective date of the group's coverage.

[5/1/92; Recompiled 11/30/01]

13.10.9.10 POLICY OR PLAN DISCLOSURE REQUIREMENTS:

A. Upon offering coverage under a policy or plan for any individual, family or group member, an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan shall provide the individual, family or group member with a written disclosure statement in accordance with the requirements of Section 59A-23B-5A and B NMSA 1978. Provided, however, that in the event of a lapse in healthcare coverage, a disclosure statement need not be offered by the same carrier upon reinstatement of the same policy or plan.

B. Before any insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan issues a policy or plan contract, the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan shall obtain from the prospective policyholder, contract holder or member a signed written statement in accordance with the requirements of Section 59A-23B-5C and D NMSA 1978.

[5/1/92; Recompiled 11/30/01]

13.10.9.11 FORMS AND RATES; RATING STANDARDS:

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 department of insurance for approval prior to use.

B. No policy or plan may be issued in the state unless the rates have first been filed with and approved by the superintendent of insurance.

C. The superintendent shall approve rates for individual and family policies or plans and disapprove any rate if the benefits offered in such policies or plans are unreasonably restricted in relation to the premium charged.

D. Rates for group policies or plans, as such terms are defined in this rule, shall be reviewed for approval by the superintendent in accordance with the rating standards contained in the Small Group Rate and Renewability Act, Section 59A-23C-1 NMSA 1978, et seq.

[5/1/92; Recompiled 11/30/01]

13.10.9.12 ADVERTISING: All printed, radio or television communication intended to be used for marketing a policy or plan in the state and the disclosures required by NMSA 1978 Section 59A-23B-5A NMSA

1978 shall be submitted for review and approval by the superintendent of insurance prior to use. The superintendent of insurance shall complete the review within thirty days or the materials submitted shall be deemed approved for use.
[5/1/92; Recompiled 11/30/01]

13.10.9.13 PENALTIES: The superintendent of insurance may revoke, suspend or refuse to continue the license or certificate of authority of any person who fails to comply with this rule and may impose such other applicable administrative penalties as may be authorized by the Insurance Code.
[5/1/92; Recompiled 11/30/01]

HISTORY OF 13.10.9 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center as:
SCC 92-2-IN, Minimum Healthcare Protection (Article 23B, Rule 1), filed 3/31/92.

History of Repealed Material: [RESERVED]