SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
SENATE BILL 39

49TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2009

AN ACT

RELATING TO HEALTH INSURANCE; REQUIRING COVERAGE FOR DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER.

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

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

"[NEW MATERIAL] 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:

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(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) shall not be denied on the basis that the services are habilitative or rehabilitative in nature; and

(4) 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.

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 coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict coverage for an individual because the individual is diagnosed as having a developmental disability.

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;

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(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. As used in this section:

(1) "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

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

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

"[NEW MATERIAL] COVERAGE FOR AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT.--

A. A blanket or group health insurance policy or 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

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(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) shall not be denied on the basis that the services are habilitative or rehabilitative in nature; and

(4) 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

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management and other managed care provisions.

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 coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict coverage for an individual because the individual is diagnosed as having a developmental disability.

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.

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

G. As used in this section:

(1) "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

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

Section 3. A new section of Chapter 59A, Article 46 NMSA 1978 is enacted to read:

"[NEW MATERIAL] 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 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.

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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) shall not be denied on the basis that the services are habilitative or rehabilitative in nature; and

(4) 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.

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 coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict coverage for an individual because the individual is diagnosed as having a developmental disability.

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.

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G. As used in this section:

(1) "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

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

Section 4. A new section of Chapter 59A, Article 47 NMSA 1978 is enacted to read:

"[NEW MATERIAL] COVERAGE FOR AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT.--

A. An individual or group health insurance policy, 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 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

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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) shall not be denied on the basis that the services are habilitative or rehabilitative in nature; and

(4) 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.

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

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maintenance contract, except as otherwise provided in Subsection B of this section.

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

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.

G. As used in this section:

(1) "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

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