

HOUSE JUDICIARY COMMITTEE SUBSTITUTE FOR
HOUSE BILL 27

56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023

This document may incorporate amendments proposed by a committee, but not yet adopted, as well as amendments that have been adopted during the current legislative session. The document is a tool to show amendments in context and cannot be used for the purpose of adding amendments to legislation.

AN ACT

RELATING TO HEALTH INSURANCE COVERAGE; AMENDING AND ENACTING SECTIONS OF THE HEALTH CARE PURCHASING ACT, THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO ELIMINATE COST SHARING FOR INSURERS THAT PROVIDE COVERAGE OF DIAGNOSTIC AND SUPPLEMENTAL BREAST EXAMINATIONS.

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

.224847.3AIC February 27, 2023 (9:54am)

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SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] DIAGNOSTIC AND SUPPLEMENTAL BREAST EXAMINATIONS.--

A. Group health coverage, including self-insurance, offered, issued, amended, delivered or renewed under the Health Care Purchasing Act that provides coverage for diagnostic and supplemental breast examinations shall not impose cost sharing for diagnostic and supplemental breast examinations.

B. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans as defined pursuant to 42 USCA Section 18022(e) or Hf11→tax- favored plans as defined pursuant to 26 USC Section 223(c)(2).←Hf11 Hf11→high deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.←Hf11

C. As used in this section:

(1) "cost sharing" means a deductible, coinsurance, copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment or similar out-of-pocket expense;

(2) "diagnostic breast examination" means a medically necessary and clinically appropriate examination of

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the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

(a) seen or suspected from a screening examination for breast cancer; or

(b) detected by another means of examination; and

(3) "supplemental breast examination" means a medically necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is:

(a) used to screen for breast cancer when there is no abnormality seen or suspected; and

(b) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer."

SECTION 2. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] DIAGNOSTIC AND SUPPLEMENTAL BREAST EXAMINATIONS.--

A. An individual or group health insurance policy, health care plan or certificate of insurance that is delivered, issued for delivery or renewed in this state that provides coverage for diagnostic and supplemental breast examinations shall not impose cost sharing for diagnostic and supplemental

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breast examinations.

B. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans as defined pursuant to 42 USCA Section 18022(e) or Hf11→tax-

~~favored plans as defined pursuant to 26 USC Section 223(c)(2).~~←Hf11 Hf11→high deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.←Hf11

C. As used in this section:

(1) "cost sharing" means a deductible, coinsurance, copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment or similar out-of-pocket expense;

(2) "diagnostic breast examination" means a medically necessary and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

(a) seen or suspected from a screening examination for breast cancer; or

(b) detected by another means of examination; and

(3) "supplemental breast examination" means a

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medically necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is:

(a) used to screen for breast cancer when there is no abnormality seen or suspected; and

(b) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer."

SECTION 3. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] DIAGNOSTIC AND SUPPLEMENTAL BREAST EXAMINATIONS.--

A. A blanket or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state that provides coverage for diagnostic and supplemental breast examinations shall not impose cost sharing for diagnostic and supplemental breast examinations.

B. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans as defined pursuant to 42 USCA Section 18022(e) or

~~tax-favored plans as defined pursuant to 26 USC Section 223(c)(2).~~ Hf11 Hf11 → high deductible health plans with health savings accounts until an eligible insured's deductible has

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been met, unless otherwise allowed pursuant to federal law. ←Hf11

C. As used in this section:

(1) "cost sharing" means a deductible, coinsurance, copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment or similar out-of-pocket expense;

(2) "diagnostic breast examination" means a medically necessary and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

(a) seen or suspected from a screening examination for breast cancer; or

(b) detected by another means of examination; and

(3) "supplemental breast examination" means a medically necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is:

(a) used to screen for breast cancer when there is no abnormality seen or suspected; and

(b) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer."

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SECTION 4. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] DIAGNOSTIC AND SUPPLEMENTAL BREAST EXAMINATIONS.--

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state that provides coverage for diagnostic and supplemental breast examinations shall not impose cost sharing for diagnostic and supplemental breast examinations.

B. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans as defined pursuant to 42 USCA Section 18022(e) or

Hf11 → ~~tax-favored plans as defined pursuant to 26 USC Section 223(c)(2).~~ ← Hf11 Hf11 → high deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law. ← Hf11

C. As used in this section:

(1) "cost sharing" means a deductible, coinsurance, copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment or similar out-of-pocket expense;

(2) "diagnostic breast examination" means a medically necessary and clinically appropriate examination of

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the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

(a) seen or suspected from a screening examination for breast cancer; or

(b) detected by another means of examination; and

(3) "supplemental breast examination" means a medically necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is:

(a) used to screen for breast cancer when there is no abnormality seen or suspected; and

(b) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer."

SECTION 5. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] DIAGNOSTIC AND SUPPLEMENTAL BREAST EXAMINATIONS.--

A. An individual or group health care plan that is delivered, issued for delivery or renewed in this state that provides coverage for diagnostic and supplemental breast examinations shall not impose cost sharing for diagnostic and supplemental breast examinations.

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B. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans as defined pursuant to 42 USCA Section 18022(e) or

Hf11 → ~~tax-favored plans as defined pursuant to 26 USC Section 223(c)(2).~~ ← Hf11 Hf11 → high deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law. ← Hf11

C. As used in this section:

(1) "cost sharing" means a deductible, coinsurance, copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment or similar out-of-pocket expense;

(2) "diagnostic breast examination" means a medically necessary and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

(a) seen or suspected from a screening examination for breast cancer; or

(b) detected by another means of examination; and

(3) "supplemental breast examination" means a medically necessary and clinically appropriate examination of

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the breast using breast magnetic resonance imaging or breast ultrasound that is:

(a) used to screen for breast cancer when there is no abnormality seen or suspected; and

(b) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer."

SECTION 6. Section 59A-22-39 NMSA 1978 (being Laws 1990, Chapter 5, Section 2) is amended to read:

"59A-22-39. COVERAGE FOR MAMMOGRAMS.--~~[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 low-dose screening mammograms for determining the presence of breast cancer. Such coverage shall make available one baseline mammogram to persons age thirty-five through thirty-nine, one mammogram biennially to persons age forty through forty-nine and one mammogram annually to persons age fifty and over. After July 1, 1992, coverage shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging facilities that have met American college of radiology accreditation standards for mammography.

~~[B. Coverage for mammograms may be subject to deductibles and coinsurance consistent with those imposed on~~

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~~other benefits under the same policy, plan or certificate.~~

~~G. The provisions of this section shall not apply to short term travel, accident only or limited or specified disease policies.]~~ The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans as defined pursuant to 42 USCA Section 18022(e) or tax-favored plans as defined pursuant to 26 USC Section 223(c)(2)."

SECTION 7. Section 59A-46-41 NMSA 1978 (being Laws 1990, Chapter 5, Section 1) is amended to read:

"59A-46-41. COVERAGE FOR MAMMOGRAMS.--~~[A.]~~ Each individual and group health maintenance organization contract delivered or issued for delivery in this state shall provide coverage for low-dose screening mammograms for determining the presence of breast cancer. Such coverage shall make available one baseline mammogram to persons age thirty-five through thirty-nine, one mammogram biennially to persons age forty through forty-nine and one mammogram annually to persons age fifty and over. After July 1, 1992, coverage shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging facilities that have met American college of radiology accreditation standards for mammography.

~~[B. Coverage for mammograms may be subject to deductibles and coinsurance consistent with those imposed on~~

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~~other benefits under the same contract.]"~~

SECTION 8. APPLICABILITY.--The provisions of this act apply to health insurance policies, health care plans, certificates of health insurance and health maintenance organization contracts that are delivered, issued for delivery or renewed in this state on or after January 1, 2024.

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