HOUSE BILL 45

46TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2003

INTRODUCED BY

Al Park

AN ACT

RELATING TO INSURANCE; PROVIDING COVERAGE FOR INFERTILITY DIAGNOSIS AND TREATMENT.

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

Section 1. A new section of the New Mexico Insurance Code, Section 59A-22-44 NMSA 1978, is enacted to read:

"59A-22-44. [NEW MATERIAL] COVERAGE FOR INFERTILITY DIAGNOSIS AND 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 infertility diagnosis and treatment.

B. Coverage for infertility diagnosis and treatment may be subject to deductibles and coinsurance consistent with

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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."

Section 2. Section 59A-23-4 NMSA 1978 (being Laws 1984, Chapter 127, Section 463, as amended by Laws 1997, Chapter 7, Section 2 and by Laws 1997, Chapter 249, Section 2 and by Laws 1997, Chapter 250, Section 2 and also by Laws 1997, Chapter 255, Section 2) is amended to read:

"59A-23-4. OTHER PROVISIONS APPLICABLE.--

A. [~~No~~] A blanket or group health insurance policy or contract shall not contain [~~any~~] a provision relative to notice or proof of loss or the time for paying benefits or the time within which suit may be brought upon the policy that in the superintendent's opinion is less favorable to the insured than would be permitted in the required or optional provisions for individual health insurance policies as set forth in Chapter 59A, Article 22 NMSA 1978.

B. The following provisions of Chapter 59A, Article 22 NMSA 1978 shall also apply as to Chapter 59A, Article 23 NMSA 1978 and blanket and group health insurance contracts:

(1) Section 59A-22-1 NMSA 1978, except Subsection C of that section; and

(2) Section 59A-22-32 NMSA 1978.

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C. The following provisions of Chapter 59A, Article 22 NMSA 1978 shall also apply as to group health insurance contracts:

(1) Section 59A-22-33 NMSA 1978;

(2) Section 59A-22-34 NMSA 1978;

(3) Section 59A-22-34.1 NMSA 1978;

(4) Section 59A-22-34.3 NMSA 1978;

[~~(4)~~] (5) Section 59A-22-35 NMSA 1978;

[~~(5)~~] (6) Section 59A-22-36 NMSA 1978;

[~~(6)~~] (7) Section 59A-22-39 NMSA 1978;

(8) Section 59A-22-39.1 NMSA 1978;

[~~(7)~~] (9) Section 59A-22-40 NMSA 1978; [~~and~~ ~~(8)~~] (10) Section 59A-22-41 NMSA 1978;

(11) Section 59A-22-42 NMSA 1978; and

(12) Section 59A-22-44 NMSA 1978."

Section 3. Section 59A-23B-3 NMSA 1978 (being Laws 1991, Chapter 111, Section 3, as amended by Laws 1997, Chapter 249, Section 3 and also by Laws 1997, Chapter 250, Section 3) is amended to read:

"59A-23B-3. POLICY OR PLAN--DEFINITION--CRITERIA.--

A. For purposes of the Minimum Healthcare Protection Act, "policy or plan" 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

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groups of fewer than twenty members formed for purposes other than obtaining insurance coverage and that meets the requirements of Subsection B of this section. For purposes of the Minimum Healthcare Protection Act, "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.

B. A policy or plan shall meet the following criteria:

(1) the individual, family or group obtaining coverage under the policy or plan has been without healthcare insurance, a health services plan or employer-sponsored healthcare coverage for the six-month period immediately preceding the effective date of its coverage under a policy or plan, provided that the six-month period shall not apply to:

(a) a group that has been in existence for less than six months and has been without healthcare coverage since the formation of the group;

(b) an employee whose healthcare coverage has been terminated by an employer;

(c) a dependent who no longer qualifies as a dependent under the terms of the contract; or

(d) an individual and an individual's dependents who no longer have healthcare coverage as a result

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of termination or change in employment of the individual or by reason of death of a spouse or dissolution of a marriage, notwithstanding rights the individual or individual's dependents may have to continue healthcare coverage on a self-pay basis pursuant to the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985;

(2) the policy or plan includes the following managed care provisions to control costs:

(a) an exclusion for services that are not medically necessary or are not covered by preventive health services; and

(b) a procedure for preauthorization of elective hospital admissions by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan; and

(3) subject to a maximum limit on the cost of healthcare services covered in any calendar year of not less than fifty thousand dollars ($50,000), the policy or plan provides the following minimum healthcare services to covered individuals:

(a) inpatient hospitalization coverage or home care coverage in lieu of hospitalization or a combination of both, not to exceed twenty-five days of coverage inclusive of any deductibles, co-payments or co-insurance; provided that a period of inpatient hospitalization coverage

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shall precede any home care coverage;

(b) prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy and one office visit per week during the ninth month and until term; provided that coverage for each office visit shall also include prenatal counseling and education and necessary and appropriate screening, including history, physical examination and the laboratory and diagnostic procedures deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member;

(c) obstetrical care, including physicians' and certified nurse midwives' services, delivery room and other medically necessary services directly associated with delivery;

(d) well-baby and well-child care, including periodic evaluation of a child's physical and emotional status, a history, a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards; provided that such evaluation and care shall be covered when performed at approximately the age intervals of birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two

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years, three years, four years, five years and six years;

(e) coverage for low-dose screening mammograms for determining the presence of breast cancer; provided that the mammogram coverage shall include one baseline mammogram for persons age thirty-five through thirty-nine years, one biennial mammogram for persons age forty through forty-nine years and one annual mammogram for persons age fifty years and over; and further provided that the mammogram coverage shall only be subject to deductibles and co-insurance requirements consistent with those imposed on other benefits under the same policy or plan;

(f) coverage for cytologic screening, to include a Papanicolaou test and pelvic exam for asymptomatic as well as symptomatic women;

(g) a basic level of primary and preventive care, including [~~but not limited to~~] no less than seven physician, nurse practitioner, nurse midwife or physician assistant office visits per calendar year, including any ancillary diagnostic or laboratory tests related to the office visit; [~~and~~]

(h) 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

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immunizations; provided that 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 or plan; and

(i) coverage for infertility diagnosis and treatment. For purposes of this subparagraph, "infertility" means the condition of a presumably healthy person evidenced by the inability to conceive or produce conception during a period of one year.

C. A policy or plan may include the following managed care and cost control features to control costs:

(1) a panel of providers who have entered into written agreements with the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan to provide covered healthcare services at specified levels of reimbursement; provided that [~~any~~] such written agreement shall contain a provision relieving the individual, family or group covered by the policy or plan from [~~any~~] an obligation to pay for [any] a healthcare service performed by the provider that is determined by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan not to be medically necessary;

(2) a requirement for obtaining a second opinion before elective surgery is performed;

(3) a procedure for utilization review by the

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insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan; and

(4) a maximum limit on the cost of healthcare services covered in [~~any~~] a calendar year of not less than fifty thousand dollars ($50,000).

D. Nothing contained in Subsection C of this section shall prohibit an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan from including in the policy or plan 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.

E. Notwithstanding any other provisions of law, a policy or plan shall not exclude coverage for losses incurred for a preexisting condition more than six months from the effective date of coverage. The policy or plan shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment recommended by or received from a physician within six months before the effective date of coverage.

F. [~~No~~] A medical group, independent practice association or health professional employed by or contracting with an insurer, fraternal benefit society, health maintenance

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organization or nonprofit healthcare plan shall not maintain [~~any~~] an action against [~~any~~] an insured person, family or group member for sums owed by an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan [~~for sums~~] that are higher than those agreed to pursuant to a policy or plan."

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

"[NEW MATERIAL] COVERAGE FOR INFERTILITY DIAGNOSIS AND 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 infertility diagnosis and treatment.

B. For the purposes of this section, "infertility" means the condition of a presumably healthy person evidenced by the inability to conceive or produce conception during a period of one year.

C. Coverage for infertility diagnosis and treatment may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same contract."

Section 5. Section 59A-47-33 NMSA 1978 (being Laws 1984, Chapter 127, Section 879.32, as amended) is amended to read:

"59A-47-33. OTHER PROVISIONS APPLICABLE.--The provisions of the Insurance Code other than Chapter 59A, Article 47 NMSA

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1978 shall not apply to health care plans except as expressly provided in the Insurance Code and that article. To the extent reasonable and not inconsistent with the provisions of that article, the following articles and provisions of the Insurance Code shall also apply to health care plans, their promoters, sponsors, directors, officers, employees, agents, solicitors and other representatives; and, for the purposes of such applicability, a health care plan may therein be referred to as an "insurer":

A. Chapter 59A, Article 1 NMSA 1978;

B. Chapter 59A, Article 2 NMSA 1978;

C. Chapter 59A, Article 4 NMSA 1978;

D. Subsection C of Section 59A-5-22 NMSA 1978;

E. Sections 59A-6-2 through 59A-6-4 and 59A-6-6 NMSA 1978;

F. Section 59A-7-11 NMSA 1978;

G. Chapter 59A, Article 8 NMSA 1978;

H. Chapter 59A, Article 10 NMSA 1978;

I. Section 59A-12-22 NMSA 1978;

J. Chapter 59A, Article 16 NMSA 1978;

K. Chapter 59A, Article 18 NMSA 1978;

[~~L. Chapter 59A, Article 19 NMSA 1978~~;]

~~M. Section 59A-22-2.1 NMSA 1978;~~

~~N.~~] L. The Policy Language Simplification Law;

M. Subsections B through E of Section 59A-22-5 NMSA

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1978;

[~~O.~~] N. Section 59A-22-14 NMSA 1978;

[~~P.~~] O. Section 59A-22-34.1 NMSA 1978;

[~~Q.~~] P. Section 59A-22-39 NMSA 1978;

[~~R.~~] Q. Section 59A-22-40 NMSA 1978;

[~~S.~~] R. Section 59A-22-41 NMSA 1978;

S. Section 59A-22-42 NMSA 1978;

T. Section 59A-22-44 NMSA 1978;

[~~T.~~] U. Sections 59A-34-7 through 59A-34-13, 59A-34-17, 59A-34-23, 59A-34-33, 59A-34-40 through 59A-34-42 and 59A-34-44 through 59A-34-46 NMSA 1978;

[~~U. Chapter 59A, Article 37 NMSA 1978~~] V. The Insurance Holding Company Law, except Section 59A-37-7 NMSA 1978;

[~~V.~~] W. Section 59A-46-15 NMSA 1978; and

[~~W.~~] X. the Patient Protection Act."

Section 6. [NEW MATERIAL] SUPERINTENDENT OF INSURANCE--ADDITIONAL POWERS.--The superintendent of insurance shall promulgate rules to define minimum coverage for infertility diagnosis and treatment.

Section 7. APPLICABILITY.--The provisions of this act apply to policies, plans, contracts and certificates delivered or issued for delivery or renewed, extended or amended pursuant to the New Mexico Insurance Code in this state on or after July 1, 2003.

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