SENATE BILL 439

**45TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2001**

INTRODUCED BY

Roman M. Maes III

AN ACT

RELATING TO HEALTH CARE; ELIMINATING THE SIX-MONTH WAITING PERIOD IN THE MINIMUM HEALTHCARE PROTECTION ACT; CLARIFYING APPLICABILITY TO THE SMALL GROUP RATE AND RENEWABILITY ACT; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978.

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

Section 1. Section 59A-23B-1 NMSA 1978 (being Laws 1991, Chapter 111, Section 1) is amended to read:

"59A-23B-1. SHORT TITLE.--[~~This act~~] Chapter 59A, Article 23B NMSA 1978 may be cited as the "Minimum Healthcare Protection Act"."

Section 2. A new section of the Minimum Healthcare Protection Act is enacted to read:

"[NEW MATERIAL] PROHIBITIONS.--A carrier, agent or broker licensed in this state shall not knowingly encourage or allow



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a group to enroll, or allow an individual member of the group or his dependent to enroll or to remain enrolled in an individual policy or plan issued through the New Mexico comprehensive health insurance pool or the New Mexico health insurance alliance if that individual would be eligible for coverage under a group policy or plan for which application is made, or which is issued pursuant to the Minimum Healthcare Protection Act. A violation of this section constitutes a violation of Chapter 59A, Article 16 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 groups of fewer than [~~twenty~~] fifty 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,

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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 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-~~

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~~pay basis pursuant to the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985;~~

[~~(2)~~] (1) 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)~~] (2) 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 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

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

(e) coverage for low-dose screening mammograms for determining the presence of breast cancer;

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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 immunizations; provided that coverage for childhood immunizations and necessary booster doses may be subject to deductibles and co-insurance consistent with those imposed on

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other benefits under the same policy or plan; and

(i) coverage for not less than forty-eight hours of inpatient care following a mastectomy and not less than twenty-four hours of inpatient care following a lymph node dissection for the treatment of breast cancer, provided that nothing in this subparagraph shall be construed as requiring the provision of inpatient coverage where the attending physician and patient determine that a shorter period of hospital stay is appropriate and further provided that coverage for minimum inpatient hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer may be subject to deductible and co-insurance consistent with those imposed on other benefits under the same policy or plan.

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 obligation to pay for any healthcare service performed by the provider that is determined by the insurer, fraternal

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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 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 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

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recommended by or received from a physician within six months before the effective date of coverage.

F. No medical group, independent practice association or health professional employed by or contracting with an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan shall maintain any action against any insured person, family or group member for sums owed by an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan, for sums higher than those agreed to pursuant to a policy or plan."

Section 4. 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 [~~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~~] pursuant to the Minimum Healthcare Protection Act unless the rates have first been filed with and approved by the superintendent. [~~This subsection shall not apply to policies~~] Policies or plans issued under the Minimum Healthcare

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Protection Act are not subject to the Small Group Rate and Renewability Act.

[~~C. 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, 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 twenty percent of the lower rate, and 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 rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom 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.~~

~~D. The provisions of this section do not preclude an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan from using health~~

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~~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.~~

~~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 5. Section 59A-23C-4 NMSA 1978 (being Laws 1991, Chapter 153, Section 4) is amended to read:

"59A-23C-4. HEALTH INSURANCE PLANS SUBJECT TO THE SMALL GROUP RATE AND RENEWABILITY ACT.--

A. Except as provided in Subsections B and C of this section, the provisions of the Small Group Rate and Renewability Act apply to any health benefit plan that provides coverage to one or more employees of a small employer.

B. The provisions of the Small Group Rate and Renewability Act shall not apply to individual health insurance policies that are subject to policy form and premium rate approval as provided in Section 59A-18-12, 59A-18-13, 59A-44-16, 59A-46-8, 59A-47-25 or 59A-47-26 NMSA 1978 or to a group policy or plan issued pursuant to the Minimum Healthcare Protection Act.

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C. Any policies or certificates of a master policy that because of solicitation by agents or through the mail or mass media advertising are treated as individual policies and subject to the approvals stated in Subsection B of this section."



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