SENATE BILL 478

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

INTRODUCED BY

Ramsay L. Gorham

AN ACT

RELATING TO HEALTH INSURANCE; AMENDING THE NEW MEXICO INSURANCE CODE TO AUTHORIZE CATASTROPHIC HEALTH INSURANCE POLICIES TO BE ISSUED TO SMALL EMPLOYERS AND INDIVIDUALS.

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

Section 1. Section 59A-16-13.1 NMSA 1978 (being Laws 1989, Chapter 304, Section 1, as amended) is amended to read:

"59A-16-13.1. CRANIOMANDIBULAR AND TEMPOROMANDIBULAR JOINT DISORDERS.--Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, no insurer or other provider of health care benefits regulated under Articles 22, 23, 24A, 44, 46, 47 or 54 of the Insurance Code shall, after July 1, 1989, issue, deliver or execute in this state any policy, plan, contract or certificate of health, medical, hospitalization, accident or sickness coverage unless the policy, plan, contract,

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certificate or other evidence of coverage provides for surgical and nonsurgical treatment of temporomandibular joint disorders and craniomandibular disorders, subject to the same conditions, limitations, prior review and referral procedures as are applicable to treatment of any other joint in the body and treatable by any practitioner of the healing arts as defined in Section 59A-22-32 NMSA 1978. The health care coverage for craniomandibular and temporomandibular joint disorders required by this section may be subject to reasonable copayments or coinsurance provisions and need not include coverage for orthodontic appliances and treatment, crowns, bridges and dentures unless the disorder is trauma related."

Section 2. Section 59A-22-33 NMSA 1978 (being Laws 1984, Chapter 127, Section 455) is amended to read:

"59A-22-33. HANDICAPPED CHILDREN--COVERAGE CONTINUED.--Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, an individual or group hospital or medical expense insurance policy delivered or issued for delivery in this state which provides that coverage of a dependent child of an insured, or of an employee or other member of the covered group, shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide, in substance, that attainment of the limiting age shall not operate to terminate the coverage of a child while the child

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is, and continues to be both incapable of self-sustaining employment, by reason of mental retardation or physical handicap, and chiefly dependent upon the policyholder for support and maintenance. However, proof of the incapacity and dependency of the child must be furnished to the insurer by the insured employee or member within thirty-one [~~(31)~~] days of the child's attainment of the limiting age and subsequently, as may be required by the insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age."

Section 3. Section 59A-22-34 NMSA 1978 (being Laws 1984, Chapter 127, Section 456, as amended) is amended to read:

"59A-22-34. NEWLY BORN CHILDREN COVERAGE.--

A. Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, all individual and group health insurance policies delivered or issued for delivery in this state and which provide coverage on an expense-incurred basis for a family member of the insured shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth.

B. Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, all individual and group health insurance policies delivered or issued for delivery in this state that do not provide coverage for a family member of the

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insured shall provide for an option to add to the coverage any newly born child of the insured, provided that the requirements of Subsection D of this section have been met.

C. The coverage for newly born children shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, where necessary to protect the life of the infant, transportation, including air transport, to the nearest available tertiary care facility for newly born infants.

D. If payment of a specific premium is required to provide coverage for a child, the policy may require that a notification of birth of a newly born child and payment of the required premium [~~must~~] be furnished to the insurer within thirty-one days after the date of birth in order to have the coverage from birth.

E. As used in this section and in Section 59A-22-35 NMSA 1978, "tertiary care facility" means a hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served."

Section 4. Section 59A-22-34.1 NMSA 1978 (being Laws 1988, Chapter 89, Section 1) is amended to read:

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"59A-22-34.1. COVERAGE FOR ADOPTED CHILDREN.--

A. Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, no individual or group health insurance policy or contract or health care plan shall be offered, issued or renewed in New Mexico on or after July 1, 1988, unless the policy, plan or contract covers adopted children of the insured, subscriber or enrollee on the same basis as other dependents.

B. The coverage required by this section is effective from the date of placement for the purpose of adoption and continues, unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.

C. As used in this section, "placement" means in the physical custody of the adoptive parent."

Section 5. Section 59A-22-34.3 NMSA 1978 (being Laws 1997, Chapter 250, Section 1) is amended to read:

"59A-22-34.3. CHILDHOOD IMMUNIZATION COVERAGE REQUIRED.--

A. Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, each individual and group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state shall

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provide coverage for childhood immunizations, as well as coverage for medically necessary booster doses of all immunizing agents used in child immunizations, in accordance with the current schedule of immunizations recommended by the American academy of pediatrics.

B. The provisions of this section shall not apply to short-term travel, accident-only or limited or specified-disease policies.

C. 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, plan or certificate."

Section 6. Section 59A-22-35 NMSA 1978 (being Laws 1984, Chapter 127, Section 457) is amended to read:

"59A-22-35. MATERNITY TRANSPORT REQUIRED.--Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, all individual and group health insurance policies delivered or issued for delivery in this state which provide maternity coverage on an expense-incurred basis shall also provide, where necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility (as defined in Section [~~456 of this article~~] 59A-22-34 NMSA 1978) for newly born infants."

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Section 7. Section 59A-22-36 NMSA 1978 (being Laws 1984, Chapter 127, Section 458) is amended to read:

"59A-22-36. HOME HEALTH CARE SERVICE OPTION REQUIRED.--

A. Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, each insurer which delivers or issues for delivery in this state an individual or group hospital expense or major medical expense insurance policy shall make available to the policyholder the option of home health care coverage which includes benefits for the services described in this section.

B. Home health care coverage offered shall include:

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

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

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

(4) 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.

C. Home health care coverage may be limited to:

(1) services provided on the written order of a licensed physician, provided such order is renewed at least

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every sixty [~~(60)~~] days;

(2) 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

(3) services, as set forth in Subsection B of [~~the~~] this section, without which the insured would have to be hospitalized.

D. Coverage shall be provided for at least one hundred [~~(100)~~] home visits per insured per year, with each home visit including up to four [~~(4)~~] hours of home health care services.

E. For the purposes of this section, "home health care" means health services provided on a part-time, intermittent basis to an individual confined to his home due to physical illness."

Section 8. Section 59A-22-39 NMSA 1978 (being Laws 1990, Chapter 5, Section 2) is amended to read:

"59A-22-39. COVERAGE FOR MAMMOGRAMS.--

A. Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, 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

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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 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 9. Section 59A-22-39.1 NMSA 1978 (being Laws 1997, Chapter 249, Section 1) is amended to read:

"59A-22-39.1. MASTECTOMIES AND LYMPH NODE DISSECTION--MINIMUM HOSPITAL STAY COVERAGE REQUIRED.--

A. Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, 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 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.

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B. Nothing in this section 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.

C. The provisions of this section shall not apply to short-term travel, accident-only or limited or specified-disease policies.

D. Coverage for minimum inpatient hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer may be subject to deductibles and co-insurance consistent with those imposed on other benefits under the same policy, plan or certificate."

Section 10. Section 59A-22-40 NMSA 1978 (being Laws 1992, Chapter 56, Section 2) is amended to read:

"59A-22-40. COVERAGE FOR CYTOLOGIC SCREENING.--

A. Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, 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 cytologic screening for determining the presence of precancerous or cancerous conditions and other health problems. The coverage shall make available cytologic screening, as determined by the health care provider in accordance with national medical standards, for women who are eighteen years of age or older and for women who are at risk

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of cancer or at risk of other health conditions that can be identified through cytologic screening.

B. Coverage for cytologic screening may be subject to deductibles and coinsurance consistent with 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.

D. For the purposes of this section:

(1) "cytologic screening" means a Papanicolaou test and a pelvic exam for asymptomatic as well as symptomatic women; and

(2) "health care provider" means any person licensed within the scope of his practice to perform cytologic screening, including physicians, physician assistants, certified nurse midwives and nurse practitioners."

Section 11. Section 59A-22-41 NMSA 1978 (being Laws 1997, Chapter 7, Section 1 and also Laws 1997, Chapter 255, Section 1) is amended to read:

"59A-22-41. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

A. Except as provided in Sections 59A-22-42 and 59A-23-4.1 NMSA 1978, each individual and group health insurance policy, health care plan, certificate of health insurance and managed health care plan delivered or issued for delivery in this state shall provide coverage for individuals

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with insulin-using diabetes, with non-insulin-using diabetes and with elevated blood glucose levels induced by pregnancy. This coverage shall be a basic health care benefit and shall entitle each individual to the medically accepted standard of medical care for diabetes and benefits for diabetes treatment as well as diabetes supplies, and this coverage shall not be reduced or eliminated.

B. Coverage for individuals with diabetes may be subject to deductibles and co-insurance consistent with those imposed on other benefits under the same policy, plan or certificate, as long as the annual deductibles or co-insurance for benefits are no greater than the annual deductibles or co-insurance established for similar benefits within a given policy.

C. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(1) blood glucose monitors, including those for the legally blind;

(2) test strips for blood glucose monitors;

(3) visual reading urine and ketone strips;

(4) lancets and lancet devices;

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(5) insulin;

(6) injection aids, including those adaptable to meet the needs of the legally blind;

(7) syringes;

(8) prescriptive oral agents for controlling blood sugar levels;

(9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(10) glucagon emergency kits.

D. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following basic health care benefits:

(1) diabetes self-management training that shall be provided by a certified, registered or licensed health care professional with recent education in diabetes management, which shall be limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a physician

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diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and

(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and

(2) medical nutrition therapy related to diabetes management.

E. When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the food and drug administration, all individual or group health insurance policies as described in Subsection A of this section shall:

(1) maintain an adequate formulary to provide these resources to individuals with diabetes; and

(2) guarantee reimbursement or coverage for the equipment, appliances, prescription drug, insulin or supplies described in this subsection within the limits of the health care plan, policy or certificate.

F. The provisions of Subsections A through E of this section shall be enforced by the superintendent.

G. The provisions of this section shall not apply to short-term travel, accident-only or limited or specified-disease policies.

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H. For purposes of this section:

(1) "basic health care benefits":

(a) means benefits for medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services; and

(b) does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment; and

(2) "managed health care plan" means a health benefit plan offered by a health care insurer that provides for the delivery of comprehensive basic health care services and medically necessary services to individuals enrolled in the plan through its own employed health care providers or by contracting with selected or participating health care providers. A managed health care plan includes only those plans that provide comprehensive basic health care services to enrollees on a prepaid, capitated basis, including the following:

(a) health maintenance organizations;

(b) preferred provider organizations;

(c) individual practice associations;

(d) competitive medical plans;

(e) exclusive provider organizations;

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(f) integrated delivery systems;

(g) independent physician-provider organizations;

(h) physician hospital-provider organizations; and

(i) managed care services organizations."

Section 12. A new section of the New Mexico Insurance Code, Section 59A-22-42 NMSA 1978, is enacted to read:

"59A-22-42. [NEW MATERIAL] CATASTROPHIC INDIVIDUAL HEALTH INSURANCE.--

A. In lieu of an individual health insurance policy containing those provisions otherwise required under the Insurance Code, each insurer that delivers or issues for delivery in this state an individual health insurance policy shall offer and make available a catastrophic individual health insurance policy.

B. As used in this section, "catastrophic individual health insurance policy" means a policy for individual health insurance:

(1) to which the following provisions are not applicable:

(a) Section 59A-16-13.1 NMSA 1978;

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

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

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

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

(f) Section 59A-22-35 NMSA 1978;

(g) Section 59A-22-36 NMSA 1978;

(h) Section 59A-22-39 NMSA 1978;

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

(j) Section 59A-22-40 NMSA 1978;

(k) Section 59A-22-41 NMSA 1978; and

(l) any other provision of law that mandates coverage of specific health care services; and

(2) that contains the following deductible provisions:

(a) self-only coverage with an annual deductible of not less than six hundred dollars ($600); and

(b) family coverage with an annual deductible of not less than one thousand two hundred dollars ($1,200)."

Section 13. 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 blanket or group health insurance policy or contract shall contain any provision relative to notice or

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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.

C. Except as provided in Section 59A-23-4.1 NMSA 1978, 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

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[~~(8)~~] (10) Section 59A-22-41 NMSA 1978."

Section 14. A new section of the New Mexico Insurance Code, Section 59A-23-4.1 NMSA 1978, is enacted to read:

"59A-23-4.1. [NEW MATERIAL] SMALL EMPLOYER OPTION--CATASTROPHIC GROUP HEALTH INSURANCE.--

A. In lieu of a group health insurance policy containing those provisions otherwise required under the Insurance Code, each insurer that delivers or issues for delivery in this state a group health insurance policy shall offer and make available a catastrophic group health insurance policy to a small employer for the benefit of the small employer's employees.

B. As used in this section, "catastrophic group health insurance policy" means a policy for group health insurance:

(1) to which the following provisions are not applicable:

(a) Section 59A-16-13.1 NMSA 1978;

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

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

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

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

(f) Section 59A-22-35 NMSA 1978;

(g) Section 59A-22-36 NMSA 1978;

(h) Section 59A-22-39 NMSA 1978;

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

(j) Section 59A-22-40 NMSA 1978;

(k) Section 59A-22-41 NMSA 1978;

(l) Section 59A-23-6 NMSA 1978;

(m) Section 59A-23E-18 NMSA 1978; and

(n) any other provision of law that mandates coverage of specific health care services; and

(2) that contains the following deductible provisions:

(a) self-only coverage with an annual deductible of not less than six hundred dollars ($600); and

(b) family coverage with an annual deductible of not less than one thousand two hundred dollars ($1,200).

C. As used in this section, "small employer" means any person, firm, corporation, partnership or association actively engaged in business that, on at least fifty percent of its working days during either of the two preceding years, employed no less than two and no more than fifty eligible employees; provided that:

(1) in determining the number of eligible employees, the spouse or dependent of an employee may, at the employer's discretion, be counted as a separate employee;

(2) companies that are affiliated companies or that are eligible to file a combined tax return for

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purposes of state income taxation shall be considered one employer; and

(3) in the case of an employer that was not in existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year."

Section 15. Section 59A-23-6 NMSA 1978 (being Laws 1983, Chapter 64, Section 1) is amended to read:

"59A-23-6. ALCOHOL DEPENDENCY COVERAGE.--

A. Except as provided in Section 59A-23-4.1 NMSA 1978, each insurer that delivers or issues for delivery in this state a group health insurance policy shall offer and make available benefits for the necessary care and treatment of alcohol dependency. Such benefits shall:

(1) be subject to annual deductibles and coinsurance consistent with those imposed on other benefits within the same policy;

(2) provide no less than thirty days necessary care and treatment in an alcohol dependency treatment center and thirty outpatient visits for alcohol dependency treatment; and

(3) be offered for benefit periods of no more than one year and may be limited to a lifetime maximum of no

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less than two benefit periods.

Such offer of benefits shall be subject to the rights of the group health insurance holder to reject the coverage or to select any alternative level of benefits if that right is offered by or negotiated with that insurer.

B. For purposes of this section, "alcohol dependency treatment center" means a facility that provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a physician or meeting the quality standards of the substance abuse bureau of the behavioral health services division of the [~~health and environment~~] department of health and which facility also:

(1) is affiliated with a hospital under a contractual agreement with an established system for patient referral;

(2) is accredited as such a facility by the joint commission on accreditation of hospitals; or

(3) meets at least the minimum standards adopted by the [~~substance abuse bureau pursuant to Section 43-3-4 NMSA 1978 for treatment of alcoholism in regional treatment centers as defined in Section 43-3-3 NMSA 1978~~] department of health for the delivery of behavioral health services relating to alcoholism.

C. This section applies to policies delivered or issued for delivery or renewed, extended or amended in this

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state on or after July 1, 1983 or upon expiration of a collective bargaining agreement applicable to a particular policyholder, whichever is later; provided that this section does not apply to blanket, short-term travel, accident-only, limited or specified disease, individual conversion policies or policies designed for issuance to persons eligible for coverage under Title [~~XVIII~~] 18 of the Social Security Act, known as medicare, or any other similar coverage under state or federal governmental plans. With respect to any policy forms approved by the department of insurance prior to the effective date of this section, an insurer is authorized to comply with this section by the use of endorsements or riders, provided such endorsements or riders are approved by the [~~department of~~] insurance division as being in compliance with this section and applicable provisions of Chapter [~~59~~] 59A NMSA 1978.

D. If an organization offering group health benefits to its members makes more than one health insurance policy or nonprofit health care plan available to its members on a member option basis, the organization shall not require alcohol dependency coverage from one health insurer or health care plan without requiring the same level of alcohol dependency coverage for all other health insurance policies or health care plans that the organization makes available to its members."

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Section 16. Section 59A-23E-18 NMSA 1978 (being Laws 2000, Chapter 6, Section 1) is amended to read:

"59A-23E-18. REQUIREMENT FOR MENTAL HEALTH BENEFITS IN A GROUP HEALTH PLAN, OR GROUP HEALTH INSURANCE OFFERED IN CONNECTION WITH THE PLAN, FOR A PLAN YEAR OF AN EMPLOYER.--

A. Except as provided in Section 59A-23-4.1 NMSA 1978, a group health plan for a plan year of an employer beginning or renewed on or after October 1, 2000, or group health insurance offered in connection with that plan, shall provide both medical and surgical benefits and mental health benefits. The plan shall not impose treatment limitations or financial requirements on the provision of mental health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. Except as provided in Section 59A-23-4.1 NMSA 1978, a group health plan for a plan year of an employer beginning on or after October 1, 2000, or group health insurance offered in connection with that plan, may:

(1) require pre-admission screening prior to the authorization of mental health benefits whether inpatient or outpatient; or

(2) apply limitations that restrict mental health benefits provided under the plan to those that are medically necessary.

C. A group health plan for a plan year of an

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employer beginning or renewed on or after January 1, 2000, or group health insurance offered in connection with that plan, may not be changed through amendment or on renewal to exclude or decrease the mental health benefits existing as of that date.

D. An employer, having at least two but not more than forty-nine employees, that is required by the provisions of Subsection A of this section to provide mental health benefits coverage in a group health plan, or group health insurance offered in connection with that plan on renewal of an existing plan, may, if a premium increase of more than one and one-half percent in the plan year results from the change in coverage:

(1) pay the premium increase;

(2) reach agreement with the employees to cost-share that amount of the premium above one and one-half percent;

(3) negotiate a reduction in coverage, but not below the coverage existing before the renewal, to reduce the premium increase to no more than one and one-half percent; or

(4) after demonstrating to the satisfaction of the insurance division that the amount of the premium increase above one and one-half percent is due exclusively to the additional coverage required by the provisions of

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Subsection A of this section, receive written permission from the division to not increase coverage.

E. An employer, having at least fifty employees, that is required by the provisions of Subsection A of this section to provide mental health benefits coverage in a group health plan, or group health insurance offered in connection with that plan on renewal of an existing plan, may, if a premium increase of more than two and one-half percent in the plan year results from the change in coverage:

(1) pay the premium increase;

(2) reach agreement with the employees to cost-share that amount of the premium above two and one-half percent;

(3) negotiate a reduction in coverage, but not below the coverage existing before applying parity requirements, to reduce the premium increase to no more than two and one-half percent; or

(4) after demonstrating to the satisfaction of the insurance division that the amount of the premium increase above two and one-half percent is due exclusively to the additional coverage provided because of the provisions of Subsection A of this section, receive written permission from the division to not increase coverage.

F. As used in this section, "mental health benefits" means mental health benefits as described in the

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group health plan, or group health insurance offered in connection with the plan; but does not include benefits with respect to treatment of substance abuse, chemical dependency or gambling addiction."