HOUSE BILL 979

43RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 1997

INTRODUCED BY

JEANNETTE WALLACE

AN ACT

RELATING TO INSURANCE; REQUIRING COVERAGE FOR CHILDHOOD IMMUNIZATIONS; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978.

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

Section 1. A new Section 59A-22-34.3 NMSA 1978 is enacted to read:

"59A-22-34.3. [NEW MATERIAL] CHILDHOOD IMMUNIZATION COVERAGE REQUIRED.--

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 childhood immunizations, as well as coverage for medically necessary booster doses of all immunizing agents used in child immunizations.

B. The provisions of this section shall not apply to

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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 2. Section 59A-23-4 NMSA 1978 (being Laws 1984, Chapter 127, Section 463, as amended) 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 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 thereof; and

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

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

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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-22-35 NMSA 1978;

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

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

(7) Section 59A-22-34.3 NMSA 1978; and

[~~(7)~~] (8) Section 59A-22-40 NMSA 1978."

Section 3. Section 59A-23B-3 NMSA 1978 (being Laws 1991, Chapter 111, Section 3, as amended) 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 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.

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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-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:

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(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 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

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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, 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

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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; [~~and~~]

(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, 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 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

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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 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

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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 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. A new Section 59A-46-38.2 NMSA 1978 is enacted to read:

"59A-46-38.2. [NEW MATERIAL] CHILDHOOD IMMUNIZATION COVERAGE REQUIRED.--

A. Each individual and group health maintenance contract delivered or issued for delivery in this state shall provide coverage for childhood immunizations, including coverage for all medically necessary booster doses of all immunizing agents used in childhood immunizations.

B. Coverage for childhood immunizations and necessary booster doses may be subject to deductibles and co-

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insurance consistent with those imposed on other benefits under the same contract."

State of New Mexico
House of Representatives

FORTY-THIRD LEGISLATURE

FIRST SESSION, 1997

February 27, 1997

Mr. Speaker:

Your CONSUMER AND PUBLIC AFFAIRS COMMITTEE, to whom has been referred

HOUSE BILL 979

has had it under consideration and reports same with recommendation that it DO PASS, and thence referred to the BUSINESS AND INDUSTRY COMMITTEE.

Respectfully submitted,

Gary King, Chairman

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.116734.1

Adopted _____ Not Adopted _____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 8 For 0 Against

Yes: 8

Excused: Rios, Sandel

Absent: None

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State of New Mexico
House of Representatives

FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

March 6, 1997

Mr. Speaker:

Your BUSINESS AND INDUSTRY COMMITTEE, to whom has been referred

HOUSE BILL 979

has had it under consideration and reports same with recommendation that it DO PASS.

Respectfully submitted,

Fred Luna, Chairman

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.116734.1

Adopted _____ Not Adopted _____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 10 For 0 Against

Yes: 10

Excused: Getty, Gubbels, Kissner

Absent: None

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FORTY-THIRD LEGISLATURE

FIRST SESSION

March 7, 1997

HOUSE FLOOR AMENDMENT number ___1___ to HOUSE BILL 979

Amendment sponsored by Representative Jeannette Wallace

1. On page 1, line 24, after "immunizations" insert ", in accordance with the current schedule of immunizations recommended by the American academy of pediatrics".

2. On page 7, line 13, after "immunizations" insert ", in accordance with the current schedule of immunizations recommended by the American academy of pediatrics".

3. On page 9, line 21, after "immunizations" insert ", in accordance with the current schedule of immunizations recommended by the American academy of pediatrics".

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_____
Jeannette Wallace

Adopted _____ Not Adopted _____
(Chief Clerk) (Chief Clerk)

Date _____

FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

March 15, 1997

Mr. President:

Your PUBLIC AFFAIRS COMMITTEE, to whom has been referred

HOUSE BILL 979, as amended

has had it under consideration and reports same with recommendation that it DO PASS.

Respectfully submitted,

_____
Shannon Robinson, Chairman

Adopted_____ Not Adopted_____
(Chief Clerk) (Chief Clerk)

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Date _____

The roll call vote was 5 For 0 Against

Yes: 5

No: 0

Excused: Adair, Ingle, Vernon, Smith

Absent: None

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