HOUSE BILL

**52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015**

INTRODUCED BY

DISCUSSION DRAFT

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH INSURANCE; 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 PROVIDE FOR PARITY BETWEEN BEHAVIORAL HEALTH BENEFITS AND OTHER BENEFITS; AMENDING A SECTION OF THE HEALTH INSURANCE PORTABILITY ACT TO ADD CERTAIN BEHAVIORAL HEALTH BENEFITS TO THE PROVISIONS OF THAT ACT; REPEALING SECTIONS OF CHAPTER 59A, ARTICLE 23 NMSA 1978 AND THE NONPROFIT HEALTH CARE PLAN LAW.

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

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

"[NEW MATERIAL] BEHAVIORAL HEALTH BENEFITS--PARITY WITH OTHER BENEFITS.--

A. Group health coverage, including any form of

self-insurance, offered, issued or renewed under the Health Care Purchasing Act, or group health coverage offered, issued or renewed in connection with the group health coverage, shall not impose treatment limitations or financial requirements on the provision of behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. Group health coverage may:

(1) require pre-admission screening prior to the authorization of behavioral health benefits, whether for inpatient, outpatient or residential treatment; or

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

C. As used in this section, "behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, including but not limited to services provided to an adult or a child at a residential treatment facility."

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

"[NEW MATERIAL] BEHAVIORAL HEALTH BENEFITS--PARITY WITH OTHER BENEFITS.--

A. An individual health insurance policy, health care plan or certificate of health insurance that is delivered,

underscored material = new
[bracketed material] = delete

issued for delivery or renewed in this state, or an individual health insurance policy, plan or certificate offered, issued or renewed in connection with a health insurance policy, plan or certificate of health insurance, shall not impose treatment limitations or financial requirements on the provision of behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. A health insurer may:

(1) require pre-admission screening prior to the authorization of behavioral health benefits, whether for inpatient, outpatient or residential treatment; or

(2) apply limitations that restrict benefits provided under the health insurance policy, plan or certificate to those that are medically necessary.

C. As used in this section, "behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, including but not limited to services provided to an adult or a child at a residential treatment facility."

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

"[NEW MATERIAL] BEHAVIORAL HEALTH BENEFITS--PARITY WITH OTHER BENEFITS.--

A. A group health insurance policy, health care

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plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state, or a group health insurance policy, plan or certificate offered, issued or renewed in connection with a health insurance policy, plan or certificate of health insurance, shall not impose treatment limitations or financial requirements on the provision of behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. A health insurer may:

(1) require pre-admission screening prior to the authorization of behavioral health benefits, whether for inpatient, outpatient or residential treatment; or

(2) apply limitations that restrict benefits provided under the group health insurance policy, plan or certificate to those that are medically necessary.

C. As used in this section, "behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, including but not limited to services provided to an adult or a child at a residential treatment facility."

**SECTION 4.** Section 59A-23E-18 NMSA 1978 (being Laws 2000, Chapter 6, Section 1) is amended to read:

"59A-23E-18. REQUIREMENT FOR [~~MENTAL~~] BEHAVIORAL HEALTH BENEFITS IN A GROUP HEALTH PLAN, OR GROUP HEALTH INSURANCE

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OFFERED IN CONNECTION WITH THE PLAN, FOR A PLAN YEAR OF AN EMPLOYER.--

A. 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~~] behavioral health benefits. The plan shall not impose treatment limitations or financial requirements on the provision of [~~mental~~] behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. 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~~] behavioral health benefits whether inpatient or outpatient; or

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

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

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~~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 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~~

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~~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.~~] C. 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 behavioral health benefits coverage from one health insurer or health care plan without requiring the same level of behavioral health benefits coverage for all other health insurance

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policies or health care plans that the organization makes available to its members.

D. As used in this section, "[~~mental~~] behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, [~~as described in the 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~~] including but not limited to services provided to an adult or a child at a residential treatment center."

**SECTION 5.** A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] BEHAVIORAL HEALTH BENEFITS--PARITY WITH OTHER BENEFITS.--

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state, or coverage that is offered, issued or renewed in connection with a health maintenance organization contract, shall not impose treatment limitations or financial requirements on the provision of behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. A health maintenance organization may:

(1) require pre-admission screening prior to

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the authorization of behavioral health benefits, whether for inpatient, outpatient or residential treatment; or

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

C. As used in this section, "behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, including but not limited to services provided to an adult or a child at a residential treatment facility."

**SECTION 6.** A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] BEHAVIORAL HEALTH BENEFITS--PARITY WITH OTHER BENEFITS.--

A. An individual or group nonprofit health care plan that is delivered, issued for delivery or renewed in this state, or coverage that is issued or renewed in connection with a health care plan, shall not impose treatment limitations or financial requirements on the provision of behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. A health care plan may:

(1) require pre-admission screening prior to the authorization of behavioral health benefits, whether for inpatient, outpatient or residential treatment; or

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

C. As used in this section, "behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, including but not limited to services provided to an adult or a child at a residential treatment facility."

**SECTION 7.** REPEAL.--Sections 59A-23-6 and 59A-47-35 NMSA 1978 (being Laws 1983, Chapter 64, Section 1 and Laws 1984, Chapter 127, Section 879.34, as amended) are repealed.



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