SENATE BILL 505

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

INTRODUCED BY

Manny M. Aragon

AN ACT

RELATING TO HEALTH CARE; ENACTING THE HEALTH SECURITY ACT TO PROVIDE FOR COMPREHENSIVE STATEWIDE HEALTH CARE; PROVIDING FOR HEALTH CARE PLANNING; ESTABLISHING PROCEDURES TO CONTAIN HEALTH CARE COSTS; CREATING A COMMISSION; PROVIDING FOR ITS POWERS AND DUTIES; PROVIDING FOR HEALTH CARE DELIVERY REGIONS AND REGIONAL COUNCILS; DIRECTING AND AUTHORIZING THE DEVELOPMENT OF A STATE HEALTH CARE PLAN.

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

Section 1. SHORT TITLE.--This act may be cited as the "Health Security Act".

Section 2. PURPOSES OF ACT.--The purposes of the Health Security Act are to:

A. create a program that ensures health care coverage to all New Mexicans through a combination of public

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and private financing; and

B. control escalating health care costs.

Section 3. DEFINITIONS.--As used in the Health Security Act:

A. "beneficiary" means a person eligible for coverage and benefits pursuant to the health plan;

B. "budget" means the total of all categories of dollar amounts of expenditures for a stated period authorized for an entity or a program;

C. "capital budget" means that portion of a budget that establishes expenditures for:

(1) acquisition or addition of substantial improvements to real property; or

(2) acquisition of tangible personal property;

D. "case management" means a system for insuring a comprehensive program that will meet an individual's need for care by coordinating and linking the components of health care;

E. "commission" means the health care commission created pursuant to the Health Security Act;

F. "consumer price index for medical care prices" means that index as published by the bureau of labor statistics of the federal department of labor;

G. "controlling interest" means:

(1) a five percent or greater ownership interest, direct or indirect, in the person controlled; or

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(2) a financial interest, direct or indirect, and, because of business or personal relationships, having the power to direct important decisions of the person controlled;

H. "financial interest" means an ownership interest of any amount, direct or indirect;

I. "group practice" means an association of health care providers that provides one or more specialized health care services or a tribal coalition in partnership or under contract with the federal Indian health service that is authorized under federal law to provide health care to Native American populations in the state;

J. "health care" means health care provider services and health facility services;

K. "health care provider" means:

(1) a person licensed or certified and authorized to provide health care in New Mexico;

(2) an individual licensed or certified by a nationally recognized professional organization and designated as a health care provider by the commission as a:

(a) prosthetist;

(b) orthotist; or

(c) oculist; or

(3) a person that is a group practice or a transportation service;

L. "health facility" means a school-based clinic,

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an Indian health facility or a licensed general hospital, special hospital, outpatient facility, psychiatric hospital, laboratory, skilled nursing facility or nursing facility;

M. "health plan" means the program that is created and administered by the commission for provision of health care pursuant to the Health Security Act;

N. "major capital expenditure" means construction or renovation of facilities or the acquisition of diagnostic, treatment or transportation equipment by a health care provider or health facility that costs more than an amount recommended and established by the commission;

O. "operating budget" means the budget of a health facility exclusive of the facility's capital budget;

P. "person" means an individual or any other legal entity;

Q. "primary care provider" means a health care provider who is a physician, osteopathic physician, nurse practitioner, physician assistant, osteopathic physician's assistant, pharmacist clinician or other health care provider certified by the commission as a primary care provider after the commission's determination that the provider provides the first level of health care for a beneficiary's health needs;

R. "provider budget" means the authorized expenditures pursuant to payment mechanisms established by the commission to pay for health care furnished by health care

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providers participating in the health plan; and

S. "transportation service" means a person providing the services of an ambulance, helicopter or other conveyance that is equipped with health care supplies and equipment and is used to transport patients to other health care providers or health facilities.

Section 4. HEALTH CARE COMMISSION CREATED--GOVERNMENTAL INSTRUMENTALITY.--The "health care commission" is created as a public body, politic and corporate, separate and apart from the state, constituting a governmental instrumentality. The commission is created and organized for the purposes of creating a health care program that ensures coverage to all New Mexicans through a combination of public and private financing of the statewide health program and controlling escalating health care costs. The commission consists of fifteen members.

Section 5. COMMISSION--APPOINTING AUTHORITY FOR MEMBERS--CREATION OF HEALTH CARE COMMISSION MEMBERSHIP NOMINATING COMMITTEE--MEMBERSHIP, TERMS AND DUTIES OF COMMITTEE.--

A. The members of the commission shall be appointed by the governor. The governor shall appoint those members in accordance with the procedures and provisions of this section.

B. There is created the "health care commission membership nominating committee", consisting of: two members appointed by the governor; three members appointed by the

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speaker of the house of representatives; three members appointed by the president pro tempore of the senate; two members appointed by the minority leader of the house of representatives; and two members appointed by the minority leader of the senate. An elected official shall not be appointed to serve on the committee. At the first meeting of the committee it shall elect a chair from its membership. The chair shall vote only in the case of a tie vote.

C. The first twelve members appointed to the committee shall have terms chosen by lot: four two-year terms; four three-year terms; and four four-year terms. Thereafter, members shall serve four-year terms. A member shall serve until his successor is appointed and qualified. Successor members shall be appointed by the appointing authority that made the initial appointment to the committee.

D. Appointed members of the committee shall have substantial knowledge of the health care system as demonstrated by education or experience. A person shall not be appointed to the committee if he or a member of his household is employed by, an officer of or has a controlling interest in a person providing health care or health insurance, directly or as an agent of a health insurer.

E. The committee shall take appropriate action to ensure that adequate prior notice of its meetings is advertised and reported in media outlets throughout the state in addition

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to publication of a legal notice in major newspapers. Publication of the legal notice shall occur once each week for the two weeks immediately preceding the date of a meeting. Meetings of the committee shall be open to the public, and public comment shall be allowed. Meetings may be closed only for discussion of candidates prior to selection. Final selection of candidates shall be by vote of the members and shall be conducted in a public meeting.

F. The committee shall hold its first meeting on or before June 15, 2004. The committee shall actively solicit, accept and evaluate applications from qualified persons for membership on the commission subject to the requirements for commission membership qualifications set forth in Section 6 of the Health Security Act.

G. No later than September 15, 2004, the committee shall submit to the governor the names of persons qualified for appointment to and those recommended for appointment to the commission by a majority of the committee. Immediately after receiving committee nominations, the governor may make one request of the committee for submission of additional names. If a majority of the committee finds that additional persons would be qualified, the committee shall promptly submit additional names and recommend those persons for appointment to the commission. The committee shall submit not fewer than two or more than three names for a membership position.

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H. Appointed committee members shall be reimbursed pursuant to the Per Diem and Mileage Act for expenses incurred in fulfilling their duties.

I. Staff to assist the committee in its duties until a commission is appointed shall be furnished by the department of health. Thereafter, commission staff shall assist the committee in its duties.

Section 6. APPOINTMENT OF COMMISSION MEMBERS--QUALIFICATIONS--TERMS.--

A. From the nominees submitted by the health care commission membership nominating committee, the governor shall appoint the members of the initial commission by November 1, 2004.

B. The terms of the initial members appointed shall be chosen by lot: five members shall be appointed for terms of four years; five members shall be appointed for terms of three years; and five members shall be appointed for terms of two years. Thereafter, all members shall be appointed for terms of four years. After initial terms are served, no member shall serve more than three consecutive four-year terms. A member shall serve until his successor is appointed and qualified.

C. When an actual vacancy occurs in the membership of the commission, the health care commission membership nominating committee shall meet and act within thirty days of the occurrence of the vacancy. From the nominees submitted,

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the governor shall fill the vacancy within thirty days after receiving final nominations.

D. Members of the commission shall include ten persons who represent consumer and employer interests, and five persons who represent either health care providers or health facilities.

E. Persons appointed who do not represent health care providers or health facilities must have a knowledge of the health care system as demonstrated by experience or education. To ensure fair representation of all areas of the state, members shall be appointed from each of the state board of education districts as follows:

(1) two from state board of education district 1;

(2) one from state board of education district 2;

(3) one from state board of education district 3;

(4) two from state board of education district 4;

(5) two from state board of education district 5;

(6) one from state board of education district 6;

(7) two from state board of education

district 7;

(8) two from state board of education district 8;

(9) one from state board of education district 9; and

(10) one from state board of education district 10.

F. A member may be removed from the commission by a majority vote of the members present at a meeting where a quorum is duly constituted. A member may be removed only for incompetence, neglect of duty or malfeasance in office. No member shall be removed without proceedings consisting of at least one notice of hearing and an opportunity to be heard. Removal proceedings shall be before the commission and in accordance with rules adopted by the commission.

G. A majority of the commission's members constitutes a quorum for the transaction of business. Annually, the commission shall elect its chairman and any other officers it deems necessary.

H. To reimburse them for expenses incurred in service on the commission, members shall receive per diem and mileage in accordance with the provisions of the Per Diem and Mileage Act. Additionally, members shall be compensated at the rate of two hundred dollars ($200) for each meeting actually attended not to exceed compensation for one hundred twenty

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meetings for a two-year period occurring in a term.

Section 7. CONFLICT OF INTEREST--DISQUALIFICATION FOR APPOINTMENT--DISCLOSURE BY MEMBERS AND DISQUALIFICATION FROM VOTING ON CERTAIN MATTERS.--

A. Except for persons appointed to represent health facilities or health care providers, a person shall be disqualified for appointment to the commission if he or a member of his household is employed by, an officer of or has a controlling interest in a person providing health care or health insurance, directly or as an agent of a health insurer.

B. The commission shall adopt a conflict-of-interest disclosure statement for use by all members that requires disclosure of a financial interest, whether or not a controlling interest, of the member or a member of his household in a person providing health care or health insurance.

C. No member of the commission shall vote on any matter in which he or a member of his household has a financial interest, except that all members representing health facilities or health care providers may vote on matters that pertain generally to health facilities or health care providers.

D. If there is a question about a conflict of interest of a commission member, the other members shall vote on whether to allow the member to vote.

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Section 8. CODE OF CONDUCT TO BE ADOPTED BY COMMISSION.--

A. At its first meeting the commission shall adopt a general code of conduct for commission members and employees subject to the commission's control. The code of conduct shall include at least those matters and activities proscribed by the Governmental Conduct Act.

B. Violation of a provision of the adopted code of conduct is grounds for removal of a commission member and grounds for dismissal of an employee.

Section 9. APPLICATION OF CERTAIN STATE LAWS TO COMMISSION.--The commission and regional councils created pursuant to the Health Security Act shall be subject to and shall comply with the provisions of the:

A. Open Meetings Act;

B. State Rules Act;

C. Inspection of Public Records Act; and

D. Public Records Act.

Section 10. CHIEF EXECUTIVE OFFICER--STAFF--CONTRACTS--BUDGETS.--

A. The commission shall appoint and set the salary of a "chief executive officer". The chief executive officer shall serve at the pleasure of the commission and has authority to carry on the day-to-day operations of the commission and the health plan.

B. The chief executive officer shall employ those

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persons necessary to administer and implement the provisions of the Health Security Act.

C. The chief executive officer and his staff shall implement the Health Security Act in accordance with that act and the rules adopted by the commission. The chief executive officer may delegate authority to employees and may organize the staff into units to facilitate its work.

D. If the chief executive officer determines that the commission staff or a state agency does not have the resources or expertise to perform a necessary task, he shall contract for performance from a person that has a demonstrated capability to perform the task. He may also contract for professional consultant services. If claims processing is provided by contract, that contract shall be approved by and executed on behalf of the commission. The contract shall require that all work be performed entirely in New Mexico. All contracts shall be reviewed by the commission at least every two years to ensure that they continue to meet the criteria and performance standards of the contract and the needs of the commission.

E. The chief executive officer shall prepare and submit an annual budget request and plan of operation to the commission for its approval.

Section 11. COMMISSION--GENERAL DUTIES.--The commission shall:

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A. adopt a five-year plan for the initial implementation of the provisions of the Health Security Act, update that plan and adopt other long- and short-range plans to provide continuity and development of the state's health care system;

B. design the health plan to fulfill the purposes of and conform with the provisions of the Health Security Act;

C. provide a program to educate the public, health care providers and health facilities about the health plan and the persons eligible to receive its benefits;

D. study and adopt as provisions of the health plan cost-effective methods of providing quality health care to all beneficiaries, according high priority to increased reliance on:

(1) preventive and primary care that includes immunization and screening examinations;

(2) providing health care in rural or underserved areas of the state;

(3) in-home and community-based alternatives to institutional health care; and

(4) case management services when appropriate;

E. establish compensation methods for health care providers and adopt standards and procedures for negotiating and entering into contracts with participating health care providers;

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F. annually, and for those projected future periods the commission believes appropriate, establish health plan budgets;

G. establish capital budgets for health facilities and include and adopt in establishing those budgets:

(1) standards and procedures for determining the budgets; and

(2) a requirement for prior approval by the commission for major capital expenditures by a health facility;

H. negotiate and enter into health care reciprocity agreements with other states and foreign countries and negotiate and enter into health care agreements with out-of-state health care providers and health facilities;

I. develop claims and payment procedures for health care providers and health facilities and include provisions to ensure timely payments and continuity of payments to enable the providers and facilities to meet their financial obligations as they become due;

J. establish a system to collect and analyze health care data and other data necessary to improve the quality, efficiency and effectiveness of health care and to control costs of health care in New Mexico, which system shall include data on:

(1) mortality, including accidental causes of death, and natality;

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(2) morbidity;

(3) health behavior;

(4) physical and psychological impairment and disability;

(5) health care system costs and health care availability, utilization and revenues;

(6) environmental factors;

(7) availability, adequacy and training of health care personnel;

(8) demographic factors;

(9) social and economic conditions affecting health; and

(10) other factors determined by the commission;

K. standardize data collection and specific methods of measurement across databases and use scientific sampling or complete enumeration for reporting health information;

L. establish a health care delivery system that is efficient to administer and that eliminates unnecessary administrative costs;

M. adopt rules necessary to implement and monitor a health plan formulary to provide prescription drugs and a pricing procedure for nonprescription drugs, durable medical equipment and supplies, eyeglasses, hearing aids and oxygen;

N. study and evaluate the adequacy and quality of

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health care furnished pursuant to the Health Security Act, the cost of each type of service and the effectiveness of cost-containment measures in the health plan;

O. study and monitor the migration of persons to New Mexico to determine if persons with costly health care needs are moving to New Mexico to receive health care, and if migration appears to threaten the financial stability of the health plan, recommend to the legislature changes in eligibility requirements, premiums or other statutory changes that may be necessary to maintain the financial integrity of the health plan;

P. study and evaluate the cost of health care provider professional liability insurance and its impact on the price of health care services and recommend statutory changes to the legislature as necessary;

Q. establish and approve changes in coverage benefits and benefit standards in the health plan;

R. conduct necessary investigations and inquiries;

S. adopt rules necessary to implement, administer and monitor the operation of the health plan;

T. adopt rules to establish a procurement process for services and property;

U. meet as needed, but no less often than once every month; and

V. report its progress in implementing the Health

Security Act to the first session of the forty-seventh legislature and report annually thereafter to the legislature and the governor on the commission's activities and the operation of the health plan and include in the annual report:

(1) a summary of information about health care needs, health care services, health care expenditures, revenues received and projected revenues and other relevant issues relating to the health plan, the initial five-year plan and future updates of that plan and other long- and short-range plans; and

(2) recommendations on methods to control health care costs and improve access to and the quality of health care for state residents, as well as recommendations for legislative action if any are found to be necessary.

Section 12. COMMISSION--AUTHORITY.--The commission has the authority necessary to carry out all duties and responsibilities required of it pursuant to the Health Security Act, whether that authority is expressly provided in that act or is necessarily implied. The commission retains responsibility for its duties but may delegate authority to the chief executive officer. However, the authority to take the following actions is expressly reserved in the commission:

A. approve the commission's budget and plan of operation;

B. approve the health plan and make changes in the

health plan, but only after legislative approval of those changes specified in Section 30 of the Health Security Act;

C. make rules and conduct both rulemaking and adjudicatory hearings in person or by use of a hearing officer;

D. issue subpoenas to persons to appear and testify before the commission and to produce documents and other information relevant to the commission's inquiry and enforce this subpoena power through an action in the district court of Santa Fe county;

E. make reports and recommendations to the legislature;

F. subject to the prohibitions and restrictions of Section 21 of the Health Security Act, apply for program waivers from any governmental entity if the commission determines that the waivers are necessary to ensure the participation by the greatest possible number of beneficiaries;

G. accept grants, apply for and receive loans and accept donations;

H. acquire or lease real property and make improvements on it and acquire by lease or by purchase tangible and intangible personal property;

I. dispose of and transfer real or personal property, but only at public sale after adequate notice;

J. enter into contracts to incur debt and borrow money in its own name and enter into financing agreements with

the state, agencies or instrumentalities of the state, or with any commercial bank or credit provider;

K. appoint and prescribe the duties of employees, fix their compensation, pay their expenses and provide an employee benefit program;

L. establish and maintain banking relationships, including establishment of checking and savings accounts and lines of credit; and

M. issue revenue bonds and participate in the programs of the New Mexico finance authority.

Section 13. ADVISORY BOARDS.--

A. The commission shall establish a "health care provider advisory board" and a "health facility advisory board". It may establish additional advisory boards to assist it in performing its duties. Advisory boards shall assist the commission in matters requiring the expertise and knowledge of the advisory boards' members.

B. The commission may appoint not more than two commission members and up to five additional persons to serve on an advisory board it creates. Advisory board members shall be paid per diem and mileage in accordance with the provisions of the Per Diem and Mileage Act.

C. Except for the health care provider advisory board and the health facility advisory board, no more than two advisory board members shall have a financial interest, direct

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or indirect, in a person providing health care or a person providing health insurance.

D. Staff and technical assistance for an advisory board shall be provided by the commission as necessary.

Section 14. HEALTH CARE DELIVERY REGIONS.--The commission shall establish health care delivery regions in the state, based on geography and health care resources. The regions may have differential fee schedules, budgets, capital expenditure allocations or other features to encourage the provision of health care in rural and other underserved areas or to otherwise tailor the delivery of health care to fit the needs of a region or a part of a region.

Section 15. REGIONAL COUNCILS.--

A. The commission shall create regional councils in the designated health care delivery regions. In selecting persons to serve as members of regional councils, the commission shall consider the comments and recommendations of persons in the region who are knowledgeable about health care and the economic and social factors affecting the region.

B. The regional councils shall be composed of the commission members who live in the region and five other members appointed by the commission. No more than two noncommission council members shall have any financial interest, direct or indirect, in a person providing health care or a person providing health insurance.

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C. Members of a regional council shall be paid per diem and mileage in accordance with the provisions of the Per Diem and Mileage Act.

D. The regional councils shall hold public hearings to receive comments, suggestions and recommendations from the public regarding regional health care needs. The councils shall report to the commission at times specified by the commission to ensure that regional concerns are considered in the development and update of the five-year plan, other short- and long-range plans and projections, fee schedules, budgets and capital expenditure allocations.

E. Staff and technical assistance for the regional councils shall be provided by the commission.

Section 16. RULEMAKING.--

A. The commission shall adopt rules necessary to carry out the duties of the commission and the provisions of the Health Security Act.

B. The commission shall not adopt, amend or repeal any rule affecting a person outside the commission without a public hearing on the proposed action before the commission or a hearing officer designated by the commission. The hearing officer may be a member of the commission's staff. The hearing shall be held in Santa Fe unless the commission determines that it would be in the interest of those affected to hold the hearing elsewhere in the state. Notice of the subject matter

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of the rule, the action proposed to be taken, the time and place of the hearing, the manner in which interested persons may present their views and the method by which copies of the proposed rule or an amendment or repeal of an existing rule may be obtained shall be published once at least thirty days prior to the hearing date in a newspaper of general circulation in the state and shall also be published in an informative non-legal format in one newspaper published in each health care delivery region and mailed at least thirty days prior to the hearing date to all persons who have made a written request for advance notice of hearing.

C. All rules adopted by the commission shall be filed in accordance with the State Rules Act.

Section 17. HEALTH PLAN.--

A. After notice and public hearing, including taking public comment and the reports of the regional councils, the commission shall adopt a health plan.

B. The health plan shall be designed to provide comprehensive, necessary and appropriate health care benefits, including preventive health care and primary, secondary and tertiary health care for acute and chronic conditions. The health plan may provide for certain health care to be phased in as the health plan budget allows.

C. The commission shall specify the following health care to be included in the health plan and shall

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designate the health care either as covered health care or health care to be phased in:

(1) preventive health services;

(2) health care provider services;

(3) health facility inpatient and outpatient services;

(4) laboratory tests and imaging procedures;

(5) hospice care;

(6) in-home, community-based and institutional long-term care services;

(7) prescription drugs;

(8) inpatient and outpatient mental and behavioral health services;

(9) drug and other substance abuse services;

(10) preventive and prophylactic dental services, including an annual dental examination and cleaning;

(11) vision appliances, including medically necessary contact lenses;

(12) medical supplies, durable medical equipment and selected assistive devices, including hearing and speech assistive devices; and

(13) experimental or investigational procedures or treatments as specified by the commission.

D. Covered health care services shall not include:

(1) surgery for cosmetic purposes other than

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for reconstructive purposes;

(2) medical examinations and medical reports prepared for purchasing or renewing life insurance or participating as a plaintiff or defendant in a civil action for the recovery or settlement of damages; and

(3) orthodontic services and cosmetic dental services except those cosmetic dental services necessary for reconstructive purposes.

E. The health plan shall specify the services to be covered and the amount, scope and duration of benefits.

F. The health plan shall include a maximum amount or percentage for administrative costs, and this maximum, if a percentage, may change in relation to the total costs of services provided under the health plan. For the sixth and subsequent calendar years of operation of the health plan, administrative costs shall not exceed five percent of the health plan budget.

G. The commission shall specify the terms and conditions for participation of health care providers and health facilities in the health plan.

H. The health plan shall contain provisions to control health care costs so that beneficiaries receive comprehensive, high-quality health care consistent with available revenue and budget constraints.

I. The health plan shall phase in beneficiaries as

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their participation becomes possible through contracts, waivers or federal legislation. The health plan may provide for certain preventive health services to be offered to all New Mexicans regardless of a person's eligibility to participate as a beneficiary.

J. The five-year plan as well as other long- and short-range plans adopted by the commission shall be reviewed by the regional councils and the commission annually and revised as necessary. Revisions shall be adopted by the commission in accordance with Section 11 of the Health Security Act. In projecting services under the health plan, the commission shall take all reasonable steps to ensure that long-term care and dental care are provided at the earliest practical times consistent with budget constraints.

Section 18. LONG-TERM CARE.--

A. Long-term care may include:

(1) home- and community-based services, including personal assistance and attendant care; and

(2) institutional care.

B. No later than one year after the effective date of the operation of the health plan, the commission shall appoint an advisory "long-term care committee" made up of representatives of health care consumers, providers and administrators to develop a plan for integrating long-term care into the health plan. The committee shall report its plan to

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the commission no later than one year from its appointment. Committee members shall receive per diem and mileage as provided in the Per Diem and Mileage Act.

C. The long-term care component of the health plan shall provide for case management and noninstitutional services where appropriate.

D. Nothing in this section affects long-term care services paid through private insurance or state or federal programs subject to the provisions of Sections 40 and 41 of the Health Security Act.

E. Nothing in this section precludes the commission from including long-term care services from the inception of the health plan.

Section 19. MENTAL AND BEHAVIORAL HEALTH SERVICES.--

A. No later than one year after appointment of the chief executive officer, the commission shall appoint an advisory "mental and behavioral health services committee" made up of representatives of mental and behavioral health care consumers, providers and administrators to develop a plan for coordinating mental and behavioral health services within the health plan. The committee shall report its plan to the commission no later than one year from its appointment. Committee members may receive per diem and mileage as provided in the Per Diem and Mileage Act.

B. The mental and behavioral health services

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component of the health plan shall provide for case management and noninstitutional services where appropriate.

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

D. Nothing in this section limits mental and behavioral health services paid through private insurance or state or federal programs subject to the provisions of Sections 40 and 41 of the Health Security Act.

Section 20. MEDICAID COVERAGE--AGREEMENTS.--The commission may enter into appropriate agreements with the human services department or other state agency for the purpose of furthering the goals of the Health Security Act. These agreements may provide for certain services provided pursuant to the medicaid program to be administered by the commission to implement the health plan.

Section 21. HEALTH PLAN COVERAGE--CONDITIONS OF ELIGIBILITY FOR BENEFICIARIES--EXCLUSIONS.--

A. An individual is eligible as a beneficiary of the health plan if the individual has been physically present in New Mexico for one year prior to the date of application for enrollment in the health plan and if the individual has a current intention to remain in New Mexico and not to reside

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elsewhere. A dependent of an eligible individual is included as a beneficiary.

B. Individuals covered under the following governmental programs shall not be brought into coverage through agreements or waivers:

(1) federal retiree health plan beneficiaries;

(2) active duty and retired military personnel; and

(3) individuals covered by the federal civilian health and medical plan for the uniformed services.

C. Federal Indian health services beneficiaries shall not be brought into coverage except through agreements with:

(1) individual tribes or pueblos;

(2) consortia of tribes or pueblos; or

(3) a federal Indian health service agency subject to the approval of the tribes or pueblos located in that agency.

D. If an individual is ineligible because of his failure to fulfill the durational residence requirement, he may choose to become eligible by paying the premium required by the health plan for his coverage for the period of time up to the date he fulfills that requirement if he is an employee who physically resides in the state without an intention to reside elsewhere and if he came to the state because of employment

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offered to him in New Mexico while he was residing elsewhere as demonstrated by furnishing that evidence of those facts required by rule adopted by the commission.

E. The commission shall prescribe by rule conditions under which a nonresident employed in the state may be eligible for coverage pursuant to the health plan.

F. An individual who is eligible for health benefits after retirement pursuant to coverage furnished by his previous employer, including coverage for payment of health care supplements if the retiree is eligible for medicare, may agree with his previous employer to participate as a beneficiary in the health plan in lieu of health care benefits available to him as a retiree, but no provision in such an agreement is enforceable that provides for permanent loss of benefits under the retiree health benefit coverage. A previous employer may agree with the commission to contribute to the health plan for the benefit of the retiree, but the agreement shall ensure that the health benefit coverage for the retiree shall be restored in the event of the retiree's ineligibility for health plan coverage.

Section 22. HEALTH PLAN COVERAGE OF NONRESIDENT STUDENTS.--

A. Except as provided in Subsection B of this section, an educational institution shall purchase coverage under the health plan for its nonresident students through fees

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assessed to these students. The governing body of an educational institution shall set the fees at the amount determined by the commission.

B. A nonresident student at an educational institution may satisfy the requirement for health care coverage by proof of coverage under a policy or plan in another state that is acceptable to the commission. The student shall not be assessed a fee in that case.

C. The commission shall adopt rules to determine proof of an individual's eligibility for the health plan or a student's proof of nonresident health care coverage.

Section 23. REMOVING INELIGIBLE PERSONS.--The commission shall adopt rules to provide procedures for removing persons no longer eligible for coverage.

Section 24. ELIGIBILITY CARD--USE--PENALTIES FOR MISUSE.--

A. A beneficiary shall receive a card as proof of eligibility. The card shall be electronically readable and shall contain a picture or electronic image, information that identifies the beneficiary for treatment and electronic billing and payment and any other information the commission deems necessary.

B. The eligibility card is not transferable. A beneficiary who lends his card to another and an individual who uses another's card shall be jointly and severally liable to

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the commission for the full cost of the health care provided to the user. The liability shall be paid in full within ten days of final determination of liability. Liabilities created pursuant to this section shall be collected by the taxation and revenue department in the same manner as delinquent taxes are collected pursuant to the Tax Administration Act.

C. A beneficiary who lends his card to another or an individual who uses another's card after being determined liable pursuant to Subsection B of this section of a previous misuse is guilty of a misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978. A third or subsequent conviction is a fourth degree felony, and the offender shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

Section 25. PRIMARY CARE PROVIDER--RIGHT TO CHOOSE--ACCESS TO SERVICES.--

A. Except as provided in the Workers' Compensation Act, a beneficiary has the right to choose a primary care provider. If he does not choose a primary care provider, one shall be assigned to him pursuant to procedures specified in rules adopted by the commission.

B. The primary care provider is responsible for providing health care provider services to the patient except for:

(1) services in medical emergencies; and

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(2) services for which the primary care provider determines that specialist services are required, in which case he shall advise the patient of the need for and the type of specialist services.

C. Except as provided in Subsections B, D and F of this section, health care provider specialists shall be paid pursuant to the health plan only if the patient has been referred by the primary care provider. Nothing in this subsection prevents a beneficiary from obtaining the services of a health care provider specialist and paying the specialist for services provided.

D. The commission shall by rule specify the conditions under which a beneficiary may select a specialist as a primary care provider.

E. The commission shall by rule specify how often and under what conditions a beneficiary may change his primary care provider.

F. The commission shall by rule specify when and under what circumstances a beneficiary may self-refer, including self-referral to chiropractic physicians, doctors of oriental medicine, mental and behavioral health services providers and other health care providers who are not primary care providers.

Section 26. DISCRIMINATION PROHIBITED.--A health care provider or health facility shall not discriminate against or

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refuse to furnish health care to a beneficiary on the basis of age, race, color, income level, national origin, religion, gender, sexual orientation, disabling condition or payment status. Nothing in this section shall require a health care provider or health facility to provide services to a beneficiary if the provider or facility is not qualified to provide the needed services and does not offer them to the general public.

Section 27. CLAIMS REVIEW.--

A. The commission shall adopt rules to provide and shall implement a comprehensive claims review program. The procedures and standards used in the program shall be disclosed in writing to applicants, beneficiaries, health care providers and health facilities at the time of application to or participation in the health plan.

B. The decision to approve or deny claims for payment shall be made in a timely manner and shall not exceed time limits established by rule of the commission. A final decision to deny payment for services shall be based on a recommendation made by a health care professional having appropriate and adequate qualifications to make the recommendation. A denial of a claim for payment of a medical specialty service shall be made only after a written recommendation for denial is made by a member of that medical specialty with credentials equivalent to those of the claimant.

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C. The fact of and the specific reasons for a denial of a health care claim shall be communicated promptly in writing to both the provider and the beneficiary involved.

Section 28. MONITORING HEALTH CARE PROVIDER AND HEALTH FACILITY PRACTICES.--

A. The commission shall adopt rules to establish and implement a continuous quality improvement program that monitors the quality and appropriateness of health care provided by the health plan. The commission shall set standards and review benefits to ensure that effective, cost-efficient, high quality and appropriate health care is provided under the health plan.

B. The commission shall review and adopt professional practice guidelines developed by state and national medical and specialty organizations, the United States agencies for health care policy and research and other organizations as it deems necessary to promote the quality and cost-effectiveness of health care provided through the health plan.

C. The quality improvement program shall include an ongoing system for monitoring patterns of practice. The commission shall appoint a health care practice advisory committee consisting of health care providers, health facilities and other knowledgeable persons to advise the commission and staff on health care practice issues. The

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committee may appoint subcommittees and task forces to address practice issues of a specific health care provider discipline or a specific kind of health facility. The advisory committee shall provide to the commission recommended standards and guidelines to be followed in making determinations on practice issues.

D. With the advice of the health care practice advisory committee, the commission shall establish a system of peer education for health care providers or health facilities determined to be engaging in aberrant patterns of practice. If the commission determines that peer education efforts have failed, the commission may refer the matter to the appropriate licensing or certifying board.

E. The commission shall provide by rule the procedures for recouping payments or withholding payments for health care determined by the commission with the advice of the health care practice advisory committee or subcommittee to be medically unnecessary. In addition, the commission may provide by rule for the assessment of administrative penalties for up to three times the amount of excess payments if it finds that excessive billings were part of an aberrant pattern of practice. Administrative penalties shall be deposited in the current school fund.

F. After consultation with the health care practice advisory committee, the commission may suspend or revoke a

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health care provider's or health facility's privilege to be paid for health care provided under the health plan based upon evidence clearly supporting a determination by the commission that the provider or facility engages in aberrant patterns of practice, including inappropriate utilization, attempts to unbundle health care services or other practices that the commission deems a violation of the Health Security Act or rules adopted pursuant to that act. As used in this subsection, "unbundle" means to divide a service into components in an attempt to increase or with the effect of increasing compensation from the health plan.

G. The commission shall report a suspension or revocation of the privilege to be paid for health care pursuant to the Health Security Act to the appropriate licensing or certifying board.

H. The commission shall report cases of suspected fraud by a health care provider or a health facility to the attorney general or to the district attorney of the county where the health care provider or health facility operates for investigation and prosecution.

Section 29. DISPUTE RESOLUTION.--

A. A person specifically and directly aggrieved by a decision of the commission has the right to judicial review of the decision by the district court of Santa Fe county. As a prerequisite to judicial review the person aggrieved must

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exhaust administrative remedies available through procedures for dispute resolution established by rule of the commission, including mandatory participation in mediation in a good-faith effort to resolve a dispute. The commission shall include in its rules for dispute resolution provisions for adequate notice to the disputants, opportunities to be heard in informal conferences prior to mediation and all procedural due process safeguards.

B. Judicial review of a contested commission decision is governed by Rule 1-074 NMRA 1999.

Section 30. HEALTH PLAN BUDGET.--

A. Annually, the commission shall develop and submit to the legislature a health plan budget. The budget shall be the commission's recommendation for the total amount to be spent by the plan for covered health care services in the next fiscal year.

B. Unless otherwise provided in the general appropriation act or other act of the legislature, the health plan budget shall be within projected annual revenues. After the legislative review and approval, the commission shall implement the health plan budget. Without specific legislative approval, the commission shall not change the level of premium charged and used to project revenue or change the employer contributions under the health plan.

C. In developing the health plan budget, the

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commission shall provide that credit be taken in the budget for all revenues produced for health care in the state pursuant to any law other than the Health Security Act.

Section 31. PAYMENTS TO HEALTH CARE PROVIDERS--CO-PAYMENTS.--

A. The commission shall prepare a provider budget. Consistent with the provider budget, the health plan shall provide payment for all covered health care rendered by health care providers. A variety of payment plans, including fee-for-service, may be adopted by the commission. Payment plans shall be negotiated with providers as provided by rule. In the event that negotiation fails to develop an acceptable payment plan, the disputing parties shall submit the dispute for resolution pursuant to Section 29 of the Health Security Act.

B. Different or supplemental payment rates may be adopted to provide incentives to help ensure the delivery of needed health care in rural and other underserved areas throughout the state.

C. An annual percentage increase in the amount allocated for provider payments in the budget shall be no greater than the annual percentage increase in the consumer price index of medical care prices published by the bureau of labor statistics of the federal department of labor using the year prior to the year in which the health plan is implemented as the baseline year. The annual limitation in this subsection

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may be adjusted up or down by the commission based on a showing of special and unusual circumstances in a hearing before the commission.

D. Payment, or the offer of payment whether or not that offer is accepted, to a health care provider for services covered by the health plan shall be payment in full for those services. A health care provider shall not charge a beneficiary an additional amount for services covered by the plan.

E. The commission may establish co-payment schedules if a required co-payment is determined to be an effective cost-control measure. No co-payment shall be required for preventive health care. When a co-payment is required, the health care provider shall not waive the co-payment.

Section 32. PAYMENTS TO HEALTH FACILITIES--CO-PAYMENTS.--

A. A health facility shall negotiate an annual operating budget with the commission. The operating budget shall be based on a base operating budget of past performance and projected changes upward or downward in costs and services anticipated for the next year. If a negotiated annual operating budget is not agreed upon, a health facility shall submit the budget to dispute resolution pursuant to Section 29 of the Health Security Act. The initial base operating budget for a health facility shall be based on the average of its operating

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budgets for a twenty-four-month period ending no later than the first day of the calendar year in which the health plan is implemented. An annual percentage increase in the amount allocated for a health facility operating budget shall be no greater than the change in the annual consumer price index for medical care prices, published annually by the bureau of labor statistics of the federal department of labor. The annual limitation in this subsection may be adjusted up or down by the commission based on a showing of special and unusual circumstances in a hearing before the commission.

B. Different or supplemental payment rates may be adopted to provide incentives to help ensure the delivery of needed health care services in rural and other underserved areas throughout the state.

C. Each health care provider employed by a health facility shall be paid from the facility's operating budget in a manner determined by the health facility.

D. The commission may establish co-payment schedules if a required co-payment is determined to be an effective cost-control measure. No co-payment shall be required for preventive care. When a co-payment is required, the health facility shall not waive the co-payment.

Section 33. HEALTH RESOURCE CERTIFICATE--COMMISSION RULES--REQUIREMENT FOR REVIEW.--

A. The commission shall adopt rules stating when a

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health facility or health care provider must apply for a health resource certificate, how the application will be reviewed, how the certificate will be granted, how an expedited review is conducted and other matters relating to health resource projects.

B. Except as provided in Subsection F of this section, no health facility or health care provider shall make or obligate itself to make a major capital expenditure without first obtaining a health resource certificate.

C. No health facility or health care provider shall acquire through rental, lease or comparable arrangement or through donation all or a part of a capital project that would have required review if the acquisition had been by purchase unless the project is granted a health resource certificate.

D. No health facility or health care provider shall engage in component purchasing in order to avoid the provisions of this section.

E. The commission shall grant a health resource certificate for a major capital expenditure or a capital project undertaken pursuant to Subsection C of this section only when the project is determined to be needed.

F. This section does not apply to:

(1) the purchase, construction or renovation of office space for health care providers;

(2) expenditures incurred solely in preparation

for a capital project, including architectural design, surveys, plans, working drawings and specifications and other related activities, but those expenditures shall be included in the cost of a project for the purpose of determining whether a health resource certificate is required;

(3) acquisition of an existing health facility, equipment or practice of a health care provider that does not result in a new service being provided or in increased bed capacity;

(4) major capital expenditures for nonclinical services when the nonclinical services are the primary purpose of the expenditure; and

(5) the replacement of equipment with equipment that has the same function and that does not result in the offering of new services.

G. No later than January 1, 2008, the commission shall report to the appropriate committees of the legislature on the capital needs of health facilities, including facilities of state and local governments, with a focus on underserved geographic areas with substantially below-average health facilities and investment per capita as compared to the state average. The report shall also describe geographic areas where the distance to health facilities imposes a barrier to care. The report shall include a section on health care transportation needs, including capital, personnel and training needs. The

report shall make recommendations for legislation to amend the Health Security Act that the commission determines necessary and appropriate.

Section 34. ACTUARIAL REVIEW--AUDITS.--

A. The commission shall provide for an annual independent actuarial review of the health plan and any funds of the commission or the plan.

B. The commission shall provide by rule for independent financial audits of health care providers and health facilities.

C. The commission, through its staff or by contract, shall perform announced and unannounced audits, including financial, operational, management and electronic data processing audits of health care providers and health facilities. The auditor shall report directly to the commission. A copy of the audit report shall be given to the state auditor.

D. Actuarial reviews, financial audits and internal audits are public documents after they have been released by the commission.

Section 35. STANDARD CLAIM FORMS FOR INSURANCE PAYMENT.--The commission shall adopt standard claim forms that shall be used by all health care providers and health facilities that seek payment through the health plan or from private persons, including private insurance companies, for health care services

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rendered in the state. Each claim form may indicate whether a person is eligible for federal or other insurance programs for payment. Each claim form shall include data elements required by the commission.

Section 36. COMPUTERIZED SYSTEM.--The commission shall require that all participating health care providers and health facilities participate in the health plan's computer network that provides for electronic transfer of payments to health care providers and health facilities; transmittal of reports, including patient data and other statistical reports; billing data, with specificity as to procedures or services provided to individual patients; and any other information required or requested by the commission.

Section 37. REPORTS REQUIRED--CONFIDENTIAL INFORMATION.--

A. The commission, through the state health information system, shall require reports by all health care providers and health facilities of information needed to allow the commission to evaluate the health plan, cost-containment measures, utilization review, health facility operating budgets, health care provider fees and any other information the commission deems necessary to carry out its duties pursuant to the Health Security Act.

B. The commission shall establish uniform reporting requirements for health care providers and health facilities.

C. Information confidential pursuant to other

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provisions of law shall be confidential pursuant to the Health Security Act. Within the constraints of confidentiality, reports of the commission are public documents.

Section 38. CONSUMER, PROVIDER AND HEALTH FACILITY ASSISTANCE PROGRAM.--

A. The commission shall establish a consumer, provider and health facility assistance program to take complaints and to provide timely and knowledgeable assistance to:

(1) eligible persons and applicants about their rights and responsibilities and the coverages provided in accordance with the Health Security Act; and

(2) health care providers and health facilities about the status of claims, payments and other pertinent information relevant to the claims payment process.

B. The commission shall establish a toll-free telephone line for the consumer, provider and health facility assistance program and shall have persons available throughout the state to assist beneficiaries, applicants, health care providers and health facilities in person.

Section 39. REIMBURSEMENT FOR OUT-OF-STATE SERVICES--HEALTH PLAN'S RIGHT TO SUBROGATION AND PAYMENT FROM OTHER INSURANCE PLANS--CHARGES FOR NONCOVERED PERSONS.--

A. If a beneficiary needs health care services out of state, those services shall be covered at the same rate that

would apply if the services were received in New Mexico. Higher charges for those services shall not be paid by the health plan unless the commission negotiates a reciprocity or other agreement with the other state or foreign country or with the out-of-state health care provider or health facility.

B. The health plan shall make reasonable efforts to ascertain any legal liability of third parties who are or may be liable to pay all or part of the health care services costs of injury, disease or disability of a beneficiary.

C. When the health plan makes payments on behalf of a beneficiary, the health plan is subrogated to any right of the beneficiary against a third party for recovery of amounts paid by the health plan.

D. By operation of law, an assignment to the health plan of the rights of a beneficiary:

(1) is conclusively presumed to be made of:

(a) a payment for health care services from any person, firm or corporation, including an insurance carrier; and

(b) a monetary recovery for damages for bodily injury, whether by judgment, contract for compromise or settlement;

(2) shall be effective to the extent of the amount of payments by the health plan; and

(3) shall be effective as to the rights of any

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other beneficiaries whose rights can legally be assigned by the beneficiary.

Section 40. PRIVATE HEALTH INSURANCE COVERAGE LIMITED.--

A. After the date the health plan is operating, no person shall provide private health insurance to a beneficiary for a health care service that is covered by the health plan except for retiree health insurance plans that do not enter into contracts with the health plan. This prohibition does not apply to supplemental benefits.

B. Nothing in this section affects insurance coverage pursuant to the federal Employee Retirement Income Security Act of 1974 unless the state obtains a congressional exemption or a waiver from the federal government. Businesses that are covered by the provisions of that act may elect to participate in the health plan.

Section 41. HEALTH PLAN FUND CREATED--FEDERAL HEALTH INSURANCE PROGRAM WAIVERS--REIMBURSEMENT TO HEALTH PLAN FROM FEDERAL AND OTHER HEALTH INSURANCE PROGRAMS.--

A. The "health plan fund" is created in the state treasury. All revenues received pursuant to the Health Security Act shall be deposited in the fund.

B. The commission shall:

(1) in conjunction with the human services department, apply to the United States department of health and human services for all waivers of requirements under health care

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programs established pursuant to the federal Social Security Act that are necessary to enable the state to deposit federal payments for services covered by the health plan into the health plan fund and to be the supplemental payer of benefits for persons receiving medicare benefits;

(2) except for those programs designated in Subsection B of Section 21 of the Health Security Act, identify other federal programs that provide federal funds for payment of health care services to individuals and apply for any waivers or enter into any agreements that are necessary to enable the state to deposit federal payments for health care services covered by the health plan into the health plan fund; provided, however, agreements negotiated with the federal Indian health service shall not impair treaty obligations of the United States government, and other agreements negotiated shall not impair portability or other aspects of the health care coverage; and

(3) seek an amendment to the federal Employee Retirement Income Security Act of 1974 to exempt New Mexico from the provisions of that act that relate to health care services or health insurance, or the commission shall apply to the appropriate federal agency for waivers of any requirements of that act if congress provides for waivers to enable the commission to extend coverage through the Health Security Act to as many New Mexicans as possible.

C. The commission shall seek payment to the health

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plan from medicaid, medicare or any other federal or other insurance program for any reimbursable payment provided under the plan.

D. The commission shall seek to maximize federal contributions and payments for health care services provided in New Mexico and shall ensure that the contributions of the federal government for health care services in New Mexico will not decrease in relation to other states as a result of any waivers, exemptions or agreements.

Section 42. INSURANCE--COMMISSION APPROVAL.--No person shall insure himself or his employees after January 1, 2006 unless the coverage terminates on the date that the insureds are eligible for coverage under the health plan. Nothing in this section prohibits insurance coverage for health care services not covered by the health plan or for individuals not eligible for coverage under the health plan.

Section 43. INSURANCE RATES--SUPERINTENDENT OF INSURANCE DUTIES.--

A. The superintendent of insurance shall work closely with the legislative finance committee pursuant to Section 44 of the Health Security Act to identify premium costs associated with health care coverage pursuant to existing insurance policies that have a medical payment component. The superintendent shall develop an estimate of expected reduction in those costs based upon assumptions of specific coverage in

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the health plan, and shall report his findings to the legislative finance committee.

B. The superintendent of insurance shall lower insurance premiums associated with medical benefits on all types of insurance policies written in New Mexico that have a medical payment component on the date the health plan is implemented.

Section 44. FINANCING THE HEALTH PLAN.--

A. The legislative finance committee shall determine financing options for the health plan. In making its determinations the committee shall be guided by the following requirements and assumptions:

(1) benefits to be included and for which costs are to be projected in determining the financing options shall be no less than the health care coverage afforded state employees; and

(2) options may set minimum and maximum levels of premium payments, sliding scale premium payments and medicare credits and employer contributions.

B. The legislative finance committee shall prepare a report of its determinations with the specific options and recommendations no later than December 15, 2003. The report shall be submitted for consideration for legislative implementation to the second session of the forty-sixth legislature.

Section 45. TEMPORARY PROVISION--TRANSITION PERIOD

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ARRANGEMENTS--PUBLICLY FUNDED HEALTH CARE SERVICE PLANS.--

A. A person who, on the date benefits are available under the Health Security Act health plan, receives health care benefits under private contract or collective bargaining agreement entered into prior to January 1, 2006 shall continue to receive those benefits until the contract or agreement expires or unless the contract or agreement is renegotiated to provide participation in the health plan.

B. A person covered by a health care plan that has its premiums paid for in any part by public money, including money from the state, a political subdivision, state educational institution, public school or other entity that receives public money to pay health insurance premiums, shall be covered by the Health Security Act health plan on the effective date that benefits are available under the plan.

Section 46. EFFECTIVE DATE.--The effective date of the provisions of:

A. Sections 43 and 44 of this act is July 1, 2003; and

B. Sections 1 though 42 and 45 of this act is June 1, 2004.

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