SENATE BILL 189

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

INTRODUCED BY

TIMOTHY Z. JENNINGS

FOR THE HEALTH CARE REFORM COMMITTEE

AN ACT

RELATING TO HEALTH CARE PROVIDERS; ENACTING THE PROVIDER SERVICE NETWORK ACT; CLARIFYING THE REQUIREMENT FOR A CERTIFICATE OF AUTHORITY UNDER THE NEW MEXICO INSURANCE CODE.

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

Section 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 3 of this act may be cited as the "Provider Service Network Act".

Section 2. [NEW MATERIAL] DEFINITIONS.--As used in the Provider Service Network Act:

A. "health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a home health agency, a diagnostic, laboratory or

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imaging center and a rehabilitation or other therapeutic health setting;

B. "health care insurer" means a person that has a valid certificate of authority in good standing under the New Mexico Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan;

C. "health care professional" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law;

D. "health care services" includes physical health services or community-based mental health or developmental disability services, including services for developmental delay;

E. "person" means an individual or other legal entity;

F. "provider" means a person that is licensed or otherwise authorized by the state to furnish health care services, including health care professionals and health care facilities; and

G. "provider service network" means two or more providers affiliated for the purpose of providing health care services on a capitated or similar prepaid, flat-fee basis.

Section 3. [NEW MATERIAL] PROVIDER SERVICE NETWORKS--INSURANCE CODE APPLICABILITY.--

A. Except as provided otherwise in this section, a provider service network shall obtain and maintain a certificate

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of authority under the New Mexico Insurance Code.

B. A provider service network is not required to obtain or maintain a certificate of authority in connection with health care coverage for which the risk of loss is directly and fully underwritten by a health care insurer, subject to any applicable deductible, coinsurance or copayment provisions.

C. A provider service network that obtains and maintains a certificate of authority as a health care insurer may contract directly with government agencies to provide goods and services to persons receiving public assistance, including medicare and medicaid.

D. A provider service network that does not obtain or maintain a certificate of authority as a health care insurer may contract in appropriate circumstances directly with government agencies to provide goods and services to persons receiving public assistance, including medicare and medicaid. The contract shall incorporate and be subject to specific financial, quality-of-service and consumer-protection standards that the contracting agency shall specify by regulation.

E. This section does not abrogate any other New Mexico Insurance Code requirements that may be applicable to provider service networks, including requirements relating to third-party administrators and examinations. This section does not bar or restrict the right of a provider service network to obtain and maintain a certificate of authority.

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Section 4. A new Section 59A-5-11.1 NMSA 1978 is enacted to read:

"59A-5-11.1. [NEW MATERIAL] EXEMPTION FROM AUTHORITY REQUIREMENT--PROVIDER SERVICE NETWORKS.--A certificate of authority shall not be required of a provider service network, except as provided in the Provider Service Network Act."

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FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

February 28, 1997

Mr. President:

Your PUBLIC AFFAIRS COMMITTEE, to whom has been referred

SENATE BILL 189

has had it under consideration and reports same with recommendation that it DO NOT PASS, but that

SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE
FOR SENATE BILL 189

DO PASS, and thence referred to the CORPORATIONS & TRANSPORTATION COMMITTEE.

Respectfully submitted,

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_____

Shannon Robinson, Chairman

Adopted_____ Not Adopted_____

(Chief Clerk) (Chief Clerk)

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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SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
SENATE BILL 189

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

AN ACT

RELATING TO HEALTH CARE PROVIDERS; ENACTING THE PROVIDER SERVICE NETWORK ACT; CLARIFYING THE REQUIREMENT FOR A CERTIFICATE OF AUTHORITY UNDER THE NEW MEXICO INSURANCE CODE; PROVIDING FOR A GUARANTY ASSOCIATION.

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

Section 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 10 of this act may be cited as the "Provider Service Network Act".

Section 2. [NEW MATERIAL] DEFINITIONS.--As used in the Provider Service Network Act:

A. "association" means the provider service network guaranty association;

B. "board" means the provider service network guaranty board;.

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C. "health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a home health agency, a diagnostic, laboratory or imaging center and a rehabilitation or other therapeutic health setting;

D. "health care insurer" means a person that has a valid certificate of authority in good standing under the New Mexico Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan;

E. "health care professional" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law;

F. "health care services" includes physical health services or community-based mental health or developmental disability services, including services for developmental delay;

G. "person" means an individual or other legal entity;

H. "provider" means a person that is licensed or otherwise authorized by the state to furnish health care services, including health care professionals and health care facilities; and

I. "provider service network" means two or more providers affiliated for the purpose of providing health care

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services on a capitated or similar prepaid, flat-fee basis.

Section 3. [NEW MATERIAL] PROVIDER SERVICE NETWORKS--INSURANCE CODE APPLICABILITY.--

A. Except as provided otherwise in this section, a provider service network shall obtain and maintain a certificate of authority under the New Mexico Insurance Code.

B. A provider service network is not required to obtain or maintain a certificate of authority in connection with health care coverage for which the risk of loss is directly and fully underwritten by a health care insurer, subject to any applicable deductible, coinsurance or copayment provisions.

C. A provider service network that obtains and maintains a certificate of authority as a health care insurer may contract directly with government agencies to provide goods and services to persons receiving public assistance, including medicare and medicaid.

D. A provider service network that does not obtain or maintain a certificate of authority as a health care insurer may contract in appropriate circumstances, including membership and participation in the association, directly with government agencies to provide goods and services to persons receiving public assistance, including medicare and medicaid. The contract shall incorporate and be subject to specific financial, quality-of-service and consumer-protection standards that the contracting agency shall specify by regulation.

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E. This section does not abrogate any other New Mexico Insurance Code requirements that may be applicable to provider service networks, including requirements relating to third-party administrators and examinations. This section does not bar or restrict the right of a provider service network to obtain and maintain a certificate of authority.

Section 4. [NEW MATERIAL] GUARANTY ASSOCIATION AND BOARD--CREATED--MEMBERSHIP.--

A. The "provider service network guaranty association" is created as an independent public nonprofit corporation. The association's purpose is to guarantee health care services obligations of its members in the event of financial insolvency, bankruptcy or other inability or failure to perform based on financial difficulties. All provider service networks contracting to provide services to public assistance recipients pursuant to Subsection D of Section 3 of the Provider Service Network Act shall organize and be members of the association. The association is not and shall not be deemed a governmental agency or instrumentality for any purpose.

B. The "provider service network guaranty board" is created. The board shall consist of the superintendent of insurance or his designee, who shall be a nonvoting, ex-officio member, and five voting members as follows:

(1) the secretary of human services or his designee, who shall serve ex officio;

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(2) two representatives of the provider service network industry, who shall be appointed by majority vote of the association's members; and

(3) two representatives of the health insurance industry, who shall be appointed by majority vote of the association's members.

C. The association shall operate subject to the board's supervision and approval. The board is a state government entity for purposes of the Tort Claims Act.

D. The secretary of human services shall notify the superintendent of insurance and the association of each contract signed pursuant to Subsection D of Section 3 of the Provider Service Network Act.

E. The superintendent of insurance shall give notice at least sixty days before the proposed effective date of the first contract entered into pursuant to Subsection D of Section 3 of the Provider Service Network Act, to each provider service network so contracting, stating the time and place of the association's initial organizational meeting.

F. At the organizational meeting and at all successive meetings, each association member shall be entitled to one vote. At the organizational meeting and any subsequent meeting at which board members are to be appointed, the association members shall elect the appointive board members by majority vote. At the organizational meeting, the members shall instruct the board

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concerning preparation of a proposed plan of operation for the association.

G. Appointive board members shall have initial terms of three years or less, staggered so that the term of at least one such board member expires on June 30 of each year. Following the initial terms, appointive board members shall have three-year terms. When a vacancy occurs in the position of an appointive board member, the remaining board members shall appoint a successor who meets the required qualifications for that position for the balance of the unexpired term. Board members may be reimbursed by the association as provided in the Per Diem and Mileage Act but shall receive no other compensation, perquisite or allowance.

Section 5. [NEW MATERIAL] PLAN OF OPERATION.--

A. The board shall submit to the superintendent of insurance for approval a plan of operation and any subsequent amendments necessary or suitable to assure proper and fair operation of the association.

B. After notice and hearing, the superintendent of insurance shall approve or disapprove the plan of operation or any subsequent amendments. The superintendent shall approve the plan or an amendment only if he finds that it provides for administering the association on a fair, reasonable and equitable basis and for sharing the association's losses on an equitable basis. The plan of operation or amendment shall become effective upon the superintendent's written approval.

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C. If the board fails to submit a plan of operation satisfactory to the superintendent of insurance within ninety days after the initial board is appointed or fails in a timely manner to submit any amendment the superintendent deems necessary at any time thereafter, the superintendent shall adopt and promulgate such plan of operation or amendment by rule. Any such rule shall continue in force until the superintendent modifies it or approves a plan of operation or an amendment submitted by the board that he deems to supersede the rule.

D. The plan of operation submitted to the superintendent of insurance shall:

(1) establish procedures for handling and accounting of the association's money, other assets and property;

(2) provide for payment of claims or provision of alternative health care services to public assistance recipients;

(3) establish regular times and places for board meetings;

(4) establish procedures for records to be kept of all financial transactions and for annual fiscal reporting to the superintendent;

(5) establish procedures for the determination and collection of assessments from members to pay claims or to provide alternative health care services and administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

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(6) establish penalties for nonpayment or late payment of assessments; and

(7) contain any additional provisions necessary and proper for the execution of the association's powers and duties.

Section 6. [NEW MATERIAL] BOARD--POWERS AND DUTIES.--The board has the power and authority to:

A. enter into contracts necessary or proper to carry out the provisions and purposes of the Provider Service Network Act, including contracts with independent contractors for the performance of the association's administrative functions;

B. sue or be sued;

C. determine and pay the association's obligations, including its obligation to pay claims or to provide alternative health care services to public assistance recipients on behalf of an insolvent or financially troubled provider service network;

D. borrow money to satisfy the association's obligations;

E. assess association members in accordance with the provisions of the Provider Service Network Act and make initial and interim assessments as may be reasonable and necessary for organizational or interim operating expenses. Interim expense assessments shall be credited as offsets against any regular assessments due following the close of the calendar year;

F. recoup expenditures on behalf of an insolvent or financially troubled provider service network from that provider service network or any other available source, including a

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governmental agency, and be subrogated to that provider service network's rights to payment to the extent of such expenditures;

G. employ or contract with appropriate legal, actuarial, clerical and other personnel as necessary to provide assistance in the operation of the association;

H. conduct periodic audits to assure the general accuracy of the financial data submitted to the association. The board shall cause the association to undergo an annual audit on a calendar-year basis of its financial records and operations by an independent certified public accountant; and

I. take all other actions, whether like or unlike the foregoing, necessary or appropriate to carry out the board's or the association's duties.

Section 7. [NEW MATERIAL] EXAMINATION.--

A. The association is subject to and responsible to pay the cost of examination by the superintendent of insurance on a periodic basis, pursuant to Chapter 59A, Article 4 NMSA 1978.

B. Not later than March 31 of each year, the board shall submit to the superintendent an audited financial report for the preceding calendar year in a form approved by the superintendent.

Section 8. [NEW MATERIAL] ASSESSMENTS.--

A. Following the end of each calendar year, the association shall determine the association's unpaid expenses for that year and estimated expenses for the following year, taking into account existing unencumbered money and assets, investment

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income and other appropriate gains and losses.

B. The secretary of human services shall report to the board annually by March 31 the amounts paid each member for services to public assistance recipients during the previous calendar year.

C. The proportion of participation of each member shall be determined annually by the board based on the secretary of human services' report, together with members' annual statements and other reports deemed necessary by the board.

D. The assessment for each member shall be determined by multiplying the total unpaid and estimated expenses by a fraction, the numerator of which equals the member's income from services to public assistance recipients pursuant to Subsection D of Section 3 of the Provider Service Network Act for the preceding calendar year and the denominator of which equals the total of all such income for all members in the state. The total of all assessments in any calendar year shall not exceed five percent of the total income of all members during the preceding calendar year from contracts pursuant to Subsection D of Section 3 of the Provider Service Network Act.

E. The board shall notify each member of the amount of each regular assessment by May 15 of each year. The member shall pay the assessment by June 15 of each year. If interim assessments are necessary, the board shall notify each member of the amounts due, which shall be paid within thirty days after the date the

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notice is mailed or otherwise delivered.

F. The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in Subsection A of this section. The member receiving the abatement or deferment shall remain liable to the association for the deficiency for four years.

G. If assessments exceed actual expenses in any year, the excess shall be held at interest and used by the board to offset future expenses. Any deficit incurred shall be recouped by assessments apportioned among the association's members pursuant to the assessment formula provided by Subsection D of this section.

H. If it appears that the maximum assessment available, together with unencumbered money and other assets, will be insufficient in any year to make all necessary payments, the association's obligations shall be paid pro rata. The unpaid portion shall be paid as soon as additional assessment proceeds or other assets become available. Notwithstanding the foregoing, the association may pay its obligations in any order it deems reasonable.

Section 9. [NEW MATERIAL] INITIAL ADMINISTRATIVE

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ASSESSMENT.--Following the superintendent of insurance's approval or adoption by rule of a plan of operation, the board shall impose an initial assessment of five thousand dollars ($5,000) on each member for each independent affiliated health care provider. New members shall also be subject to an initial assessment on the same basis. Proceeds of the initial assessment shall not be considered as income to offset expenses for purposes of determining future assessments. Regular assessments to establish and to operate the association shall first be made after the end of the first calendar year of operation.

Section 10. [NEW MATERIAL] NOTIFICATION TO PAY CLAIMS OR PROVIDE SERVICES.--

A. The association shall be liable to pay claims or to provide alternative health care services for insolvent or financially troubled members who are not fulfilling obligations to provide such services to public assistance recipients under contracts pursuant to Subsection D of Section 3 of the Provider Service Network Act. The association's obligation shall commence on the date the secretary of human services gives the association notice that a member is failing, because of insolvency or financial difficulties, to provide some or all of such services.

B. Nothing the Provider Service Network Act shall be deemed to authorize or obligate the association to pay or otherwise assume any obligation of a provider service network prior to the date of notification, or any obligation thereafter other than the

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obligation to provide services to public assistance recipients under a contract pursuant to Subsection D of Section 3 of the Provider Service Network Act. In no event shall the association be liable to the creditors of a provider service network.

Section 11. A new Section 59A-5-11.1 NMSA 1978 is enacted to read:

"59A-5-11.1. [NEW MATERIAL] EXEMPTION FROM AUTHORITY REQUIREMENT--PROVIDER SERVICE NETWORKS.--A certificate of authority shall not be required of a provider service network, except as provided in the Provider Service Network Act."

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FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

March 4, 1997

Mr. President:

Your CORPORATIONS & TRANSPORTATION COMMITTEE, to whom has been referred

SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR SENATE BILL 189

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

Respectfully submitted,

_____

Roman M. Maes, III, Chairman

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Adopted_____ Not Adopted_____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 7 For 0 Against

Yes: 7

No: 0

Excused: Fidel, McKibben, Robinson

Absent: None

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State of New Mexico
House of Representatives

FORTY-THIRD LEGISLATURE

FIRST SESSION, 1997

March 17, 1997

Mr. Speaker:

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

SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR SENATE BILL 189

has had it under consideration and reports same with recommendation that it DO PASS, amended as follows:

1. On page 1, line 14, before the period insert "; MAKING AN APPROPRIATION.".

2. On page 4, line 25, strike "who shall serve ex officio".

3. On page 9, line 10, strike "and".

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4. On page 9, between lines 13 and 14, insert the following new subsections to read:

"J. reinsure any or all of the risk of the association; and

K. assess each original and new provider service network an initial administrative fee of five thousand dollars ($5,000) times the number of providers in the provider service network. If a provider service network adds new members to increase the number of providers, then that provider service network shall pay an additional administrative fee of five thousand dollars ($5,000) for each additional provider. An employee of a provider shall not be used in computing the administrative fee due under this subsection.".

5. On page 9, line 21, after "ASSESSMENTS" insert "--FUND CREATED".

6. On page 9, strike lines 22 through 25, and on page 10, strike line 1 and insert in lieu thereof:

"A. The "provider service network guarantee fund" is created in the state treasury. The fund shall be administered by the board and money in the fund is appropriated to the board to carry out the provisions of the Provider Service Network Act. Money in the fund shall be invested by the state treasurer as other state funds are invested; provided that interest on the fund shall be credited to the fund. Any unexpended or unencumbered balance remaining in the fund at the end of any fiscal year shall not revert.".

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7. On page 10, line 3, strike "annually by March 31" and insert in lieu thereof "within thirty days of the close of each calendar quarter".

8. On page 10, lines 4 and 5, strike "the previous calendar year" and insert in lieu thereof "that calendar quarter".

9. On page 10, line 11, after "multiplying" strike the remainder of the line and on line 12, strike "the numerator of which equals".

10. On page 10, line 14, strike "year" and strike lines 15 through 20 and insert in lieu thereof "quarter by a percentage set by the board not to exceed five percent.".

11. On page 10, strike lines 21 through 25, and on page 11, strike line 1 and insert a new subsection to read:

"E. The board shall notify each member of the amount of the assessment within forty-five days of the close of a calendar quarter. The member shall pay the assessment within sixty days of the close of a calendar quarter.".

12. On page 11, strike line 25 and on page 12, strike lines 1 through 10.

13. Renumber the succeeding sections accordingly.

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Respectfully submitted,

_____

Gary King, Chairman

Adopted _____ Not Adopted _____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 7 For 0 Against

Yes: 7

Excused: Johnson, Rios, Vigil

Absent: None

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