SENATE BILL 767

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

INTRODUCED BY

BEN D. ALTAMIRANO

AN ACT

RELATING TO HEALTH INSURANCE; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978 TO REQUIRE INSURANCE COVERAGE FOR ADVANCED PRACTICE NURSING SERVICES.

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

Section 1. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] INSURANCE COVERAGE--ADVANCED PRACTICE NURSING SERVICES.--

A. All individual and group subscriber contracts delivered or issued for delivery in New Mexico that provide for treatment of persons for the prevention, cure or correction of any illness or physical or mental condition shall include coverage for the services of an advanced practice nurse.

B. As used in this section, "advanced practice

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nursing" means the practice of professional registered nursing by a registered nurse who has been prepared through an educational program to function beyond the scope of practice of professional registered nursing, including certified nurse practitioners, certified registered nurse anesthetists and clinical nurse specialists."

Section 2. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] ADVANCED PRACTICE NURSES--DISCRIMINATION PROHIBITED.--Advanced practice nurses as a class of licensed providers willing to meet the terms and conditions offered by a health maintenance organization shall not be excluded from the health maintenance organization."

Section 3. Section 59A-15-16 NMSA 1978 (being Laws 1991, Chapter 125, Section 22, as amended) is amended to read:

"59A-15-16. JURISDICTION OVER HEALTH CARE BENEFITS PROVIDERS PRESUMED.--Notwithstanding any other provision of law and except as provided in the Health Care Benefits Jurisdiction Act, [~~any~~] a person who provides coverage in this state for health benefits, including coverage for medical, surgical, hospital, osteopathic, advanced practice nursing, acupuncture and oriental medicine, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental or optometric expenses, whether such coverage is by direct payment, reimbursement or otherwise, shall be presumed to be subject to

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the provisions of the Insurance Code and the jurisdiction of the superintendent unless the person provides evidence satisfactory to the superintendent that he is subject exclusively to the jurisdiction of another agency of this state or the federal government."

Section 4. Section 59A-22-32 NMSA 1978 (being Laws 1984, Chapter 127, Section 454, as amended) is amended to read:

"59A-22-32. FREEDOM OF CHOICE OF HOSPITAL, PRACTITIONER.--

A. Within the area and limits of coverage offered an insured and selected by him in the application for insurance, the right of any person to exercise full freedom of choice in the selection of any hospital for hospital care or of any practitioner of the healing arts or optometrist, psychologist, podiatrist, certified nurse-midwife, registered lay midwife or registered nurse in [~~expanded~~] advanced practice, as defined in Subsection B of this section, for treatment of any illness or injury within his scope of practice shall not be restricted under any new policy of health insurance, contract or health care plan issued after June 30, 1967 in this state or in the processing of any claim thereunder. Any person insured or claiming benefits under any such health insurance policy, contract or health care plan providing within its coverage for payment of service benefits or indemnity for hospital care or treatment of persons for the cure or correction of any physical or mental condition shall be deemed to have complied with the

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requirements of the policy, contract or health care plan as to submission of proof of loss upon submitting written proof supported by the certificate of any hospital currently licensed by the department of health [~~and environment department~~] or any practitioner of the healing arts or optometrist, psychologist, podiatrist, certified nurse-midwife, registered lay midwife or registered nurse in [~~expanded~~] advanced practice.

B. As used in this section:

(1) "hospital care" means hospital service provided through a hospital [~~which~~] that is maintained by the state or any political subdivision of the state or any place [~~which~~] that is currently licensed as a hospital by the department of health [~~and environment department~~] and has accommodations for resident bed patients, a licensed professional registered nurse always on duty or call, a laboratory and an operating room where surgical operations are performed, but the term does not include a convalescent or nursing or rest home;

(2) "practitioner of the healing arts" means any person holding a license or certificate provided for in Chapter 61, Article 4, 5, 6, 10 or 14A NMSA 1978 authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, injury, disease, deformity or physical or mental condition;

(3) "optometrist" means any person holding a

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license provided for in Chapter 61, Article 2 NMSA 1978;

(4) "podiatrist" means any person holding a license provided for in Chapter 61, Article 8 NMSA 1978;

(5) "psychologist" is one who is duly licensed or certified in the state where the service is rendered and has a doctoral degree in psychology and has had at least two years of clinical experience in a recognized health setting or has met the standards of the national register of health service providers in psychology;

(6) "certified nurse-midwife" means any person licensed by the board of nursing as a registered nurse and who is registered with the public health [~~services~~] division of the department of health [~~and environment department~~] as a certified nurse-midwife;

(7) "registered lay midwife" means any person who practices lay midwifery and is registered as a registered lay midwife by the public health [~~services~~] division of the department of health [~~and environment department~~]; and

(8) "registered nurse in [~~expanded~~] advanced practice" means any person licensed by the board of nursing as a registered nurse approved for [~~expanded~~] advanced practice pursuant to the Nursing Practice Act as a [~~certified nurse practitioner~~] advanced practice nurse, certified registered nurse anesthetist, certified clinical nurse specialist in psychiatric mental health nursing or clinical nurse specialist

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in private practice and who has a master's degree or doctorate in a defined clinical nursing [~~speciality~~] specialty and is certified by a national nursing organization.

C. This section shall apply to any such policy [~~which~~] that is delivered or issued for delivery in this state on or after July 1, 1979 and to any existing group policy or plan on its anniversary or renewal date after June 30, 1979 or at expiration of the applicable collective bargaining contract, if any, whichever is later."

Section 5. Section 59A-22A-3 NMSA 1978 (being Laws 1993, Chapter 320, Section 61) is amended to read:

"59A-22A-3. DEFINITIONS.--As used in the Preferred Provider Arrangements Law:

A. "advanced practice nursing" means the practice of professional registered nursing by registered nurses who have been prepared through additional formal education as defined in Sections 61-3-23.2 through 61-3-23.4 NMSA 1978 to function beyond the scope of practice of professional registered nursing, including licensed certified nurse practitioners, certified registered nurse anesthetists and clinical nurse specialists;

[~~A.~~] B. "covered person" means any person on whose behalf the health care insurer is obligated to pay for or to provide health benefit services;

[~~B.~~] C. "covered services" means health care services [~~which~~] that the health care insurer is obligated to

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pay for or to provide under a health benefit plan;

[~~C.~~] D. "emergency care" means covered services delivered to a covered person after the sudden onset of a medical condition manifesting itself by acute symptoms that are severe enough that:

(1) the lack of immediate medical attention could result in:

(a) placing the person's health in jeopardy;

(b) serious impairment of bodily functions; or

(c) serious dysfunction of any bodily organ or part; or

(2) a reasonable person believes that immediate medical attention is required;

[~~D.~~] E. "health benefit plan" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer [~~which~~] that defines the covered services and benefit levels available;

[~~E.~~] F. "health care insurer" means any person who provides health insurance in this state. For the purposes of the Small Group Rate and Renewability Act, "carrier" or "insurer" includes a licensed insurance company, a licensed fraternal benefit society, a prepaid hospital or medical service plan, a health maintenance organization, a nonprofit health care

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organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation;

[~~F.~~] G. "health care provider" means providers of health care services licensed as required in this state;

[~~G.~~] H. "health care services" means services rendered or products sold by a health care provider within the scope of the provider's license. The term includes hospital, medical, surgical, dental, advanced practice nursing, vision and pharmaceutical services or products;

[~~H.~~] I. "preferred provider" means a health care provider or group of providers [~~who have~~] that has contracted with a health care insurer to provide specified covered services to a covered person; and

[~~I.~~] J. "preferred provider arrangement" means a contract between or on behalf of the health care insurer and a preferred provider [~~which~~] that complies with all the requirements of the Preferred Provider Arrangements Law."

Section 6. Section 59A-22A-6 NMSA 1978 (being Laws 1993, Chapter 320, Section 64) is amended to read:

"59A-22A-6. PREFERRED PROVIDER PARTICIPATION REQUIREMENTS.--Health care insurers may place reasonable limits on the number or classes of preferred providers [~~which~~] that satisfy the standards set forth by the health care insurer; provided that there is no discrimination against providers on

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the basis of religion, race, color, national origin, age, sex or marital status; and further provided that selection of preferred providers is primarily based on, but not limited to, cost and availability of covered services and the quality of services performed by the providers. Health insurers shall use outcomes measurements recognized by the health care providers affected to evaluate the ability of the class to provide the care required under the provider agreement. As part of the annual report required under Chapter 59A, Article 23B NMSA 1978, the health insurer shall provide the public with information on the criteria and method of analysis used to determine the numbers and classes of providers."

Section 7. Section 59A-23B-3 NMSA 1978 (being Laws 1991, Chapter 111, Section 3, as amended) is amended to read:

"59A-23B-3. POLICY OR PLAN--DEFINITION--CRITERIA.--

A. For purposes of the Minimum Healthcare Protection Act, "policy or plan" means a healthcare benefit policy or healthcare benefit plan that the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan chooses to offer to individuals, families or groups of fewer than twenty members formed for purposes other than obtaining insurance coverage and that meets the requirements of Subsection B of this section. For purposes of the Minimum Healthcare Protection Act, "policy or plan" shall not mean a healthcare policy or healthcare benefit plan that an insurer,

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health maintenance organization, fraternal benefit society or nonprofit healthcare plan chooses to offer outside the authority of the Minimum Healthcare Protection Act.

B. A policy or plan shall meet the following criteria:

(1) the individual, family or group obtaining coverage under the policy or plan has been without healthcare insurance, a health services plan or employer-sponsored healthcare coverage for the six-month period immediately preceding the effective date of its coverage under a policy or plan, provided that the six-month period shall not apply to:

(a) a group that has been in existence for less than six months and has been without healthcare coverage since the formation of the group;

(b) an employee whose healthcare coverage has been terminated by an employer;

(c) a dependent who no longer qualifies as a dependent under the terms of the contract; or

(d) an individual and an individual's dependents who no longer have healthcare coverage as a result of termination or change in employment of the individual or by reason of death of a spouse or dissolution of a marriage, notwithstanding rights the individual or individual's dependents may have to continue healthcare coverage on a self-pay basis pursuant to the provisions of the federal Consolidated Omnibus

Budget Reconciliation Act of 1985;

(2) the policy or plan includes the following managed care provisions to control costs:

(a) an exclusion for services that are not medically necessary or are not covered by preventive health services; and

(b) a procedure for preauthorization of elective hospital admissions by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan; and

(3) subject to a maximum limit on the cost of healthcare services covered in any calendar year of not less than fifty thousand dollars ($50,000), the policy or plan provides the following minimum healthcare services to covered individuals:

(a) inpatient hospitalization coverage or home care coverage in lieu of hospitalization or a combination of both, not to exceed twenty-five days of coverage inclusive of any deductibles, co-payments or co-insurance, provided that a period of inpatient hospitalization coverage shall precede any home care coverage;

(b) prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy and one office visit per

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week during the ninth month and until term, provided that coverage for each office visit shall also include prenatal counseling and education and necessary and appropriate screening, including history, physical examination and the laboratory and diagnostic procedures deemed appropriate by the [~~physician~~] licensed provider based upon recognized [~~medical criteria~~] and prevailing standards of care for the risk group of which the patient is a member;

(c) obstetrical care, including physicians' and certified nurse midwives' services, advanced practice nurses certified in obstetrics and gynecology, delivery room and other medically necessary services directly associated with delivery;

(d) well-baby and well-child care, including periodic evaluation of a child's physical and emotional status, a history, a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with recognized and prevailing [~~medical~~] standards of care; provided that such evaluation and care shall be covered when performed at approximately the age intervals of birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years and six years;

(e) coverage for low-dose screening

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mammograms for determining the presence of breast cancer; provided that the mammogram coverage shall include one baseline mammogram for persons age thirty-five through thirty-nine years, one biennial mammogram for persons age forty through forty-nine years and one annual mammogram for persons age fifty years and over; and further provided that the mammogram coverage shall only be subject to deductibles and co-insurance requirements consistent with those imposed on other benefits under the same policy or plan;

(f) coverage for cytologic screening, to include a Papanicolaou test and pelvic exam for asymptomatic as well as symptomatic women; and

(g) a basic level of primary and preventive care, including, but not limited to, no less than seven physician, [~~nurse practitioner, nurse midwife~~] advanced practice nurse, clinical specialist or physician assistant office visits per calendar year, including any ancillary diagnostic or laboratory tests related to the office visit.

C. A policy or plan may include the following managed care and cost-control features to control costs:

(1) a panel of providers who have entered into written agreements with the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan to provide covered healthcare services at specified levels of reimbursement; provided that any such written agreement shall

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contain a provision relieving the individual, family or group covered by the policy or plan from any obligation to pay for any healthcare service performed by the provider that is determined by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan not to be medically necessary;

(2) a requirement for obtaining a second opinion before elective surgery is performed;

(3) a procedure for utilization review by the insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan; and

(4) a maximum limit on the cost of healthcare services covered in any calendar year of not less than fifty thousand dollars ($50,000).

D. Nothing contained in Subsection C of this section shall prohibit an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan from including in the policy or plan additional managed care and cost-control provisions that the superintendent of insurance determines to have the potential for controlling costs in a manner that does not cause discriminatory treatment of individuals, families or groups covered by the policy or plan.

E. Notwithstanding any other provisions of law, a policy or plan shall not exclude coverage for losses incurred for a pre-existing condition more than six months from the

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effective date of coverage. The policy or plan shall not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment recommended by or received from a [~~physician~~] licensed provider within six months before the effective date of coverage.

F. No medical group, independent practice association or health professional employed by or contracting with an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan shall maintain any action against any insured person, family or group member for sums owed by an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan, for sums higher than those agreed to pursuant to a policy or plan."

Section 8. Section 59A-46-2 NMSA 1978 (being Laws 1993, Chapter 266, Section 2) is amended to read:

"59A-46-2. DEFINITIONS.--As used in the Health Maintenance Organization Law:

A. "basic health care services":

(1) means medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital [~~and physician care~~], physician and advanced practice nursing care, diagnostic laboratory and diagnostic and therapeutic radiological services; but

(2) does not include mental health services or services for alcohol or drug abuse, dental or vision services or

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long-term rehabilitation treatment;

B. "capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided and includes the cost associated with operating staff model facilities;

C. "carrier" means a health maintenance organization, an insurer, a nonprofit health care plan or other entity responsible for the payment of benefits or provision of services under a group contract;

D. "copayment" means an amount an enrollee must pay in order to receive a specific service that is not fully prepaid;

E. "deductible" means the amount an enrollee is responsible to pay out of pocket before the health maintenance organization begins to pay the costs associated with treatment;

F. "enrollee" means an individual who is covered by a health maintenance organization;

G. "evidence of coverage" means a policy, contract or certificate showing the essential features and services of the health maintenance organization coverage that is given to the subscriber by the health maintenance organization or by the group contract holder;

H. "extension of benefits" means the continuation of

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coverage under a particular benefit provided under a contract or group contract following termination with respect to an enrollee who is totally disabled on the date of termination;

I. "grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee;

J. "group contract" means a contract for health care services that by its terms limits eligibility to members of a specified group and may include coverage for dependents;

K. "group contract holder" means the person to [~~which~~] whom a group contract has been issued;

L. "health care services" means any services included in the furnishing to any individual of medical, mental, dental, advanced practice nursing or optometric care or hospitalization or nursing home care or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human physical or mental illness or injury;

M. "health maintenance organization" means any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or

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deductibles;

N. "health maintenance organization agent" means a person who solicits, negotiates, effects, procures, delivers, renews or continues a policy or contract for health maintenance organization membership or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself, or a person who advertises or otherwise holds himself out to the public as such;

O. "individual contract" means a contract for health care services issued to and covering an individual and it may include dependents of the subscriber;

P. "insolvent" or "insolvency" means that the organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction;

Q. "managed hospital payment basis" means agreements in which the financial risk is related primarily to the degree of utilization rather than to the cost of services;

R. "net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt;

S. "participating provider" means a provider as defined in Subsection U of this section who, under an express contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment,

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other than copayment or deductible, directly or indirectly from the health maintenance organization;

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

U. "provider" means any physician, hospital or other person licensed or otherwise authorized to furnish health care services;

V. "replacement coverage" means the benefits provided by a succeeding carrier;

W. "subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization or, in the case of an individual contract, the person in whose name the contract is issued; and

X. "uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the superintendent."

Section 9. Section 59A-46-7 NMSA 1978 (being Laws 1993, Chapter 266, Section 7) is amended to read:

"59A-46-7. QUALITY ASSURANCE PROGRAM.--

A. A health maintenance organization shall establish

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procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility and continuity of care.

B. A health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and non-institutional settings. The program shall include, at a minimum, the following:

(1) a written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(2) a written quality assurance plan that describes the following:

(a) the health maintenance organization's scope and purpose in quality assurance;

(b) the organizational structure responsible for quality assurance activities;

(c) contractual arrangements, where appropriate, for delegation of quality assurance activities;

(d) confidentiality policies and

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procedures;

(e) a system of ongoing evaluation activities;

(f) a system of focused evaluation activities;

(g) a system for credentialing providers and performing peer review activities; and

(h) duties and responsibilities of the designated physician or advanced practice nurse responsible for the quality assurance activities;

(3) a written statement describing the system of ongoing quality assurance activities, including:

(a) problem assessment, identification, selection and study;

(b) corrective action, monitoring, evaluation and reassessment; and

(c) interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(4) a written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies [~~method~~] methods of topic selection, study, data collection, analysis, interpretation and report format; and

(5) written plans for taking appropriate

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corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

C. A health maintenance organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available for examination by the superintendent and by the secretary of health if requested by the superintendent but shall not be disclosed to third parties except as permitted by the provisions of Chapter 59A, Article 46 NMSA 1978.

D. A health maintenance organization shall ensure the use and maintenance of an adequate patient record system that will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

E. Except as otherwise restricted or prohibited by state or federal law, enrollee clinical records shall be available to the superintendent or an authorized designee for examination and review to ascertain compliance with this section or as deemed necessary by the superintendent.

F. A health maintenance organization shall establish

a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff."

Section 10. Section 59A-46-35 NMSA 1978 (being Laws 1987, Chapter 335, Section 1, as amended) is amended to read:

"59A-46-35. PROVIDER DISCRIMINATION PROHIBITED.--No class of licensed individual providers willing to meet the terms and conditions offered by a health maintenance organization shall be excluded from a health maintenance organization. For purposes of this section, "providers" means those persons licensed under [~~Articles~~] Chapter 61, Article 2, 3, 4, 5, 6, 8, 9, 10 or 11 [~~of Chapter 61~~] NMSA 1978."

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FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

March 17, 1997

Mr. President:

Your PUBLIC AFFAIRS COMMITTEE, to whom has been referred

SENATE BILL 767

has had it under consideration and reports same WITHOUT RECOMMENDATION, and thence referred to the CORPORATIONS & TRANSPORTATION COMMITTEE.

Respectfully submitted,

_____
Shannon Robinson, Chairman

Adopted_____ Not Adopted_____
(Chief Clerk) (Chief Clerk)

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FORTY-SECOND LEGISLATURE
SECOND SESSION

KEYBOARD(TYPE SLUGS) Page 25

Date _____

The roll call vote was 6 For 0 Against

Yes: 6

No: 0

Excused: Ingle, Vernon, Rodarte

Absent: None

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FORTY-SECOND LEGISLATURE
SECOND SESSION

KEYBOARD(TYPE SLUGS) Page 26

FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

March 19, 1997

Mr. President:

Your CORPORATIONS & TRANSPORTATION COMMITTEE, to whom has been referred

SENATE BILL 767

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

Respectfully submitted,

_____

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FORTY-SECOND LEGISLATURE
SECOND SESSION

KEYBOARD(TYPE SLUGS)

Roman M. Maes, III, Chairman

Adopted_____ Not Adopted_____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 10 For 0 Against

Yes: 10

No: 0

Excused: None

Absent: None

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