SENATE BILL 1240

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

INTRODUCED BY

MANNY M. ARAGON

AN ACT

RELATING TO HEALTH CARE; ENACTING THE HEALTH CARE ACT TO PROVIDE FOR COMPREHENSIVE STATEWIDE HEALTH CARE, PLANNING AND COST SAVINGS; CREATING A COMMISSION; PROVIDING ITS POWERS AND DUTIES; PROVIDING FOR TRANSFERS; MAKING AN APPROPRIATION.

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

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

Section 2. PURPOSE OF ACT.--The purpose of the Health Care Act is to create a publicly financed statewide health program to provide coverage for health care services for all state residents and to control escalating health care costs.

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

A. "capital budget" means that portion of a health care facility's global budget that applies to real property and tangible personal property, including buildings, machinery and equipment and transportation equipment;

B. "capitation" means a set fee for providing specified health care services for all members of an enrolled group;

C. "commission" means the health care commission created pursuant to the Health Care Act;

D. "director" means the director of the commission;

E. "eligible person" means:

(1) except as provided in Paragraphs (2) through (7) of this subsection, a person who has resided in the state for at least one year and any child of that person who lives with the person and is in the legal custody of the person;

(2) a public employee, including an employee of the state or any political subdivision of the state and an employee of a public school or state educational institution;

(3) a medicaid or medicare recipient as participation is authorized by federal statute, regulation, waiver or agreement;

(4) a person entitled to health care services through the veterans' administration as participation is authorized by federal statute, regulation, waiver or agreement;

(5) a person, except federal retirees covered by other federal health insurance plans as participation is authorized by federal statute, regulation, waiver or agreement;

(6) a person covered by a health insurance plan pursuant to the provisions of the federal Employee Retirement Income Security Act of 1974 as participation is authorized by federal statute, regulation, waiver or agreement or as a business covered by the provisions of that act chooses to be covered under the provisions of the health care plan; or

(7) a person becoming eligible by paymnt of a premium pursuant to Section 17 of the Health Care Act,

F. "global budget" means the prospective operating budget of a health care facility, excluding the capital budget;

G. "group practice" means a health maintenance organization or other association of health care providers that provides one or more specialized health care services, such as laboratory services, x-Ray services, emergency care and inpatient or outpatient hospital services;

H. "health care facility" means a clinic, general or special hospital, outpatient facility, psychiatric hospital, laboratory, skilled nursing facility or nursing facility. For the purpose of determining global budgets, "health care facility" includes a group practice or transportation service;

I. "health care provider" means:

(1) a person licensed or certified in New Mexico as a:

(a) physician;

(b) osteopathic physician;

(c) physician assistant or osteopathic physician's assistant;

(d) chiropractic physician;

(e) dentist;

(f) psychologist, social worker; professional clinical mental health counselor, professional mental health counselor, marriage and family therapist or registered mental health counselor;

(g) optometrist;

(h) podiatrist;

(I) pharmacist;

(j) pharmacist clinician;

(k) registered nurse or certified nurse practitioner;

(l) visiting nurse service, private duty registry or other certified home health agency;

(m) doctor of oriental medicine;

(n) physical therapist;

(o) massage therapist;

(p) occupational therapist;

(q) speech-language pathologist;

(r) audiologist;

(s) respiratory care practitioner;

(t) midwife;

(u) dietician or nutritionist;

(v) transportation service; or

(w) other practitioner of the healing arts designated as a health care provider by the commission;

(2) a person 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 group practice or transportation service for that portion of the group practice or transportation service that is paid pursuant to a fee schedule established by the commission;

J. "health plan" means the mechanism developed by the commission for provision of health care services pursuant to the Health Care Act;

K. "implicit price deflator" means a measure of inflation that is published in the United States department of commerce survey of current business;

L. "major capital expenditure" means the purchase of diagnostic, treatment or transportation equipment costing fifty thousand dollars ($50,000) or more or construction or renovation of facilities;

M. "person" means a legal entity;

N. "primary care provider" means a licensed

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physician, osteopathic physician, nurse practitioner, physician's assistant, osteopathic physician's assistant, pharmacist clinician or other provider certified by the commission as a primary care provider who provides the first level of health care for an eligible person's health needs, as specified by the commission;

O. "provider budget" means the fee schedule established by the commission each year to pay for health care services provided by health care providers participating in the health plan; and

P. "transportation service" means ambulance, helicopter or other transport that is equipped with emergency supplies and equipment and is used to transport patients to health care providers or facilities and other transportation authorized by the commission.

Section 4. HEALTH CARE COMMISSION CREATED--VOTING AND NONVOTING MEMBERS.--

A. The "health care commission" is created as an adjunct agency pursuant to the Executive Reorganization Act. The general services department, the department of health and the human services department shall cooperate with the commission and assist it as needed. The commission consists of fifteen voting members and nine nonvoting members. The voting members, all of whom shall be appointed by the governor with the advice and consent of the senate, are:

(1) four persons who represent consumer interests, at least one of whom represents elderly consumer interests and at least one of whom represents Native American interests;

(2) two persons who represent persons with physical or mental impairments that limit one or more of their major life activities;

(3) five persons who represent either health care providers or health care facilities;

(4) two persons who represent business ownership interests, with one person representing employers of more than fifteen persons and one person representing employers of fifteen persons or fewer; and

(5) two persons who represent organized labor.

B. The voting members appointed shall reflect the ethnic, gender, economic and geographic diversity of the state. To ensure fair geographic representation of all areas of the state, members shall be appointed from each of the state board of education districts established by the 1991 Educational Redistricting Act 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.

C. The initial voting members of the commission shall be appointed by the governor by August 1, 1997. The terms of the initial voting members appointed shall be staggered as follows: five members shall be appointed for a term of four years; five members shall be appointed for a term of three years; and five members shall be appointed for a term 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 two consecutive four-year terms.

D. A voting member may be removed from the

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commission only for incompetence, neglect of duty or malfeasance in office. The governor shall initiate removal proceedings. No voting member shall be removed without having first been given notice of hearing and an opportunity to be heard. The supreme court has exclusive original jurisdiction over proceedings to remove a voting member. The supreme court's decision on removal shall be final.

E. A majority of the commission's voting members constitutes a quorum for the transaction of business. The commission shall choose annually its chairman and any other officers it deems necessary.

F. Voting members shall receive per diem and mileage in accordance with the provisions of the Per Diem and Mileage Act.

G. The commission is composed of the following nine nonvoting members:

(1) the secretary of health;

(2) the secretary of human services;

(3) the secretary of children, youth and families;

(4) the secretary of taxation and revenue;

(5) a person designated by the New Mexico office of Indian affairs, after consultation with the federal Indian health services;

(6) two members of the house of representatives

appointed by the speaker of the house, including one member of the majority party and one member of the minority party; and

(7) two members of the senate, including one member of the majority party and one member of the minority party appointed by the committees' committee of the senate, or, if the senate appointments are made in the interim, by the president pro tempore of the senate after consultation with and agreement of a majority of the members of the committees' committee.

H. The governor shall recommend to the legislature by January 1, 1998 the need for compensation for commission members.

Section 5. CONFLICT OF INTEREST.--

A. Except for nonvoting members and members appointed to represent health care facilities or health care providers, no commission member or a member of his immediate family shall have any financial interest, direct or indirect, in a person providing health care services or health care insurance.

B. The commission shall adopt a conflict of interest disclosure statement for use by all members that specifies financial interests of the member or member of his immediate family in a person providing the health care services or health care insurance.

C. No member of the commission shall vote on any

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matter in which he or a member of his immediate family has a financial interest.

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

Section 6. DIRECTOR--STAFF--CONTRACTS--BUDGETS.--

A. To assist in carrying out its duties, the commission shall appoint and set the salary of a "director". The director shall serve at the pleasure of the commission.

B. The director may employ those persons necessary to carry out the purposes of the Health Care Act. Employees are subject to the provisions of the Personnel Act.

C. The director and his staff shall implement the Health Care Act in accordance with that act and the policies and regulations adopted by the commission.

D. If the director determines that commission staff or another state agency does not have the resources or expertise to perform a necessary task, the commission may contract with a person that has a demonstrated capability to perform the task. If claims processing is provided by contract, that contract shall require that all work shall be performed entirely in New Mexico. All contracts shall be reviewed 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 director may contract with consultants that the director deems necessary to advise him or the commission in carrying out the provisions of the Health Care Act.

F. The director shall prepare an annual budget and plan of operation for the commission. He shall submit both to the commission for its approval before implementation.

Section 7. COMMISSION--GENERAL POWERS AND DUTIES.--The commission shall:

A. adopt a five-year program of operation to implement the provisions of the Health Care Act;

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

C. study and adopt the most cost-effective methods of providing health care services to all eligible persons, according high priority to increased reliance on:

(1) preventive and primary care, including immunization and screening examinations;

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

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

(4) case management services when appropriate;

D. establish fee schedules and other compensation for health care providers and adopt standards and procedures for negotiating and entering into contracts with participating health care providers;

E. establish global budgets for health care facilities and adopt:

(1) standards and procedures for determining base budgets and annual global budgets for health care facilities; and

(2) a capital expenditure program that requires prior approval for major capital expenditures by health care facilities;

F. 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 care facilities;

G. develop a payment system for health care providers and health care facilities that affords continuity of payments;

H. collect and analyze health care data and other data necessary to improve the efficiency and effectiveness of health care services and to control costs of health care services in New Mexico, and shall include data on:

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

(2) morbidity;

(3) health behavior;

(4) disability;

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

(6) environmental factors;

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

(8) demographic factors;

(9) social and economic conditions affecting health; and

(10) other factors determined by the commission;

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

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

K. adopt rules and regulations necessary to implement and monitor a state formulary to provide prescription drugs, medicine, durable medical equipment and supplies, eyeglasses, hearing aids, oxygen and related services;

L. study and evaluate the adequacy and quality of health care services furnished pursuant to the Health Care Act, the cost of each type of service and the effectiveness of cost-containment measures in the health plan;

M. 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 services. If migration appears to threaten the financial stability of the health plan, the commission shall recommend to the legislature changes in eligibility requirements, premiums or other statutory changes that may be necessary to maintain the financial stability of the health plan;

N. study and evaluate the cost of medical professional liability and medical professional liability insurance and recommend statutory changes to the legislature as necessary;

O. set or approve changes in benefit standards covered by the health plan;

P. conduct necessary investigations and inquiries and compel by subpoena the submission of information and documents that the commission considers necessary to carry out its duties;

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

R. meet as needed, but no less than once every three months; and

S. report annually 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 and other relevant issues relating to the health plan and the five-year program; 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 8. ADVISORY BOARDS.--

A. The commission may establish advisory boards to assist it in performing its duties.

B. The commission shall establish a "health care provider advisory board" to advise and assist the commission in all decisions requiring the expertise of health care providers. Each noncommission member shall represent a different licensed health profession.

C. The commission may appoint commission members and up to five additional persons to serve on each advisory board it creates. Advisory board members who are not commission members may be paid per diem and mileage in accordance with the provisions of the Per Diem and Mileage Act.

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

Section 9. 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, global budgets, capital allocations or other features to encourage the provision of health care services in rural and other underserved areas.

Section 10. REGIONAL COUNCILS.--

A. The commission shall create regional councils in the health care delivery regions of the state.

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

C. Members of a regional council may 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 so that regional concerns are considered in the development and update of the five-year program, fee schedules and global budgets.

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

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Section 11. COMMISSION, COUNCILS AND ADVISORY BOARDS--MEETINGS.--All meetings of the commission, councils and advisory boards shall be conducted pursuant to the provisions of the Open Meetings Act.

Section 12. RULES AND REGULATIONS.--

A. The commission shall adopt reasonable regulations necessary to carry out the duties of the commission and the provisions of the Health Care Act.

B. No regulation affecting any person or agency outside the commission shall be adopted, amended or repealed 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 of the regulation, 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 regulation, proposed amendment or repeal of an existing regulation may be obtained shall be published once at least thirty days prior to the hearing date in a newspaper of general circulation 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 and regulations adopted by the commission shall be filed in accordance with the State Rules Act.

Section 13. 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 services to be phased in as the health plan budget allows.

C. The commission shall specify the health care services to be included as covered by the health plan and shall include:

(1) preventive health services;

(2) provider services;

(3) inpatient and outpatient medical services;

(4) laboratory tests and imaging procedures;

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

(6) prescription drugs;

(7) inpatient and outpatient mental health services;

(8) drug and substance abuse services;

(9) preventive and prophylactic dental services, including an annual dental examination and cleaning, but not including orthodontic services;

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

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

(12) experimental treatment services as specified on a case-by-case basis by the commission.

D. Covered services shall not include:

(1) surgery for cosmetic purposes other than 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) cosmetic dental services except for reconstructive purposes.

E. The health plan shall specify the services to be covered and the amount, scope and duration of benefits. The plan shall include a maximum amount or percentage for administrative costs, and this maximum may be variable in relation to total costs of services provided under the health

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plan.

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

G. The commission shall control health care costs so that eligible persons receive comprehensive health services, consistent with budget constraints, including needed health care services in rural and other underserved areas.

H. The health plan shall phase in eligible persons as their participation becomes possible through agreements, waivers or federal legislation. The health plan may provide for certain preventive health care services to be offered to all New Mexicans regardless of eligibility.

I. The five-year program 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 12 of the Health Care Act. In projecting services under the health plan, the commission shall take all reasonable steps to ensure that long-term care, mental health services and dental care are provided at the earliest practical times consistent with budget constraints.

J. Any changes in health care services offered by the health plan shall be approved by the commission.

Section 14. LONG-TERM CARE.--

A. Long-term care may include:

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

(2) hospice care; and

(3) institutional care.

B. No later than one year after appointment of the director, the commission shall appoint a "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 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.

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

D. Nothing in this section affects long-term care services paid through federal programs or private insurance.

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

Section 15. MENTAL HEALTH SERVICES.--

A. Mental health services may include:

(1) services for acute and chronic conditions;

(2) home- and community-based services; and

(3) institutional care.

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B. No later than one year after appointment of the director, the commission shall appoint a "mental health services committee" made up of representatives of mental health care consumers, providers and administrators to develop a plan for integrating mental health services into 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.

C. The mental health services component of the health plan shall provide for service coordination, case management and noninstitutional services where appropriate.

D. Nothing in this section affects mental health services paid through federal programs or private insurance.

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

Section 16. MEDICAID COVERAGE--JOINT POWERS AGREEMENTS.--The commission may enter into joint powers agreements with the human services department in accordance with the Joint Powers Agreements Act for the purpose of furthering the goals of the Health Care Act. These agreements may transfer certain medicaid functions to the commission to allow the commission to implement the health plan.

Section 17. HEALTH PLAN COVERAGE--ELIGIBLE PERSONS--

NONRESIDENT STUDENTS--ELIGIBILITY CARD--PENALTIES.--

A. An eligible person shall be covered by the health plan, but a person who has not resided in New Mexico for at least one year may become an eligible person upon payment of a premium as determined by the commission.

B. State educational institutions shall purchase coverage under the health plan for its out-of-state and emancipated students through fees assessed to students. The board of regents or other governing body of a state educational institution shall set the fees at the amount determined by the commission.

C. A student at a state educational institution who has not resided in the state for one year may demonstrate proof of health insurance coverage by a policy in another state that is acceptable to the commission, and his fee shall be reduced as provided by the commission.

D. The commission shall adopt regulations to determine proof of a person's eligibility for the health plan or a student's proof of nonresident insurance coverage. The regulations shall provide a method for the purging of eligibility when a person is no longer eligible for coverage.

E. An eligible person 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 person for treatment and electronic billing and

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payment and any other information the commission deems necessary.

F. The eligibility card is not transferable. A person who lends his card to another and a person who uses another's card shall each be liable to the commission for the full cost of the health care services provided to the user. Each person shall pay the liability in full within ten days of being billed. If either person does not pay his liability, the other person shall be liable for that share. Liabilities 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.

G. A person who lends his card to another or a person who uses another's card a second time 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. Persons convicted pursuant to this subsection are also liable for the amounts specified in Subsection F of this section.

Section 18. PRIMARY CARE PROVIDER--RIGHT TO CHOOSE--ACCESS TO SERVICES.--

A. Except as provided in the Workers' Compensation Act, an eligible person has the right to choose a primary care provider. If an eligible person does not choose a primary care provider, one shall be assigned by procedures pursuant to regulations of the commission.

B. The primary care provider shall be responsible for providing medical treatment, other than medical emergencies. If the expertise of another health care provider is needed, the primary care provider shall make a referral to the appropriate specialty. Except as provided in Subsections C and E of this section, health care provider specialists shall be paid only if the patient has been referred by the patient's primary care provider.

C. The commission shall by regulation specify the conditions under which an eligible person may select a specialist as a primary care provider. The commission shall set primary care provider rates for specialists when serving as primary care providers.

D. The commission shall by regulation specify how often and under what conditions an eligible person may change his primary care provider.

E. The commission shall by regulation specify when and under what circumstances an eligible person may self-refer, including self-referral to chiropractors, acupuncturists, mental health professionals and other health care providers who are not primary care providers.

Section 19. DISCRIMINATION PROHIBITED.--No health care provider or health care facility shall discriminate against or refuse to furnish health care services to a person covered by the plan on the basis of 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 care facility to care for a patient if it is not qualified to provide the needed care and it does not offer that needed care to the general public.

Section 20. UTILIZATION REVIEW--MONITORING--EFFICIENCY OF OPERATIONS--PENALTIES.--

A. The commission shall implement an evaluation and monitoring program that considers, at a minimum, access to care, quality of care and utilization of care provided by the health plan, including geographic distribution of health care resources.

B. The commission shall set standards and review benefits to ensure that effective, cost-efficient and appropriate health care services are rendered.

C. The commission shall establish an ongoing system for monitoring patterns of practice and peer review. The system shall include the appointment of an advisory group consisting of health care providers, health care facilities and other knowledgeable persons to advise the commission and staff on health care practice issues.

D. The commission shall establish a system of peer education for health care providers or health care facilities

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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 regulation the procedures for recouping payments or withholding payments for health care services determined by the commission to be medically unnecessary. In addition, the commission may provide by regulation 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 peer review advisory group, the commission may suspend or revoke a health care provider's or health care facility's privilege to provide health care services under the health plan for aberrant patterns of practice, including overutilization, unnecessary referrals, attempts to unbundle health care services or other practices that the commission deems a violation of the Health Care Act or regulations adopted pursuant to that act. As used in this section, "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 to practice under the Health Care 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 care facility to the attorney general or to the district attorney of the county where the health care provider or health care facility operates for investigation and prosecution.

I. 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 services provided through the health plan.

Section 21. HEALTH PLAN BUDGET.--

A. Each year, the commission shall develop a health plan budget. The budget shall establish the total amount to be spent by the plan for covered health care services in the next year. The budget shall include provider budgets and global budgets.

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.

C. In developing the health plan budget, the commission shall provide that credit be taken in that budget for all revenues produced for health care services and facilities in

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the state pursuant to any law other than the Health Care Act.

Section 22. PROVIDER BUDGET--PAYMENTS TO HEALTH CARE PROVIDER--CO-PAYMENTS.--

A. Consistent with budget constraints, the health plan shall provide payment for all covered health care services rendered by health care providers. A variety of payment plans, including fee-for-service, compensation caps and capitated payments may be adopted by the commission. Payment plans shall be negotiated with providers as provided by regulation.

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. The annual percentage increase in provider budgets shall be no greater than the percentage increase in the implicit price deflator using one year prior to implementation of the health plan as the baseline year.

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 patient covered under the health plan any additional amounts for services covered by the plan.

E. The commission may set co-payments if co-payment is determined to be an effective cost-control measure. No co-payment shall be required for preventive care or if it creates a barrier to medically necessary care. When a co-payment is required, the health care provider or health care facility shall not waive the co-payment.

Section 23. GLOBAL BUDGET--PAYMENTS TO HEALTH CARE FACILITIES.--

A. A health care facility shall negotiate an annual global budget with the commission. The global budget shall be based on a base budget of past performance and projected changes upward or downward in costs and services anticipated for the next year. If a negotiated agreement is not reached, the commission shall set the global budget for the health care facility. The initial base budget for a health care facility shall be based on a twelve-month period that is no later than the year the health plan is implemented, appropriately adjusted by the implicit price deflator not to exceed five percent a year from 1995 to the first global budget. Thereafter, increases in global budgets are limited by the implicit price deflator.

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 globally budgeted health care facility shall be paid from the budget allocation in a manner determined by the health care facility.

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Section 24. CAPITAL BUDGETS--COMMISSION APPROVAL REQUIRED FOR MAJOR CAPITAL EXPENDITURE.--

A. The commission shall adopt an annual capital budget.

B. Allocations to geographic areas and to individual health care facilities and health care providers shall be based on need and shall be calculated so that the minimum access standards adopted by the commission are considered for all areas of the state, and shall ensure the efficient development and operation of necessary facilities.

C. No major capital expenditure shall be made by a health care provider or health care facility without prior approval. The director of the commission has approval authority for major capital expenditures between fifty thousand dollars ($50,000) and five hundred thousand dollars ($500,000), based on regulations adopted by the commission. The commission has approval authority for major capital expenditures over five hundred thousand dollars ($500,000).

D. The approval of any proposed major capital expenditure shall be based on efforts to do all of the following:

(1) fulfill unmet needs;

(2) preclude unnecessary expansion of facilities and services;

(3) ensure the efficient development of health

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care facilities that are appropriate to the services provided;

(4) ensure sufficient access to health care facilities; and

(5) ensure access to efficacious new technologies.

E. No health care facility or health care provider shall engage in component purchasing to avoid restrictions on major capital expenditures. The commission may deduct the total cost of component purchases in the next year's capital budget or the appropriate operating budget. As used in this subsection, "component purchasing" means the purchase of component parts or other purchasing practice with the effect of circumventing major capital expenditure restrictions.

F. There is a two-year moratorium on major capital expenditures beginning July 1, 1997. The commission may grant waivers to the moratorium in emergencies.

G. No later than January 1, 1998, the commission shall report to the appropriate committees of the legislature on the capital needs of health care facilities, including facilities of state and local governments, with a focus on underserved geographic areas with substantially below-average health care facilities and investment per capita as compared to the state average. The report shall also describe geographic areas where the distance to health care facilities imposes a barrier to care. The report shall include a section on health care transportation needs, including capital, personnel and training needs.

Section 25. 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 regulation for independent financial audits of health care providers and health care 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 care 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 26. STANDARD CLAIM FORMS FOR INSURANCE PAYMENT.--The commission shall adopt standard claim forms that shall be used by all health care providers and health care facilities that seek payment through the health plan or from private persons, including private insurance companies, for health care services 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 27. COMPUTERIZED SYSTEM.--The commission shall require that all health care providers and health care facilities participate in the health plan's computer network that provides for electronic transfer of payments to health care providers and health care 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 28. REPORTS REQUIRED--CONFIDENTIAL INFORMATION.--

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

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

C. Information confidential pursuant to other provisions of law shall be confidential under the Health Care Act. Within the constraints of confidentiality, reports of the commission are public documents.

Section 29. OMBUDSMAN PROGRAM.--

A. The commission shall establish an ombudsman 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 Care Act; and

(2) health care providers and health care facilities about 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 ombudsman programs and shall have ombudsmen available throughout the state to assist eligible persons, applicants, health care providers and health care facilities in person.

Section 30. APPEALS--MEDIATION--FAIR HEARING.--

A. An applicant for or recipient of a health care service may appeal a decision related to eligibility, covered services or a primary care provider's referral decision.

B. A health care provider or health care facility may appeal a decision related to claims, budgets or right to practice.

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C. An appeal of a decision may be summarily settled by the director if the person filing for an appeal presents evidence satisfactory to the director that an erroneous decision had been made. If the summary appeal is unsuccessful, the person may request mediation or a hearing.

D. The commission shall by regulation establish procedures for a mediation process. The regulations shall provide for the selection of a mediator that is acceptable to all parties.

E. The commission shall by regulation establish procedures for the filing of a request for hearing and the time limits within which a request may be filed. The commission may grant reasonable extensions of the time limits. If the request for hearing is not filed within the specified time or within whatever extension the commission may grant, the initial decision shall be final. Upon receipt of a timely request, the commission shall give the appellant reasonable notice of an opportunity for a fair hearing in accordance with the regulations of the commission.

F. The hearing shall be conducted by a hearing officer designated by the director. The hearing officer may be an employee of the commission if there is no conflict of interest in the appointment of the employee.

G. The powers of the hearing officer include administering oaths or affirmations to witnesses called to testify, taking testimony, examining witnesses, admitting or excluding evidence and reopening any hearing to receive additional evidence. The technical rules of evidence and rules of civil procedure shall not apply. The hearing shall be conducted so that the contentions or defenses of each party to the hearing are amply and fairly presented. Either party may be represented by counsel or other representative of his designation, and he or his representative may conduct cross-examinations. Any oral or documentary evidence may be received, but the hearing officer may exclude irrelevant, immaterial or unduly repetitious evidence. A verbatim record by audio recording or other means shall be made.

H. The commission shall review the verbatim record of the proceedings and shall make a decision based on the record. A written notice of decision shall be sent by certified mail to the person requesting the hearing.

Section 31. REVIEW AND APPEAL.--

A. Within thirty days after the date written notice of the decision of the commission is mailed, an applicant, recipient, health care provider or health care facility may file a notice of appeal with the court of appeals, together with a copy of the notice of the decision. The clerk of the court shall transmit a copy of the notice of appeal to the director.

B. The filing of a notice of appeal shall not stay the enforcement of the decision of the commission, but the commission may grant, or the court upon motion and good cause shown may order, a stay.

C. Appeals shall be taken as provided in the Rules of Appellate Procedure.

D. The review of the court shall be made upon the decision and the record of the proceedings.

E. The court shall set aside a decision and order of the commission only if found to be:

(1) arbitrary, capricious or an abuse of discretion;

(2) not supported by substantial evidence in the record as a whole; or

(3) otherwise not in accordance with law or the rules and regulations of the commission.

Section 32. REIMBURSEMENT FOR OUT-OF-STATE SERVICES--HEALTH PLAN'S RIGHT TO SUBROGATION AND PAYMENT FROM OTHER INSURANCE PLANS--CHARGES FOR NON-COVERED PERSONS.--

A. If an eligible person 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. Additional charges for those services shall not be paid by the health care plan unless the commission has negotiated a reciprocity or other agreement with the other state or foreign country or with the out-of-state health care provider or health care facility.

B. If an otherwise eligible person has a separate health insurance plan that covers the same services, the health plan has the right of subrogation to receive payment from the separate health insurance plan for all covered services paid by the health plan. In those circumstances, the health plan shall be the payer of last resort. Any services provided by a separate health insurance plan not covered in the health plan shall not be affected.

C. Nothing in this section affects an ineligible person's responsibility for payment of health care services.

Section 33. PRIVATE HEALTH INSURANCE COVERAGE LIMITED--COMMUNITY RATING REQUIRED.--

A. Except as provided in Subsection B of Section 32 of the Health Care Act, no person shall provide private health insurance to an eligible person for a health care service that is covered by the health plan.

B. Health insurance for a health care service that is not covered by the health plan shall be based on a system of community rating in which an insurer shall charge the same premium for the same coverage to each New Mexico resident, regardless of a person's individual circumstances for pre-existing condition, medical risk, job risk, age or gender.

C. Nothing in this section shall be construed to affect insurance coverage pursuant to the federal Employee Retirement Income Security Act of 1974 unless the state obtains

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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 34. FEDERAL HEALTH INSURANCE PROGRAM WAIVERS--REIMBURSEMENT TO PLAN FROM FEDERAL AND OTHER HEALTH INSURANCE PROGRAMS.--

A. The commission, in conjunction with the human services department, shall:

(1) apply to the United States department of health and human services for all waivers of requirements under health care programs established pursuant to the federal Social Security Act, as amended, that are necessary to enable the state to deposit federal payments for services covered by the health plan into the plan's fund and to be the supplemental payer of benefits for persons receiving medicare benefits;

(2) 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 plan's fund; provided, however, agreements negotiated with Indian health services 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

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(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 Care Act to as many New Mexicans as possible.

B. The commission shall seek payment to the health plan from medicaid, medicare or any other federal or other insurance program for any reimbursable payment provided under the plan.

C. 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 35. INSURANCE--COMMISSION APPROVAL.--No person shall insure himself or his employees after July 1, 1997 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 people not eligible for coverage under the health plan.

Section 36. [NEW MATERIAL] INSURANCE RATES--COMMISSION AND SUPERINTENDENT OF INSURANCE DUTIES.--

A. The commission shall work closely with the superintendent of insurance to identify health care cost savings that have been achieved as a result of implementation of the health plan. The commission and the superintendent shall identify savings by insurance companies on payments made for medical services through motor vehicle liability insurance, homeowners' insurance, workers' compensation insurance or other insurance policies that have a medical payment component. The commission and the superintendent shall report their findings to the legislature.

B. The superintendent shall lower insurance premiums associated with medical benefits on all types of insurance policies written in New Mexico that have a medical payment component as soon as data indicate health care savings have been achieved as a result of operation of the health plan.

Section 37. TEMPORARY PROVISION--TRANSITION PERIOD ARRANGEMENTS--PUBLICLY FUNDED HEALTH CARE SERVICE PLANS.--

A. A person who, on the date benefits are available under the Health Care Act health plan, receives health care benefits under private contract or collective bargaining agreement entered into prior to July 1, 1997 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 services 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 Care Act health plan on the effective date that benefits are available under the plan.

Section 38. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 1997.

FORTY-THIRD LEGISLATURE

FIRST SESSION, 1997

March 10, 1997

Mr. President:

Your PUBLIC AFFAIRS COMMITTEE, to whom has been referred

SENATE BILL 1240

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 1240

is reported WITHOUT RECOMMENDATION, 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 4 For 3 Against

Yes: 4

No: Adair, Boitano, Ingle

Excused: Vernon

Absent: None

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SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
SENATE BILL 1240

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

AN ACT

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

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

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

Section 2. PURPOSE OF ACT.--The purposes of the Health Care Act are to create a publicly financed statewide health program to provide coverage for health care services for all state residents and to control escalating health care costs.

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

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

B. "capital budget" means that portion of a budget that establishes dollar amounts for expenditures for:

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

(2) acquisition of tangible personal property;

C. "capitation" means allocation of health plan funds to a health care provider based on the number of individuals whose health care must be covered by the provider, with respect to all benefits available under the health plan, for a calendar year or part of a calendar year;

D. "commission" means the health care commission created pursuant to the Health Care Act;

E. "director" means the director of the commission;

F. "global budget" means the prospective operating budget of a health facility, excluding the capital budget;

G. "group practice" means a health maintenance organization, an association of health care providers that provides one or more specialized health care services, such as laboratory services, x-ray services, emergency care and inpatient or outpatient hospital services, a tribally operated health care center or tribal coalitions in partnership or under contract with the Indian health service that is authorized under federal law to provide health care to Native American populations in the state;

H. "health care provider" means:

(1) a person licensed or certified in New Mexico as a:

(a) physician;

(b) osteopathic physician;

(c) physician assistant or osteopathic physician's assistant;

(d) chiropractic physician;

(e) dentist;

(f) psychologist, social worker; professional clinical mental health counselor, professional mental health counselor, marriage and family therapist or registered mental health counselor;

(g) optometrist;

(h) podiatrist;

(i) pharmacist;

(j) pharmacist clinician;

(k) registered nurse or certified nurse practitioner;

(l) visiting nurse service, private duty registry or other certified home health agency;

(m) doctor of oriental medicine;

(n) physical therapist;

(o) massage therapist;

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(p) occupational therapist;

(q) speech-language pathologist;

(r) audiologist;

(s) respiratory care practitioner;

(t) midwife;

(u) dietician or nutritionist;

(v) transportation service; or

(w) other practitioner of the healing arts designated as a health care provider by the commission;

(2) a person 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 group practice or transportation service for that portion of the group practice or transportation service that is paid pursuant to a fee schedule established by the commission;

I. "health facility" means a clinic, general or special hospital, outpatient facility, psychiatric hospital, laboratory, skilled nursing facility or nursing facility. For the purpose of determining global budgets, "health facility" includes a group practice or transportation service;

J. "health plan" means the mechanism developed by the commission for provision of health care services pursuant to the

Health Care Act;

K. "health plan budget" means all expenditures for the health plan, including the costs of services and benefits provided, administration, data gathering and other activities;

L. "implicit price deflator" means a measure of inflation that is published in the United States department of commerce survey of current business;

M. "major capital expenditure" means construction or renovation of facilities or the purchase of diagnostic, treatment or transportation equipment costing more than an amount established by the legislature after the commission completes a study and makes recommendations on this matter;

N. "person" means a legal entity;

O. "primary care provider" means a licensed physician, osteopathic physician, nurse practitioner, physician assistant, osteopathic physician's assistant, pharmacist clinician or other 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;

P. "provider budget" means the fee schedule established by the commission each year to pay for health care services provided by health care providers participating in the health plan; and

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

Section 4. HEALTH CARE COMMISSION CREATED--VOTING AND NONVOTING MEMBERS.--

A. The "health care commission" is created as an adjunct agency pursuant to the Executive Reorganization Act. The general services department, the department of health and the human services department shall cooperate with the commission and assist it as needed. The commission consists of fifteen voting members and nine nonvoting members. The voting members, all of whom shall be appointed by the governor with the advice and consent of the senate, are:

(1) four persons who represent consumer interests, at least one of whom represents elderly consumer interests;

(2) two persons who represent persons with physical or mental impairments that limit one or more of their major life activities;

(3) five persons who represent either health care providers or health facilities;

(4) two persons who represent business ownership interests, with one person representing employers of more than fifteen persons and one person representing employers of fifteen persons or fewer; and

(5) two persons who represent organized labor.

B. The voting members appointed shall reflect the ethnic,

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gender, economic and geographic diversity of the state. To ensure fair geographic representation of all areas of the state, members shall be appointed from each of the state board of education districts established by the 1991 Educational Redistricting Act 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.

C. The initial voting members of the commission shall be appointed by the governor by July 1, 1998. The terms of the initial voting members appointed shall be staggered as follows: five members shall be appointed for a term of four years; five members shall be appointed for a term of three years; and five members shall be appointed for a term 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.

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D. A voting member may be removed from the commission only for incompetence, neglect of duty or malfeasance in office. No voting member shall be removed without having first been given notice of hearing and an opportunity to be heard. The supreme court has exclusive original jurisdiction over proceedings to remove a voting member. The supreme court's decision on removal shall be final.

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

F. Voting members shall receive per diem and mileage in accordance with the provisions of the Per Diem and Mileage Act.

G. The commission is composed of the following nine nonvoting members:

(1) the secretary of health;

(2) the secretary of human services;

(3) the secretary of children, youth and families;

(4) the secretary of taxation and revenue;

(5) a person designated by the New Mexico office of Indian affairs, after consultation with the federal Indian health service;

(6) two members of the house of representatives, including one member of the majority party and one member of the minority party, appointed by the speaker of the house; and

(7) two members of the senate, including one member of the majority party and one member of the minority party, appointed by the committees' committee of the senate, or, if the senate appointments are made in the interim, by the president pro tempore of the senate after consultation with and agreement of a majority of the members of the committees' committee.

H. The governor shall recommend to the legislature by January 1, 1998 whether or not the members of the commission should be compensated.

Section 5. CONFLICT OF INTEREST.--

A. Except for nonvoting members and members appointed to represent health facilities or health care providers, no commission member or a member of his immediate family shall have any financial interest, direct or indirect, in a person providing health care services or health insurance.

B. The commission shall adopt a conflict of interest disclosure statement for use by all members that requires disclosure of financial interests of the member or a member of his immediate family in a person providing the health care services or health insurance.

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

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

Section 6. DIRECTOR--STAFF--CONTRACTS--BUDGETS.--

A. To assist in carrying out its duties, the commission shall appoint and set the salary of a "director", subject to the provisions of Section 10-9-5 NMSA 1978. The director shall serve at the pleasure of the commission.

B. The director may employ those persons necessary to administer and implement the provisions of the Health Care Act. Employees are subject to the provisions of the Personnel Act.

C. The director and his staff shall implement the Health Care Act in accordance with that act and the policies and regulations adopted by the commission. The director may delegate authority to employees and may organize the staff into units to facilitate its work.

D. If the director determines that commission staff or another state agency does not have the resources or expertise to perform a necessary task, the commission may contract with a person that has a demonstrated capability to perform the task. If claims processing is provided by contract, that contract shall require that all work shall be performed entirely in New Mexico. All contracts shall be reviewed 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 director may contract with consultants that the director deems necessary to advise him or the commission in carrying out the provisions of the Health Care Act.

F. The director shall prepare an annual budget and plan of operation for the commission. He shall submit both to the commission for its approval before implementation.

Section 7. COMMISSION--GENERAL POWERS AND DUTIES.--The commission shall:

A. adopt a five-year program of operation to implement the provisions of the Health Care Act;

B. 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;

C. study and adopt the most cost-effective methods of providing health care services to all beneficiaries, according high priority to increased reliance on:

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

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

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

(4) case management services when appropriate;

D. establish compensation mechanisms for health care providers and adopt standards and procedures for negotiating and

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entering into contracts with participating health care providers;

E. establish a health plan budget;

F. establish global budgets for health facilities and adopt:

(1) standards and procedures for determining base budgets and annual global budgets for health facilities; and

(2) a capital expenditure program that requires prior approval for major capital expenditures by health facilities;

G. 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;

H. develop a payment system for health care providers and health facilities that ensures continuity of payments to enable the providers and facilities to meet their financial obligations as they become due;

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

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

(2) morbidity;

(3) health behavior;

(4) physical and psychological impairment and disability;

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

(6) environmental factors;

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

(8) demographic factors;

(9) social and economic conditions affecting health; and

(10) other factors determined by the commission;

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

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

L. adopt rules and regulations necessary to implement and monitor a state formulary to provide prescription drugs, medicine, durable medical equipment and supplies, eyeglasses, hearing aids, oxygen and related services;

M. study and evaluate the adequacy and quality of health care services furnished pursuant to the Health Care Act, the cost of each type of service and the effectiveness of cost-containment measures in the health plan;

N. 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 services, 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;

O. study and evaluate the cost of health care provider professional liability and health care provider professional liability insurance and recommend statutory changes to the legislature as necessary;

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

Q. conduct necessary investigations and inquiries and compel by subpoena the submission of testimony, information and documents that the commission considers necessary to carry out its duties;

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

S. meet as needed, but no less than once every three months; and

T. report annually 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 and the five-year program; 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 8. COMMISSION--AUTHORITY.--The commission has the authority necessary to carry out all duties and responsibilities required of it pursuant to the Health Care Act, whether that authority is expressly provided in that act or is necessarily implied. The commission may delegate its general authority to the director except for specific authority or direction that is granted to the commission by a provision of the Health Care Act and authority, which is expressly reserved in the commission, to take the following actions:

A. sue and defend suits brought against it, subject to the provisions of the Tort Claims Act;

B. enter into contracts;

C. approve its budget and plan of operation;

D. approve the health plan and make changes in the health plan;

E. adopt regulations, written policies and procedures to implement the health plan and the provisions of the Health Care Act;

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

G. make reports and recommendations to the legislature;

H. apply for program waivers from any governmental entity; and

I. accept grants, apply for and receive loans and accept donations.

Section 9. ADVISORY BOARDS.--

A. The commission may establish advisory boards to assist it in performing its duties.

B. The commission shall establish a "health care provider advisory board" to advise and assist the commission in all decisions requiring the expertise of health care providers. Each noncommission member shall represent a different licensed health profession.

C. No more than two advisory board members shall have any financial interest, direct or indirect, in a person providing health care services or a person providing health insurance.

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

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

Section 10. 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, global budgets, capital expenditure allocations or other features to encourage the provision of health care services in rural and other underserved areas.

Section 11. REGIONAL COUNCILS.--

A. The commission shall create regional councils in the health care delivery regions of the state.

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

C. Members of a regional council may 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 program, fee schedules, global budgets and capital expenditure allocations.

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

Section 12. COMMISSION, COUNCILS AND ADVISORY BOARDS--MEETINGS.--All meetings of the commission, councils and advisory boards shall be conducted pursuant to the provisions of the Open Meetings Act.

Section 13. RULES AND REGULATIONS.--

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

B. No regulation affecting any person outside the commission shall be adopted, amended or repealed 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 of the regulation, 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 regulation or an amendment or repeal of an existing regulation may be obtained shall be published once at least thirty days prior to the hearing date in a newspaper

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of general circulation 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 and regulations adopted by the commission shall be filed in accordance with the State Rules Act.

Section 14. 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 services to be phased in as the health plan budget allows.

C. The commission shall specify the health care services to be included as covered by the health plan but shall include:

(1) preventive health services;

(2) health care provider services;

(3) health facility inpatient and outpatient services;

(4) laboratory tests and imaging procedures;

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

(6) prescription drugs;

(7) inpatient and outpatient mental health services;

(8) drug and substance abuse services;

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

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

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

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

D. Covered services shall not include:

(1) surgery for cosmetic purposes other than 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. The 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.

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

G. The health plan shall contain provisions to control health care costs so that beneficiaries receive comprehensive health services, consistent with budget constraints, including needed health care services in rural and other underserved areas.

H. The health plan shall phase in beneficiaries as their participation becomes possible through contracts, waivers or federal legislation. The health plan may provide for certain preventive health care services to be offered to all New Mexicans regardless of eligibility.

I. The five-year program 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 13 of the Health Care Act. In projecting services under the health plan, the commission shall take all reasonable steps to ensure that long-term care, mental health services and dental care are provided at the earliest practical times consistent with budget constraints.

Section 15. LONG-TERM CARE.--

A. Long-term care may include:

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

(2) hospice care; and

(3) institutional care.

B. No later than one year after appointment of the director, 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 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.

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

D. Nothing in this section affects long-term care services paid through federal programs or private insurance subject to the provisions of Sections 34 and 35 of the Health Care Act.

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

Section 16. MENTAL HEALTH SERVICES.--

A. Mental health services may include:

(1) services for acute and chronic conditions;

(2) home- and community-based services; and

(3) institutional care.

B. No later than one year after appointment of the director, the commission shall appoint an advisory "mental health services committee" made up of representatives of mental health care consumers, providers and administrators to develop a plan for integrating mental health services into 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.

C. The mental health services component of the health plan shall provide for service coordination, case management and noninstitutional services where appropriate.

D. Nothing in this section affects mental health services paid through federal programs or private insurance subject to the provisions of Sections 34 and 35 of the Health Care Act.

E. Nothing in this section precludes the commission from including mental health services from the inception of the health plan.

Section 17. MEDICAID COVERAGE--JOINT POWERS AGREEMENTS.--The commission may enter into joint powers agreements with the human services department in accordance with the Joint Powers Agreements Act for the purpose of furthering the goals of the Health Care Act. These agreements may provide for certain medicaid functions to be administered by the commission to allow the commission to implement the health plan.

Section 18. HEALTH PLAN COVERAGE--CONDITIONS OF ELIGIBILITY FOR BENEFICIARIES--NONRESIDENT STUDENTS--ELIGIBILITY CARD--

PENALTIES.--

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 present intention to remain in New Mexico and not to reside elsewhere. A dependent of an eligible individual is included as a beneficiary. An individual is not eligible for coverage if he is covered for the same or similar benefits pursuant to a private or governmental health insurance policy or plan, but he becomes eligible when that coverage terminates or agreements or waivers are accomplished under which coverage under the health plan is available. Individuals covered under the following governmental programs shall not be brought into coverage through agreements or waivers:

(1) federal retiree health plan beneficiaries;

(2) Indian health service beneficiaries, but individuals who are covered by tribal providers that are in partnership with or have contracts with the Indian health service may be brought under coverage through agreement between the tribal providers and the commission;

(3) active duty military personnel; and

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

B. An educational institution shall purchase coverage under the health plan for its nonresident students through fees assessed to these students. The governing body of an educational institution shall set the fees at the amount determined by the commission.

C. A nonresident student at an educational institution may demonstrate health insurance or plan coverage by proof of coverage under a policy or plan in another state that is acceptable to the commission. The fee that students shall be assessed shall be specified by the commission.

D. The commission shall adopt regulations to determine proof of an individual's eligibility for the health plan or a student's proof of nonresident health insurance or plan coverage.

E. The commission shall adopt regulations to provide a method for the purging of eligibility when a beneficiary is no longer eligible for coverage.

F. 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.

G. 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 be liable to the commission for the full cost of the health care services provided to the user. The liability shall be paid in full within ten days of billing. Liabilities created pursuant to this section shall be

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collected by the taxation and revenue department in the same manner as delinquent taxes are collected pursuant to the Tax Administration Act.

H. A beneficiary who lends his card to another or an individual who uses another's card a second time 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 19. 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 under procedures in regulations adopted by the commission.

B. The primary care provider shall be responsible for providing health care services other than services in medical emergencies. If the expertise of another health care provider is needed, the primary care provider shall make a referral to the appropriate specialty. Except as provided in Subsections C and E of this section, health care provider specialists shall be paid pursuant to the health plan only if the patient has been referred by the patient's 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.

C. The commission shall by regulation specify the conditions under which a beneficiary may select a specialist as a primary care provider. The commission shall set primary care provider rates for specialists when serving as primary care providers.

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

E. The commission shall by regulation specify when and under what circumstances a beneficiary may self-refer, including self-referral to chiropractors, acupuncturists, mental health professionals and other health care providers who are not primary care providers.

Section 20. DISCRIMINATION PROHIBITED.--No health care provider or health facility shall discriminate against or refuse to furnish health care services to a beneficiary on the basis of 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 21. GRIEVANCE PROCEDURES.--The commission shall adopt regulations to cover and shall implement a prompt and fair grievance procedure to respond to complaints of applicants, beneficiaries, health care providers and health facilities.

Section 22. UTILIZATION REVIEW.--

A. The commission shall adopt regulations to cover and shall implement a comprehensive utilization 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 of the health plan to approve or deny health care services for payment shall be made in a timely manner. A final decision to deny payment for services shall be made by a health care professional having appropriate and adequate qualifications to make the decision. The utilization review program shall be designed to ensure that beneficiaries have proper access to health care services, including referrals to necessary specialists. A decision made in the utilization review program shall be subject to the grievance procedures under regulations adopted pursuant to Section 21 of the Health Care Act.

Section 23. MONITORING HEALTH CARE PROVIDER PRACTICES.--

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

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 services provided through the health plan.

C. The quality improvement program shall include an ongoing system for monitoring patterns of practice. The commission shall appoint an advisory group consisting of health care providers, representatives of health facilities and other knowledgeable persons to advise the commission and staff on health care practice issues. The advisory group shall provide to the commission recommended standards and guidelines to be followed in making determinations on practice issues.

D. 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 regulation the procedures for recouping payments or withholding payments for health care services determined by the commission to be medically unnecessary. In addition, the commission may provide by regulation

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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 peer review advisory group, the commission may suspend or revoke a health care provider's or health facility's privilege to provide health care services under the health plan for aberrant patterns of practice, including overutilization, unnecessary referrals, attempts to unbundle health care services or other practices that the commission deems a violation of the Health Care Act or regulations adopted pursuant to that act. As used in this section, "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 to practice under the Health Care 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 24. HEALTH PLAN BUDGET.--

A. Each year, the commission shall develop a health plan budget. The budget shall establish the total amount to be spent by the plan for covered health care services in the next year. The budget shall include administrative budgets, provider budgets and global budgets.

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.

C. In developing the health plan budget, the commission shall provide that credit be taken in that budget for all revenues produced for health care services and facilities in the state pursuant to any law other than the Health Care Act.

Section 25. PROVIDER BUDGET--PAYMENTS TO HEALTH CARE PROVIDER--CO-PAYMENTS.--

A. Consistent with budget constraints, the health plan shall provide payment for all covered health care services rendered by health care providers. A variety of payment plans, including fee-for-service, compensation caps and capitated payments may be adopted by the commission. Payment plans shall be negotiated with providers as provided by regulation. In the event that negotiation fails to develop an acceptable payment plan, the disputing parties shall submit the payment plan to mediation. The commission shall adopt regulations governing the procedures for mediation. If the disputed payment plan is not resolved in mediation, the disputing parties shall submit the payment plan to binding arbitration pursuant to the Uniform Arbitration Act and regulations to be

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adopted by 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. The annual percentage increase in provider budgets shall be no greater than the percentage increase in the implicit price deflator using one year prior to implementation of the health plan as the baseline year.

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 any additional amounts for services covered by the plan.

E. The commission may set co-payments if co-payment is determined to be an effective cost-control measure. No co-payment shall be required for preventive care or if it creates a barrier to medically necessary care. When a co-payment is required, the health care provider shall not waive the co-payment.

Section 26. GLOBAL BUDGET--PAYMENTS TO HEALTH FACILITIES--CO-PAYMENTS.--

A. A health facility shall negotiate an annual global budget with the commission. The global budget shall be based on a base budget of past performance and projected changes upward or downward in costs and services anticipated for the next year. If a negotiated annual global budget is not reached, a health facility shall submit the budget to mediation. The commission shall adopt regulations governing the procedures for mediation. If the disputed budget is not resolved in mediation, the health facility shall submit the budget to binding arbitration pursuant to the Uniform Arbitration Act and regulations adopted by the commission. The initial base budget for a health facility shall be based on a twelve-month period that is no later than the year the health plan is implemented, appropriately adjusted by the implicit price deflator not to exceed five percent a year from 1996 to the first global budget. Thereafter, increases in global budgets are limited by the implicit price deflator.

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 globally budgeted health facility shall be paid from the budget allocation in a manner determined by the health facility.

D. The commission may set co-payments if co-payment is determined to be an effective cost-control measure. No co-payment shall be required for preventive care or if it creates a barrier to medically necessary care. When a co-payment is required, the health facility shall not waive the co-payment.

Section 27. HEALTH RESOURCE CERTIFICATE--COMMISSION REGULATIONS--REQUIREMENT FOR REVIEW.--

A. The commission shall adopt regulations pertaining to when a 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. No health facility or health care provider shall undertake a capital project or obligate a health facility or health care provider to undertake a project without first obtaining a health resource certificate, except as provided in Subsection F of this section.

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 capital project 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) a capital project for which a binding contractual obligation was incurred prior to the effective date of this section;

(3) 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;

(4) 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;

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

(6) 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, 1999, 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 Care Act by adding to that act dollar limitations to apply in denying or approving capital expenditures.

Section 28. 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 regulation 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 29. 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 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 30. COMPUTERIZED SYSTEM.--The commission shall require that all 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 31. 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 global budgets, health care provider fees and any other information the commission deems necessary to carry out its duties under the Health Care Act.

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

C. Information confidential pursuant to other provisions of law shall be confidential under the Health Care Act. Within the constraints of confidentiality, reports of the commission are public documents.

Section 32. OMBUDSMAN PROGRAM.--

A. The commission shall establish an ombudsman 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 Care Act; and

(2) health care providers and health facilities about 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 ombudsman programs and shall have ombudsmen available throughout the state to assist beneficiaries, applicants, health care providers and health facilities in person.

Section 33. REIMBURSEMENT FOR OUT-OF-STATE SERVICES--HEALTH PLAN'S RIGHT TO SUBROGATION AND PAYMENT FROM OTHER INSURANCE PLANS--CHARGES FOR NON-COVERED 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. Additional charges for those services shall not be paid by the health plan unless the commission has negotiated 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 other beneficiaries whose rights can legally be assigned by the beneficiary.

Section 34. PRIVATE HEALTH INSURANCE COVERAGE LIMITED.--

A. After the health plan is effective, 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.

B. Nothing in this section shall be construed to affect 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 35. FEDERAL HEALTH INSURANCE PROGRAM WAIVERS--REIMBURSEMENT TO HEALTH PLAN FROM FEDERAL AND OTHER HEALTH INSURANCE PROGRAMS.--

A. The commission, in conjunction with the human services department, shall:

(1) apply to the United States department of health and human services for all waivers of requirements under health care programs established pursuant to the federal Social Security Act, as amended, that are necessary to enable the state to deposit federal payments for services covered by the health plan into the plan's fund and to be the supplemental payer of benefits for persons receiving medicare benefits;

(2) 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

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necessary to enable the state to deposit federal payments for health care services covered by the health plan into the plan's fund; provided, however, agreements negotiated with the 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 Care Act to as many New Mexicans as possible.

B. The commission shall seek payment to the health plan from medicaid, medicare or any other federal or other insurance program for any reimbursable payment provided under the plan.

C. 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 36. INSURANCE--COMMISSION APPROVAL.--No person shall insure himself or his employees after July 1, 1999 unless the

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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 37. INSURANCE RATES--COMMISSION AND SUPERINTENDENT OF INSURANCE DUTIES.--

A. The commission shall work closely with the superintendent of insurance to identify health care cost savings that have been achieved as a result of implementation of the health plan. The commission and the superintendent shall identify savings by insurance companies on payments made for medical services through motor vehicle liability insurance, homeowners' insurance, workers' compensation insurance or other insurance policies that have a medical payment component. The commission and the superintendent shall report their findings to the legislature.

B. The superintendent shall lower insurance premiums associated with medical benefits on all types of insurance policies written in New Mexico that have a medical payment component as soon as data indicate health care savings have been achieved as a result of operation of the health plan.

Section 38. FINANCING THE HEALTH PLAN.--

A. The legislative finance committee, in cooperation with the New Mexico health policy commission, shall determine financing options for the health plan. In making its determinations the

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committee shall be guided by the following requirements and assumptions:

(1) the health plan budget shall be no greater than the health care expenditures projected for the 1998 calendar year would have been had the health plan been in effect;

(2) benefits to be costed in determining the financing options shall be equivalent to basic health care coverage afforded state employees; and

(3) options shall set minimum and maximum levels of premium payments and employer contributions and include a system for reasonable co-payments except for preventive care and for those beneficiaries at or below one hundred percent of the poverty level.

B. The legislative finance committee shall prepare a report of its determinations with the specific options and recommendations no later than December 15, 1997. The report shall be submitted for consideration for legislative implementation to the second session of the forty-third legislature.

Section 39. TEMPORARY PROVISION--TRANSITION PERIOD ARRANGEMENTS--PUBLICLY FUNDED HEALTH CARE SERVICE PLANS.--

A. A person who, on the date benefits are available under the Health Care Act health plan, receives health care benefits under private contract or collective bargaining agreement entered into prior to July 1, 1999 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

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plan.

B. A person covered by a health care services 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 Care Act health plan on the effective date that benefits are available under the plan.

Section 40. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 1997.