HOUSE BILL 10

50TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2011

INTRODUCED BY

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AN ACT

RELATING TO HEALTH INSURANCE; AMENDING THE PREFERRED PROVIDER ARRANGEMENTS LAW TO PROVIDE FOR REIMBURSEMENT ARRANGEMENTS OUTSIDE OF PREFERRED PROVIDER ARRANGEMENTS.

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

SECTION 1. Section 59A-22A-4 NMSA 1978 (being Laws 1993, Chapter 320, Section 62) is amended to read:

"59A-22A-4. PREFERRED PROVIDER ARRANGEMENTS.--

A. Notwithstanding any provisions of law to contrary, any health care insurer may enter into preferred provider arrangements.

[~~A.~~] B. Such arrangements shall:

(1) establish the amount and manner of payment to the preferred provider. Such amount and manner of payment may include capitation payments for preferred providers;

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(2) include mechanisms [~~which~~] that are designed to minimize the cost of the health benefit plan; for example:

(a) the review or control of utilization of health care services; or

(b) procedures for determining whether health care services rendered are medically necessary; and

(3) assure reasonable access to covered services available under the preferred provider arrangement and an adequate number of preferred providers to render those services.

[~~B.~~] C. Such arrangements shall not unfairly deny health benefits for medically necessary covered services.

D. Such arrangements shall not prohibit a health care provider, hospital or outpatient surgery center that is located within the geographic coverage area of the health benefit plan from entering into an arrangement, similar to those accepted by health care providers, hospitals or outpatient surgery centers that enter into preferred provider arrangements. The arrangement for health care providers shall include reasonable payment that is at least equal to the average reimbursement for other health care providers in that specialty and practice setting; provided that the health care insurer may terminate, discontinue or not renew the arrangement if a federally designated health care provider peer review

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organization concurs with the insurer regarding the decision to terminate, discontinue or not renew the contract.

[~~C.~~] E. If an entity enters into a contract providing covered services with a health care provider, but is not engaged in activities [~~which~~] that would require it to be licensed as a health care insurer, such entity shall file with the superintendent information describing its activities, a description of the contract or agreement it has entered into with the health care providers and such other information as is required by the provisions of the Health Care Benefits Jurisdiction Act and any regulations promulgated under its authority. Employers who enter into contracts with health care providers for the exclusive benefit of their employees and dependents are subject to the Health Care Benefits Jurisdiction Act and are exempt from this requirement only to the extent required by federal law."

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

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

A. "basic health care services":

(1) means medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory, diagnostic and therapeutic radiological services and services

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of pharmacists and pharmacist clinicians; but

(2) does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment;

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

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

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

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

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

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

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the subscriber by the health maintenance organization or by the group contract holder;

H. "extension of benefits" means the continuation of coverage under a particular benefit provided under a contract or group contract following termination with respect to an enrollee who is totally disabled on the date of termination;

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

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

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

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

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

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

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

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

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

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

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S. "nonparticipating provider" means a provider that does not have an agreement with a health maintenance organization to provide health care services to enrollees pursuant to an express service contract or arrangement with the health maintenance organization;

[~~S.~~] T. "participating provider" means a provider as defined in Subsection [~~U~~] V of this section who, under an express contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization;

[~~T.~~] U. "person" means an individual or other legal entity;

[~~U.~~] V. "provider" means a physician, pharmacist, pharmacist clinician, hospital or other person licensed or otherwise authorized to furnish health care services;

[~~V.~~] W. "replacement coverage" means the benefits provided by a succeeding carrier;

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

[~~X.~~] Y. "uncovered expenditures" means the costs to

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

[~~Y.~~] Z. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act; and

[~~Z.~~] AA. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act."

SECTION 3. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] NONPARTICIPATING PROVIDERS--PAYMENT AGREEMENTS.--When a health maintenance organization enters into a payment arrangement with a group of nonparticipating providers, it shall reimburse those nonparticipating providers at a rate that is at least equal to the average reimbursement for other providers in that specialty and practice setting for that geographic region. The health maintenance organization may elect to terminate, discontinue or not renew the payment arrangement if a federally designated provider peer review organization concurs with the health maintenance organization regarding the decision to terminate, discontinue or not renew the contract."

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SECTION 4. Section 59A-57-6 NMSA 1978 (being Laws 1998, Chapter 107, Section 6) is amended to read:

"59A-57-6. FAIRNESS TO HEALTH CARE PROVIDERS--GAG RULES PROHIBITED--GRIEVANCE PROCEDURE FOR PROVIDERS.--

A. [~~No~~] A managed health care plan [~~may~~] shall not:

(1) adopt a gag rule or practice that prohibits a health care provider from discussing a treatment option with an enrollee even if the plan does not approve of the option;

(2) include in any of its contracts with health care providers any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary services to an enrollee; [~~or~~]

(3) require a health care provider to violate any recognized fiduciary duty of [~~his~~] the provider's profession or place [~~his~~] the provider's license in jeopardy; or

(4) prohibit any health care provider that is located within the geographic coverage area of the managed health care plan from entering into a contract similar to those accepted by physicians, hospitals or outpatient surgery centers entering into such contracts. The contract for health care providers shall include reasonable payment equivalent to or within the range of the payment schedule for other providers in that specialty or practice setting; provided that the managed

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health care plan may terminate, discontinue or not renew the contract if a federally designated health care provider peer review organization in the state concurs with the managed health care plan regarding the decision to terminate, discontinue or not renew the contract.

B. A managed health care plan that proposes to terminate a health care provider from the [~~managed health care~~] plan shall explain in writing the rationale for its proposed termination and deliver reasonable advance written notice to the provider prior to the proposed effective date of the termination.

C. A managed health care plan shall adopt and implement a process pursuant to which health care providers may raise with the plan concerns that they may have regarding operation of the plan, including concerns regarding quality of and access to health care services, the choice of [~~health care~~] providers and the adequacy of the plan's provider network. The process shall include, at a minimum, the right of the provider to present the provider's concerns to a plan committee responsible for the substantive area addressed by the concern and the assurance that the concern will be conveyed to the plan's governing body. In addition, a managed health care plan shall adopt and implement a fair hearing plan that permits a health care provider to dispute the existence of adequate cause to terminate the provider's participation with the plan to the

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extent that the relationship is terminated for cause and shall include in each provider contract a dispute resolution mechanism."