SENATE BILL 227

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

INTRODUCED BY

Peter Wirth

AN ACT

RELATING TO HEALTH INSURANCE; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978 TO PROVIDE BENCHMARKS FOR CALCULATING "USUAL AND CUSTOMARY" REIMBURSEMENT FOR HEALTH CARE SERVICES RECEIVED OUTSIDE OF A PREFERRED PROVIDER ARRANGEMENT OR A HEALTH MAINTENANCE ORGANIZATION'S NETWORK; PROVIDING GUIDELINES FOR PREFERRED PROVIDER ARRANGEMENTS IN GROUP HEALTH COVERAGE PURSUANT TO THE HEALTH CARE PURCHASING ACT.

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

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] PREFERRED PROVIDER ARRANGEMENTS.--

A. Group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act may provide for incentives for eligible

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participants to use the health care services of preferred providers. Group health coverage that provides for such incentives shall include the following provisions:

(1) a provision that emergency care rendered during the course of an emergency will be reimbursed as though the eligible participant had been treated by a preferred provider in cases when an eligible participant receives emergency care for services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider; and

(2) a provision that clearly identifies the differentials in benefit levels for health care services of preferred providers and benefit levels for health care services of non-preferred providers.

B. If a group coverage plan provides differences in benefit levels payable to preferred providers compared to other providers, those differences shall not unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for eligible participants to use the preferred provider.

C. When a group coverage plan makes reimbursement for health care services according to a "usual and customary" rate or a "usual, customary and reasonable" rate to a health care provider who is not a preferred provider, the group coverage plan shall determine that rate based upon the

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prevailing market cost of that particular service delivered in the geographic area where the insurer delivered the services. The health coverage plan shall calculate the prevailing market cost by obtaining data from an independent database of such costs and by using statistics developed using generally accepted professional standards for statistical analysis.

D. For the purposes of this section:

(1) "emergency care" means covered services delivered to a covered person after the sudden onset of a medical condition manifesting itself by acute symptoms that are severe enough that:

(a) the lack of immediate medical attention could result in: 1) placing the person's health in jeopardy; 2) serious impairment of bodily functions; or 3) serious dysfunction of any bodily organ or part; or

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

(2) "health care services" means services rendered or products sold by a health care provider within the scope of the provider's license, certification or other legal authorization to practice. "Health care services" includes hospital, medical, surgical, dental, vision and pharmaceutical services or products;

(3) "preferred provider" means a health care provider or group of providers who have contracted with the

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group coverage plan to provide specified covered services to a covered person; and

(4) "preferred provider arrangement" means a contract between or on behalf of the group coverage plan and a preferred provider that complies with the provisions of this section."

SECTION 2. Section 59A-22A-5 NMSA 1978 (being Laws 1993, Chapter 320, Section 63) is amended to read:

"59A-22A-5. HEALTH BENEFIT PLANS.--

A. Health care insurers may issue health benefit plans [~~which~~] that provide for incentives for covered persons to use the health care services of preferred providers. Such policies or subscriber agreement shall contain at least the following provisions:

(1) a provision that, if a covered person receives emergency care for services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider, that emergency care rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider; and

(2) a provision [~~which~~] that clearly identifies the differentials in benefit levels for health care services of preferred providers and benefit levels for health care services of non-preferred providers.

B. If a health benefit plan provides differences in

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benefit levels payable to preferred providers compared to other providers, such differences shall not unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

C. When a health care insurer makes reimbursement for health care services according to a "usual and customary" rate or a "usual, customary and reasonable" rate to a health care provider who is not a preferred provider, the health care insurer shall determine that rate based upon the prevailing market cost of that particular service delivered in the geographic area where the insurer delivered the services. The health care insurer shall calculate the prevailing market cost by obtaining data from an independent database of such costs and using statistics developed using generally accepted professional standards for statistical analysis."

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

"[NEW MATERIAL] NONPARTICIPATING PROVIDER REIMBURSEMENT--"USUAL AND CUSTOMARY" RATES--STANDARDS.--When making reimbursement for health care services to a nonparticipating provider pursuant to a "usual and customary" rate or a "usual, customary and reasonable" rate, a health maintenance organization shall determine that rate based upon the prevailing market cost of that particular service delivered in

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the geographic area where the nonparticipating provider delivered the services. The health maintenance organization shall calculate the prevailing market cost by obtaining data from an independent database of such costs and using statistics developed using generally accepted professional standards for statistical analysis."

SECTION 4. 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 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;

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

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

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

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

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

H. "extension of benefits" means the continuation of 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

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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;

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

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[~~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;

S. "nonparticipating provider" means a provider who 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 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

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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;

V. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act;

W. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act;

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

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

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

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

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the superintendent

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

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