F I S C A L I M P A C T R E P O R T

SPONSOR Stewart **ORIGINAL DATE** 01/27/11 **LAST UPDATED** **HB** 10

SHORT TITLE Reimbursement Outside of Preferred Providers **SB**

ANALYST Esquibel

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY11	**FY12**		
	No Fiscal Impact		

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department
Public Regulation Commission

SUMMARY

Synopsis of Bill

House Bill 10 amends Section 59A-22A-4, NMSA 1978 to 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 a preferred provider arrangement.

§59A-57-6, NMSA 1978 is amended to 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.

Both amended sections in House Bill 10 require that arrangements and contracts for physician payments shall be equivalent to the pay schedule for other physicians in that specialty and practice setting. In addition, it enables a health care insurer and a managed health care plan to have the ability to terminate an arrangement or contract once a federally designated physician peer review organization concurs with the insurer or managed health care plan.

House Bill 10 creates Section 3 in §59A-57-6, NMSA 1978 which determines 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. In addition, it enables the health maintenance organization to have the ability to terminate, discontinue or not renew the payment arrangement if a federally designated provider peer review organization concurs with the health maintenance organization.

SIGNIFICANT ISSUES

The Public Regulation Commission submitted the following information:

An entity located within the geographic coverage area wishing to enter into a preferred provider arrangement must adhere to 13.10.21, NMAC, Health Care Services and Provider Credentialing Required for HMOs. Currently, the HMO shall review and approve the contracting entity's credential verification program before contracting and shall require that the entity comply with all applicable requirements of this regulation.

Each health care insurer through its managed health care plan shall adhere to 13.10.22, NMAC, Managed Health Care Plan Compliance. The purpose of this rule is to ensure the availability, accessibility, and quality of health care services provided by health care insurers through managed health care plans, and to regulate trade practices in the insurance business and related businesses by prohibiting unfair or deceptive acts or practices.

RAE/bym