AN ACT

RELATING TO INSURANCE; ENACTING THE PATIENT PROTECTION ACT; PROVIDING PROTECTIONS FOR PERSONS IN MANAGED HEALTH CARE PLANS; APPLYING PATIENT PROTECTIONS TO MEDICAID MANAGED CARE; IMPOSING A CIVIL PENALTY; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978; MAKING AN APPROPRIATION.

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

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

"SHORT TITLE.--Sections 1 through 11 of this act may be cited as the "Patient Protection Act"."

Section 2. A new section of the New Mexico Insurance Code is enacted to read:

"PURPOSE OF ACT.--The purpose of the Patient Protection Act is to regulate aspects of health insurance by specifying patient and provider rights and confirming and clarifying the authority of the department to adopt regulations to provide protections to persons enrolled in managed health care plans. The insurance protections should ensure that managed health care plans treat patients fairly and arrange for the delivery of good quality services."

Section 3. A new section of the New Mexico Insurance Code is enacted to read:

"DEFINITIONS.--As used in the Patient Protection Act:

A. "continuous quality improvement" means an ongoing and systematic effort to measure, evaluate and improve a managed health care plan's process in order to improve continually the quality of health care services provided to enrollees;

B. "covered person", "enrollee", "patient" or "consumer" means an individual who is entitled to receive health care benefits provided by a managed health care plan;

C. "department" means the insurance department;

D. "emergency care" means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in jeopardy to a person's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to a person;

E. "health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting;

F. "health care insurer" means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan;

G. "health care professional" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law;

H. "health care provider" or "provider" means a person that is licensed or otherwise authorized by the state to furnish health care services and includes health care professionals and health care facilities;

I. "health care services" includes, to the extent offered by the plan, physical health or community-based mental health or developmental disability services, including services for developmental delay;

J. "managed health care plan" or "plan" means a health care insurer or a provider service network when offering a benefit that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health care insurer or provider service network. "Managed health care plan" or "plan" does not include a health care insurer or

provider service network offering a traditional fee-for-service indemnity benefit or a benefit that covers only short-term travel, accident-only, limited benefit, student health plan or specified disease policies;

K. "person" means an individual or other legal entity;

L. "point-of-service plan" or "open plan" means a managed health care plan that allows enrollees to use health care providers other than providers under direct contract with or employed by the plan, even if the plan provides incentives, including financial incentives, for covered persons to use the plan's designated participating providers;

M. "provider service network" means two or more health care providers affiliated for the purpose of providing health care services to covered persons on a capitated or similar prepaid flat-rate basis that hold a certificate of authority pursuant to the Provider Service Network Act;

N. "superintendent" means the superintendent of insurance; and

O. "utilization review" means a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients."

Section 4. A new section of the New Mexico Insurance Code is enacted to read:

"PATIENT RIGHTS--DISCLOSURES--RIGHTS TO BASIC AND COMPREHENSIVE HEALTH CARE SERVICES--GRIEVANCE PROCEDURE--UTILIZATION REVIEW PROGRAM--CONTINUOUS QUALITY PROGRAM.--

A. Each covered person enrolled in a managed health care plan has the right to be treated fairly. A managed health care plan shall arrange for the delivery of good quality and appropriate health care services to enrollees as defined in the particular subscriber agreement. The department shall adopt regulations to implement the provisions of the Patient Protection Act and shall monitor and oversee a managed health care plan to ensure that each covered person enrolled in a plan is treated fairly and in accordance with the requirements of the Patient Protection Act. In adopting regulations to implement the provisions of Subparagraphs (a) and (b) of Paragraph (3) and Paragraphs (5) and (6) of Subsection B of this section regarding health care standards and specialists, utilization review programs and continuous quality improvement programs, the department shall cooperate with and seek advice from the department of health.

B. The regulations adopted by the department to protect patient rights shall provide at a minimum that:

(1) prior to or at the time of enrollment, a managed health care plan shall provide a summary of benefits and exclusions, premium information and a provider listing; within a reasonable time after enrollment and at subsequent

periodic times as appropriate, a managed health care plan shall provide written material that contains, in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, limitations, exclusions, conditions of eligibility, prior authorization requirements, enrollee financial responsibility for payments, grievance procedures, appeal rights and the patients' rights generally available to all covered persons;

(2) a managed health care plan shall provide health care services that are reasonably accessible and available in a timely manner to each covered person;

(3) in providing reasonably accessible health care services that are available in a timely manner, a managed health care plan shall ensure that:

(a) the plan offers sufficient numbers and types of qualified and adequately staffed health care providers at reasonable hours of service to provide health care services to the plan's enrollees;

(b) health care providers that are specialists may act as primary care providers for patients with chronic medical conditions, provided the specialists offer all basic health care services that are required of them by a managed health care plan;

(c) reasonable access is provided to out-of-network health care providers if medically necessary

covered services are not reasonably available through participating health care providers or if necessary to provide continuity of care during brief transition periods;

(d) emergency care is immediately available without prior authorization requirements, and appropriate out-of-network emergency care is not subject to additional costs; and

(e) the plan, through provider selection, provider education, the provision of additional resources or other means, reasonably addresses the cultural and linguistic diversity of its enrollee population;

(4) a managed health care plan shall adopt and implement a prompt and fair grievance procedure for resolving patient complaints and addressing patient questions and concerns regarding any aspect of the plan, including the quality of and access to health care, the choice of health care provider or treatment and the adequacy of the plan's provider network. The grievance procedure shall notify patients of their right to obtain review by the plan, their right to obtain review by the superintendent, their right to expedited review of emergent utilization decisions and their rights under the Patient Protection Act;

(5) a managed health care plan shall adopt and implement a comprehensive utilization review program. The basis of a decision to deny care shall be disclosed to an

affected enrollee. The decision to approve or deny care to an enrollee shall be made in a timely manner, and the final decision shall be made by a qualified health care professional. A plan's utilization review program shall ensure that enrollees have proper access to health care services, including referrals to necessary specialists. A decision made in a plan's utilization review program shall be subject to the plan's grievance procedure and appeal to the superintendent; and

(6) a managed health care plan shall adopt and implement a continuous quality improvement program that monitors the quality and appropriateness of the health care services provided by the plan."

Section 5. A new section of the New Mexico Insurance Code is enacted to read:

"CONSUMER ASSISTANCE--CONSUMER ADVISORY BOARDS --OMBUDSMAN OFFICE--REPORTS TO CONSUMERS--SUPERINTENDENT'S ORDERS TO PROTECT CONSUMERS.--

A. Each managed health care plan shall establish and adequately staff a consumer assistance office. The purpose of the consumer assistance office is to respond to consumer questions and concerns and assist patients in exercising their rights and protecting their interests as consumers of health care.

B. Each managed health care plan shall establish a

consumer advisory board. The board shall meet at least quarterly and shall advise the plan about the plan's general operations from the perspective of the enrollee as a consumer of health care. The board shall also review the operations of and be advisory to the plan's consumer assistance office.

~~C. The department shall establish and adequately staff a managed care ombudsman office, either within the department or by contract. The purpose of the managed care ombudsman office shall be to assist patients in exercising their rights and help advocate for and protect patient interests. The department's managed care ombudsman office shall work in conjunction with each plan's consumer assistance office and shall independently evaluate the effectiveness of the plan's consumer assistance office. The department's managed care ombudsman office may require a plan's consumer assistance office to adopt measures to ensure that the plan operates effectively to protect patient rights and inform consumers of the information to which they are entitled.~~

D. The department shall prepare an annual report assessing the operations of managed health care plans subject to the department's oversight, including information about consumer complaints.

E. A person adversely affected may file a complaint with the superintendent regarding a violation of the Patient Protection Act. Prior to issuing any remedial order

regarding violations of the Patient Protection Act or its regulations, the superintendent shall hold a hearing in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978. The superintendent may issue any order he deems necessary or appropriate, including ordering the delivery of appropriate care, to protect consumers and enforce the provisions of the Patient Protection Act. The superintendent shall adopt special procedures to govern the submission of emergency appeals to him in health emergencies."

Section 6. A new section of the New Mexico Insurance Code is enacted to read:

"FAIRNESS TO HEALTH CARE PROVIDERS--GAG RULES PROHIBITED--GRIEVANCE PROCEDURE FOR PROVIDERS.--

A. No managed health care plan may:

(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 profession or place his license in jeopardy.

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

Section 7. A new section of the New Mexico Insurance Code is enacted to read:

"POINT-OF-SERVICE OPTION PLAN.--

A. Except as otherwise provided in this section, the department may require a plan that offers a point-of-service plan or open plan to include in any managed health care plan it offers an option for a point-of-service plan or open plan to the extent that the department determines that the open plan option is financially sound.

B. No health care insurer may be required to offer a point-of-service plan or open plan as an option under a medicaid-funded managed health care plan unless the human services department has established such a requirement as part of a procurement for managed health care under the medicaid program."

Section 8. A new section of the New Mexico Insurance Code is enacted to read:

"ADMINISTRATIVE COSTS AND BENEFIT COSTS DISCLOSURES.--The department shall adopt regulations to ensure that both the administrative costs and the direct costs of providing health care services of each managed health care plan are fully and fairly disclosed to consumers in a uniform manner that allows meaningful cost comparisons among plans."

Section 9. A new section of the New Mexico Insurance Code is enacted to read:

"PRIVATE REMEDIES TO ENFORCE PATIENT AND PROVIDER INSURANCE RIGHTS--ENROLLEE AS THIRD-PARTY BENEFICIARY TO ENFORCE RIGHTS.--

A. A person who suffers a loss as a result of a violation of a right protected pursuant to the provisions of the Patient Protection Act, its regulations or a managed health care plan may bring an action to recover actual damages or the sum of one hundred dollars ($100), whichever is greater.

B. A person likely to be damaged by a denial of a right protected pursuant to the provisions of the Patient Protection Act or its regulations may be granted an injunction under the principles of equity and on terms that the court considers reasonable. Proof of monetary damage or intent to violate a right is not required.

C. To protect and enforce an enrollee's rights in a managed health care plan, an individual enrollee participating in or eligible to participate in a managed health care plan shall be treated as a third-party beneficiary of the managed health care plan contract between the plan and the party with which the plan directly contracts. An individual enrollee may sue to enforce the rights provided in the contract that governs the managed health care plan; provided, however, that the plan and the party to the contract may amend the terms of, or terminate the provisions of, the contract without the enrollee's consent.

D. The relief provided pursuant to this section is in addition to other remedies available against the same

conduct under the common law or other statutes of this state.

E. In any class action filed pursuant to this section, the court may award damages to the named plaintiffs as provided in this section and may award members of the class the actual damages suffered by each member of the class as a result of the unlawful practice.

F. Nothing in the Patient Protection Act is intended to make a plan vicariously liable for the actions of independent contractor health care providers."

Section 10. A new section of the New Mexico Insurance Code is enacted to read:

"APPLICATION OF ACT TO MEDICAID PROGRAM.--

A. Except as otherwise provided in this section, the provisions of the Patient Protection Act apply to the medicaid program operation in the state. A managed health care plan offered through the medicaid program shall grant enrollees and providers the same rights and protections as are granted to enrollees and providers in any other managed health care plan subject to the provisions of the Patient Protection Act.

B. Nothing in the Patient Protection Act shall be construed to limit the authority of the human services department to administer the medicaid program, as required by law. Consistent with applicable state and federal law, the human services department shall have sole authority to

determine, establish and enforce medicaid eligibility criteria, the scope, definitions and limitations of medicaid benefits and the minimum qualifications or standards for medicaid service providers.

C. Medicaid recipients and applicants retain their right to appeal decisions adversely affecting their medicaid benefits to the human services department, pursuant to the Public Assistance Appeals Act. Notwithstanding other provisions of the Patient Protection Act, a medicaid recipient or applicant who files an appeal to the human services department pursuant to the Public Assistance Appeals Act may not file an appeal on the same issue to the superintendent pursuant to the Patient Protection Act, unless the human services department refuses to hear the appeal. The superintendent may refer to the human services department any appeal filed with the superintendent pursuant to the Patient Protection Act if the complainant is a medicaid beneficiary and the matter in dispute is subject to the provisions of the Public Assistance Appeals Act.

D. Any managed health care plan participating in the medicaid managed care program as of the effective date of the Patient Protection Act and that is in compliance with contractual and regulatory requirements applicable to that program shall be deemed to comply with any requirements established in accordance with that act until July 1, 1999;

provided that, from the effective date of that act, any rights established under that act beyond those under requirements of the human services department shall apply to enrollees in medicaid managed health care plans."

Section 11. A new section of the New Mexico Insurance Code is enacted to read:

"PENALTY.--In addition to any other penalties provided by law, a civil administrative penalty of up to ten thousand dollars ($10,000) may be imposed for each violation of the Patient Protection Act. An administrative penalty shall be imposed by written order of the superintendent made after holding a hearing as provided for in Chapter 59A, Article 4 NMSA 1978."

Section 12. Section 59A-1-16 NMSA 1978 (being Laws 1984, Chapter 127, Section 16) is amended to read:

"59A-1-16. EXEMPTED FROM CODE.--In addition to organizations and businesses otherwise exempt, the Insurance Code shall not apply to:

A. a labor organization that, incidental only to operations as a labor organization, issues benefit certificates to members or maintains funds to assist members and their families in times of illness, injury or need, and not for profit;

B. the credit union share insurance corporation, as identified in Chapter 58, Article 12 NMSA 1978, and similar

corporations and funds for protection of depositors, shareholders or creditors of financial institutions and businesses other than insurers; or

C. the risk management division of the general services department or to insurance of public property or public risks by any agency of government not otherwise engaged in the business of insurance, except the provisions of the Patient Protection Act shall apply to the risk management division and any managed health care plan it offers."

Section 13. Section 59A-46-30 NMSA 1978 (being Laws 1993, Chapter 266, Section 29, as amended) is amended to read:

"59A-46-30. STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER LAWS.--

A. The provisions of the Insurance Code other than Chapter 59A, Article 46 NMSA 1978 shall not apply to health maintenance organizations except as expressly provided in the Insurance Code and that article. To the extent reasonable and not inconsistent with the provisions of that article, the following articles and provisions of the Insurance Code shall also apply to health maintenance organizations and their promoters, sponsors, directors, officers, employees, agents, solicitors and other representatives. For the purposes of such applicability, a health maintenance organization may therein be referred to as an "insurer":

(1) Chapter 59A, Article 1 NMSA 1978;

(2) Chapter 59A, Article 2 NMSA 1978;

(3) Chapter 59A, Article 3 NMSA 1978;

(4) Chapter 59A, Article 4 NMSA 1978;

(5) Subsection C of Section 59A-5-22 NMSA 1978;

(6) Sections 59A-6-2 through 59A-6-4 and 59A-6-6 NMSA 1978;

(7) Chapter 59A, Article 8 NMSA 1978;

(8) Chapter 59A, Article 10 NMSA 1978;

(9) Section 59A-12-22 NMSA 1978;

(10) Chapter 59A, Article 16 NMSA 1978;

(11) Chapter 59A, Article 18 NMSA 1978;

(12) Chapter 59A, Article 19 NMSA 1978;

(13) Section 59A-22-14 NMSA 1978;

(14) Chapter 59A, Article 23B NMSA 1978;

(15) Sections 59A-34-9 through 59A-34-13, 59A-34-17, 59A-34-23, 59A-34-36 and 59A-34-37 NMSA 1978;

(16) Chapter 59A, Article 37 NMSA 1978; and

(17) the Patient Protection Act.

B. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed as violating any provision of law relating to solicitation or advertising by health professionals, but health professionals shall be individually subject to the laws, rules, regulations and

ethical provisions governing their individual professions.

C. Any health maintenance organization authorized under the provisions of the Health Maintenance Organization Law shall not be deemed to be practicing medicine and shall be exempt from the provisions of laws relating to the practice of medicine."

Section 14. Section 59A-47-33 NMSA 1978 (being Laws 1984, Chapter 127, Section 879.32, as amended by Laws 1997, Chapter 7, Section 4 and by Laws 1997, Chapter 248, Section 3 and also by Laws 1997, Chapter 255, Section 4) is amended to read:

"59A-47-33. OTHER PROVISIONS APPLICABLE.--The provisions of the Insurance Code other than Chapter 59A, Article 47 NMSA 1978 shall not apply to health care plans except as expressly provided in the Insurance Code and that article. To the extent reasonable and not inconsistent with the provisions of that article, the following articles and provisions of the Insurance Code shall also apply to health care plans, their promoters, sponsors, directors, officers, employees, agents, solicitors and other representatives; and, for the purposes of such applicability, a health care plan may therein be referred to as an "insurer":

A. Chapter 59A, Article 1 NMSA 1978;

B. Chapter 59A, Article 2 NMSA 1978;

C. Chapter 59A, Article 4 NMSA 1978;

D. Subsection C of Section 59A-5-22 NMSA 1978;

E. Sections 59A-6-2 through 59A-6-4 and 59A-6-6 NMSA 1978;

F. Section 59A-7-11 NMSA 1978;

G. Chapter 59A, Article 8 NMSA 1978;

H. Chapter 59A, Article 10 NMSA 1978;

I. Section 59A-12-22 NMSA 1978;

J. Chapter 59A, Article 16 NMSA 1978;

K. Chapter 59A, Article 18 NMSA 1978;

L. Chapter 59A, Article 19 NMSA 1978;

M. Subsections B through E of Section 59A-22-5 NMSA 1978;

N. Section 59A-22-14 NMSA 1978;

O. Section 59A-22-34.1 NMSA 1978;

P. Section 59A-22-39 NMSA 1978;

Q. Section 59A-22-40 NMSA 1978;

R. Section 59A-22-41 NMSA 1978;

S. Sections 59A-34-9 through 59A-34-13 and 59A-34-23 NMSA 1978;

T. Chapter 59A, Article 37 NMSA 1978, except Section 59A-37-7 NMSA 1978;

U. Section 59A-46-15 NMSA 1978; and

V. the Patient Protection Act."

~~Section 15. APPROPRIATION.--Five hundred thousand dollars ($500,000) is appropriated from the general fund to~~

~~the department of insurance for expenditure in fiscal year 1999 to pay salaries and benefits and other costs necessary to establish a managed care ombudsman office and administer the provisions of the Patient Protection Act. Any unexpended or unencumbered balance remaining at the end of fiscal year 1999 shall revert to the general fund.~~

Section 16. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 1998.