SENATE BILL 517

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

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AN ACT

RELATING TO HEALTH INSURANCE; ENACTING SECTIONS OF THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE PATIENT PROTECTION ACT TO PROVIDE FOR INTERNAL APPEALS OF ADVERSE DETERMINATIONS.

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

SECTION 1. 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. "adverse determination" means:

(1) a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time;

(2) a denial, reduction or termination of, or a failure to provide or make payment in whole or in part for, a

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benefit, including a denial, reduction, termination or failure to provide or make payments that is based on a determination of an enrollee's eligibility to participate in a plan; or

(3) a denial, reduction of, termination of or failure to provide or make payment, in whole or in part, for a benefit resulting from:

(a) the application of any utilization review; or

(b) a determination that a benefit that is otherwise provided is experimental, investigational, not medically necessary or not appropriate;

[~~A.~~] B. "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.~~] C. "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

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operating staff model facilities;

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

[~~E.~~] F. "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.~~] G. "enrollee" means an individual who is covered by a health maintenance organization;

[~~G.~~] H. "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.~~] I. "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.~~] J. "grievance" means a [~~written~~] complaint

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relating to a matter that does not involve an adverse determination, 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.~~] K. "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.~~] L. "group contract holder" means the person to whom a group contract has been issued;

[~~L.~~] M. "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.~~] N. "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.~~] O. "health maintenance organization agent"

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

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

R. "internal appeal" means a review by a health maintenance organization of an adverse determination;

[~~Q.~~] S. "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.~~] T. "net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt;

[~~S.~~] U. "participating provider" means a provider as defined in Subsection [~~U~~] W of this section who, under an express contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide

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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.~~] V. "person" means an individual or other legal entity;

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

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

[~~W.~~] Y. "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.~~] Z. "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 the superintendent;

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

[~~Z.~~] BB. "pharmacist clinician" means a pharmacist

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who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act."

SECTION 2. Section 59A-46-11 NMSA 1978 (being Laws 1993, Chapter 266, Section 11) is amended to read:

"59A-46-11. GRIEVANCE PROCEDURES--INTERNAL APPEALS.--

A. Every health maintenance organization shall establish and maintain a grievance procedure that has been approved by the superintendent to provide procedures for the resolution of grievances initiated by enrollees. The health maintenance organization shall maintain records regarding grievances received since the date of its last examination of such grievances.

B. The superintendent or [~~his~~] the superintendent's designee may examine such grievance procedures and records.

C. A health maintenance organization shall implement and maintain an internal appeal system that:

(1) provides reasonable procedures for the resolution of an oral or written internal appeal requesting a redetermination or revision of an adverse determination;

(2) allows an appellant to initiate an internal appeal in accordance with clearly established guidelines;

(3) ensures that expedited internal appeals are available, pursuant to which the health maintenance organization shall make a decision within twenty-four hours of

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a written or oral internal appeal, for matters in which:

(a) the life or health of an enrollee is in jeopardy;

(b) the enrollee's ability to regain maximum function is in jeopardy;

(c) the enrollee's health care provider reasonably requests an expedited decision; or

(d) in the opinion of the enrollee's health care provider with knowledge of the enrollee's condition, the enrollee would be subject to severe pain or discomfort that cannot be adequately managed without the care or treatment that is the subject of the adverse determination;

(4) ensure that an enrollee may file a standard internal appeal pursuant to which the health maintenance organization shall issue a decision within five business days of receiving the appellant's written or oral internal appeal;

(5) provides that a health maintenance organization shall issue a decision notice in accordance with clearly established written guidelines that inform an appellant of the decision, including notice as to whether a benefit will be provided or fully funded; and

(6) considers an internal appeal of an adverse determination to have been made if an appellant, within thirty days of issuance of an adverse determination, expresses orally

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or in writing, any dissatisfaction or disagreement with the adverse determination to a health maintenance organization or the health maintenance organization's agent.

D. In cases of internal appeals of adverse determinations relating to a prescription drug benefit, a health maintenance organization shall issue immediate electronic authorization to the enrollee's pharmacy authorizing the continued coverage of the prescription drug that is the subject of the internal appeal pending the decision of the internal appeal.

E. Without regard to whether the adverse determination is upheld on review, a health maintenance organization shall not charge an enrollee for the cost of a health care benefit, including a prescription drug benefit, that is the subject of an internal appeal received during the period the review was considered except for an applicable copayment, coinsurance or deductible under the applicable health maintenance organization contract."

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

"[NEW MATERIAL] ADVERSE DETERMINATION--NOTIFICATIONS.--When making an adverse determination, a health maintenance organization shall provide a written explanation for the adverse determination and an explanation of the health maintenance organization's procedures and deadlines for filing

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an internal appeal of the adverse determination with the health maintenance organization. This notice shall include an explanation of the grounds, procedures and deadlines for making an expedited internal appeal. In the notice, a covered person shall be notified of the covered person's right to receive upon request and free of charge:

A. the internal rules, guidelines, protocols or other criteria upon which the health care insurer relied in making the adverse determination; and

B. in an adverse determination made in reliance upon a medical necessity finding or relating to the experimental nature of a treatment, an explanation of the scientific or clinical judgment for the determination."

SECTION 4. Section 59A-57-3 NMSA 1978 (being Laws 1998, Chapter 107, Section 3) is amended to read:

"59A-57-3. DEFINITIONS.--As used in the Patient Protection Act:

A. "adverse determination" means:

(1) a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time;

(2) a denial, reduction or termination of, or a failure to provide or make payment in whole or in part for, a benefit, including a denial, reduction, termination or failure to provide or make payments that is based on a determination of

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an enrollee's eligibility to participate in a plan; or

(3) a denial, reduction of, termination of or failure to provide or make payment, in whole or in part, for a benefit resulting from:

(a) the application of any utilization review; or

(b) a determination that a benefit that is otherwise provided is experimental, investigational, not medically necessary or not appropriate;

B. "appellant" means an enrollee, a person acting on behalf of an enrollee or an enrollee's health care provider who files an internal appeal;

[~~A.~~] C. "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.~~] D. "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.~~] E. "department" means the office of superintendent of insurance [~~department~~];

[~~D.~~] F. "emergency care" means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be

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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;

G. "grievance" means a complaint to a health care insurer relating to a matter that does not involve an adverse determination;

[~~E.~~] H. "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.~~] I. "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.~~] J. "health care professional" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized

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by the state to provide health care services consistent with state law;

[~~H.~~] K. "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.~~] L. "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;

M. "internal appeal" means a review by a health care insurer of an adverse determination;

[~~J.~~] N. "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.~~] O. "person" means an individual or other legal

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entity;

[~~L.~~] P. "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.~~] Q. "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.~~] R. "superintendent" means the superintendent of insurance; and

[~~O.~~] S. "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 5. A new section of the Patient Protection Act is enacted to read:

"[NEW MATERIAL] ADVERSE DETERMINATION--NOTIFICATIONS--INTERNAL APPEALS.--

A. When making an adverse determination, a health

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care insurer shall provide a written explanation for the adverse determination and an explanation of the health care insurer's procedures and deadlines for filing an internal appeal of the adverse determination with the health care insurer. This notice shall include an explanation of the grounds, procedures and deadlines for making an expedited internal appeal. In the notice, a covered person shall be notified of the covered person's right to receive upon request and free of charge:

(1) the internal rules, guidelines, protocols or other criteria upon which the health care insurer relied in making the adverse determination; and

(2) in an adverse determination made in reliance upon a medical necessity finding or relating to the experimental nature of a treatment, an explanation of the scientific or clinical judgment for the determination.

B. A health care insurer shall implement and maintain an internal appeal system that:

(1) provides reasonable procedures for the resolution of an oral or written internal appeal requesting a redetermination or revision of an adverse determination;

(2) allows an appellant to initiate an internal appeal in accordance with clearly established guidelines;

(3) ensures that expedited internal appeals

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are available, pursuant to which the health care insurer shall make a decision within twenty-four hours of a written or oral internal appeal, for matters in which:

(a) the life or health of an enrollee is in jeopardy;

(b) the enrollee's ability to regain maximum function is in jeopardy;

(c) the enrollee's health care provider reasonably requests an expedited decision; or

(d) in the opinion of the enrollee's health care provider with knowledge of the enrollee's condition, the enrollee would be subject to severe pain or discomfort that cannot be adequately managed without the care or treatment that is the subject of the adverse determination;

(4) ensure that an enrollee may file a standard internal appeal pursuant to which the health care insurer shall issue a decision within five business days of receiving the appellant's written or oral internal appeal;

(5) provides that a health care insurer shall issue a decision notice in accordance with clearly established written guidelines that inform an appellant of the decision, including notice as to whether a benefit will be provided or fully funded; and

(6) considers an internal appeal of an adverse determination to have been made if an appellant, within thirty

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days of issuance of an adverse determination, expresses orally or in writing, any dissatisfaction or disagreement with the adverse determination to a health care insurer or the insurer's agent.

C. In cases of internal appeals of adverse determinations relating to a prescription drug benefit, a health care insurer shall issue immediate electronic authorization to the enrollee's pharmacy authorizing the continued coverage of the prescription drug that is the subject of the internal appeal pending the decision of the internal appeal.

D. Without regard to whether the adverse determination is upheld on review, a health care insurer shall not charge an enrollee for the cost of a health care benefit, including a prescription drug benefit that is the subject of an internal appeal received during the period the review was considered except for an applicable copayment, coinsurance or deductible under the applicable plan."