SENATE BILL 92

54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019

INTRODUCED BY

Bill Tallman

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH; AMENDING SECTIONS OF THE PATIENT PROTECTION ACT TO PROVIDE FOR REGULATION OF PHARMACY BENEFITS MANAGER PRACTICES.

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

SECTION 1. Section 59A-57-3 NMSA 1978 (being Laws 1998, Chapter 107, Section 3, as amended) is amended to read:

"59A-57-3. 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

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"consumer" means an individual who is entitled to receive health care benefits provided by a managed health care plan;

C. "department" means the office of superintendent of insurance;

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; a pharmacy; 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;

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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 or specified disease policies;

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

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L. "pharmacy benefits manager" means a person or a wholly or partially owned or controlled subsidiary of a person that provides claims administration, benefit design and management, pharmacy network management, negotiation and administration of product discounts, rebates and other benefits accruing to the pharmacy benefits manager or other prescription drug or device services to third parties, but "pharmacy benefits manager" does not include any of the following that provides formulary services to its own patients, employees, members or beneficiaries:

(1) a licensed health care facility;

(2) a pharmacy;

(3) a licensed health care professional;

(4) a health insurer;

(5) a union;

(6) a health maintenance organization;

(7) a medicare advantage plan; or

(8) a prescription drug plan;

[~~L.~~] M. "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;

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[~~M.~~] N. "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.~~] O. "superintendent" means the superintendent of insurance; and

[~~O.~~] P. "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 2. 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~~] or a pharmacy benefits manager 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 managed health care plan or pharmacy benefits manager 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

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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.

B. A managed health care plan or a pharmacy benefits manager that proposes to terminate a health care provider from the managed health care plan or pharmacy benefits manager 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~~] Each managed health care plan and pharmacy benefits manager shall adopt and implement a process pursuant to which health care providers may raise with the managed health care plan or pharmacy benefits manager concerns that [~~they may~~] health care providers have regarding operation of the managed health care plan or pharmacy benefits manager, including concerns regarding quality of and access to health care services, the choice of [~~health care~~] providers and the adequacy of the managed health care plan's or pharmacy benefits manager's provider network. The process shall include, at a minimum, the right of the provider to present the provider's concerns to a managed health care plan or pharmacy benefits manager committee responsible for the substantive area addressed by the concern and the assurance that the concern

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will be conveyed to the managed health care plan's or pharmacy benefits manager's governing body. In addition, [~~a~~] each managed health care plan and pharmacy benefits manager 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 managed health care plan or pharmacy benefits manager to the extent that the relationship is terminated for cause and shall include in each provider contract a dispute resolution mechanism."

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