SENATE BILL 5

44TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SPECIAL SESSION, 1999

INTRODUCED BY

Timothy Z. Jennings

AN ACT

RELATING TO HEALTH; MAKING CHANGES IN THE PATIENT PROTECTION ACT; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978.

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

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

"59A-57-1. SHORT TITLE.--[~~Sections 1 through 11 of this act~~] Chapter 59A, Article 57 NMSA 1978 may be cited as the "Patient Protection Act"."

Section 2. Section 59A-57-2 NMSA 1978 (being Laws 1998, Chapter 107, Section 2) is amended to read:

"59A-57-2. PURPOSE OF ACT.--The purpose of the Patient Protection Act is to regulate certain aspects of health insurance by specifying patient and provider rights, [~~and~~] confirming and clarifying the authority of the [~~department~~]

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division to adopt regulations to provide [~~protections to~~] protection of persons enrolled in [~~managed health care~~] plans [~~The insurance protections should ensure~~] and ensuring that [~~managed health care~~] plans treat patients fairly and arrange for the delivery of good quality services."

Section 3. 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. "clean claim" means a manually or electronically submitted claim that contains all the required data elements necessary for accurate determination without the need for additional information from outside of the plan's system and that contains no material deficiency or impropriety, including lack of substantiating documentation currently required by the plan or particular or unusual circumstances requiring special treatment that prevents timely payment from being made by the plan;

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

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~~health care benefits provided by a managed health care plan;~~

~~C. "department" means the insurance department;~~

[~~D.~~] C. "emergency care" means health care procedures, treatments or services delivered to [~~a covered person~~] an enrollee 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;

D. "enrollee" means a person who is entitled to health care benefits pursuant to a plan;

E. "health care facility" means an institution [~~providing~~] that is licensed or otherwise authorized by the state to provide 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;~~] and includes 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~~

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~~organization, nonprofit health care plan or prepaid dental plan~~];

[~~G.~~] F. "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.~~] G. "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.~~] H. "health care services" includes, to the extent offered by the plan, physical health, [~~or community-based mental~~] behavioral health or developmental disability services [~~including~~] and includes 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~~

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~~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;~~]

I. "insurer" means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, managed care organization, provider service network, plan or prepaid dental plan;

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

[~~L.~~] K. "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

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1 providers;

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

8 [N. "superintendent" means the superintendent of
9 insurance;] and

10 [O.] M. "utilization review" means a system for
11 reviewing the appropriate and efficient allocation of health
12 care services given or proposed to be given to a patient or
13 group of patients."

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

16 "59A-57-4. [PATIENT] ENROLLEE RIGHTS--DISCLOSURES--
17 RIGHTS TO BASIC AND COMPREHENSIVE HEALTH CARE
18 SERVICES--GRIEVANCE PROCEDURE-- UTILIZATION REVIEW PROGRAM--
19 CONTINUOUS QUALITY PROGRAM.--

20 A. [Each covered person enrolled in a managed
21 health care plan] An enrollee has the right to be treated
22 fairly. A [managed health care] plan shall arrange for the
23 delivery of good quality and appropriate health care services
24 to enrollees as defined in the particular subscriber
25 agreement. The [department] division shall adopt

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[~~regulations~~] rules 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~~] enrollee is treated fairly and in accordance with the requirements of the Patient Protection Act. In adopting [~~regulations~~] rules to implement the provisions of Subparagraphs (a) and (b) of Paragraph [~~(3)~~] (5) and Paragraphs [~~(5)~~] (7) and [~~(6)~~] (10) of Subsection B of this section, [~~regarding health care standards and specialists, utilization review programs and continuous quality improvement programs~~] the [~~department~~] division shall cooperate with and seek advice from the department of health.

B. The [~~regulations~~] rules adopted by the [~~department~~] division to protect patient rights shall provide at a minimum that:

(1) prior to or at the time of enrollment and periodically thereafter as appropriate, 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~~]

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financial responsibility for payments, grievance procedures, appeal rights and the patients' rights generally available to all covered persons;] to all enrollees either directly or, in the case of a group policy, through their employer, a written description of the plan that contains, in a clear, concise and readily understandable form, a full and fair disclosure of:

(a) the plan's benefits and exclusions, limitations, premium information, health care providers, conditions of eligibility, prior authorization requirements, enrollee financial responsibility for payments, grievance procedures, appeal rights and customer service phone line information;

(b) the plan's provisions for referrals or authorizations for specialty care, behavioral health services and hospital services;

(c) the plan's procedures, if any, for changing health care providers; and

(d) a summary of enrollees' rights established pursuant to the Patient Protection Act and rules adopted pursuant to that act;

(2) upon request of an enrollee, a plan shall provide information on the rules and provisions that are directly related to an enrollee's health care, including formularies, enrollees' and health care providers' referral procedures and utilization review;

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(3) if an enrollee is responsible for paying any portion of a bill, an insurer or health care provider shall provide the enrollee with a copy of an intelligible bill, including the portion and amount paid by the plan, but this requirement does not apply to a flat co-pay paid by the enrollee at the time the service is required;

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

[(3)] (5) 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] enrollees with chronic medical conditions [provided] if 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

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participating health care providers or if necessary to provide continuity of care during brief transition periods;

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

(e) reimbursement for emergency care or ambulance service is not contingent upon time constraints of less than seven days for notification by the enrollee to the plan or any other entity that the care or services have been used; and

[~~(e) the plan~~] (f) 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)~~] (6) a [~~managed health care~~] plan [~~shall~~] adopt and implement a prompt and fair grievance procedure for resolving [~~patient~~] enrollees' complaints and addressing [~~patient~~] enrollees' 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~~] require notification of enrollees of their right to obtain review by the plan, their right to obtain review by the superintendent,

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their right to expedited review of emergent utilization decisions and their rights under the Patient Protection Act;

[~~(5)~~] (7) a [~~managed health care~~] plan [~~shall~~] adopt and implement a comprehensive utilization review program in which:

(a) the basis of a decision to deny care shall be disclosed to an affected enrollee;

(b) the decision to approve or deny care to an enrollee shall be made in a timely manner; and

(c) the final decision shall be made by a qualified health care professional;

(8) a plan's utilization review program [~~shall~~] ensure that enrollees have proper access to health care services, including referrals to necessary specialists;

(9) 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)~~] (10) 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 Patient Protection Act, Section 59A-57-4.1 NMSA 1978, is enacted to read:

"59A-57-4.1. [NEW MATERIAL] REPORTS OF DENIAL OF CARE--SANCTIONS.--

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A. The division shall file a report with the legislature annually that includes at a minimum:

(1) a summary of the aggregate data regarding denial of care categorized by:

(a) access issues;

(b) benefit or claim limitations; and

(c) administrative issues;

(2) a summary of the aggregate data regarding internal grievances and appeals; and

(3) any need for additional statutory direction to achieve its duties and objectives.

B. The superintendent may hold a hearing in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978 to determine if a plan is denying care excessively or unjustly. The superintendent may issue an order against an insurer that he deems necessary or appropriate to protect consumers regarding the denial of care, including ordering the prompt delivery of appropriate care, impositions of sanctions or the taking of disciplinary action that may include fines or license revocation."

Section 6. Section 59A-57-5 NMSA 1978 (being Laws 1998, Chapter 107, Section 5) is amended to read:

"59A-57-5. CONSUMER ASSISTANCE--CONSUMER ADVISORY BOARDS [~~OMBUDSMAN OFFICE~~]--REPORTS TO CONSUMERS--DUTIES AND POWERS OF DIVISION AND SUPERINTENDENT--SUPERINTENDENT'S ORDERS TO

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PROTECT CONSUMERS.--

A. [~~Each managed health care~~] A 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~~] enrollees in exercising their rights and protecting their interests as consumers of health care.

B. [~~Each managed health care~~] A 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.

[~~D.~~] C. The [~~department~~] division in conjunction with the commission shall:

(1) prepare an annual report assessing the operations of [~~managed health care~~] plans subject to the [~~department's~~] division's oversight, including information about consumer complaints;

(2) develop or use standardized, quantitative performance measurements of plans based on a five point rating scale;

(3) survey high-use health care consumers, purchasers and health care providers to assess the quality of

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1 clinical and service-related aspects of health care arranged
2 for or provided by plans in accordance with measurements
3 developed pursuant to Paragraph (2) of this subsection; and
4 (4) develop or use, test, refine and produce
5 one or more plan performance grade cards to provide consumers
6 with accurate, reliable and timely comparisons of plans.
7 [E.] D. A person adversely affected may file a
8 complaint with the superintendent regarding a violation of the
9 Patient Protection Act or the rules adopted pursuant to that
10 act. Prior to issuing any remedial order regarding violations
11 of the Patient Protection Act or its [regulations] rules, the
12 superintendent shall hold a hearing in accordance with the
13 provisions of Chapter 59A, Article 4 NMSA 1978. The
14 superintendent may issue any order he deems necessary or
15 appropriate, including ordering the delivery of appropriate
16 care, to protect consumers and enforce the provisions of the
17 Patient Protection Act. The superintendent shall adopt
18 special procedures to govern the submission of emergency
19 appeals to him in health emergencies."
20 Section 7. Section 59A-57-6 NMSA 1978 (being Laws 1998,
21 Chapter 107, Section 6) is amended to read:
22 "59A-57-6. FAIRNESS TO HEALTH CARE PROVIDERS--GAG RULES
23 PROHIBITED--GRIEVANCE PROCEDURE FOR PROVIDERS.--
24 A. No [managed health care] plan may:
25 (1) adopt a gag rule or practice that

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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~~] a contract with a health care [~~providers any provisions~~] provider a provision that [~~offer~~] offers 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. No contract or element of a contract between an insurer or plan and a health care provider shall include any provision that has the effect of relieving either party of liability for its actions or inactions.

C. A plan shall:

(1) provide in a timely manner the necessary authorization or response to any inquiry by a health care provider required to provide health care services; and

(2) reasonably exhaust available local resources if requested by the enrollee or his designee for providing necessary health care services.

[~~B.~~] D. 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

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and deliver reasonable advance written notice to the provider prior to the proposed effective date of the termination.

[~~C.~~] E. A [~~managed health care~~] plan shall adopt and implement a process pursuant to which health care 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~~] a health care provider to present the provider's concerns to a plan committee responsible for the substantive health care services 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~~] process 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 health care provider contract a dispute resolution mechanism.

F. Nothing in this section prohibits a plan from taking action against a health care provider if the plan has evidence that the provider's actions are illegal, constitute medical malpractice or are contrary to accepted medical practices."

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Section 8. Section 59A-57-7 NMSA 1978 (being Laws 1998, Chapter 107, Section 7) is amended to read:

"59A-57-7. POINT-OF-SERVICE OPTION PLAN.--

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

B. No [~~health care insurer~~] plan 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 9. A new section of the Patient Protection Act, Section 59A-57-7.1 NMSA 1978, is enacted to read:

"59A-57-7.1. [NEW MATERIAL] PENALTY FOR LATE PAYMENT FOR SERVICES--NOTICE FOR CLAIMS RECEIVED--STANDARD FORMS.--

A. A contract entered into between a plan and a participating health care provider shall provide that if the plan fails to make payment to that provider within thirty days after a clean claim has been submitted by the provider to the plan, the plan shall be liable for the amount due and unpaid

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plus interest on that amount at the rate of one and one-half percent per month computed on a daily basis.

B. If a plan contests a claim of a participating health care provider, that plan shall notify the participating provider in writing within thirty days of receipt of the claim with the specific reason why it is not liable for the claim or request additional information necessary to determine liability for the claim.

C. If a portion of the claim submitted to the plan by the participating health care provider for payment is in dispute, the plan shall pay the undisputed portion of that claim in accordance with provisions of Subsection A of this section.

D. By December 1, 2000, the division shall promulgate rules to require plans to:

(1) provide timely notice to participating health care providers of claims received, both for claims received electronically and for claims submitted manually; and

(2) utilize standardized forms for all claims, authorization and other official communication between a participating health care provider and the plan regarding payment for health care services."

Section 10. Section 59A-57-8 NMSA 1978 (being Laws 1998, Chapter 107, Section 8) is amended to read:

"59A-57-8. ADMINISTRATIVE COSTS AND BENEFIT COSTS

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DISCLOSURES.-- The [~~department~~] division shall adopt [~~regulations~~] rules to ensure that both the administrative costs and the direct costs of a plan 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 11. Section 59A-57-9 NMSA 1978 (being Laws 1998, Chapter 107, Section 9) is amended to read:

"59A-57-9. 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~~] rules adopted pursuant to its provisions or the provisions of 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~~], rules adopted pursuant to its provisions or the provisions of a plan may be granted [~~an injunction under the principles of equity and on terms that the court considers reasonable~~] injunctive relief. Proof of monetary damage or intent to violate a right is not required

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1 as a condition of obtaining injunctive relief.

2 C. To protect and enforce an enrollee's rights in
3 a [managed health care] plan, an individual enrollee
4 participating in or eligible to participate in a [managed
5 health care] plan shall be treated as a third-party
6 beneficiary of the [managed health care] plan contract between
7 the plan and the party with which the plan directly contracts.
8 An individual enrollee may sue to enforce the rights provided
9 in the contract that governs the [managed health care] plan
10 [provided, however, that], but the plan and the party to the
11 contract may amend the terms of, or terminate the provisions
12 of, the contract without the enrollee's consent.

13 D. [The] Relief provided pursuant to this section
14 is in addition to other remedies available against the same
15 conduct under the common law or other statutes of this state.

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

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

24 Section 12. Section 59A-57-10 NMSA 1978 (being Laws
25 1998, Chapter 107, Section 10) is amended to read:

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"59A-57-10. APPLICATION OF ACT TO MEDICAID PROGRAM.--

A. Except as otherwise provided in this section, the provisions of the Patient Protection Act and rules adopted pursuant to that act apply to the medicaid program operation in the state. A [~~managed health care~~] plan offered through the medicaid program shall grant enrollees and health care 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~~] limits 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~~

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~~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~~] an 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~~] July 1, 1998 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~~] the Patient Protection 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~~] July 1, 2000. Effective July 1, 2000, the rules promulgated by the department to implement the Patient Protection Act shall apply to medicaid managed care plans except when and to the extent such rules are in conflict with rules or conditions imposed on the state or on such plans by the federal government."

Section 13. Section 59A-57-11 NMSA 1978 (being Laws

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1 1998, Chapter 107, Section 11) is amended to read:

2 "59A-57-11. PENALTY.--In addition to any other penalties
3 provided by law, a civil administrative penalty of up to ten
4 thousand dollars ($10,000) may be imposed for each violation
5 by a plan of a prohibitive provision or a mandatory
6 requirement of the Patient Protection Act. An administrative
7 penalty shall be imposed by written order of the
8 superintendent made after holding a hearing as provided for in
9 Chapter 59A, Article 4 NMSA 1978."

10 Section 14. A new section of the Patient Protection Act,
11 Section 59A-57-12 NMSA 1978, is enacted to read:

12 "59A-57-12. [NEW MATERIAL] CONFIDENTIALITY.--Nothing in
13 the Patient Protection Act requires disclosure of information
14 that is otherwise privileged or confidential under any other
15 provision of law."

16 Section 15. EFFECTIVE DATE.--The effective date of the
17 provisions of this act is July 1, 2000.

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