SENATE BILL 374

47TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2005

INTRODUCED BY

Mary Kay Papen

AN ACT

RELATING TO HEALTH INSURANCE; AMENDING THE PATIENT PROTECTION ACT TO PROVIDE FOR REVIEWS BY AND APPEALS TO THE PUBLIC REGULATION COMMISSION.

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) is amended to read:

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

A. "commission" means the public regulation commission;

[~~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

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enrollees;

[~~B.~~] C. "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.~~] D. "department" means the insurance [~~department~~] division of the commission;

[~~D.~~] E. "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.~~] F. "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.~~] G. "health care insurer" means a person that has a valid certificate of authority in good standing under the

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Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan;

[~~G.~~] H. "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.~~] I. "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.~~] J. "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.~~] K. "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

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benefit or a benefit that covers only short-term travel, accident-only, limited benefit, student health plan or specified disease policies;

[~~K.~~] L. "person" means an individual or other legal entity;

[~~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;

[~~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-57-4 NMSA 1978 (being Laws 1998,

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Chapter 107, Section 4) is amended to read:

"59A-57-4. 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.

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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

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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~~] commission, 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

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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~~] commission; 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 3. Section 59A-57-4.1 NMSA 1978 (being Laws 2003, Chapter 327, Section 2) is amended to read:

"59A-57-4.1. EXTERNAL GRIEVANCE APPEALS--APPOINTMENT--COMPENSATION.--

A. The superintendent [~~may~~] shall appoint one or more qualified individuals other than the superintendent to review external grievance appeals.

B. The superintendent shall fix the reasonable compensation of each appointee based upon, but not limited to, compensation amounts suggested by national or state legal or medical professional societies, organizations or associations.

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C. Upon completion of the external grievance appeal review, the superintendent shall prepare a detailed statement of compensation due each appointee and shall present the statement to the enrollee's health insurer.

D. The enrollee's health insurer shall pay the compensation directly to each appointee who participated in the external grievance appeal review.

E. The [~~superintendent~~] commission shall [~~promulgate~~] adopt rules to implement this section."

Section 4. 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--[~~SUPERINTENDENT'S~~] COMMISSION'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

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and be advisory to the plan's consumer assistance office.

[~~D.~~] C. 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.~~] D. 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~~] commission shall hold a hearing in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978. The [~~superintendent may~~] commission shall 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~~] commission shall adopt special procedures to govern the submission of emergency appeals [~~to him in~~] for health emergencies."

Section 5. Section 59A-57-11 NMSA 1978 (being Laws 1998, Chapter 107, Section 11) is amended to read:

"59A-57-11. 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~~] commission

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made after holding a hearing as provided for in Chapter 59A, Article 4 NMSA 1978."

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