AN ACT

RELATING TO INSURANCE; INCLUDING PHARMACISTS AND PHARMACIST CLINICIANS AS PROVIDERS OF SERVICE.

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) is amended to read:

"59A-46-2. DEFINITIONS.--As used in the Health Maintenance Organization Law:

A. "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. "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 operating staff model facilities;

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

E. "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. "enrollee" means an individual who is covered by a health maintenance organization;

G. "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. "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. "grievance" means a written complaint 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. "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. "group contract holder" means the person to whom a group contract has been issued;

L. "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. "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. "health maintenance organization agent" 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, or a person who advertises or otherwise holds himself out to the public as such;

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

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

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

S. "participating provider" means a provider as defined in Subsection U of this section who, under an express contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide 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. "person" means an individual or other legal entity;

U. "provider" means a physician, pharmacist,

pharmacist clinician, hospital or other person licensed or otherwise authorized to furnish health care services;

V. "replacement coverage" means the benefits provided by a succeeding carrier;

W. "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. "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. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act; and

Z. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act."

Section 2. Section 59A-47-3 NMSA 1978 (being Laws 1984, Chapter 127, Section 879.1, as amended) is amended to read:

"59A-47-3. DEFINITIONS.--As used in Chapter 59A, Article 47 NMSA 1978:

A. "health care" means the treatment of persons for the prevention, cure or correction of any illness or physical or mental condition, including optometric services;

B. "item of health care" includes any services or materials used in health care;

C. "health care expense payment" means a payment for health care to a purveyor on behalf of a subscriber, or such a payment to the subscriber;

D. "purveyor" means a person who furnishes any item of health care and charges for that item;

E. "service benefit" means a payment that the purveyor has agreed to accept as payment in full for health care furnished the subscriber;

F. "indemnity benefit" means a payment that the purveyor has not agreed to accept as payment in full for health care furnished the subscriber;

G. "subscriber" means any individual who, because of a contract with a health care plan entered into by or for the individual, is entitled to have health care expense payments made on the individual's behalf or to the individual by the health care plan;

H. "underwriting manual" means the health care plan's written criteria, approved by the superintendent, that defines the terms and conditions under which subscribers may be selected. The underwriting manual may be amended from

time to time, but amendment will not be effective until approved by the superintendent. The superintendent shall notify the health care plan filing the underwriting manual or the amendment thereto of the superintendent's approval or disapproval thereof in writing within thirty days after filing or within sixty days after filing if the superintendent shall so extend the time. If the superintendent fails to act within such period, the filing shall be deemed to be approved;

I. "acquisition expenses" includes all expenses incurred in connection with the solicitation and enrollment of subscribers;

J. "administration expenses" means all expenses of the health care plan other than the cost of health care expense payments and acquisition expenses;

K. "health care plan" means a nonprofit corporation authorized by the superintendent to enter into contracts with subscribers and to make health care expense payments;

L. "agent" means a person appointed by a health care plan authorized to transact business in this state to act as its representative in any given locality for soliciting health care policies and other related duties as may be authorized;

M. "solicitor" means a person employed by the

licensed agent of a health care plan for the purpose of soliciting health care policies and other related duties in connection with the handling of the business of the agent as may be authorized and paid for the person's services either on a commission basis or salary basis or part by commission and part by salary;

N. "chiropractor" means any person holding a license provided for in the Chiropractic Physician Practice Act;

O. "doctor of oriental medicine" means any person licensed as a doctor of oriental medicine under the Acupuncture and Oriental Medicine Practice Act;

P. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act; and

Q. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act."