SENATE BILL 104

49TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2009

INTRODUCED BY

Dede Feldman

AN ACT

RELATING TO HEALTH CARE; PROVIDING FOR PATIENT CHOICE AND ACCESS TO QUALIFIED PHYSICIANS, HOSPITALS AND OUTPATIENT SURGERY CENTERS; AMENDING CERTAIN SECTIONS OF THE NEW MEXICO INSURANCE CODE.

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

Section 1. Section 59A-22A-4 NMSA 1978 (being Laws 1993, Chapter 320, Section 62) is amended to read:

"59A-22A-4. PREFERRED PROVIDER ARRANGEMENTS.--

A. Notwithstanding any provisions of law to contrary, any health care insurer may enter into preferred provider arrangements.

[~~A.~~] B. Such arrangements shall:

(1) establish the amount and manner of payment to the preferred provider. Such amount and manner of payment

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may include capitation payments for preferred providers;

(2) include mechanisms [~~which~~] that are designed to minimize the cost of the health benefit plan; for example:

(a) the review or control of utilization of health care services; or

(b) procedures for determining whether health care services rendered are medically necessary; and

(3) assure reasonable access to covered services available under the preferred provider arrangement and an adequate number of preferred providers to render those services.

[~~B.~~] C. Such arrangements shall not unfairly deny health benefits for medically necessary covered services.

D. Such arrangements shall not prohibit any physician, hospital or outpatient surgery center that meets the stated quality and credentialing requirements and that is located within the geographic coverage area of the health benefit plan from entering into an arrangement, similar to those accepted by physicians, hospitals or outpatient surgery centers entering into preferred provider arrangements. The arrangement for physicians shall include reasonable payment equivalent to or within the range of the payment schedule for other physicians in that specialty and practice setting; provided, however, that the health care insurer may terminate,

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discontinue or not renew the arrangement if a federally designated physician peer review organization concurs with the insurer.

[~~C.~~] E. If an entity enters into a contract providing covered services with a health care provider, but is not engaged in activities [~~which~~] that would require it to be licensed as a health care insurer, such entity shall file with the superintendent information describing its activities, a description of the contract or agreement it has entered into with the health care providers and such other information as is required by the provisions of the Health Care Benefits Jurisdiction Act and any regulations promulgated under its authority. Employers who enter into contracts with health care providers for the exclusive benefit of their employees and dependents are subject to the Health Care Benefits Jurisdiction Act and are exempt from this requirement only to the extent required by federal law."

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~~] 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 plan does not approve of

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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 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; or

(4) prohibit any physician, hospital or outpatient surgery center that meets the stated quality and credentialing requirements and that is located within the geographic coverage area of the managed health care plan from entering into a contract, similar to those accepted by physicians, hospitals or outpatient surgery centers entering into such contracts. The contract for physicians shall include reasonable payment equivalent to or within the range of the payment schedule for other physicians in that specialty or practice setting; provided, however, that the managed health care plan may terminate, discontinue or not renew the contract if a federally designated peer review organization in the state concurs with the managed health care plan.

B. 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 and deliver

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

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

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