SENATE BILL 436

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

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AN ACT

RELATING TO HEALTH INSURANCE; AMENDING AND ENACTING NEW SECTIONS OF THE PREFERRED PROVIDER ARRANGEMENTS LAW, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO REQUIRE THAT SCHOOL-BASED HEALTH CENTERS ARE INCLUDED IN RESTRICTED NETWORKS.

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

SECTION 1. Section 59A-22A-3 NMSA 1978 (being Laws 1993, Chapter 320, Section 61) is amended to read:

"59A-22A-3. DEFINITIONS.--As used in the Preferred Provider Arrangements Law:

A. "covered person" means any person on whose behalf the health care insurer is obligated to pay for or to provide health benefit services;

B. "covered services" means health care services

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[~~which~~] that the health care insurer is obligated to pay for or to provide under a health benefit plan;

C. "emergency care" means covered services delivered to a covered person after the sudden onset of a medical condition manifesting itself by acute symptoms that are severe enough that:

(1) the lack of immediate medical attention could result in:

(a) placing the person's health in jeopardy;

(b) serious impairment of bodily functions; or

(c) serious dysfunction of any bodily organ or part; or

(2) a reasonable person believes that immediate medical attention is required;

D. "health benefit plan" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer [~~which~~] that defines the covered services and benefit levels available;

E. "health care insurer" means any person who provides health insurance in this state. For the purposes of the Small Group Rate and Renewability Act, "carrier" or "insurer" includes a licensed insurance company, a licensed fraternal benefit society, a prepaid hospital or medical

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service plan, a health maintenance organization, a nonprofit health care organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation;

F. "health care provider" means providers of health care services licensed as required in this state;

G. "health care services" means services rendered or products sold by a health care provider within the scope of the provider's license. The term includes hospital, medical, surgical, dental, vision and pharmaceutical services or products;

H. "preferred provider" means a health care provider or group of providers who have contracted with a health care insurer to provide specified covered services to a covered person; [~~and~~]

I. "preferred provider arrangement" means a contract between or on behalf of the health care insurer and a preferred provider [~~which~~] that complies with all the requirements of the Preferred Provider Arrangements Law;

J. "primary care" means the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services; "primary care" includes the provision of mental health care services if those services are integrated into the health care provider's service array; and

K. "school-based health center" means an entity

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licensed by the department of health as a health facility that:

(1) is located in or near a school facility of a school district or charter school or of an Indian tribe or tribal organization;

(2) is organized through school, community and health care provider relationships;

(3) provides health care through health professionals who are licensed, certified or otherwise authorized pursuant to state law to render primary care services; and

(4) is administered by one of the following entities:

(a) a hospital;

(b) the department of health;

(c) a community health center licensed by the department of health;

(d) a nonprofit health care agency;

(e) a local educational agency or regional education cooperative;

(f) a program administered by the federal Indian health service or the bureau of Indian affairs; or

(g) a program operated by an Indian tribe or a tribal organization."

SECTION 2. Section 59A-22A-4 NMSA 1978 (being Laws 1993,

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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 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; and

(4) assure reasonable access to covered services at school-based health centers.

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

[~~C.~~] D. If an entity enters into a contract

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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 3. Section 59A-46-2 NMSA 1978 (being Laws 1993, Chapter 266, Section 2, as amended) 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

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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

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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,

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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~~] that person, or a person who advertises or otherwise [~~holds himself out~~] makes any representation 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. "network provider" means a person or a group of persons licensed, certified or otherwise authorized to provide health care services in the state that has entered into a written agreement with a health maintenance organization to provide health care services to eligible individuals;

[~~R.~~] S. "net worth" means the excess of total

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admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt;

[~~S.~~] T. "participating provider" means a provider as defined in Subsection [~~U~~] Y 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;

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

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

[~~T.~~] W. "person" means an individual or other legal entity;

X. "primary care" means the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services; "primary care" includes the provision of mental health care services if those services are integrated into the health care provider's service array;

[~~U.~~] Y. "provider" means a physician, pharmacist, pharmacist clinician, hospital or other person licensed or otherwise authorized to furnish health care services;

Z. "restricted network provision" means any

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provision that conditions the payment of benefits, in whole or in part, on the use of network providers;

[~~V.~~] AA. "replacement coverage" means the benefits provided by a succeeding carrier;

BB. "school-based health center" means an entity licensed by the department of health as a health facility that:

(1) is located in or near a school facility of a school district or charter school or of an Indian tribe or tribal organization;

(2) is organized through school, community and health care provider relationships;

(3) provides health care through health professionals who are licensed, certified or otherwise authorized pursuant to state law to render primary health care services; and

(4) is administered by one of the following entities:

(a) a hospital;

(b) the department of health;

(c) a community health center licensed by the department of health;

(d) a nonprofit health care agency;

(e) a local educational agency or regional education cooperative;

(f) a program administered by the

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federal Indian health service or the bureau of Indian affairs; or

(g) a program operated by an Indian tribe or a tribal organization;

[~~W.~~] CC. "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; and

[~~X.~~] DD. "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 4. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] RESTRICTED NETWORK--SCHOOL-BASED HEALTH CENTER REQUIREMENT.--An individual or group health maintenance

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organization contract that is delivered, issued for delivery or renewed in this state and that contains a restricted network provision shall include as a network provider any school-based health center within the service area of the contract."

SECTION 5. 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

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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;

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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;

R. "network provider" means a person or a group of persons licensed, certified or otherwise authorized to

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provide health care services in the state that has entered into a written agreement with a health care plan to provide services to eligible individuals;

S. "primary care" means the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services; "primary care" includes the provision of mental health services if those services are integrated into the health care provider's service array; and

T. "school-based health center" means an entity licensed by the department of health as a health facility that:

(1) is located in or near a school facility of a school district or charter school or of an Indian tribe or tribal organization;

(2) is organized through school, community and health care provider relationships;

(3) provides health care through health professionals who are licensed, certified or otherwise authorized pursuant to state law to render primary health care services; and

(4) is administered by one of the following entities:

(a) a hospital;

(b) the department of health;

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(c) a community health center licensed by the department of health;

(d) a nonprofit health care agency;

(e) a local educational agency or regional education cooperative;

(f) a program administered by the federal Indian health service or the bureau of Indian affairs; or

(g) a program operated by an Indian tribe or a tribal organization."

SECTION 6. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] RESTRICTED NETWORK--SCHOOL-BASED HEALTH CENTER REQUIREMENT.--An individual or group health care plan that is delivered, issued for delivery or renewed in this state and contains a restricted network provision shall include as a network provider any school-based health center within the service area of the health care plan."

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