

1 SENATE BILL 291

2 **53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017**

3 INTRODUCED BY

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10 AN ACT

11 RELATING TO HEALTH COVERAGE; AMENDING AND ENACTING SECTIONS OF
12 THE HEALTH CARE PURCHASING ACT, THE NEW MEXICO INSURANCE CODE,
13 THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT
14 HEALTH CARE PLAN LAW TO ESTABLISH LIMITATIONS ON HEALTH
15 COVERAGE AND PROVIDER CONTRACT CHANGES.

16
17 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

18 SECTION 1. Section 13-7-15 NMSA 1978 (being Laws 2013,
19 Chapter 138, Section 1) is amended to read:

20 "13-7-15. PRESCRIPTION DRUGS--PROHIBITED FORMULARY
21 CHANGES--NOTICE REQUIREMENTS.--

22 A. [~~As of January 1, 2014~~] Group health coverage,
23 including any form of self-insurance, offered, issued or
24 renewed under the Health Care Purchasing Act that provides
25 coverage for prescription drugs categorized or tiered for

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1 purposes of cost-sharing through deductibles or coinsurance
2 obligations shall not make any of the following changes to
3 coverage for a prescription drug [~~within one hundred twenty~~
4 ~~days of any previous change to coverage for that prescription~~
5 ~~drug, unless a generic version of the prescription drug is~~
6 ~~available] less than ninety days prior to the beginning date of
7 the plan year in which these changes are to take effect or at
8 any time during a current plan year:~~

9 (1) reclassify a drug to a higher tier of the
10 formulary;

11 (2) reclassify a drug from a preferred
12 classification to a non-preferred classification, unless that
13 reclassification results in the drug moving to a lower tier of
14 the formulary;

15 (3) increase the cost-sharing, copayment,
16 deductible or coinsurance charges for a drug;

17 (4) remove a drug from the formulary;

18 (5) establish a prior authorization
19 requirement;

20 (6) impose or modify a drug's quantity limit;

21 or

22 (7) impose a step-therapy restriction.

23 [~~B. The administrator for the group health coverage~~
24 ~~shall give the affected enrollee at least sixty days' advance~~
25 ~~written notice of the impending change when it is determined~~

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1 ~~that one of the following modifications will made to a~~
2 ~~formulary:~~

3 ~~(1) reclassification of a drug to a higher~~
4 ~~tier of the formulary;~~

5 ~~(2) reclassification of a drug from a~~
6 ~~preferred classification to a non-preferred classification,~~
7 ~~unless that reclassification results in the drug moving to a~~
8 ~~lower tier of the formulary;~~

9 ~~(3) an increase in the cost-sharing,~~
10 ~~copayment, deductible or coinsurance charges for a drug;~~

11 ~~(4) removal of a drug from the formulary;~~

12 ~~(5) addition of a prior authorization~~
13 ~~requirement;~~

14 ~~(6) imposition or modification of a drug's~~
15 ~~quantity limit; or~~

16 ~~(7) imposition of a step-therapy restriction~~
17 ~~for a drug.~~

18 ~~G.]~~ B. Notwithstanding the provisions of
19 ~~[Subsections]~~ Subsection A ~~[and B]~~ of this section, the
20 administrator for group health coverage may immediately and
21 without prior notice remove a drug from the formulary if the
22 drug:

23 (1) is deemed unsafe by the federal food and
24 drug administration; or

25 (2) has been removed from the market for any

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1 reason.

2 ~~[D-]~~ C. The administrator for group health coverage
3 prescription drug benefits shall provide to each affected
4 enrollee the following information in plain language regarding
5 prescription drug benefits:

6 (1) notice that the group health plan uses one
7 or more drug formularies;

8 (2) an explanation of what the drug formulary
9 is;

10 (3) a statement regarding the method the group
11 health plan uses to determine the prescription drugs to be
12 included in or excluded from a drug formulary; and

13 (4) a statement of how often the group health
14 plan administrator reviews the contents of each drug formulary.

15 ~~[E-]~~ D. As used in this section:

16 (1) "formulary" means the list of prescription
17 drugs covered by group health coverage; and

18 (2) "step therapy" means a protocol that
19 establishes the specific sequence in which prescription drugs
20 for a specified medical condition and medically appropriate for
21 a particular patient are to be prescribed."

22 **SECTION 2.** Section 59A-22-49.4 NMSA 1978 (being Laws
23 2013, Chapter 138, Section 2) is amended to read:

24 "59A-22-49.4. PRESCRIPTION DRUGS--PROHIBITED FORMULARY
25 CHANGES--NOTICE REQUIREMENTS.--

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1 A. ~~[As of January 1, 2014]~~ An individual or group
2 health insurance policy, health care plan or certificate of
3 health insurance that is delivered, issued for delivery or
4 renewed in this state and that provides prescription drug
5 benefits categorized or tiered for purposes of cost-sharing
6 through deductibles or coinsurance obligations shall not make
7 any of the following changes to coverage for a prescription
8 drug ~~[within one hundred twenty days of any previous change to~~
9 ~~coverage for that prescription drug, unless a generic version~~
10 ~~of the prescription drug is available]~~ less than ninety days
11 prior to the beginning date of the policy, plan or certificate
12 year in which these changes are to take effect or at any time
13 during a current policy, plan or certificate year:

14 (1) reclassify a drug to a higher tier of the
15 formulary;

16 (2) reclassify a drug from a preferred
17 classification to a non-preferred classification, unless that
18 reclassification results in the drug moving to a lower tier of
19 the formulary;

20 (3) increase the cost-sharing, copayment,
21 deductible or coinsurance charges for a drug;

22 (4) remove a drug from the formulary;

23 (5) establish a prior authorization
24 requirement;

25 (6) impose or modify a drug's quantity limit;

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1 or

2 (7) impose a step-therapy restriction.

3 [~~B.~~ The insurer shall give the affected insured at
4 least sixty days' advance written notice of the impending
5 change when it is determined that one of the following
6 modifications will be made to a formulary:

7 (1) ~~reclassification of a drug to a higher~~
8 ~~tier of the formulary;~~

9 (2) ~~reclassification of a drug from a~~
10 ~~preferred classification to a non-preferred classification,~~
11 ~~unless that reclassification results in the drug moving to a~~
12 ~~lower tier of the formulary;~~

13 (3) ~~an increase in the cost-sharing,~~
14 ~~copayment, deductible or coinsurance charges for a drug;~~

15 (4) ~~removal of a drug from the formulary;~~

16 (5) ~~addition of a prior authorization~~
17 ~~requirement;~~

18 (6) ~~imposition or modification of a drug's~~
19 ~~quantity limit; or~~

20 (7) ~~imposition of a step-therapy restriction~~
21 ~~for a drug.~~

22 ~~G.]~~ B. Notwithstanding the provisions of
23 [~~Subsections~~] Subsection A [~~and B~~] of this section, the insurer
24 may immediately and without prior notice remove a drug from the
25 formulary if the drug:

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1 (1) is deemed unsafe by the federal food and
2 drug administration; or

3 (2) has been removed from the market for any
4 reason.

5 ~~[D-]~~ C. The insurer shall provide to each affected
6 insured the following information in plain language regarding
7 prescription drug benefits:

8 (1) notice that the insurer uses one or more
9 drug formularies;

10 (2) an explanation of what the drug formulary
11 is;

12 (3) a statement regarding the method the
13 insurer uses to determine the prescription drugs to be included
14 in or excluded from a drug formulary; and

15 (4) a statement of how often the insurer
16 reviews the contents of each drug formulary.

17 ~~[E-]~~ D. As used in this section:

18 (1) "formulary" means the list of prescription
19 drugs covered by a policy, plan or certificate of health
20 insurance; and

21 (2) "step therapy" means a protocol that
22 establishes the specific sequence in which prescription drugs
23 for a specified medical condition and medically appropriate for
24 a particular patient are to be prescribed."

25 **SECTION 3.** Section 59A-23-7.13 NMSA 1978 (being Laws

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1 2013, Chapter 138, Section 3) is amended to read:

2 "59A-23-7.13. PRESCRIPTION DRUGS--PROHIBITED FORMULARY
3 CHANGES--NOTICE REQUIREMENTS.--

4 A. ~~[As of January 1, 2014, an individual or]~~ A
5 group or blanket health insurance policy, health care plan or
6 certificate of health insurance that is delivered, issued for
7 delivery or renewed in this state and that provides
8 prescription drug benefits categorized or tiered for purposes
9 of cost-sharing through deductibles or coinsurance obligations
10 shall not make any of the following changes to coverage for a
11 prescription drug ~~[within one hundred twenty days of any~~
12 ~~previous change to coverage for that prescription drug, unless~~
13 ~~a generic version of the prescription drug is available]~~ less
14 than ninety days prior to the beginning date of the policy,
15 plan or certificate year in which these changes are to take
16 effect or at any time during a current policy, plan or
17 certificate year:

18 (1) reclassify a drug to a higher tier of the
19 formulary;

20 (2) reclassify a drug from a preferred
21 classification to a non-preferred classification, unless that
22 reclassification results in the drug moving to a lower tier of
23 the formulary;

24 (3) increase the cost-sharing, copayment,
25 deductible or coinsurance charges for a drug;

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- 1 (4) remove a drug from the formulary;
2 (5) establish a prior authorization
3 requirement;
4 (6) impose or modify a drug's quantity limit;
5 or
6 (7) impose a step-therapy restriction.

7 ~~[B. The insurer shall give the affected insured at~~
8 ~~least sixty days' advance written notice of the impending~~
9 ~~change when it is determined that one of the following~~
10 ~~modifications will be made to a formulary:~~

11 ~~(1) reclassification of a drug to a higher~~
12 ~~tier of the formulary;~~

13 ~~(2) reclassification of a drug from a~~
14 ~~preferred classification to a non-preferred classification,~~
15 ~~unless that reclassification results in the drug moving to a~~
16 ~~lower tier of the formulary;~~

17 ~~(3) an increase in the cost-sharing,~~
18 ~~copayment, deductible or coinsurance charges for a drug;~~

19 ~~(4) removal of a drug from the formulary;~~

20 ~~(5) addition of a prior authorization~~
21 ~~requirement;~~

22 ~~(6) imposition or modification of a drug's~~
23 ~~quantity limit; or~~

24 ~~(7) imposition of a step-therapy restriction~~
25 ~~for a drug.~~

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1 ~~E.~~ B. Notwithstanding the provisions of
2 [~~Subsections~~] Subsection A [~~and B~~] of this section, the insurer
3 may immediately and without prior notice remove a drug from the
4 formulary if the drug:

5 (1) is deemed unsafe by the federal food and
6 drug administration; or

7 (2) has been removed from the market for any
8 reason.

9 ~~D.~~ C. The insurer shall provide to each affected
10 insured the following information in plain language regarding
11 prescription drug benefits:

12 (1) notice that the insurer uses one or more
13 drug formularies;

14 (2) an explanation of what the drug formulary
15 is;

16 (3) a statement regarding the method the
17 insurer uses to determine the prescription drugs to be included
18 in or excluded from a drug formulary; and

19 (4) a statement of how often the insurer
20 reviews the contents of each drug formulary.

21 ~~E.~~ D. As used in this section:

22 (1) "formulary" means the list of prescription
23 drugs covered by a policy, plan or certificate of health
24 insurance; and

25 (2) "step therapy" means a protocol that

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1 establishes the specific sequence in which prescription drugs
2 for a specified medical condition and medically appropriate for
3 a particular patient are to be prescribed."

4 SECTION 4. Section 59A-46-50.4 NMSA 1978 (being Laws
5 2013, Chapter 138, Section 4) is amended to read:

6 "59A-46-50.4. PRESCRIPTION DRUGS--PROHIBITED FORMULARY
7 CHANGES--NOTICE REQUIREMENTS.--

8 A. [~~As of January 1, 2014~~] An individual or group
9 health maintenance organization contract that is delivered,
10 issued for delivery or renewed in this state and that provides
11 prescription drug benefits categorized or tiered for purposes
12 of cost-sharing through deductibles or coinsurance obligations
13 shall not make any of the following changes to coverage for a
14 prescription drug [~~within one hundred twenty days of any~~
15 ~~previous change to coverage for that prescription drug, unless~~
16 ~~a generic version of the prescription drug is available~~] less
17 than ninety days prior to the beginning date of the plan year
18 in which these changes are to take effect or at any time during
19 a current plan year:

20 (1) reclassify a drug to a higher tier of the
21 formulary;

22 (2) reclassify a drug from a preferred
23 classification to a non-preferred classification, unless that
24 reclassification results in the drug moving to a lower tier of
25 the formulary;

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- 1 (3) increase the cost-sharing, copayment,
2 deductible or coinsurance charges for a drug;
3 (4) remove a drug from the formulary;
4 (5) establish a prior authorization
5 requirement;
6 (6) impose or modify a drug's quantity limit;
7 or
8 (7) impose a step-therapy restriction.

9 ~~[B. The health maintenance organization shall give~~
10 ~~the affected subscriber at least sixty days' advance written~~
11 ~~notice of the impending change when it is determined that one~~
12 ~~of the following modifications will be made to a formulary:~~

13 ~~(1) reclassification of a drug to a higher~~
14 ~~tier of the formulary;~~

15 ~~(2) reclassification of a drug from a~~
16 ~~preferred classification to a non-preferred classification,~~
17 ~~unless that reclassification results in the drug moving to a~~
18 ~~lower tier of the formulary;~~

19 ~~(3) an increase in the cost-sharing,~~
20 ~~copayment, deductible or coinsurance charges for a drug;~~

21 ~~(4) removal of a drug from the formulary;~~

22 ~~(5) addition of a prior authorization~~
23 ~~requirement;~~

24 ~~(6) imposition or modification of a drug's~~
25 ~~quantity limit; or~~

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1 ~~(7) imposition of a step-therapy restriction~~
2 ~~for a drug.~~

3 ~~G.]~~ B. Notwithstanding the provisions of
4 ~~[Subsections]~~ Subsection A ~~[and B]~~ of this section, the health
5 maintenance organization may immediately and without prior
6 notice remove a drug from the formulary if the drug:

7 (1) is deemed unsafe by the federal food and
8 drug administration; or

9 (2) has been removed from the market for any
10 reason.

11 ~~D.]~~ C. The health maintenance organization shall
12 provide to each affected subscriber the following information
13 in plain language regarding prescription drug benefits:

14 (1) notice that the health maintenance
15 organization uses one or more drug formularies;

16 (2) an explanation of what the drug formulary
17 is;

18 (3) a statement regarding the method the
19 health maintenance organization uses to determine the
20 prescription drugs to be included in or excluded from a drug
21 formulary; and

22 (4) a statement of how often the health
23 maintenance organization reviews the contents of each drug
24 formulary.

25 ~~E.]~~ D. As used in this section:

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1 (1) "formulary" means the list of prescription
2 drugs covered pursuant to a health maintenance organization
3 contract; and

4 (2) "step therapy" means a protocol that
5 establishes the specific sequence in which prescription drugs
6 for a specified medical condition and medically appropriate for
7 a particular patient are to be prescribed."

8 SECTION 5. Section 59A-47-45.4 NMSA 1978 (being Laws
9 2013, Chapter 138, Section 5) is amended to read:

10 "59A-47-45.4. PRESCRIPTION DRUGS--PROHIBITED FORMULARY
11 CHANGES--NOTICE REQUIREMENTS.--

12 A. [~~As of January 1, 2014~~] An individual or group
13 health care plan that is delivered, issued for delivery or
14 renewed in this state and that provides prescription drug
15 benefits categorized or tiered for purposes of cost-sharing
16 through deductibles or coinsurance obligations shall not make
17 any of the following changes to coverage for a prescription
18 drug [~~within one hundred twenty days of any previous change to~~
19 ~~coverage for that prescription drug, unless a generic version~~
20 ~~of the prescription drug is available~~] less than ninety days
21 prior to the beginning date of the plan year in which these
22 changes are to take effect or at any time during a current plan
23 year:

24 (1) reclassify a drug to a higher tier of the
25 formulary;

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1 (2) reclassify a drug from a preferred
2 classification to a non-preferred classification, unless that
3 reclassification results in the drug moving to a lower tier of
4 the formulary;

5 (3) increase the cost-sharing, copayment,
6 deductible or coinsurance charges for a drug;

7 (4) remove a drug from the formulary;

8 (5) establish a prior authorization requirement;

9 (6) impose or modify a drug's quantity limit; or

10 (7) impose a step-therapy restriction.

11 ~~[B. The health care plan shall give the affected~~
12 ~~subscriber at least sixty days' advance written notice of the~~
13 ~~impending change when it is determined that one of the~~
14 ~~following modifications will be made to a formulary:~~

15 ~~(1) reclassification of a drug to a higher tier~~
16 ~~of the formulary;~~

17 ~~(2) reclassification of a drug from a preferred~~
18 ~~classification to a non-preferred classification, unless that~~
19 ~~reclassification results in the drug moving to a lower tier of~~
20 ~~the formulary;~~

21 ~~(3) an increase in the cost-sharing, copayment,~~
22 ~~deductible or coinsurance charges for a drug;~~

23 ~~(4) removal of a drug from the formulary;~~

24 ~~(5) addition of a prior authorization~~
25 ~~requirement;~~

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1 ~~(6) imposition or modification of a drug's~~
2 ~~quantity limit; or~~
3 ~~(7) imposition of a step-therapy restriction for~~
4 ~~a drug.~~

5 ~~E.]~~ B. Notwithstanding the provisions of
6 [~~Subsections~~] Subsection A [~~and B~~] of this section, the health
7 care plan may immediately and without prior notice remove a
8 drug from the formulary if the drug:

9 (1) is deemed unsafe by the federal food and
10 drug administration; or

11 (2) has been removed from the market for any
12 reason.

13 ~~D.]~~ C. The health care plan shall provide to each
14 affected subscriber the following information in plain language
15 regarding prescription drug benefits:

16 (1) notice that the health care plan uses one or
17 more drug formularies;

18 (2) an explanation of what the drug formulary
19 is;

20 (3) a statement regarding the method the health
21 care plan uses to determine the prescription drugs to be
22 included in or excluded from a drug formulary; and

23 (4) a statement of how often the health care
24 plan reviews the contents of each drug formulary.

25 ~~E.]~~ D. As used in this section:

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1 (1) "formulary" means the list of prescription
2 drugs covered by a health care plan; and

3 (2) "step therapy" means a protocol that
4 establishes the specific sequence in which prescription drugs
5 for a specified medical condition and medically appropriate for
6 a particular patient are to be prescribed."

7 SECTION 6. A new section of the Health Care Purchasing
8 Act is enacted to read:

9 "[NEW MATERIAL] ANNUAL PROVIDER CONTRACTS--SHORTER
10 CONTRACTS.--

11 A. A group health plan administrator, including the
12 administrator of any form of self-insurance offered, issued or
13 renewed under the Health Care Purchasing Act, that contracts
14 with a provider for a full plan year's health care services or
15 supplies to be delivered to enrollees of a group health plan
16 shall execute that provider contract no sooner than ninety days
17 from the beginning date of the plan year in which the health
18 care services or supplies are to be delivered pursuant to that
19 provider contract.

20 B. A provider contract shall not be modified or
21 rescinded during the plan year to which it applies.

22 C. Nothing in this section shall be construed to
23 prohibit a group health plan administrator from executing a new
24 provider contract at any time for health care services or
25 supplies to be delivered during the plan year in which the new

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1 provider contract is executed; provided that the provider
2 contract terminate by the end of the plan year in which it was
3 executed.

4 D. As used in this section:

5 (1) "new provider contract" means a contract
6 entered into with a provider with which a group health plan
7 administrator did not enter into a contract for health care
8 services or supplies to be delivered during the current or
9 preceding plan year; and

10 (2) "provider" means:

11 (a) a health facility licensed by the
12 department of health; or

13 (b) an individual or group of individuals
14 licensed or otherwise authorized to provide health care
15 services or supplies in the ordinary course of business."

16 SECTION 7. A new section of Chapter 59A, Article 22 NMSA
17 1978 is enacted to read:

18 "[NEW MATERIAL] ANNUAL PROVIDER CONTRACTS--SHORTER
19 PROVIDER CONTRACTS.--

20 A. An insurer that contracts with a provider for a
21 full plan year's services to be delivered to insureds under an
22 individual health insurance policy, health care plan or
23 certificate of health insurance that is delivered, issued for
24 delivery or renewed in this state shall execute that provider
25 contract no sooner than ninety days from the beginning date of

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1 the plan year in which the health care services or supplies are
2 to be delivered pursuant to that provider contract.

3 B. A provider contract shall not be modified or
4 rescinded during the policy, plan or certificate year to which
5 it applies.

6 C. Nothing in this section shall be construed to
7 prohibit an insurer from executing a new provider contract at
8 any time for health care services or supplies to be delivered
9 during that policy, plan or certificate year; provided that the
10 provider contract terminate by the end of the policy, plan or
11 certificate year in which it was executed.

12 D. As used in this section:

13 (1) "new provider contract" means a contract
14 entered into with a provider with which an insurer did not
15 enter into a contract for health care services or supplies to
16 be delivered during the current or preceding policy, plan or
17 certificate year; and

18 (2) "provider" means:

19 (a) a health facility licensed by the
20 department of health; or

21 (b) an individual or group of individuals
22 licensed or otherwise authorized to provide health care
23 services or supplies in the ordinary course of business."

24 SECTION 8. A new section of Chapter 59A, Article 23 NMSA
25 1978 is enacted to read:

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1 "[NEW MATERIAL] ANNUAL PROVIDER CONTRACTS--SHORTER

2 PROVIDER CONTRACTS.--

3 A. An insurer that contracts with a provider for a
4 full plan year's services to be delivered to insureds under a
5 group or blanket health insurance policy, health plan or
6 certificate of health insurance that is delivered, issued for
7 delivery or renewed in this state shall execute the provider
8 contract no sooner than ninety days from the beginning date of
9 the plan year in which the health care services or supplies are
10 to be delivered pursuant to that provider contract.

11 B. A provider contract shall not be modified or
12 rescinded during the policy, plan or certificate year to which
13 it applies.

14 C. Nothing in this section shall be construed to
15 prohibit an insurer from executing a new provider contract at
16 any time for health care services or supplies to be delivered
17 during the policy, plan or certificate year in which the new
18 provider contract is executed; provided that the provider
19 contract terminate by the end of the policy, plan or
20 certificate year in which it was executed.

21 D. As used in this section:

22 (1) "new provider contract" means a contract
23 entered into with a provider with which an insurer did not
24 enter into a contract for health care services or supplies to
25 be delivered during the current or preceding policy, plan or

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1 certificate year; and

2 (2) "provider" means:

3 (a) a health facility licensed by the
4 department of health; or

5 (b) an individual or group of individuals
6 licensed or otherwise authorized to provide health care
7 services or supplies in the ordinary course of business."

8 SECTION 9. A new section of the Health Maintenance
9 Organization Law is enacted to read:

10 "[NEW MATERIAL] ANNUAL PROVIDER CONTRACTS--SHORTER
11 PROVIDER CONTRACTS.--

12 A. A health maintenance organization that contracts
13 with a provider for a full plan year's services to be delivered
14 to enrollees under an individual or group health maintenance
15 organization contract that is delivered, issued for delivery or
16 renewed in this state shall execute the provider contract no
17 sooner than ninety days from the beginning date of the plan
18 year in which the health care services or supplies are to be
19 delivered pursuant to that provider contract.

20 B. A provider contract shall not be modified or
21 rescinded during the plan year to which it applies.

22 C. Nothing in this section shall be construed to
23 prohibit a carrier from executing a new provider contract at
24 any time for health care services or supplies to be delivered
25 during the plan year in which the new provider contract is

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1 executed; provided that the provider contract terminate by the
2 end of the plan year in which it was executed.

3 D. As used in this section:

4 (1) "new provider contract" means a contract
5 entered into with a provider with which the group health plan
6 administrator did not enter into a contract for health care
7 services or supplies to be delivered during the current or
8 preceding plan year;

9 (2) "provider" means:

10 (a) a health facility licensed by the
11 department of health; or

12 (b) an individual or group of individuals
13 licensed or otherwise authorized to provide health care
14 services or supplies in the ordinary course of business; and

15 (3) "provider contract" means a contract for
16 health care services or supplies that a carrier enters into
17 with a health care provider for health care services or
18 supplies that the carrier will provide to enrollees pursuant to
19 an individual or group health maintenance organization
20 contract."

21 SECTION 10. A new section of the Nonprofit Health Care
22 Plan Law is enacted to read:

23 "[NEW MATERIAL] ANNUAL PROVIDER CONTRACTS--SHORTER
24 PROVIDER CONTRACTS.--

25 A. A health care plan that contracts with a

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1 provider for a full calendar year's services to be delivered to
2 subscribers under an individual or group health care plan
3 contract that is delivered, issued for delivery or renewed in
4 this state shall execute that provider contract no sooner than
5 ninety days from the beginning date of the plan year in which
6 the health care services or supplies are to be delivered
7 pursuant to that provider contract.

8 B. A provider contract shall not be modified or
9 rescinded during the plan year to which it applies.

10 C. Nothing in this section shall be construed to
11 prohibit a health care plan from executing a new provider
12 contract for health care services or supplies to be delivered
13 during the plan year in which the new provider contract is
14 executed; provided that the new provider contract terminate by
15 the end of the plan year in which it was executed.

16 D. As used in this section:

17 (1) "new provider contract" means a contract
18 entered into with a provider with which the health care plan
19 did not enter into a contract for health care services or
20 supplies to be delivered during the current or preceding plan
21 year; and

22 (2) "provider contract" means a contract for
23 health care services or supplies that a health care plan enters
24 into with a provider for health care services or supplies that
25 the health care plan will provide to subscribers pursuant to an

.205660.1

underscoring material = new
~~[bracketed material] = delete~~

1 individual or group health care plan contract."

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